

# **Devon Safeguarding Children Board**

## **DSCB SCR CN05**

### **Serious Case Review**

**Executive Summary of a Review of the  
Circumstances Surrounding the Deaths of  
Child A and Child B who Both Died in 2007  
aged 7 and 4**

## **1. Introduction**

- 1.1 This document provides an executive summary of the report of the serious case review commissioned by the Devon Safeguarding Children Board on 17<sup>th</sup> September 2007.
- 1.2 A serious case review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and well being of children in the future.
- 1.3 This serious case review has been undertaken in line with the 2006 *Working Together to Safeguard Children* guidance (HM Government) and the Serious Case Review policy guidance of the Devon Safeguarding Children Board.

## **2 The circumstances that led to a serious case review being undertaken in this case.**

- 2.1 The bodies of Child A, Child B and their father were found following a house fire. On the basis of forensic tests the police enquiry concluded that the father had attacked Child A and Child B with the intention of killing them, before setting fire to the house.
- 2.2 The Devon Safeguarding Children Board decided that the circumstances of the case met the criteria for conducting a serious case review in that:

“A child has died and abuse or neglect is known or suspected to be a factor in the death of the child.”

## **3 Methodology**

- 3.1 The review was undertaken by a Serious Case Review Committee composed of the following members:

Rory McCallum, Director Early Years and Families,  
Devon Children & Young People Services

Chris Dimmelow, Head of Safeguarding,  
Devon Children & Young People Services

Helen Hyland, Designated Nurse for Child Protection,  
Devon Primary Care Trust

Charles Holme, Designated Doctor for Child Protection,  
Devon Primary Care Trust

Beverley Dubash, Principal Education Welfare Officer,  
Devon County Council

Julie Fielding, Acting Detective Chief Inspector for Public Protection,  
Devon and Cornwall Constabulary

- 3.2 Individual management reviews were requested from the following agencies:

- Devon and Cornwall Constabulary.
- Devon Primary Care Trust (Health Visiting, Midwifery and School Nursing Services). This incorporates inherited information from Hounslow and Spelthorne Community and Mental Health Trust and Basildon Primary Care Trust.
- Devon Primary Care Trust. (Local GP practice).
- Devon Children and Young Person's Service (Education Service).
- Devon Children and Young Person's Service (Local Joint Agency Team for Children with Special needs.)
- Local Pre-school Playgroup.
- Devon and Cornwall Fire Service were requested produce an individual management review but were asked to provide a report of their response to the fire.

3.3 John Ingham, an independent social worker, was commissioned to write the overview report. In the course of his work, John Ingham considered all the individual management reviews, interviewed a community paediatrician and had access to child protection records.

3.4 Following the completion of the Serious Case Review the children's Mother and Maternal Grandparents were invited to comment on its findings. They all declined to become significantly involved in the process other than to express a view that no agency could have taken any alternative action.

#### **4 Terms of Reference**

4.1 The Serious Case Review Committee established initial terms of reference that were subsequently revised following evaluation by Ofsted. The initial and revised terms of reference covered the following aspects of the case from the beginning of 2005 to the summer of 2007:

- Risk assessments
- Children's disability and its impact on the family
- Agency contacts with the family and safeguarding activities
- Detailed involvement by agencies with the father and mother, and identification of mental health issues
- Response to domestic violence
- The impact of any cultural, linguistic or religious issues on the family
- The support received from members of the extended family

#### **5 Key Issues in this Case**

5.1 The overview report identified the following issues that appeared to be key to inter agency work and outcomes in this case:

- The full family history was never known to any individual agency involved with the family prior to summer of 2007.
- The father had a tragic family background but this was either not known or not given full consideration by any agency.
- Child A had a disability that was known to agencies, but there was no full consideration of the impact of this disability on the life of the family.

- There was no awareness or consideration of the possibility of domestic violence until a serious incident shortly before the children died.
- Despite indications of marital difficulties there was a marked hesitancy by agencies to delve too deeply into problems that were revealed.
- Communication between the Joint Agency Team and the school and community paediatrician was good but less effective with health visitors and the GP.
- Communication was not well developed between statutory agencies and voluntary sector early years services.
- The father's life was dominated by work and few agencies made efforts to involve him.
- No agencies had significant concerns about the welfare or safety of the children.
- Agencies did not consider the possible help or support that may have been available from the extended family.
- Record keeping, particularly by the three Primary Care Trusts involved, was not well managed. There was only one recorded use of an assessment tool.
- Agencies failed to analyse the possible impact of known risk factors in this family.
- Work pressures appear to have contributed to a significant delay by the Joint Agency Team in responding when the family was referred.
- Staff in the Police, The Minor Injuries Unit and the Playgroup were insufficiently trained in domestic violence.
- Following a serious incident of domestic violence, there was a failure to follow domestic violence and child protection procedures. The subsequent reliance on a family arrangement failed to safeguard the children.

5.2 The overview report identified the following examples of good practice:

- There were some good examples of interagency liaison and communication in relation to child A's disability.
- Some good efforts were made to support the family in dealing with Child A's disability, including the provision of respite care.

## 6 Conclusions

The serious case review drew the following conclusions from the available evidence:

- There was no evidence that the children were living in an abusive household and no earlier indications of domestic violence that might have warranted a more intrusive response.
- No thorough social history was developed that might have helped identify and prioritise issues in this case.
- Several agencies offered help to address Child A's disability, but their efforts were not well coordinated.
- The father's mental health problems were not known to any agency and it remains unclear what led him to take the actions leading to the

death of his children and his suicide. The outcome could not have been predicted by any agency.

- Police decision making was influenced by the mother's wish for her husband not to be arrested. There may have been a different outcome if Force procedures had been followed.
- The lack of training in domestic violence in the Police was significant as was the need for all agencies to be alert to the need for communication about potential risks in families. This is particularly important in a case such as this where there was no involvement by children's social care.

## **7 Recommendations**

The serious case review resulted in a series of recommendations for all agencies involved in this case. Most of the recommendations contained elements that were common to all agencies. The key recommendations are as follows:

- Child protection training must be improved to ensure that all agencies are aware of potential risks to children and in particular the risks associated with male partners.
- Staff in all agencies must be more aware of the indicators of domestic violence and the associated risks for children.
- All agencies must work to improve the quality of record keeping as a tool for information sharing and the identification of risks to children, and must ensure that information is shared appropriately in safeguarding cases.
- All assessments must be undertaken within specified timescales and must take account of historical information, known risk factors and possible indicators of abuse. This must include consideration of the significance of a child's disability. All assessments must contain appropriate multi agency contributions.

In addition the serious case review recommended that the Devon Safeguarding Children Board should:

- Monitor and review the operation of the serious case review process to ensure that all agencies have appropriately trained staff who are aware of SCR requirements.
- Request that the Department for Children Schools and Families should commission research or raise awareness of known risk factors in cases of child murder linked with parental suicide.