East Sussex Local Safeguarding Children Board (LSCB)

Serious Case Review

Executive Summary
In respect of

DC & BC

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BACKGROUND INFORMATION

The family:	DC born 2001 BC born 2003 Mother AB Father EF
Children's ethnic origin	Both children were White British
The needs of the family with reference to equality & diversity	The children grew up in a family living in a predominantly white working class area. There were no particular additional needs related specifically to this background, nor did this family stand out as having significantly greater needs than many in this area.
Legal status of the children at the time of the incident	Living with mother who had parental responsibility
Date of incident	2008
Responsible Local Authority	East Sussex
Contact person	Head of Children's Safeguards, East Sussex County Council
Factors leading to the decision to carry out a Serious Case Review	In 2008 two young siblings, aged 7 and 5, were killed in a house fire at the family home. The death of the two children plus review of previous agency involvement demonstrated emerging issues concerning inter-agency working. East Sussex LSCB considered that the threshold for a Serious Case Review had been met. The East Sussex LSCB agreed that lessons could be learnt concerning inter-agency working.

1. Critical Incident

1.1 In 2008 the East Sussex Fire and Rescue Service and the South East Coast Ambulance Service attended an emergency call to a fire at the home address of AB and her two children, DC aged 7 and BC aged 5. At the premises the bodies of the two children were recovered. A police investigation followed but no charges were brought.

1.2 Following the fire it was established that the family had had contact with a number of agencies going back to the birth of DC and had had significant contact for a range of issues including domestic abuse and difficulties with the behaviour of the children.

1.3 East Sussex Safeguarding Board agreed that the grounds were met for a Serious Case Review under "Working Together to Safeguard Children" (2006).

2. Terms of reference and scope of the review.

2.1 In addition to the general guidance issued to writers of agency reports entitled *Individual Management Reviews – Pro-forma for the report,* the letter to agencies from the Chair of the Local Safeguarding Children Board set out the following specific terms of reference: -

- To review whether there are any concerns from individual agency records which might have raised concerns about the children's safety
- To consider if there are any indications that AB's mental health or use of alcohol or other substances impacted on the safety or welfare of the children
- To review if agencies shared information appropriately to safeguard the children
- To examine whether any agencies who visited the home had any concerns about fire safety and if so whether they acted appropriately.

Subsequent discussion with the Government Office of the South East (GOSE) added one further point:

- To consider if the property met fire safety standards.

2.2 Although the original terms of reference were discussed with the Government Office of the South East (GOSE), subsequent evaluation of the SCR by Ofsted deemed them to be inadequate and they were amended to extend the period of time covered by the Serious Case Review (SCR) and to consider the following:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Did actions accord with assessments and decisions made? Were appropriate services offered and provided, or relevant enquiries made, in the light of assessments? When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about services for the children? Was this information recorded?

3. The Review Group

- An Independent Chair
- Head of Children's Safeguards, East Sussex County Council
- Designated Doctor for Child Protection, East Sussex
- Head of Community Safety, East Sussex Fire and Rescue Service
- Principal Education Welfare Officer, East Sussex Children's Services
- Executive Director of Nursing, Sussex Partnership Foundation NHS Trust

- Head of Safeguarding, Action for Children
- Named General Practitioner (GP). East Sussex, Downs and Wealden PCT
- Head of Legal Services, East Sussex County Council
- Child Protection and Domestic Abuse Manager, Sussex Police.
- Offender Management Director, Sussex Probation Area
- Senior Head of Community Services, Borough Council

4. The Review Process

4.1 To request management reports from the chief officers and chief executives of the relevant agencies.

4.2 To consider the agency management reviews and their implications for the individual agencies and inter-agency working.

4.3 To produce a report agreed by all the members of the Review Group for consideration by the Steering Group of the East Sussex Safeguarding Children Board.

4.4 Reports were submitted by:
Children's Services, East Sussex County Council (ESCC) - both from social care and education services
East Sussex Downs and Weald PCT
East Sussex Hospitals Trust
Sussex Partnership Trust
South East Coast Ambulance Service, National Health Service (NHS) Trust
Sussex Probation Area
Sussex Police
District Council, Housing Services
Action for Children
East Sussex Fire and Rescue Service

5. Relevant Family History

5.1 Prior to the fire AB alleged she had been a victim of serious domestic abuse from her partner, the children's father (EF), on several occasions and she reported that her children had witnessed significant levels of abuse during that time. Despite support being offered AB was often reconciled with her partner and intervention by agencies was not successful in ensuring that the children were protected from the emotional harm of witnessing the alleged abuse.

5.2 In April 2006 EF was prosecuted for assault on AB and received a one year community sentence for which he was supervised by Probation. But by September 2006 EF was once again before the court for breaching his order and this then happened again in October 2006. In addition in October 2006 EF was described as being verbally aggressive to the supervisor for his community order. As part of this prosecution and the subsequent one in the autumn of 2006 EF was assessed by Probation as posing a medium risk to his partner, his children and to the public with recognition that the degree of risk would increase were he to use alcohol or drugs or were there to be a change in his circumstances such as loss of accommodation or his relationship breaking down.

5.3 On 15th May 2006 a response was received by Probation from Children's Services Department (CSD) saying that EF was not known to CSD for any issues relating to child protection. This clearly contradicted information contained within earlier records in both agencies but no follow up action was taken at this time to clarify the apparent anomaly.

5.4 In 2006 East Sussex Fire and Rescue Service made a routine fire safety information visit to the children's school when DC was present.

5.5 In October 2006 the Probation service made another referral to CSD to outline concern about EF's anger and aggression to Probation staff and hence their concern that this propensity for violence and alleged use of alcohol and drugs could indicate that the children could be at risk. EF was also reported as showing no remorse for his attack on his partner. CSD visited and assessed the situation once again and concluded that the couple had a good relationship with the school and that school staff were well placed to support the children. However the assessment also noted that the children were lively and displaying attention seeking behaviour such as head banging and hitting themselves against the floor and walls. This behaviour in the children was again linked to difficulties between the parents. Given the ongoing role of Probation in working with EF, CSD concluded that there was no need for involvement at that time. However as a result of his poor commitment to the community order EF received a short custodial sentence in December 2006. During his period in prison intelligence suggested that he was involved in use of drugs and he displayed inappropriate behaviour towards a female staff member. EF was not subject to post release supervision.

5.6 On 31st October 2006 CSD made contact with the Probation service and were told that EF would be referred to a Community Psychiatric Nurse (CPN) and would receive anger management support. There was also a phone call to the GP who reported that EF had sought help with his anger and that in 2004 he had been detained by the Police under the Mental Health Act after being found at a location in East Sussex.

5.7 From 2007 school staff were identifying DC and subsequently BC as troubled children whose challenging behaviour appeared to be linked to inconsistent parenting and alleged domestic abuse perpetrated by their father.

5.8 Attempts were made to help the children cope better in school, with the school requesting support from a voluntary agency. This work was initially successful, although AB was inconsistent in following advice.

5.9 There was a social work assessment early in 2008, following referral from the school, which decided to work with the family in a supportive way rather than through a formal child protection plan. Following the initial assessment and child protection enquiries, there was subsequently some delay in allocation and follow up of the actions from the Core Assessment.

5.10 AB acknowledged to a number of agencies that she had a problem with her use of alcohol but the level of her use and the potential impact on her parenting capacity was unclear. She was offered support for these problems, which included a second period of involvement from the voluntary agency.

5.11 An allegation of domestic abuse in 2008 resulted in EF being remanded into custody. Inter-agency working after this incident concentrated on the physical safety of AB and how this could be improved via work to make her home safer. This included a limited fire risk assessment by the domestic abuse support agency. There was insufficient consideration of the potential impact on the children of this situation and there was poor communication with the school about this event which took place in the summer holidays. Later DC was referred by his school to a play therapist, whilst awaiting further work from the domestic abuse support agency.

5.12 The family were discussed at a Multi Agency Risk Assessment Conference in 2008 but the outcome of the meeting was not recorded prominently and consistently across the relevant agencies.

5.13 On 28th January 2008 the internal Special Education Needs (SEN) log at the School has a note that indicates concerns about the children which the school record as having led to a referral to CSD but there is no evidence that such a referral was received by CSD.

[Addendum to paragraph 5.13
Since the writing of this report in 2009 further information has become available and presented and accepted at the inquest (October 2011), that show that the records held by the school do indicate that a referral was made to CSD in January 2008, although there is no record with the CSD that this referral was received.]

5.14 On 7th August 2008 a Social Work manager recorded the decision not to proceed to an Initial Child Protection Conference given the high levels of co-operation.

5.15 During the process of the serious case review it was reported by AB and EF that the children may have had an interest in fire but this was not known by any agency prior to the fire.

6. Lessons Learned, Conclusions and Recommendations

6.1 Lessons Learned

6.1.1 Undoubtedly a more consistent and coherent multi agency response to the problems faced within this family would have resulted in closer attention to the needs of the two children. At times interagency communication was inadequate. It does not follow however that the deaths of the children would have been prevented, had communication been better.

6.1.2 Opportunities were missed to develop a fuller picture of what was going on and what standards of parenting were available from both mother and father to DC and BC and this would have been assisted by a fuller assessment process by CSD and by the formal framework of a Child Protection Conference. EF was perceived as a pernicious influence in this family, and it is clear that the level of violence that he subjected his partner to and the consequent trauma for the children was totally unacceptable. However there appears to have been a somewhat one dimensional response to him and the concerns that he was repeatedly raising about the care offered by AB as a result of her alcohol misuse.

6.1.3 Fire safety within the family home was not considered by any professional working with this family to be a presenting and imminent problem because the fact of the fascination with fire from both children was not known to workers. Their parents, who appear to have known about this did not act to ensure that adequate fire safety measures were in place. It is not clear if they were aware of the support available from East Sussex Fire and Rescue Service (ESFRS) for children who demonstrate fire setting behaviour.

6.1.4 At the time of the review of the SCR process neither the final Fire Safety Investigation Report nor the Coroner's report was available to the panel. The delay in this case being considered by the Coroner may mean that further relevant information becomes available at a later date and this may impact further on the SCR process.

[Addendum to paragraph 6.1.4
The Inquest was held in October 2011 and delivered a verdict of misadventure. The Coroner stated that the school, Social Services, and all other agencies could not have done anything else for the children.]

6.2 Conclusions

6.2.1 In relation to the Terms of Reference of the Review:

- **To review whether there are any concerns from individual agency records which might have raised concerns about the children's safety**

There is evidence within agency records that confirms an awareness of concerns about the physical and emotional safety of the children in the context of domestic abuse but insufficient attention to the consequences of maternal alcohol misuse. Although physical standards of care were inconsistent at times it was probably not poor enough or pervasive enough to warrant the label of physical neglect. However the children were certainly living in an emotionally abusive and neglectful context, if not all the time then certainly for a large part of it, due to persistent domestic abuse, parental substance misuse, inability to set consistent boundaries to their behaviour and a father in particular that did not appear able to consider their needs above his own. There is nothing that would lead to the conclusion that fire safety for these two children was an issue that agencies were aware of.

- **To consider if there are any indications that AB's mental health or use of alcohol or other substances impacted on the safety or welfare of the children**

There is no direct evidence to suggest that AB's mental health or use of other substances impacted negatively on the safety or welfare of the children, although it is possible that use of cocaine and cannabis would have decreased her capacity to meet their needs. There is evidence to suggest that AB's use of alcohol had a negative impact on the care of her children.

- **To review if agencies shared information appropriately to safeguard the children**

Overall information sharing within the system was patchy and there were occasions when information was not shared fully, for example the fact that information of the assault was not passed on between CSD and school in July

2008. At times different agencies adopted different positions about the significance of the information being shared, for example the referral by Probation to CSD in October 2006.

- **To examine whether any agencies who visited the home had any concerns about fire safety and if so whether they acted appropriately.**

There is no evidence to suggest that any agency who visited the home in the context of formal work had any concerns about fire safety. An extended family member, who was also a serving fire officer, did fit fire alarms into the family home as a routine safety precaution that he under-took with all his family members.

- **To consider if the property met fire safety standards.**

The property met the required fire safety standards when it was built in the 1970s.

- **Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?**

There is evidence to suggest that several agencies were aware of the needs of the children, for example this is explicitly stated in records from the School, the Action on Barriers to Learning (ABLE) project and the Crime Reduction Initiative (CRI). Similarly records from school and CSD in particular make an appropriate link between the challenging behaviour of the children and the emotionally abusive context within the family. Referrals between agencies were certainly made although not always followed up fully eg the referral between Probation and CSD and it would appear that agencies knew how to make referrals between them. There is one example when there is discrepancy between school and CSD records as to whether a referral was made to CSD. Staff at the Housing department had less explicit concentration on the experience for the children but this is perhaps understandable in the context of this case. Probation did not sufficiently integrate the assessment and management of the risk to EF's children into their management of EF's supervision. CSD did not perceive the level of concern to warrant a child protection framework and the needs of the children were not held as firmly in mind as they should have been.

[Addendum to paragraph 6.2.1
Since the writing of this report in 2009 further information has become available and presented and accepted at the inquest (October 2011) that shows that the school did make two referrals to CSD at the appropriate time.]

- **Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?**

Organisations had policies and procedures in place for promoting and safeguarding the welfare of the children and for acting on their concerns. However, information exchange on the occasions stated, between Probation and CSD was also inadequate.

- **Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?**

Services were provided in a sensitive and appropriate manner.

- **Did actions accord with assessments and decisions made? Were appropriate services offered and provided, or relevant enquiries made, in the light of assessments? When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about services for the children? Was this information recorded?**

Children's Services did not manage the intervention within the formal framework of a child protection conference and therefore actions were based on assessment of the children being in need of family support only. Actions largely accorded with assessments and decisions but were not underpinned by a full assessment of possible risk of harm. School records give several examples where the children spontaneously volunteered information about their feelings and this information was used to make a referral to CSD.
The most striking opportunity to ascertain the wishes and feelings of these children came via the Achieving Best Evidence (ABE) process in 2008 and this was missed in a single agency interview by the police. In that the views of the children were largely absent in the work they were neither recorded nor taken account of in the decision making by agencies.

6.3 Recommendations

1. East Sussex LSCB should work with its member agencies to identify individual member agency assessment procedures that should be amended to include fire safety as a part of the risk assessment with a view to increasing the numbers of vulnerable families referred to East Sussex Fire and Rescue Service by those member agencies. Assessment made in relation to the provision of the Sanctuary Scheme and similar services should be included.

2. As recommended in a previous SCR the LSCB should ensure that the impact of domestic abuse on children's social/emotional development and behaviour is reinforced via training and briefings to all agencies and remind practitioners that child protection investigations should take this fully into account

3. East Sussex LSCB should ensure as recommended in a previous SCR, that the link between the Multi Agency Risk Assessment Conference (MARAC) and information sharing is reviewed to ensure that there is a common understanding of the process that facilitates improved information sharing.

4. East Sussex LSCB should ensure that its Child Protection training is reviewed to ensure that the impact on parenting capacity of alcohol misuse is highlighted and that active steps are taken to measure the extent of use.

5. Depending upon the outcome from the audit recommended by a previous SCR into processes surrounding Strategy Discussions, if it shows a wider problem the LSCB should ensure that the CSD and other agencies take appropriate steps.

6. East Sussex LSCB should take steps to satisfy itself that the recent changes in CSD duty have improved assessment processes and allocation.

7. The LSCB should facilitate the improvement of record keeping in General Practice by endorsing an earlier SCR recommendation commending to the

PCT the implementation of the Royal College of General Practitioners/National Society for the Prevention of Cruelty to Children toolkit.

8. The LSCB should undertake a themed audit on the extent to which organisations that are engaged primarily with adults are sufficiently focussed on the needs of children.

9. The LSCB should consider commissioning research to determine whether there are differential responses being applied by agencies in the context of social deprivation in geographical areas.

10. The LSCB should review the current Statement of Referral form to see whether it reflects information about race and equality issues adequately.

11. The LSCB should ask East Sussex Fire and Rescue Service and Sussex Police to consider whether information exchange processes between the two agencies are adequate or whether they limit effective interagency communication.

12. The LSCB should ask Sussex Police and Children's Services to review the ABE process to ensure that the needs of children are balanced effectively with evidential needs and the LSCB should negotiate with the other two LSCB's in Sussex to ensure that the review is then extended to encompass such issues on a Sussex wide basis.

13. The LSCB should ask the Government of the South East (GOSE) to raise with the Department for Children Schools and Family (DCSF) what action is needed to address the issue of accessing the medical records of adults when consent is denied in the context of undertaking SCRs.

Glossary

ABE	**Achieving Best Evidence**
ABLE	**Action on Barriers to Learning**
CPN	**Community Psychiatric Nurse**
CRI	**Crime Reduction Initiative**
CSD	**Children's Services Department**
DSCF	**Department of Schools, Children and Families**
ESCC	**East Sussex County Council**
ESFRS	**East Sussex Fire and Rescue Service**
GOSE	**Government Office of the South East**
GP	**General Practitioner**
LSCB	**Local Safeguarding Children Board**
MARAC	**Multi Agency Risk Assessment Conference**
NHS	**National Health Service**
PCT	**Primary Care Trust**
SCR	**Serious Case Review**
SEN	**Special Educational Needs**