# SERIOUS CASE REVIEW

# CHILD B

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**Independent Overview Author**

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## INTRODUCTION

### Circumstances leading up to this review

1. In February 2015, the father of Child B locked himself in a bedroom with her. The Police were called and during the incident, Child B was stabbed a number of times by her father. He was shot by the Police. Both received serious, life threatening injuries; both have survived. Child B has been able to return to reasonable physical health and functioning. At the time of the incident Child B was 16 years old.

### Decision to hold a Serious Case Review (SCR)

2. This Case was referred to the Kent Safeguarding Children Board (KSCB) on 25th February 2015 and was subject to an initial discussion at the KSCB Case Review Group on 6th March 2015, from which there was a recommendation for a SCR.

3. On 13th March 2015 the circumstances of the case were related to the KSCB Independent Chair, Gill Rigg, who agreed to commission a SCR.

4. The decision to undertake a SCR was based on *Working Together 2015* and Regulation 5 of the LSCB regulations 2006:

> It is considered that the case meets regulation 5(2) (a) abuse or neglect is known or suspected, and (b) (i) the child has died, or the child has been seriously harmed and there is a cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

5. The rationale behind the decision for the SCR was that Child B was seriously harmed and there was concern as to the way in which Board partners had worked together..

### Scope and Terms of Reference for the Serious Case Review

6. The SCR Panel membership, the scope, methodology and key themes for the review can be found at Appendix 1 of this report.

### The Independent Overview Report Author

7. This report has been compiled by Hilary Corrick Ranger. She is a qualified social worker, registered with the Health and Social Care Professions Council (HCPC) and has many years of experience of social care services, the majority with services for children and families, including in local and national government. Her most recent work includes a SCR, professional advisor to elected Members and a service review. She has not worked for any of the services contributing to this SCR

### Family composition

8. Child B is the middle daughter of this father and mother. She was born in September 1998. She has an older sibling, born in April 1995, and a younger sister born in May 2001. Both parents are in their 40s.

## SUMMARY OF CHRONOLOGIES

This summary is broken down in to time periods, culminating in a more detailed narrative of events leading up to the serious incident in February 2015.

**Early years in Kent**

9. The family lived in Kent when the children were very young. The family was known to the Police in 2002 when the father was arrested for an assault on the mother and was then found to have firearms and offensive weapons.

**2004 - 2006**

10. Between 2004 and September 2007, the family lived in a Northern County where there were a number of interactions with health, social care and police. It is reported that the elder children and mother were treated for asthma and their GP reported that the younger sibling had "hypermobility in all joints, but this should improve with time". Health agencies reported a number of "did not attends" (DNA) for their health monitoring appointments.

11. The father had a number of encounters with the police, including for domestic abuse, criminal damage and possession of a bladed article. One of these incidents related to threats being made to the mother when the children were ages 5, 7 and 11. This matter was referred to Children's Social Care by Child B's school. There was a Strategy Discussion and Section 47 enquiries were started by the Northern County Children's Services. The father was convicted and received a suspended sentence and requirement of an Integrated Domestic Abuse Programme (IDAP). He was a statutory Probation case from October 2006.

12. There was an Initial Assessment but no Child Protection conference and the case was closed to Children's Social Care as relationships were seen to have improved and it was expected that Probation would monitor the situation.

**2007 – 2011**

13. In 2007, it was recorded by Mental Health Services that mother suffered from early childhood and relationship issues with her parents, including alleged sexual abuse by her step-father

14. A referral was made to the Northern County' Children's Social Care from the Police following a suicide attempt by the mother with the children in her car. A Section 47 investigation was started but not concluded as the mother and children moved to Kent. The Northern County Children's Social Care made a referral to Kent Specialist Children's Services (SCS) in August 2007. They also informed Kent SCS that the father was considered a risk to his wife and children if they were to reunite as a family.

15. The mother and the children moved back to Kent on a permanent basis in August 2007. The father moved into the family home in November, 2007.

16. A further Core Assessment was completed by Kent in October 2007 and the children were designated Children in Need (CIN). An Initial Child Protection Conference (ICPC) was thought unnecessary at that time because the parents were not living in the same household. During October the father stayed in the home in Kent to care for the children while his wife was in hospital. It was intended that he would leave when she was discharged. A conversation took place between the Police and a Social Worker who had visited and they had no concerns about the children, but said that should the father remain at the address when the mother came out of hospital there would need to be a Child Protection (CP) Conference.

17. Although the father remained in the household when the mother came out of hospital there was no ICPC.

18. There is evidence that the Kent School had liaised with the previous school and had received information of considerable concern regarding the children. This was shared with Kent SCS but not actioned. These concerns were not escalated.

19. There was also communication between the Named Nurse in the Northern County and the Kent Community Health Foundation Trust (KCHFT) School Nurse about the mother's history of mental illness, Post Natal Depression and alcohol issues.

20. Supervision of the father transferred to Kent Probation Service. As a requirement of his suspended sentence, he started on the Integrated Domestic Abuse Programme (IDAP).

21. The father attended all required Probation and IDAP sessions. However, he showed little insight into his controlling and abusive behaviour and its impact on his wife and children. He refused to look for work and there were significant financial and housing difficulties during the period of his supervision on probation.

22. It seemed that the mother was in receipt of Incapacity Benefit, was also applying for Disability Living Allowance, and that father was applying for Carers' Allowance. There was evidence that the parents relied on the older sibling to prevent them arguing.

23. Risk assessments were managed through Multi-Agency Public Protection (MAPPA) meetings, of which there were six between January and October in 2008. All but the final one assessed the father as "highly probable" to harm both his wife and the children.

24. A professionals' meeting was held in April 2008 where the children were seen as at 'high risk'. Both the Social Worker and the Probation Officer reported concerns of risk with the father: his abuse of the mother in the past; his obsessive behaviour, stalking her; his drinking, his jealousy and emotional abuse. He was seen to minimise his violence and abusive behaviour and to deny difficulties and the impact of this behaviour on the children. The mother also minimised the violence and abuse and the risk to herself and the children.

25. In June 2008, a strategy discussion was held followed by an ICPC. The children were made subject to a Child Protection Plan (CPP) as it was believed that they were at risk of physical and emotional abuse. The mother made a complaint to the Ombudsman that, while she did not agree that the children should be subject to a plan, the risk was identified much earlier and the ICPC should have been held then and that the older sibling's views should have been sought before the Conference. The Ombudsman upheld the latter part of the complaint. The father also made a complaint to SCS about the ICPC: that although he may have posed a risk when he first moved to Kent, this was not now the case.

26. Following the ICPC, the School Nurse spoke to the Community Paediatrician, who asked to see Child B as well as her younger sister. It was then agreed between the mother and the School Nurse that the children would not be seen in the School Nurse's clinic as they would be seeing the Community Paediatrician. The older sibling, who was not being seen by paediatric services, was not offered a School Nurse clinic appointment.

27. At the first Review Child Protection Conference (RCPC) three months later (September 2008), the children came off the plan and became CiN once more. This decision was opposed by the Police and Probation Officer, who expressed concerns about the high level of risk still posed by the father. The decision was made because of the family's willingness to engage and the progress they had made. The mother was considered the primary protective adult for the children and it was seen as her responsibility to seek prompt and appropriate assistance should the father present an unacceptable level of risk to her children's welfare. The decision was not challenged or escalated by either Police or Probation. Child B was described in the meeting as "a sad little girl", and the older sibling was to be referred for mental health support. Much of the meeting focused on the family's financial and housing difficulties. There was discussion about whether the MAPPA process could continue once the father's Probation Order ended in October 2008; the Police were to clarify the situation. No representatives from education attended.

28. It was planned that the risk from the father would continue to be monitored through the Police Protection Unit (PPU) / Domestic Abuse Unit (DAU).

29. In September 2008, the mother presented to the local Hospital A&E Department with 'bruising to bridge of nose, walked into patio door'. There is limited documentation and no evidence that issues such as domestic violence and safeguarding children concerns were raised.

30. At the final MAPPA meeting in October 2008, the risk of violence by the father was assessed as 'high' by the Probation Officer; although they acknowledged that it was difficult to predict when an incident would occur. It was said that the risk was not suitable for managing through the MAPPA process because the number of agencies involved would be reduced. In December 2008, a Multi-Agency Risk Assessment Conference (MARAC) was held, with attendance from the mother, Police, school and SCS. At this time the primary school was aware that the mother was in hospital and the children were being cared for by the father and "auntie and her boyfriend".

31. In December 2008, in Kent, the older sibling was assessed by a Community Paediatrician who identified significant concerns, including a history of self-harm, issues with eating and self-perception, caring responsibilities within the family, and selective mutism. (This was mentioned a number of times throughout the older sibling's history, although other reports suggested that when her mother was not present she was perfectly communicative.) The specialist reported that the older sibling was subject to a CIN plan. She was seen by the Community Paediatrician as "a significantly emotionally damaged girl". A referral was made to Child and Adolescent Mental Health Services (CAMHS) This was comprehensive and contained the significant concerns identified.

32. She was seen by CAMHS in March 2009 and assessed as suitable to receive services. In January 2010, (a year after the original referral), the family were informed that there was still a lengthy waiting list for services. They were asked to contact the clinic if they still wished to be seen. As there was no response the case was closed in March 2010.

33. From early 2009 onwards, the older sibling presented disruptive and challenging behaviour in school. Detentions and fixed term exclusions followed. There is some evidence in her Year 5 school report that Child B may have been struggling to cope with her home life.

34. In February 2009, there was a review of domestic violence priorities at Town A Police Station and the case was discussed. It was thought the father was becoming agitated and that the Social Worker was aware and planning to visit. In March 2009, the father was reported missing following a row with his wife. He returned three days later.

35. In April 2009, the case was closed to Kent SCS.

36. In June 2009, the older sibling was reviewed by the Consultant Paediatrician. The mother said she had engaged with CAMHS, but in fact she had only had an assessment and no services were available. The mother requested an Autistic Spectrum Disorder (ASD) assessment. The older sibling was assessed as having no signs of ASD or Social Communication Disorder. In December 2009 the older sibling failed to attend a further follow up appointment with the Community Paediatrician.

37. The mother had regular input from the Mental Health Services with regards to self-harm and depression, secondary to alcohol misuse. There is no evidence that this was discussed or addressed in subsequent consultations.

38. In October 2009, the younger sibling, aged 8 years, was diagnosed with coeliac disease. Other medical problems were investigated over a number of years.

39. There are a number of documented episodes of DNA for the younger sibling to various paediatric appointments. The GP noted concerns in the medical records in November 2009 with regards to the number of DNA appointments, fractured wrist and continued use of supplemental feeding. However, there is no evidence that any subsequent actions were taken

40. In March 2010, a physiotherapy appointment for the older sibling found self-harm marks on her, and communicated with the GP about this. However, a GP review did not take place at this time and even when she came to the GP with acute respiratory tract infection only a month later, this was not discussed.

41. In May 2010, the GP wrote to CAMHS saying that the older sibling had been seen for persistent headaches and had disclosed that she was self-harming by cutting herself. The older sibling told the GP she was attending Family Therapy. The GP believed this and was not aware that CAMHS had closed the case. Later that month, the school also wrote to CAMHS and reported that the older sibling was self-harming. They requested that CAMHS re-open the case.

42. The older sibling was subsequently reviewed by a GP who reviewed her notes following a telephone consultation and invited her for a face to face review, which then resulted in a referral to CAHMS on the 10th May 2010.

43. Concern that the older sibling may have been self-harming was expressed by the school when they saw a scar on her arm. Her mother said she was seeing a counsellor at CAMHS, which the school were not aware of. The student support manager contacted CAMHS and found that, in fact the CAMHS case had been closed because of non-engagement. A further referral was made by the school and a “priority” CAMHS appointment was offered to the family for the end of July 2010. This appointment was not kept.

44. A subsequent appointment was attended but was concluded prematurely by the clinician (an experienced, but junior nurse) as it was hard to get information from the family and they did not engage. The case was closed. The mother expressed herself

as “bemused” as to why the referral had been made. By this time older sibling had left school.

45. In July 2010, the older sibling left the local Academy School, a year early as requested by her parents, in order to undertake a performing arts course at the local College. With the benefit of hindsight it may be that this decision was made so that she could take on caring responsibilities for her parents and sisters.

46. The older sibling presented at the GP practice with her mother for contraceptive advice in September 2010, aged 15 years. She was assessed on her own. There was no documentation of a risk assessment being carried out in keeping with the ‘Safeguarding Sexually Active Young People’s Procedures’ (SSAYP). There is also no evidence to suggest a Fraser competence assessment was carried out at the time, which given her age and vulnerabilities, would be important.

47. A referral was sent from the GP dated 14th September 2010 to School Nursing requesting that the younger sibling be seen in an enuresis clinic. The School Nurse telephoned the mother and she agreed for another referral to Community Paediatric services. The younger sibling was not seen by the School Nursing Service at this time.

48. In March 2011, the GP made a new referral to CAMHS. S/he had seen the mother and the older sibling both together and alone, and reported concerns that the older sibling had an “established, significant eating disorder”. She weighed only 7.5 stone and aimed to get below 7 stone. An assessment appointment was offered for later that month, and that was followed up with a further appointment to complete the assessment. The CAMHS clinician discussed the older sibling with the Eating Disorder Service (EDS) and agreed a referral to them. The key points of the comprehensive assessment were reported to the GP

49. The older sibling was seen by the EDS twice in June 2011, but in July she said she no longer wished to be seen and the case was closed. Her weight had increased and her BMI was now at a healthy level.

50. A silent 999 call was received from the house in May 2011. When the Police responded everyone in the house denied making the call, but the father said that the older sibling, then aged 15 years, had been found to be pregnant and they were discussing this. It was believed that she may have made the call.

51. In October 2011, an ambulance was called out by the Police to the father who believed he was being poisoned. He was taken to hospital for a routine psychiatric assessment. There is no further information about this incident.

**2012 - 2013**

52. In October 2012, the younger sibling was increasingly distressed by pains in her legs which made her cry and led to her being sent home from school. She went to the GP on a number of occasions with joint pain: her mother thought she had hypermobility, which had been diagnosed in the Northern County in 2004, but subsequently seen as better in 2005. Her mother said that a private physiotherapist had recently diagnosed Ehlers-Danlos syndrome and prescribed exercises. The GP sent a letter, October 2012, “To Whom it May Concern” requesting help for transport for younger sibling to school. The County organised transport for younger sibling from November 2012.

53. Her GP referred her to a geneticist at Guy's Hospital whom she saw in March 2013 to confirm or exclude this diagnosis. A second opinion was sought in September 2013 from a Paediatric Rheumatologist; neither specialist confirmed the diagnosis of hypermobility nor found any evidence of excessive joint movement. Both noted significant psychosocial issues in the family.

54. Medical opinion is that she had not got hypermobility and should have no problem with mobility. However, her mother had convinced the school and the education services that she has this problem and there is evidence that the younger sibling herself believed this. Due to her health issues, the younger sibling had required additional support from the school including a reduced timetable and access to the Learning Resource Centre.

55. On 5th October 2012, the father presented to his GP in Kent with muscle pains following a road traffic accident where he veered off a road and hit a tree. He refused a hospital review at the time.

56. In the early hours of 29th October 2012, the Police received a silent 999 call from the family address. It was evident that the father was suffering from a mental health crisis, stating that someone was trying to kill him and he had been poisoned. The Mental Health Crisis Team (MHCT) was called. They had had no previous involvement with him. He declined the offer of help, but agreed to see his GP. The Out of Hours GP sent him to the hospital for blood tests to see if he had in fact been poisoned. While there he was seen by the Liaison Psychiatry team and told them of his belief that his wife was having an affair.

57. A referral to SCS was 'considered' by Kent and Medway Partnership Trust (KMPT) at the first contact with this family on 29th October 2012 as the father was in crisis. A telephone call was made to SCS and the mental health team were asked to assess and review before sending a formal referral. SCS followed this up on 6th November, but as the children were now staying with their aunt, they again asked the team to review the next day. As events progressed the father was sectioned under the Mental Health Act (MHA) and admitted to hospital on 7th November 2012. The mother was expressing suicidal thoughts and the referral for the children was documented as sent.

58. On 21st November 2012, SCS sent an email to CRHT stating they have not received a referral for the children. The MHCT made no formal referral to SCS until this email, despite having considered doing so three weeks earlier.

59. The father was followed up at home by the MHCT service. A discussion was held with SCS, who asked MHCT to monitor safeguarding and respond as appropriate. There were two home visits by a consultant on 30th October 2012, one of whom found him paranoid but not sectionable. The family were planning a trip to Euro Disney the following day "for a break".

60. He was next seen after the trip on 2nd November 2012, when he declined medical intervention. Following a call from his sister on 4th November, there was a further home visit with her present on 5th November. His sister said she had taken the children to stay with her and the mother had gone to stay with her sister. That day, a member of MHCT called SCS "about the referral". They were told the discussion on the 29th October was a consultation not a referral.

61. The father was sectioned on 7th November 2012 under the Mental Health Act 2008 (MHA) and a referral made the same day to SCS, although in fact, on the 19th November, SCS said that they had not opened a case. The KMPT and SCS accounts

are difficult to reconcile. It would seem that KMPT thought that they had made a formal referral which SCS did not receive, or at least did not identify it as a formal referral at that time, as detailed in paragraph 57.

62. In hospital, the father was diagnosed with morbid jealousy / persistent delusional disorder. It was felt he was at risk of harming his wife. As the father had refused an informal admission he was admitted under Section 2 of the MHA which he immediately appealed. He refused medication stating that he would only take it one day before his tribunal 'so it would look good'. The father's tribunal was held on 16th November 2012. He started to take medication on 15th but he did not win the appeal. He was allowed home on leave on 19th November. He had been taking his prescribed medication. SCS were informed of his leave. It was discovered at this time that due to an error in the paperwork, the mother was able to displace the compulsory admission so the father was now an informal patient.

63. On 23rd November 2012, he was discharged home. He persisted in his belief that his wife was having an affair. He was seen daily at home by MHCT and SCS began an Initial Assessment, which was completed on November 28th. As a result of this, the children were designated CiN. A Core Assessment was planned. In the assessment it was noted that the younger sibling had Ehlers-Danlos syndrome (although this had never actually been diagnosed).

64. The School completed a Common Assessment Framework (CAF) form on 22nd November in respect of the younger sibling and her health issues, as well as the fact that since the father's illness, Child B and her younger sibling had become the mother's main carers.

65. The mother recommenced on antidepressants in November 2012; she was referred for an urgent assessment at the Community Mental Health Team (CMHT) at that time. This seems to have been a reactive episode following the mental health sectioning of her husband. She was reviewed regularly at the practice for this until May 2013. Despite being on anti-depressants on a regular basis, she did not have a documented GP depression review for 14 months, which is of concern given the presence of child protection reviews for the family and the significance of the impact of mental health issues on the wellbeing of the children.

66. At a MHCT visit on 30th November 2012, the mother mentioned attending an alcohol services appointment – the first mention of this issue. The team graded the risk 'red'. The children were seen by SCS and were unable to identify anyone they could talk to. The older sibling said she felt unsupported by professionals: social services had previously offered support and then disappeared. It is presumed that this refers to 2008 when the children were subject to a Child Protection Plan (CPP) and had a designated Social Worker.

67. By 12th December, the MHCT risk was graded 'amber'. On 14th December 2012, the forensic examination recommended a readmission but the father did not consent to admission on a voluntary basis. On 16th December, there appeared to be a marked improvement in his presentation and it was questionable whether he was detainable due to his level of cooperation and reduced symptoms. The father said there was nothing wrong with him and he intended to stop taking medication in February 2013. He showed no insight and his beliefs remained the same. The mother remained anxious and said that the father continued to voice paranoid thoughts about her. The father was discharged from MHCT on 21st December and referred to the Recovery Team.

68. On 28th December 2012, the father was found on the roof of a hotel refusing to come down as he believed two men were trying to kill him. He had been sending threatening texts to the mother. He was sectioned. Hospital staff were concerned at the level of violence he showed in hospital (he attacked a nurse), and the mother's inability to accept that he posed a risk to the children. She was concerned as to how she would manage without him. He was transferred to the Forensic Mental Health Unit, the Medium Secure Care Unit (MSCU).

69. There is limited documentation in the GP notes with regards to the monitoring of the father's mental health. There was some documentation relating to mental health service, contact from the police and the issuing of medical certificates. Given the severity and impact of his mental health problems on his family and the fact that the children were subject to child protection plans, this is of concern.

70. The father was transferred to the Trevor Gibbens Unit and continued to reiterate the same history of his wife's affairs. On 2nd January 2013, the mother said that she felt the father had improved in the past 2 days and said he understood now that the affairs didn't happen. The mother also said he has never been violent to her and would never harm her. (It was known however, that the father had a previous violent aggressive outburst towards the mother involving knives.) A Tribunal hearing was held on 9th January 2013, where the father's detention was upheld. The mother presented evidence to the Tribunal that she hoped would lead to him being discharged, although the father's sister thought the mother was trying to get him out of hospital too soon.

71. While the father was an in-patient in the MSCU, "couples counselling" was provided for him and his wife by a Clinical Psychologist, and therapeutic sessions held with the children.

72. On 2nd January 2013, the father's Section 2 order was changed to a Section 3 Treatment Order for 6 months. As a result of the Core Assessment and concerns expressed by the hospital as well as the school, SCS held strategy discussions on 28th January 2013 and 13th February, and an ICPC on the 28th February, when all three girls were made the subject of CPPs on the grounds of emotional abuse.

73. Both parents attended the conference, (the father with support from the MSCU), as well as the older sibling and a maternal aunt. It was noted in the minutes that the older sibling was particularly vulnerable and sad, feeling let down by professionals and not believing that life could ever be any different. Neither parent accepted the need for a CPP and the mother just wanted the father to be home to be her carer. A paternal aunt, who was not present at the conference, told the Social Worker that the mother was not honest with professionals and was fabricating the younger sibling's illness.

74. Child B and her younger sibling were referred to the Young Carers service on 29th January 2013. Both girls said they would like help with caring for their mother (getting out and pushing the wheelchair, meals preparation, ironing), walking the dogs, and would like someone to talk to. Visits to meet the children were undertaken by SCS, and a further referral made to CAMHS in respect of the older sibling who was self-harming and had a possible eating disorder. Because of her age, this referral was passed on to Adult Mental Health services.

75. Even during the period of their father's detention under Section 2 of the Mental Health Act in 2012/13, Child B did not exhibit any real concerns at school. In particular, she was commended for her continued achievement on reaching or exceeding her target grades with no safeguarding or behavioural issues apparent. The younger sibling's health difficulties seem to have been particularly severe during the period her father

was detained in hospital. Her attendance dropped significantly over this period. This did not impact significantly on her academic attainment as the school had made reasonable adjustments to ensure she could fully access the curriculum.

76. From March 2013, a Psychologist worked individually with the father and then jointly with him and his wife. Couple work was undertaken with the father and mother jointly by a Social Worker and the Psychologist from the MSCU. There were regular child protection visits and Core Group meetings. Counselling was provided at school for Child B and her younger sister. At the RCPC on 15th May 2013, the older sibling was discharged from a CPP because she was 18 years of age and therefore could not be on a plan. No referral was made to Adult Safeguarding. Child B and her younger sibling remained subject to CPP in respect of Emotional Abuse. The focus from this conference was the discharge home of the father and the safety plans for the mother and the children in the event of further issues. The MSCU Mental Health Social Worker worked with Child B and her younger sibling to help them understand their father's illness, help them identify who they could turn to in an emergency and develop safety plans.

77. The older sibling was referred to CAMHS by the Social Worker in March 2013. The CAMHS Access Point considered this referral, but as she was one month away from her 18th birthday, the referral was forwarded to the Community Mental Health Team (CMHT). The local Access Team wrote back to CAMHS stating they were unable to accept a referral before someone's 18th birthday.

78. The older sibling's details were therefore placed on CAMHS waiting list for assessment. However, as she had not been seen by her 18th birthday, CAMHS re-referred her to CMHT in April 2013. She was assessed, seen for 7 sessions and then discharged back to the care of her GP in July 2013.

79. Since this time, CAMHS and CMHT have a shared arrangement in place and have a joint transition protocol whereby young people who may require a continued mental health service post 18 can be referred to CMHT 6 months prior to transfer to allow transition work to take place.

80. The father was discharged home from the hospital on 26th June 2013 with a Community Treatment Order (CTO). This is a legal power under the MHA 2008 which can be made under certain circumstances, for example, when a patient has been the subject of a Section. This meant that the father received his medication by injection which lasted a month at a time.

81. A Relapse Plan was sent by the MSCU Social Worker to the school in September 2013 outlining who Child B and her younger sibling would talk to if they were concerned about things at home. The school would not need to be involved in the plan but were given a number for the Community Mental Health Team.

82. A risk assessment was undertaken by a Consultant Psychiatrist on 16th July 2013. This noted that the father's history of violence towards his partner had continued impact on the children. Further reviews by a Consultant Psychiatrist noted that whilst he was stable and compliant with medication, his risk to himself and others was low.

83. There is clear documentation of the CPP and communication from SCS in the older sibling's medical notes. Furthermore, from October 2013, there are three monthly entries of the use of the Safeguarding Children and Young people toolkit. It is not clear what was discussed and what the outputs and subsequent actions from these meetings were.

84. At the RCPC in November 2013, Child B and her younger sibling ceased to be subject to a CPP and were designated CiN. There was confidence that, although the children did not engage easily with Social Workers, other agencies such as MHCT and the school had effective supportive relationships with them. The CP Chair felt that there was a sense of a network around the children which would keep them safe. The last social work visit took place in December 2013, although the case was not closed for a further six months (July 2014).

85. The father had an outpatient review in November 2013, following a period of sleep deterioration and wakefulness. It was attributed to a longer period between injections. His CTO renewal meeting was held in December 2013 and the Order renewed for a further six months. The father said he would like his medication reduced in the future.

**2014 – 2015**

86. In January 2014, the MSCU Social Worker passed on that the father had told his wife that he thought he could manage without medication and would like this to happen at some point in the future. The mother also told the Social Worker he was considering appealing his CTO; the Social Worker told the mother that could result in his return to hospital.

87. At his medical review at the end of January 2014, the father confirmed that he wished to come off his medication eventually. He repeated this at an appointment in February. Later in February *his* father spoke to a Community Psychiatric Nurse (CPN) and expressed his concerns about his son's current mental state which he felt was deteriorating.

88. In March 2014, the father's appeal against the CTO was heard. The Order was upheld, but it was agreed his medication could be reviewed with a view to a reduction in dosage. At his next medical review in April 2014, the dosage was reduced but the Consultant was clear that the father needed to be on medication long term, stating

> *The Father has shown no insight into his illness and declared a wish to eventually come off medications. This, he (the psychiatrist), considers a risk as his recovery period has been relatively short. The Father has a history of non-compliance with medication; if he decides to not comply with his psychotic medication he is likely to have a relapse in his mental illness thereby increasing his risk to self and others.*

89. In April 2014, the same Consultant believed "strongly" that the father should be on antipsychotic drugs long term.

90. In June 2014, the father was assessed as doing well. He asked again to come off his medication but agreed a further injection the next day. The (different) Consultant said that the father should be allowed to take responsibility for his own medication and the risks had been mitigated by his engagement, his increased awareness and the support of his family. This would seem to have been the last risk assessment. The CTO was discharged on the 18th June 2014.

91. After the end of the injection period he went on to tablets (July 2014).

**Key Episode**

The decision to end the CTO for the father, the consultant only met father twice and had no opportunity to be aware of the background, was a significant factor in the subsequent events. This was in contradiction of the previous consultant's firmly stated view.

There was clear psychiatric advice that it would not be safe for the father to come off medication and yet a different Consultant thought he should be "allowed to take responsibility" for this. This Consultant considered the patient to be honest, as did the care coordinator, but in fact this was not the case. There was clear evidence that he did not wish to be on medication and that he would be likely to stop taking medication if he had the responsibility for this. There would appear to be no system for challenge or review of such decisions.

This has been subject to an internal KMPT Significant Incident Investigation and associated action plan. The response to this plan will be reported back to the Kent Safeguarding Children Board in order to provide re-assurance that appropriate practice and supervisory oversight is in place when reviewing patient discharge from a CTO.

92. In August 2014, the father's father told his own support worker that the father's mental health was deteriorating. The father denied this and said he wanted to try without medication. He was advised to wait 6 months.

93. On 5th October 2014, the father had been 'doing so well' it was decided that he could be discharged and 'fast tracked' back into the system if required. He was seen by his community mental health Social Worker in October 2014 and told he would be having a new Care Coordinator as she was going on planned sick leave. He said that he did not want that. It was agreed therefore, that his last appointment would be in December 2014, with a view to discharge in January 2015.

94. At that appointment, he was apparently told that he could start weaning himself off his medication. The father had a nominal change of Care Coordinator prior to his file being closed on the 6th February 2015. There was no 'risk assessment' or contact with his new Care Coordinator prior to discharge and he remained consistent with his delusional thoughts and his desire to come off his medication. At this time the father's father told CRHT that he was really concerned about the father's mental state: he was spending lots of time in bed, planning to come off medication and the family felt he was deteriorating.

**Key episode**

The decision to discharge the father, despite the fact that the care coordinator had never met him and did no risk assessment was a significant factor in the subsequent events: the father had always said he wished to come off his medication, and he had remained fixed in his paranoid and delusional beliefs. The fact that he did not wish his case to be transferred should have been a warning sign.

At the point of discharge, there was no Care Plan Approach meeting, no risk assessment and no other mechanism for challenge. This was contrary to KMPT policy and procedures.

95. The mother attended the GP surgery on 30th January 2015 in respect of weight management. She was given repeat prescriptions for asthma medication and anti-depressants which she had been on continuously since November 2011. There was no documentation of a mental health or risk assessment at that time.

96. On 9th February 2015, the father locked himself in a bedroom with the two younger girls. The Police were called. During the incident father stabbed Child B a number of times and he himself was shot by the Police.

## REFLECTIONS FROM THE FAMILY

97. The family was informed in a letter that the SCR process was underway and the Independent Author met with Child B and the younger sibling together, and their mother and the older sibling at a Family Centre.

### The family as described in the records

98. It is evident from the agency reports for this SCR that the mother was extremely dominant in all contacts with the family and overwhelmed professionals trying to engage with the children. It was always her perspective that was heard.

99. In much of the early work with the children and family, the focus was on the parents, particularly their financial and housing problems.

100. There was later evidence of engagement with the children, although much of this was in the presence of the parents.

101. During the events of 2012-13, the children were seen as part of the Initial Assessment. The older sibling commented that "there were things in the family that are not normal", but there was no clarification as to what this meant. The social work report for the ICPC says that the children were "interviewed", and it is not clear if they were seen alone. The children felt that they were unable to identify anyone they could talk to.

102. Child B and her younger sibling were spoken to as part of the School's CAF and the Schools' Designated Child Protection Coordinator reported the wide range of household tasks the girls have to do while their father was in hospital.

103. Child B's views were included in the Core Assessment where she says that she was worried about her mother's drinking. The children felt that with their father away, they had no-one to talk to. She told the MHCT Social Worker that she had found the information provided useful as it had helped her understand why some things happened that shouldn't have. She identified her father and mother as people she would talk to if she was worried in the future, followed by her maternal aunt, older sibling and 2 school friends. She said she had a phobia about talking to teachers. The younger sibling said she would talk to Child B or their older sibling, no-one else.

104. Both younger girls had Relapse and Safety Plans and letters to give to an adult if they had concerns about their father's mental health in the future.

105. At a later home visit, the older sibling said that the CP plan was unnecessary. She said her views were misrepresented: her suicide attempt was related to school not family. She herself sees and hears things, like her father, and it is normal for them. She was taken off the CPP at the first Review Conference because she was over 18. At the Police enquiry into the 2015 events, she said that she felt "disappointed" by being taken off the plan just because she was 18. She felt she needed the support that was

withdrawn, despite the fact that the records show that she avoided contact with visiting Social Workers and did not engage.

106. She also said that when father was discharged from hospital she felt she had been appointed his carer, but had not been given any training or explanation as to what this would involve.

107. In summary, there is good evidence of considerable work being undertaken with Child B and the younger sibling by the MSCU providing family therapy, the CMHT Social Worker visiting regularly and seeing them alone both at home and at school and by Social Workers from SCS also seeing them. They were very involved in the Relapse and Safety Plans. Some effort went into trying to engage with the older sibling but while it would seem, in retrospect, that this was important to her, at no time did she engage with any of the workers.

**Meetings with family members:**

**Child B and her younger sibling**

108. Child B told the Independent Author, with agreement from her younger sister, that they were too young to remember whether the family was supported when they came back to Kent from the Northern County, but they felt unsupported when their father was in hospital in 2012–13 and when he came home. They remembered seeing a "psychologist" at school but this was not helpful. Social workers did visit them but there was no reliability or consistency. Child B said: "God knows who any of them were, God knows why they came, God knows what they were doing".

109. They said it was the same with their current Social Worker, who does not stay very long and does not make regular appointments.

110. To the question as to "why they did not use their Safety and Relapse letters", they both said that everything had just seemed normal before the incident; they had not noticed anything out of the ordinary. Both said that possibly the older sibling would have noticed something as she was the one who knew what was happening in the family.

111. Child B went on to express considerable anger that services for her would end in September when she becomes 18 years old. She said that her physical wounds may have healed but her emotional wounds would probably always stay with her. She plans to go to university in a year's time, away from home. She has no wish to have contact with her father.

112. She also felt that the issue of her younger sister's pain in her legs and muscle weakness should have been resolved by now.

**The older sibling**

113. The Independent Author found the older sibling, like her sisters, articulate and compelling. She expressed considerable anger at the failure to protect the girls over many years. She recalled well the events in the Northern County and felt that even then, the children should have been protected and taken into care. She believed both parents had behaved in ways that were dangerous to their children and the children should have been better protected by the authorities.

114. Even when her father was in hospital, services from the MSCU focused on keeping the family together when this was just maintaining a façade. Her father was always good at

deceiving the doctors; she believes his dosage was too low once it was reduced and when he was discharged and able to take responsibility for his own medication, he was always likely to relapse.

115. The signs of her father's deterioration were obvious, she said: prolonged muttering to himself, being nasty to the dogs, drinking more – but the family myth of "happy families" was maintained by everyone, including her mother, grandparents and aunts.

116. The older sibling believes that her sisters' Relapse and Safety Plan was to "tell their older sibling", but she does not know what she would have done had they done so. She had no contact details for relevant professionals and did not think anyone would have taken her seriously.

117. The older sibling feels angry about the loss of services to her when she was 18 and is concerned about this happening to Child B. She is also concerned about her own future and how she can learn to relate to people who have had a "normal" family life. She missed out on education and she feels her future is limited.

**The mother**

118. The mother believes that the family were let down by services, which came on line too late when they returned from the Northern County and then were not sustained after the father was discharged from hospital. Although she thinks that the family work from the MSCU was "brilliant", she believes, like the older sibling, that the father's drugs were on a dose lower than he needed and that he should have been maintained on injections. She said that she told the doctors both these things and so did the father's father, but no one took any notice of them.

119. Like Child B and the younger sibling, she did not notice that her husband was deteriorating, though she thinks the older sibling may have done. She said the only sign, in retrospect, was that he gave up work.

120. She considers that the issue of the youngest sibling's muscle weakness should have been resolved and denies that she was involved in fabricating or inducing the condition.

**The wider family**

121. There is evidence of support to the family from wider family members throughout the chronology of agency activity. The paternal relatives in particular gave information about the state of the father's mental health and both aunts indicated that they thought the mother had some responsibility for the youngest child's health issues. There is no evidence of any formal mobilising of this family engagement by the use of Family Group Conferences or family meetings. However, the older sibling felt that all relatives wanted to protect the father or had other agendas which meant that they were not as supportive or protective as they might have been to the children.

## REFLECTIONS ON KEY PRACTICE THEMES AND EVENTS

122. These are the views of the Independent Author of this report, based on the meetings with members of the family, Agency IMRs, Professionals' Learning Event, research, other SCRs and experience.

**What was life like for the children in this family?**

123. There is some evidence of what life was like for the older sibling, Child B and the younger sibling in the earlier section of this Overview Report. It seems that there was some daily structure (regular school attendance, clean, ironed clothes, homework done, appointments kept). It seems likely that power was held very firmly in the parents' hands, with the mother setting the narrative and holding the finance. The father was also controlling with moods and anger. The mother herself suffered from depression. There was violence between the parents and they threw things at each other.

124. The older sibling seems to have been seriously unhappy throughout the entire period covered by the review. She was seen as, and saw herself as, responsible for moderating parental conflict and protecting her sisters. Although workers felt they failed to engage her, it would seem that she felt let down by the system when interventions ceased.

125. Both Child B and the younger sibling presented as more resilient, with Child B in particular achieving well in school, appearing cheerful and well-balanced and engaging up to a point with the development of the Safety and Relapse Plan. In the event it was not triggered, despite the fact that evidence from the Police enquiry suggests that all the family members were aware that the father had stopped taking his medication.

126. The younger sibling had a range of symptoms of ill health and disability, which may or may not have been Fabricated or Induced, but nevertheless caused her pain and unhappiness. She described in a letter how the pain in her legs made her cry and she hated being different from her peers by having a special diet and having transport to school. She was more anxious than Child B in school and, while she had friends of her own, seemed to rely particularly on her sister.

127. Evidence from the CAF suggests that the girls did a lot of household chores and dog walking and the older sibling in particular, found the responsibility for her parents' harmony (acknowledged by her parents), her father's symptoms and the care of the younger sibling, burdensome.

128. Professionals were aware of some of these stresses for the children and considerable effort was put in to trying to engage with them. All the children were involved in the work by MSCU and the MHCT as well as Social Workers from SCS, and good relationships seem to have been established with Child B and her younger sister. All workers remarked upon the guardedness of the children and their lack of total commitment to the work. Although the Safety and Relapse Plans were not acted upon and did not protect the children, it is possible that the sessions with the children were important to them.

**Multi-agency working**

129. There is evidence of some excellent multi-agency information sharing particularly through the MAPPA and child protection processes. What is very evident from the Individual Management Reviews (IMR) and the Professionals' Event is how little agencies, including health agencies, knew about the children's health issues. It was not that health was not involved in multi-agency discussions, because CP Conferences generally had either a health representative (usually from the School Nursing Service), or reports from there, and the representative seems to have taken on a liaison role with other health agencies. It is more that the range of health issues within this family meant

that even within health there was no point where all the information was held in one place. The GP practice held the information scattered across all five patients.

130. It was also the case that information shared by one agency does not necessarily hold the same resonance for another. For example, Probation and the Police were very clear that the father was seen as early as in 2008, as very high risk and very dangerous, and yet the children were taken off a CPP after only three months, against the advice of these two agencies.

131. Unpicking this decision in hindsight is difficult, but it would appear that the parents had made a number of complaints about the CP process to the Ombudsman, at least one of which had been upheld. The mother was assertive and often threatened legal action. Much of the focus of work by agencies, other than Probation, had been on housing and finance management and these problems had reduced for the family. The date of the conference was changed without the Probation Officer's knowledge, and she was unable to attend the new date so there was no representative actually at the meeting. The parents did not wish their children to be subject to a plan and neither did the older sibling who was at the Review Conference, although this is at odds with what she subsequently said. This may have been the deciding factor in removing the children from a Plan.

132. There is evidence of really committed and planned joint working with the children by Social Workers from the MHCT and SCS, and good sharing of information between the MSCU and SCS.

133. It was recognised that there was a number of changes in Social Worker for the family. Links with other agencies were undoubtedly affected. The complexity of the health economy and changes within each aspect – for example, the move of CAMHS from Kent Community Health Foundation Trust (KCHFT) to Sussex Partnership Foundation Trust (SPFT); the additional trainees within the GP practice – undoubtedly meant that professional focus on clients / patients was diminished.

134. The decision by MHCT not to accept a referral from CAMHS for older sibling shortly before her 18th birthday is poor practice. It was good practice that CAMHS held the referral and re-referred when older sibling had had her birthday. The CAMHS decision that the younger sibling did not meet their thresholds should have been questioned by the referrer.

**Risk assessments**

135. It is not clear whether any agency used formal risk assessment tools. The Integrated Health Report suggests that none of the services within the local Hospital Trust (in particular the School Nursing Service) or KCHFT identified any risks to respond to. Had the children been identified as vulnerable within those services, there are risk assessments for young people that could have been completed. CAMHS might have completed a formal risk assessment for the older sibling when she presented with self harming, and subsequently an eating disorder, but did not do so.

136. Once the children had been identified as CiN, GP medical records recorded a coding of 'vulnerable child', although this was not on a flagging system. This documentation was seen within the notes of all involved family members. The risk assessment embedded in the KSCB Safeguarding Sexually Active Young People's Procedures could have been completed when older sibling sought contraceptive advice from the practice. This might have alerted the practice to other issues within her life.

137. In mental health, risk assessments must constantly be carried out, especially at key points such as discharge, or a major decision such as the discharge of the CTO, but in fact there is no evidence that a single, formal risk assessment was completed.

138. There was a prompt discussion with SCS at the father's first presentation to CMHT, although a referral was not immediately processed. Mental health staff informed SCS of the potential risks to the children and attended the ICPC with the father. The extended family voiced their concerns regarding the children's wellbeing on many occasions; this was documented in the patient notes.

139. The father's care plan was shared with other professionals within the core group. When the risk was considered to be escalating i.e. when the family were pressing for discharge against professional advice, SCS were informed. However, there is no evidence on the agency case recording system to indicate that a risk assessment was undertaken prior to discharge as per KMPT Care Planning Assessment (CPA) Policy.

140. The Probation Service assessed the father as posing a high or very high level of risk. This view, and the evidence for it, was shared through MAPPA meetings and the child protection process. Probation Officers worked closely with the Women's Safety Worker to mitigate risk, and continued to identify and share evidence for their view about the risk father posed until the Order ended.

141. SCS learnt of the risk posed by the father from other agencies through the MAPPA and CP processes. There was reliance on the mother to protect the children and alert professionals if problems became acute, but there was no risk assessment by any agency of the risks posed by the mother's reliance on the father for support, her determination to have him at home, and the risk that she herself had posed on occasion to the children, through her alcohol consumption and mental ill health. The issue of Fabricated or Induced Illness was never explored, but it is at least possible that the mother posed a significant risk to the children's well-being, particularly to the younger sibling. At no point was it seriously considered how much risk would be so unacceptable that the children would have to be removed. In fact, in 2012 the parents believed that SCS wished to place the children with their maternal aunt but were reassured that this was not the case.

142. There was a lot of work undertaken with the children to mitigate risk by involving them in drawing up a Relapse and Safety Plan and helping them identify adults they could go to. There was no assessment of whether they would be able to follow this through. The children, especially Child B and the younger sibling, were seen as resilient because of their attendance, demeanour and achievement at school. They may well be more resilient than some other children would be in their circumstances but resilience can be eroded (*Research in Practice: promoting resilience in children, young people and families*, 2011*)* and prolonged and / or acute stress are known ways to erode resilience. It would have been helpful if some measure of the children's resilience had been taken so that professionals could have been sure that it was being promoted and not eroded.

143. There are core processes in place in adult mental health services which are well established: regular risk assessments and CPA meetings at least 3 monthly. In addition, Risk Forums have been held since 2012 on a monthly basis.

144. There is no evidence that a risk assessment was completed prior to the father's discharge, in line with the KMPT policy. In fact there is no evidence that key procedures were adhered to rigorously.

**Effective decision making**

145. The decisions made around the discharge of the father into the community on a CTO and subsequently to discharge the CTO, seem to have been taken by professionals without the full history or any form of risk assessment. It was identified that the father would pose a danger should he cease his medication and it was known that he was always determined to stop taking his medication when he could.

146. Any one of these factors is known to increase the vulnerability of children; together they are known as "the toxic trio", (i.e. substance misuse, mental health and domestic abuse). Given the added factors of ill health, possible Fabricated or Induced Illness (FII) and financial difficulties, a reliance on universal services (school and GP) to keep these children safe was overly optimistic.

147. It was similarly unfortunate that CPP ceased, again after a relatively short period, not long before the father was discharged from MHCT services. Work with the children and family had been joint between workers from both agencies, and the fact that one withdrew could have had an influence on the other ending their involvement. Although the children appeared to be a "closed book" (Social Worker) in fact they seem to have engaged at some level and the lack of outside agency support may have made them feel isolated. Indeed, placing the burden of control and monitoring on the vulnerable members of the father's family, in retrospect was an unwise thing to do.

148. The decisions made around the discharge of the father into the community on a CTO and subsequently to discharge the CTO, seem to have been taken by professionals without the full history or any form of risk assessment. It was identified that the father would pose a danger should he cease his medication, and it was known that he was always determined to stop taking his medication when he could. The stabbing of Child B and the serious injuries sustained by her father could be said to have been the direct result of the decision to discharge the CTO. To then discharge him from the service such a short time after the end of the CTO at his own request knowing his history and his intentions was an unfortunate sequel.

**Parental mental ill health, alcohol misuse and domestic abuse**

149. Agencies were aware that there was a long history of domestic abuse of his wife by the father dating back to 2007 at least. They also knew that the mother had a history of alcohol abuse, and that the father too was a heavy drinker. The father's violence was not seen as an effect of a severe psychotic mental illness until he was sectioned in 2012. His Probation Officers noted his irrational thinking and fixed beliefs about the need to control his wife, but did not necessarily connect it to mental illness. They identified the risk and the fact that the IDAP course and his supervision on a Probation Order did not seem to have mitigated the risk.

150. The mother was always seen as a protective factor, even though by the time the father was discharged from MHCT services, she was known to suffer from depression.

## SUMMARY AND CONCLUSIONS

151. This appeared to be a complex and dysfunctional family.

152. There were two key periods when this family were known to specialist agencies: 2007-08 when they moved back to Kent from the Northern County with the father on a CPO

supervised by Probation Services, and 2012-14 when he was suffering from an acute paranoid psychotic illness.

153. There were two key strands of work with the family during those periods: one was joint specialist multi-agency work which focused on the father's behaviour and the protection of his family, and the second was the provision of mainstream and targeted health services to the children. The mother's own mental health, physical health and the family financial issues were swept into the first agenda, but although agencies worked closely with the children during the second period, no professional put the two strands of work together to consider whether the mother was herself part of the risk to the children rather than a protective factor. No professional took a holistic approach to the children's needs and no agency held all of the information.

**Risk presented by father**

154. When the father's supervision by the Probation Service ended, his Probation Officer considered that his level of risk had not altered since he started supervision: it remained high. He was thought highly likely to be a risk to the mother, but it could not be predicted when. As soon as the father was discharged from Probation, his MAPPA level was reduced, he was not seen as suitable for monitoring through the MAPPA process and no other process was put in its place.

155. No other Police led process was put into place in late 2012 when the family were again seen in crisis. The Police knew the history and had the detailed recordings from Probation, but did not refer the father to MARAC, MAPPA, the Combined Safeguarding Team or any other process for managing high risk perpetrators of domestic abuse, even when the referral did not come in the context of domestic violence.

156. The long history of the father's violent and controlling behaviour towards the mother is well documented in SCS, Probation, Police and MHCT records and yet no agency apart from Probation seemed to have considered him as potentially seriously dangerous. Once he was on medication, it did appear that his violence was controlled, but he continued to believe he would be fine without medication. His insight remained very low and his ideas quite fixed. It is clear he needed to remain on medication for the foreseeable future and would only be able to come off it under very controlled situations.

157. It is hard not to see the issues of the mother's difficulties and their impact on her children's health and wellbeing as separate to her husband's mental illness, but of course they must be intertwined.

158. Given that MHCT was aware that the father was planning to come off his medication, their assumption must have been that the children and the mother would alert the medical authorities when he came off his medication and if he began to deteriorate.

159. It was important that the children had their Relapse and Safety Plans and a sense of involvement, but they were a flimsy safety net at best. As he deteriorated it is likely that he became increasingly controlling and paranoid and the family culture was that members do not talk to professionals (teachers or others) outside the family and the mother needed the father at home.

160. Agencies had become focused on brief interventions and targeted therapies which did not necessarily take into account chronic and long standing concerns. There is some evidence that the family functioned better when specialist services were involved and that all of the children actually valued having someone engaged with them. The fact

that things were going well did not necessarily mean that it was the time to cease the work. There was a failure to recognise the serious and long term risk posed by father.

161. There were three key moments when an understanding of that risk might have prevented the serious harm caused to both Child B and her father:
- The decision to allow the father to manage his own medication (4th June 2014);
- The decision to discharge the CTO (18th June 2014);
- The decision to close the case (3rd December 2014).

**Children's health issues**

162. While not as life-threatening as the father's chronic long term mental illness, the impact of health problems, on the younger sibling in particular, was significant. Despite no diagnosis of hypermobility, both GPs and school behaved as though there had been. Nothing seems to have ameliorated her pain and distress. There was a long delay in offering CAMHS to the older sibling and professionals were unable to engage her. No agency or professional had a holistic approach to the children's health. It is possible that this family "translates" emotional distress into physical symptoms. It is also possible that this is a situation of FII. Without a family-based assessment it is impossible to know. In the meantime, the younger sibling in particular, suffered.

163. It remains a significant concern that services ceased for the older sibling when she became 18 and may have ceased for Child B in October 2016, despite their obvious vulnerability. Admirably, CAMHS has continued for this sibling group, but that too could cease at any time. Despite their apparent lack of engagement with services, it would seem that the girls value them and gain from them, and are upset and angry at the loss of services because of their ages.

**Positive practice developments:**

164. During the Professionals' Learning Event, attendees identified positive recent developments within agencies:

- Signs of Safety now widely used within Kent;
- Reorganisation in SCS means the same Social Workers see children throughout their involvement with the service;
- The MARAC process is more robust;
- Improved processes in KMPT;
- More robust case transfer processes are now in place.

**KEY LEARNING THEMES**

165. From the agency IMRs, the following points were identified:

- People with a history of violence, and a serious psychotic illness, will always be vulnerable to a relapse which could put people close to them or members of the public, at risk;
- Brief interventions may not be sufficient for long-standing concerns;
- It is not appropriate to place the responsibility for monitoring the health of a person with a serious mental illness on those affected on the rare occasions where close contacts or family are seen to be at risk;
- Health chronologies are really important and can identify serious concerns not apparent in single records;
- The needs of children do not cease when they become legally adults;

- Past behaviour is a good predictor of future behaviour;
- Staff should be encouraged to work with families as a whole rather than respond to each problem or person individual; Think child, think parent, think family;
- Always be aware of family history.

166. From the Professional's Learning Event, there were a range of issues in relation to health services. The complexity of health concerns became overwhelming to the staff involved. The number of health reports meant that important information could get lost. The only professional with all of the health related information was the GP, but there was no attendance from the GP practice at the key multi-agency meetings. It was felt by professionals that at times GP's may struggle to provide consistency of care to families. Additionally, there was a lack of shared records within health agencies, for example, CAMHS and Adult Mental Health do not have shared records. There was also a lack of sharing records between agencies, which is an issue particularly when the children were subject to CPP's.

167. More generally, there was a lack of consistency of workers for both the children and the family. It was unclear how the mother was viewed by agencies, as it appears that she was seen as both a risk and a protective factor. Given that she had her own mental health issues, issues in relation to alcohol consumption, a minimisation of the risks posed by the father, and a perceived manipulation of professions, this should have been a key feature. There was professional optimism, and there was a lack of professional curiosity and challenge. Professionals need to be very aware of the past history, given that past behaviour is a good predictor of future behaviour.

168. Where risk assessments are undertaken, they need to consider all of the family members and all of the agency information, and should be shared. The views of connected family members should be given due consideration. It is not clear whether school was a "safe haven" for Child B and her younger sibling, as they both presented as cheerful, with good attendance and achieving well. However, this could have been a façade masking serious issues.

169. Finally, there were organisational pressures, such as staff shortages and changes on many of the agencies, particularly within the two key organisations, MHCT and SCS at key periods".

**RECOMMENDATIONS**

170. All agencies involved with this family undertook management reviews of their engagement to provide an independent, open and critical analysis of individual and organisational practice. These reports include single agency recommendations and action plans. In addition, KMPT undertook a Serious Incident Investigation and have produced a detailed report with a comprehensive action plan. Updates on agencies' action plans will be monitored by KSCB.

171. Further recommendations for Kent Safeguarding Children Board to consider are as follows:

    1. The seven clinical commissioning groups within Kent need to ensure that integrated health and mental health services are commissioned which contractually provide assurance in relation to the risks for families managing the needs of individuals with long term mental health conditions as well as the communication between health and other agencies in relation to these risks.

2. KSCB should review the current Resolution of Professional Disagreements (escalation) policy to ensure that it is effective and implement any deficits identified.

3. KSCB should remind agencies that where there has been multi-agency working with a complex case and an agency is planning to close the case, there should always be a planned "ending" discussion to ensure all agencies have shared information and children are adequately protected by robust plans for the future.

4. Where a young person approaching 18 years of age is subject to a Child Protection Plan, SCS should introduce a procedural requirement at the Child Protection Conference preceding the young person's 18th birthday that ensures that the Conference Chair ensures that the conference considers ongoing support for the young person in their transition. An audit of the implementation of this will be part of the 2017/8 audit programme.

5. KSCB should develop a multi-agency Adult Mental Health awareness raising training programme that covers adult mental health issues, legislation and processes.

6. KSCB should ensure that the recommendations from the KMPT Serious Incident Investigation are included in the KMPT IMR Action Plan and are monitored by the KSCB Case Review Group and reported to the Board.

**APPENDIX 1:**

## SCR Panel membership, scope, methodology, key themes and issues

### Membership of the Serious Case Review Panel

1. The following professionals were members of the Serious Case Review Panel:

- Detective Child Inspector, Kent Police, Public Protection Unit
- Designated Nurse, Ashford and Canterbury and Coastal Clinical Commissioning Group (CCG)
- Head of Safeguarding, Kent and Medway NHS Social Care and Partnership Trust
- Designated Nurse, West Kent Clinical Commissioning Group
- Principal Officer, Safeguarding in Education, KCC Education Safeguarding Unit
- Approved Premises Manager, National Probation Service
- Principal Social Worker, Kent County Council Specialist Children's Services
- Interim Named Nurse for Safeguarding, Sussex Partnership Trust
- Designated Doctor for Safeguarding for Area, NHS England

### Time period covered by the review

2. The SCR was commissioned to consider the events relating to the family from 2007 when the family moved from the Northern County to Kent until the evening of the 9th February 2015. However, it was felt that a summary of the significant events in the Northern County from the preceding two years would add to the overall picture of the issues relating to this family.

### Methodology

3. The SCR Panel appointed Hilary Corrick Ranger as the independent author of the SCR Overview report. She has over forty years' experience of social care services, the majority with services for children and families. She has experience of working as a practitioner and senior manager in local and national government. She has a professional social work qualification and is registered with the Health and Care Professions Council (HCPC). She works throughout the United Kingdom as an independent consultant, within local authority children and adult services, as well as the health economy and the voluntary sector. The main focus of her work is safeguarding. She has undertaken SCRs and provided overview reports to several LSCBs. She has not worked for any of the services contributing to this serious case review.

4. The SCR Panel requested a report, including a chronology, from each of the agencies which had been involved with Child B and her family. The report, referred to here as an Individual Management Review (IMR) was intended to describe and analyse the agency's involvement with Child B and her family. The following agencies provided reports:

- Kent Police
- Ashford and Canterbury and Coastal CCG
- Kent and Medway NHS Social Care and Partnership Trust (KMPT)
- West Kent Clinical Commissioning Group
- KCC Education Safeguarding Unit
- Kent, Surrey and Sussex Community Rehabilitation Company (KSS CRC)

- National Probation Service (East and SE Region)
- KCC Specialist Children's Services (SCS)
- Sussex Partnership NHS Foundation Trust (SPFT)
- Kent Community Health Foundation NHS Trust (KCHFT)

5. In addition, summaries of involvement were provided from the Northern County (from the Police, Social Care and GP), and a chronology was submitted from the South East Coast Ambulance Service.

6. An Integrated Health Report (IHR) was prepared to include all health agencies within Kent which were involved with the family.

7. A professionals' learning event was held with frontline staff who had worked with Child B and her family to share their experiences with each other, reflect together on the key events of her life, respectfully challenge each other and explore what, if anything could have been done differently. The professionals present engaged fully in the discussions and were open and not defensive. Not all attendees had known the family prior to the incident: some were currently working with members of the family, some were managers of front-line workers and some were authors of agency IMRs.

8. A letter was sent to the family informing them that a Serious Case Review was to be held in respect of the events that occurred on February 9th 2015. Agencies represented at the SCR Panel agreed to discuss with front-line practitioners involved with Child B and her family how best to involve Child B and her family in the review. The author met with each of the children and their mother separately.

**Key issues at the outset**:

- What was life like for these children in this family?
- What was the impact of Multi-Agency working?
- How were risk assessments undertaken?
- How effective was the multi-agency and single agency decision making?
- How did parental mental health, alcohol abuse and domestic abuse impact on agencies' responses to this family?

**Issues:**

- How do we listen to children when parents' needs are so overwhelming?
- Fabricated illness: when is it suspected and what then happens?
- How do we protect children within volatile situations?
- How do we challenge professional decisions made by other agencies?
- What are the barriers to sharing information?

**Parallel processes**

9. The following processes were being undertaken with regard to this incident:
   - A criminal investigation
   - An Independent Police Complaints Commission (IPCC) investigation into the shooting by Police of father,
   - A KMPT Serious Incident Investigation (this was commenced following the initial incident, however, in line with the then guidance, was put on hold pending the conclusion of the criminal proceedings)

10. Police investigations are now complete.