# Hillingdon
# Safeguarding Children Board

## Serious Case Review

## Child X

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## 1 INTRODUCTION

1.1 In December 2016, emergency services were called to an address in Hillingdon and found a seven-year-old child and his mother deceased. Subsequent investigations concluded that both the Mother and child's death had been caused by an overdose of insulin. A suicide note, written by Mother was found at the scene. The initial conclusions of police investigations were that this was a case of murder/suicide.

1.2 A coroner's inquest in June 2018 concluded that the child was unlawfully killed, and the Mother then died by suicide.

1.3 A review of information known to statutory agencies revealed that Mother had worked as a nurse, the child's parents had been involved in an acrimonious separation and that Mother had contact with agencies as a result of alcohol and mental health problems. Mother had also had contact with the Metropolitan Police and Thames Valley Police following a rape allegation. Another allegation that she had been harassing her ex-partner via text messages was investigated by the Thames Valley police force. There had also been some contact with Hillingdon Children's Social Care and limited contact with mental health services.

## 2 DECISION TO CARRY OUT A SERIOUS CASE REVIEW

2.1 At the time of the deaths the Chair of the LSCB and the then assistant director children's safeguarding decided that the threshold had *not* been met for a serious case review or a safeguarding adult review. The (then) national panel whose role was to have an overview of children's serious case reviews were notified and did not disagree with Hillingdon's decision. Hillingdon were however informed that Thames Valley Police had decided that the case met their criteria for an individual management review and that this would be carried out by their serious case and domestic homicide review team.

2.2 It is the view of the author of this report that statutory guidance in place at that time[1] should have led to a decision to commission a children's serious case review in early 2017. New national safeguarding arrangements for children would mean that a local rapid review of available information would be carried out and shared with the new national child safeguarding practice review panel[2] who would be able to review the circumstances and provide appropriate challenge regarding any decisions made.

2.3 The case was reviewed by the Hillingdon Child Death Overview Panel in May 2018 which recommended that the decision not to conduct a review should be re-considered. Following a consideration meeting on 9th August 2018, a decision was made to commission a local serious case review with consideration of any specific

[1] Department for Education (2015) *Working Together to Safeguard Children*
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf

learning in relation to adult safeguarding and this decision was ratified by the new national panel.

2.4 During the process of this review the new national safeguarding arrangements for children came into force and as a consequence although this report was commissioned by the (then) Hillingdon Safeguarding Children Board, this Board no longer exists. The responsibility for overseeing local learning and practice development as a result of this review will therefore sit with the newly formed Hillingdon Safeguarding Children Partnership. As the mother of Child X died and the review has identified lessons relevant to her circumstances, learning and recommendations relevant to work with adults will be overseen by the Hillingdon Safeguarding Adults Board.

## 3 THE SERIOUS CASE REVIEW PROCESS

3.1 An independent lead reviewer, Jane Wonnacott was appointed to carry out the review and write this report. Jane is a qualified social worker with over twenty years' experience of conducting Serious Case Reviews and is the author of over one hundred reports. She is independent of all organisations in Hillingdon.

3.2 A review team made up of senior professionals from Hillingdon was appointed to work with the lead reviewer. Members of the review team were:

- Designated Nurse Safeguarding Children, Hillingdon CCG
- Named Nurse Safeguarding Children, The Hillingdon Hospital Foundation Trust
- Deputy Borough Director, Central and North West London NHS Foundation Trust
- Detective Sergeant Specialist Crime Review Group, Met Police
- Head of Partnership & Quality Assurance, London Borough Hillingdon
- Lead CP Advisor for Schools
- LSCB/SAB Business Manager
- Named Nurse, Safeguarding Children, Central and North West London NHS Foundation Trust Community Health
- Service Manager CAFCASS

3.3 The terms of reference for the review are attached at Appendix One.

3.4 Written chronologies of professional involvement with Mother, Child X and his family were requested and analysed by the review team. Organisations who contributed information at this stage were:

- Cafcass
- CCG 1 (GP practice)
- Central and North West London NHS Foundation Trust (mental health, health visiting and school nursing Services)
- Hillingdon Children's Social Care

- Metropolitan Police
- Primary School attended by Child X
- Thames Valley Police (chronology and individual management review).

3.5 The Metropolitan Police submitted additional information from their report to the coroner following the deaths. This was seen by the lead reviewer only and where relevant, information has been included within this report.

3.6 Verbal information was obtained from a nursing agency to try and confirm Mother's sequence of employment during the review period.

3.7 Inquiries were made of a private residential substance misuse rehabilitation centre attended by Mother, but it was impossible to obtain any information as the centre has closed.

3.8 The review team are very grateful for the contribution made by Child X's father who, despite the very painful circumstances was able to help the lead reviewer and the team develop the questions for the review and understand more fully the circumstances leading up to the death of Child X and his mother.

3.9 Practitioners from organisations who had direct involvement with the family or were involved in significant decision making were invited to meet with the lead reviewer and a member of the review team in order to explore the factors influencing practice and lessons for the future.

3.10 The lead reviewer worked with the review team to agree a draft report and this was shared with Child X's father and practitioners who had contributed to the review.

3.11 It was after this stage of the review that it became possible to identify a private hospital where Mother had worked during the period under review. Information within the chronology indicated that there may be information relevant to the review process and the hospital submitted a chronology. A meeting was also held with senior staff at the hospital and this helped to identify further lines of inquiry which contributed to the learning within this report.

3.12 An updated report was agreed by the review team and shared with Father before being accepted by both Hillingdon Safeguarding Children Partnership and the Safeguarding Adults Board prior to publication.

## 4 CASE BACKGROUND

4.1 All members of the family were Irish nationals and moved to the UK from Ireland in 2011 to pursue professional careers.

4.2 Mother had previously lived in England where she had trained as a nurse. During this period, in 2003 (and prior to her relationship with Father) she reported to police that she was being harassed by her landlord. In 2005 there is a police record of contact

from Mother following an argument with her previous partner and the partner told police that Mother had assaulted him. She was arrested on suspicion of assault and this resulted in no further police action. In 2006 Mother called police to report that her previous partner and his new flatmate had been threatening her and in 2007 reported the theft of a mobile phone.

4.3 Child X was born in Ireland in October 2009. Mother and Father came to England for employment reasons in 2011 and rented houses in the London Borough of Harrow and then Hillingdon. At the time of the incident Mother and Child X were living in the London Borough of Hillingdon and Father lived nearby.

4.4 Mother worked as a nurse but was also wishing to train as a lawyer as she had completed a law degree in Ireland.

## 5 SUMMARY OF AGENCY INVOLVEMENT

5.1 Mother was seen by GP in October 2011 and was diagnosed with alcohol dependence syndrome. She admitted to drinking excessively (in excess of 60 units per week) in the evenings once Child X had gone to bed. She said that this had started after she gave up work when Child X was born. Mother was starting a new job and the alcohol was causing severe anxiety. The GP requested medical investigations and gave advice about support but did not take any further action to investigate any impact her alcohol use might have had on her parenting. As Child X was only two years old a discussion with the health visitor would have been prudent at this stage. The GP concerned has retired and it has not been possible to explore this episode any further.

5.2 In 2012, Mother had several visits to the GP with minor ailments and was referred to an Ear Nose and Throat (ENT) specialist. This referral noted alcohol dependence syndrome.

5.3 The health visitor made a home visit in March 2013 but would have been unaware of the concerns relating to alcohol use. All was noted to be well and Mother was taking Child X to routine appointments (for example for immunisations) and consulting appropriately for any other childhood ailments.

5.4 ENT investigations could not find any cause for Mother's symptoms and Mother wrote to the GP complaining about the ENT treatment saying that her symptoms were causing her to be "stressed out". She also reported feeling anxious and depressed. Medical records for this period show several missed appointments.

5.5 It is thought that during 2014[3], Maternal Grandmother paid for Mother to attend a residential substance misuse rehabilitation centre in Kent. There is no requirement

[3] Some records date this as 2015

for private facilities to notify the registered GP and there is no record that Mother's GP was aware of this treatment episode. The facility is now closed.

The last inspection report for the facility by the Care Quality Commission, (prior to its closure), notes that patients were not asked any questions about children during the assessment process and it is therefore reasonable to assume that little if any consideration was given to the impact of Mother's alcohol use on Child X. Mother subsequently told professionals that this facility treated her for PTSD and it was only due to the diligence of the Cafcass practitioner in 2015, who checked the name of the facility on the internet (see paragraph 5.63) that this was challenged.

The isolation of private treatment facilities from mainstream health care is an area for consideration which is explored in Finding Five.

5.6 Medical records do show that in September 2014 Mother was prescribed anti-depressants by her GP citing depression caused by the recent death of her father. In January 2015 her GP wrote a letter at her request to the university where she was registered for her law course. This explained she had been unable to attend due to a bereavement reaction and the ending of a long-term relationship. At this stage the GP referred to IAPT Talking Therapies[4] but Mother did not take this service up.

5.7 A child minder looked after Child X for a very short time between September and November 2014. She was supposed to have him prior to school and after school but before school sessions did not happen as Mother was running late and took him to school herself. Collection was at 6pm but quite often there was confusion and miscommunication between the parents so sometimes he was collected at 7pm or the childminder would drop him back at home. The childminder has told the review that Father was always chatty and sociable, but she felt Mother was possibly depressed. There was however no specific safeguarding concern that would have warranted contact with Children's Social Care. The arrangement ended when the childminder needed to reduce the number of children she was caring for.

5.8 From April 2014 through to August 2015 Mother worked as an accident and emergency agency nurse in two hospitals. Both hospitals asked the agency not to send her again. Complaints related to conduct issues including poor relationships with colleagues and inconsistent work practices such as being missing from her workstation and using her mobile phone on duty. Alongside this Mother obtained a permanent role as a nurse in the urgent care department of a private hospital in December 2014. The private hospital obtained two refences, one of them clinical reference. Both references were good.

[4] IAPT stands for Improving Access to Psychological Therapy and is an NHS service designed to offer short-term psychological therapies to people suffering from anxiety, depression and stress.

5.9 On 7th February 2015 Mother reported being a victim of rape to the Metropolitan Police who began the investigation by immediately dispatching officers to her home address. Whilst at the home, evidence was taken including a urine sample. Mother had met the alleged offender on social media and the Metropolitan Police immediately informed Thames Valley Police as the alleged offence was in their area. Thames Valley officers took steps to secure and manage the crime scene. At this stage there is evidence of good liaison between Thames Valley and Metropolitan Police officers.

5.10 The Metropolitan Police alerted their serious sexual assault team and arrangements were made to take Mother to the appropriate venue for a full forensic medical examination. Whilst at this venue officers asked Mother various questions including about her child. She disclosed that she had been drinking alcohol and it is the view of the officers that the questions about her child, and a concern about how her drinking would be viewed in court, prompted her to refuse to be examined and ask for the urine sample taken at the centre to be destroyed. (She had originally agreed to the sample in order to ascertain whether her drinks had been spiked). Three days later Mother again told a Metropolitan Police officer who was involved in the investigation that she was "a drinker".

5.11 There is nothing in the police records to indicate that any consideration was given to Child X's welfare in the light of Mother's alcohol consumption and whether a "child coming to the notice of the police" (MERLIN) should have been completed and sent to relevant agencies. Mother was advised to see her GP.

5.12 Two days after the rape allegation Mother was suspended from work at the private hospital pending an investigation into an allegation that she had reported for work smelling of alcohol and, having explained the recent rape allegation, was referred to occupational health with the offer of counselling. Mother told the occupational health department that she only drank socially and denied drinking excessively. After three weeks leave Mother was passed as fit to return to work by occupational health

5.13 Eight days after the rape allegation Mother had a telephone consultation with the GP and mentioned rape, a new partner and that she had been "drinking alcohol ++". She also said the police were aware. The GP records note she was to go to HAGAM [5] and to be referred for primary counselling. GP referred to Hillingdon Primary Care Psychological Therapies Services and Counselling and IAPT Talking Therapies[6] service. Medication to help sleep was prescribed.

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| At this point there had been opportunities to consider in more depth the impact of Mother's alcohol use on Child X and her own wellbeing and circumstances. |

[5] Hillingdon Action Group for Addiction Management – a voluntary organisation
[6] IAPT stands for Improving Access to Psychological Therapy and is an NHS service designed to offer short-term psychological therapies (CBT) to people suffering from anxiety, depression and stress

Neither the GP in 2011 nor the police officers in 2015 alerted children's social care. Although her employer had noted concerns these were believed to be a "one off" due to stress and did not compromise the safety of patients.

February 2015 was the second occasion when the GP was aware of Mother's alcohol use but did not consider any impact this might be having on either her parenting or her role as a nurse. The GP consultation was over the telephone (as is now increasingly common practice) and Mother's demeanour and nonverbal cues would not have been apparent. In addition, from discussion with the GP, it is not routine for questions to be asked about dependents when discussing alcohol use.

The need for all professionals to think more carefully about their response to known alcohol use is explored further in Finding Two.

5.14 Mother prevaricated as to whether she wished for a prosecution to go ahead but eventually decided that she did wish to proceed, and a video recorded interview took place in the presence of both Metropolitan Police and Thames Valley officers. Two days prior to the interview the suspect in the rape case handed himself in and was arrested by Thames Valley Police.

5.15 At the point of the video interview, there seems to have been a misunderstanding between Thames Valley and Metropolitan Police officers about the provision of victim care. Thames Valley Officers noted that this would be provided by the Metropolitan Police as Mother lived in their area, but this was not the understanding of Metropolitan police officers. This is explored further in Finding One.

5.16 In March 2015 a telephone assessment was completed by IAPT Talking Therapies and Mother declined any further input from them. Following discussion with a supervisor, a letter was sent to the GP informing them that Mother would be discharged from the service.

5.17 Around this time, Child X's school became concerned about his poor attendance and frequent lateness and asked to meet with Mother to discuss this. Mother met with the head teacher and informed them that her relationship with Father had ended and this was stressful. She also said she would be returning to work as a nurse, had no family nearby and felt isolated.

5.18 In fact Mother was working as a nurse and in April 2015 her probation period (as a new employee) was extended due to continuing concerns about her relationship difficulties with other staff, poor work practices such as using a mobile phone whilst patients were waiting to be seen, being late for work and trying to order an anti-viral medication which was not on the inventory because she thought it should be kept in stock. These issues were considered alongside other reports that she was a capable and caring nurse.

5.19 Thames Valley Police reviewed the rape case in April 2015 and ascertained that victim liaison had not been provided by the Metropolitan Police and that they had no further contact with Mother after the video interview. There was then repeated attempts (documented in the records) by Thames Valley officers to seek further clarification about victim care arrangements.

> Although communication between the two police forces had worked well in respect of the rape investigation there remained a misunderstanding about the provision of victim care. This meant that Mother did not receive any ongoing support from several months from the time of the video interview. There are different processes within each force which were not appreciated by front line officers and this is discussed further in Finding One.

5.20 On 28th April 2015, a nursing agency received a reference from a nursing sister at the private hospital as Mother had applied to resume work with them; the reference was completed on the template supplied by the nursing agency and was understood by them to be a professional reference. There is no record of this reference in the hospital's HR records. In fact, it was not until July 2015 that Mother asked the employer if she could be provided with a reference and was told that any request should be sent to the HR department of the hospital from the requesting employer. No such requests were received.

5.21 On 6th May 2015 Mother's employment at the private hospital was terminated. She became very distressed and phoned a colleague at home that evening telling them that she was going to take her own life. When this was discussed with a hospital manager the next day, the Metropolitan Police were called and asked to carry out a welfare check, which they did.

5.22 Mother submitted an appeal against her termination of employment, but her appeal was not upheld. Mother went to obtain further work via a nursing agency.

5.23 In June 2015 a Detective Constable from Thames Valley Police contacted Mother to update her on the forensic results which showed enough alcohol use to produce marked drunkenness, drowsiness impaired coordination, reduced inhibitions and memory impairment. The police record notes that Mother requested that the police officer accompany her to an Employment Tribunal as she had been dismissed from her job as a nurse. Information obtained for this review indicates that this may have related to Mother failing to pass her probationary period at a hospital where she had obtained employment. This kind of support was not a role for the police, but the officer concerned made an urgent referral to victim support to request support for Mother. Mother was supported by a colleague at the dismissal appeal meeting.

5.24 The rape investigation was then signed off and sent to the Crown Prosecution Service.

5.25 Mother had a telephone consultation with the GP on 6th July 2015 and the records note that she wanted it documented that she had not had alcohol for nearly five months. As well as reporting further ENT symptoms she told the GP that she had ongoing depression and did not want this documented in her notes. As a result of this consultation the GP made a second referral to IAPT Talking Therapies.

5.26 Following a telephone assessment by IAPT, it was noted that Mother was unhappy about confidentiality procedures and did not want to continue with the assessment. The therapist discussed this with the supervisor within the team who called Mother back to clarify her concerns about confidentiality. As a result, Mother was referred to secondary care (Community Mental Health Team) as it was agreed that she needed longer therapy and more support. The notes of this call refer to Child X as being a "protective factor".

> The term "protective factor" has a specific meaning within mental health assessments and is widely used. Rutter (1985)[7] for example defined protective factors as "those factors that modify, ameliorate or alter a person's response to some environmental hazard that predisposes to a maladaptive outcome." Protective factors can be biological, psychological or within the family and community. In this case Mother's close relationship with her child would have been understood as a factor reducing the risk of a deterioration in her mental state or likelihood of self-harm. However, this analysis needs to include a second step which questions what this means for the lived experience of the child and whether there is any impact on the care being given. This is discussed further in Finding Two.

5.27 The Community Mental Health Team discussed the case at an urgent referral meeting and decided that the psychology service should complete a risk review. Mother was contacted and was happy to accept this service and was placed on the waiting list.

5.28 On 30th July, Mother was contacted by a specially trained officer[8] from Thames Valley Police. The delay in making contact was due to the discussions that had taken place with the Metropolitan Police Service as to who would be responsible.

5.29 Mother told the specially trained officer that she found it hard to go out, was suffering from Post-Traumatic Stress Disorder and had seen her GP about counselling. She told the officer that this was affecting her ability to work as an accident and emergency nurse. With her consent a referral was made to the Independent Sexual Advisor Service. (Mother did not take this up)

5.30 Late in August 2015, Mother was notified by Thames Valley Police that the Crown Prosecution Service were taking no further action following police investigation into

[7] Rutter, M. (1985. b) Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry*; 147: 598–611.
[8] A specially trained officer is an officer trained to support victims of sexual crime.

the rape. The decision was not to charge due to conflicting evidence. Mother was visited at home by the officer in charge from Thames Valley Police to discuss this and was very angry and upset and said she intended to dispute the decision.

5.31 Three days later the police officer was concerned that Mother was at a crisis point and contacted the Metropolitan Police to request a “child safeguarding referral”. The Metropolitan Police call taker suggested that it would be preferable for this to be made directly by Thames Valley Police and provided the number for Hillingdon Children’s Social Care. As it was a bank holiday there was no answer and the Thames Valley Police officer contacted another department within the Metropolitan Police and subsequently recorded that she had agreed with them that the Metropolitan Police were to make a referral the same day.

5.32 Metropolitan Police records for that day note concerns from Thames Valley Police about Mother’s vulnerability and an “Adult Coming to Notice” MERLIN was created and shared with “Hillingdon Adult Social Care”. It seems that at this point there was a disconnect between the phone call which mentioned a child safeguarding referral and the information which was received via e-mail from Thames Valley Police which focused on Mother’s needs as a vulnerable adult.

5.33 The Community Mental Health Team note a MERLIN report received by the police which noted the no further action decision by the Crown Prosecution Service, the death of her father, that she had become a single parent and had lost her job. Mother was contacted and asked to call the duty team and the plan was also to discuss the police notification with the psychiatrist in the urgent referrals meeting. Following this a letter was sent asking Mother to contact the assessment and grief therapy duty worker. A copy of the letter was sent to the GP.

5.34 Mother appealed the decision on her case with the Crown Prosecution Service.

5.35 In September 2015 a parent contacted the school concerned that Mother appeared to have been drinking alcohol when dropping off Child X. The head teacher left a message for Mother to phone back and later met with Mother who said that her GP had prescribed sleeping tablets and she was going to receive therapy after a court case in relation to an assault. Mother stated, ‘she used to have a drink to help her out’. The head teacher offered support through a Team Around the Family (TAF) meeting and allocation of a key worker. Mother declined this offer.

5.36 In October 2015, Mother had not contacted mental health services and a decision was made to discharge her back to the GP to review. A fax was sent to the GP.

5.37 In November 2015 there was an issue regarding pick up of Child X from school as Paternal Grandmother and Mother arrived on same day. Father visited school next day apologising and shared concerns about Child X’s well-being and fear Mother was taking Child X to Ireland and not returning. The head teacher wrote to both parents requesting a meeting to clarify future collection arrangements of Child X.

*The following sequence of events is set out in detail as it is important in understanding how information that Mother had said she would kill herself and her child was communicated and assessed through the system.*

5.38 On 26th November 2015, Father contacted Thames Valley Police reporting harassment by Mother who was sending excessive abusive messages to him. Father expressed concern for the welfare of his son and made the police aware of information given to him by Maternal Grandmother that Mother had said "I will kill myself and take the child with me'. This resulted in a domestic harassment and an adult protection report on the police recording system. The domestic harassment report was linked to the rape allegation.

5.39 Later in the day on 27th November, the Thames Valley Police officer in charge placed an update in the adult protection report outlining Mother had told the officer. *"Told her mother she feels like killing herself although she has made threats since 2012 and no indication of carrying out the threats, but I feel with the rape appeal, stress of being a nurse and single mother and her partner asking for full custody that there needs to be safeguarding for Mother's mental state."* The police sergeant emailed the specially trained officer from the rape case to advise of the domestic incident so that safeguarding of Mother could be discussed. The report that was uploaded to the police system noted that the case was assessed as medium risk due to "suspect stress over the rape case appeal and a child being caught in the middle".

5.40 There were therefore two police reports; a domestic incident report and an adult protection report. The domestic incident report did not initially have the child protection flag ticked and Child X was not listed on the report. This lack of flag was picked up within six days by the Force Crime Registrar. The adult protection report also did not have the child protection flag ticked and this omission was not picked up. This may have been because the statement that Mother had made about killing herself and her child was not copied over verbatim into the adult protection report. The emphasis in the report was on the threat *she has told her mother she feels like killing herself.* The emphasis was therefore on the adult rather than the child who, although mentioned, was not recorded in such a way that it prompted a child protection referral. When the adult protection report was reviewed the decision was that no referral was needed as *there is no record of consent to share personal information or indication that the person lacks capacity to make decisions.* The decision not to make an adult safeguarding referral was influenced by police understanding that family members were trying to arrange a home visit from a GP and Mother had attended a private rehabilitation centre for alcohol misuse.

5.41 On 27th November Mother contacted the school to say she would not attend a meeting and that Child X would not be in school as he was unwell. The head teacher contacted the education safeguarding lead in the Local Authority for advice. They advised that the previous allegations by a parent regarding Mother's drinking could be malicious, the school should keep monitoring and the parents should seek legal advice about contact.

5.42 Father also contacted the school and met with the head teacher on 27th November. He was told that the education safeguarding lead had been consulted and the situation did not reach the threshold for involvement by Children's Social Care. The school were informed by Father that the police would be making a MASH referral.

> More appropriate advice from the education safeguarding lead would have been for the school to make a direct referral to Hillingdon Children's Social Care. However, the school were reassured by Father saying that police were referring to MASH but at this stage they were not aware that this was Thames Valley Police referring to Buckinghamshire MASH (their local MASH team).

5.43 On 3rd December, Father told Thames Valley Police that Mother had sent further concerning messages. The police officer confirmed that the adult protection report that had been created would be sent to the Metropolitan Police. There was also communication with the specially trained officer regarding the messages to alert her to examples of Mother's state of mind. Many of the messages sent by Mother referred to Child X who featured in many of the disagreements.

5.44 On Saturday 5th December 2015, Father made an urgent application for a Child Arrangements Order and Prohibited Steps due to his concern that Mother was planning to permanently remove Child X to Ireland. Within the application several 'harm boxes' were ticked, and Father raised concerns about Mother's mental health and alcohol dependency. He also noted her threat to kill herself and their child. He sought a full transfer of Child X's living arrangements to him.

5.45 Also, on Saturday 5th December the Thames Valley Police MASH risk assessor reviewed the domestic incident report and classified it as standard on the basis that Mother did not pose risk of serious harm to Father. The risk assessor reiterated that one of the concerns was that Mother stated that she would kill herself and "take the child with me" and a task was set for Bucks MASH adult protection to review on Monday 7th December, but this task was closed incorrectly due to the officer's inexperience with the police recording system. Because it was filed it was not reviewed by a MASH supervisor.

5.46 Despite this, further discussion took place between uniformed officers and the specially trained officer and on 8th December it was recommended that the referral to the Metropolitan Police should go ahead with flagging to notify Children's Social Care and maybe the education officer.

5.47 On 10th December 2015 Mother was notified that her appeal regarding the Crown Prosecution Service's decision in the rape case had not been successful.

5.48 On 11th December Mother reported to the GP that her partner was subjecting her to psychological damage. She denied depression or suicidal ideation and refused medication. She told the GP she had had some private counselling.

5.49 On 11th December Father's court application was passed to the Cafcass central intake team whose role is to screen for immediate safeguarding concerns within 24 hours. This was done and a referral sent to Hillingdon Children's Social Care. This referral did not include the information about Mother's threats to kill herself and her child. Within Cafcass, the case then transferred to a family court advisor in the early intervention team whose role is to prepare a standard safeguarding letter for the court which sets out the outcome of lateral checks and any welfare or safeguarding concerns. At this stage the Cafcass worker noted that no further safeguarding steps were needed as a referral had been sent to Children's Social Care and completed checks by sending out standard letters to all agencies.

5.50 One of these checks was with Buckinghamshire MASH who did not note any involvement with the family; one reason for this might be that the checks were requested in the child's name and contact with MASH had been in respect of police contact with Mother. Also, police checks were "level 1" checks which check any known convictions, cautions and arrests but would not give details of any other police involvement. Even if level 2 checks had been carried out these are force specific and if sent to the Metropolitan Police would not have revealed information known to Thames Valley. Cafcass were therefore not aware of the details of current involvement by Thames Valley Police.

5.51 On 14th December, the specially trained officer in Thames Valley Police asked the officer in charge of the harassment case to transfer both the domestic incident and the adult protection reports to the Metropolitan Police. This was done via OBRT[9] and information passed over included a string of background e-mails. No crime reference number was requested from the Metropolitan Police as would be usual practice and there is no record as to these being received and any action taken. In this case it would have been better practice within Thames Valley Police for the information to have been managed and passed over via MASH.

5.52 The next day the specially trained officer was informed by the Independent Sexual Violence Advisor (ISVA) that Mother did not wish to engage with their service and that she had been verbally abusive over the phone.

The sequence of events in December 2015 shows a series of individual errors and misunderstandings across a complex system. The cumulative effect meant that Mother's threats to kill herself and her child were not properly assessed. In summary:

1. Within Thames Valley Police, the threat to kill herself *and* her child was recorded in the domestic incident report but not the adult protection report. As a result of an administrative error the request for Buckinghamshire MASH adult protection assessor to review the domestic incident report was not actioned.
2. This error could have been rectified by the plan of Thames Valley officers to send

[9] OBRT is a unit who deal with low level bulk crime reports and the transfer of certain reports between other forces and outside agencies.

both domestic incident and adult protection reports to the Metropolitan Police with supporting e-mails asking for a child protection referral. However, the transfer of information did not go via MASH (which would have been best practice) but via a general information transfer system and there is no record of this having been received by the Metropolitan Police.

3. The school were reassured by information from Father that MASH had been informed but did not understand that this was not a referral to the local MASH team where Child X lived.
4. As the Metropolitan Police had not received any referral naming Child X this would not have shown in any checks carried out by Cafcass.
5. Although Cafcass had received information from Father about Mother's threats this was not passed in the referral to Hillingdon Children's Social Care who could not take this into account in their subsequent assessment.

5.53 On the morning of 16th December 2015 Father contacted the school to enquire about school holidays and if Mother had advised them if she would be taking Child X out of school early. Later that afternoon Mother contacted school to advise she would be taking Child X to Ireland for her brother's wedding.

5.54 The Cafcass family court advisor made contact with Father over the telephone. He reiterated concerns about Mother and advised that Police were also concerned due to messages Mother had sent. Father also updated them on the arrangements made in court the previous day at an urgent hearing regarding Mother's undertaking to return from Ireland and arrangements made for him to speak on the phone to Child X.

5.55 Following the referral from Cafcass, a social worker from Hillingdon MASH spoke to Mother over the telephone and she said that she believed that Father had made the allegations as he wanted custody of Child X. She described looking after Child X alone and also referred to the loss of her father, being raped and resulting anxiety and panic attacks. She said she had asked her mother to come from Ireland to support her, whilst she went to a treatment centre for the anxiety and panic attacks and Father thought this related to treatment for alcohol. She said that Father had taken out a non-molestation order against her and he knew it would affect her registration as a nurse. She confirmed that she had sent the text messages after receiving a letter from his solicitors containing false information. She agreed to agency checks being conducted.

5.56 MASH received information from the school and the education participation team regarding Child X's attendance as being only 80% and concerns regarding Mother's alcohol use. Child X was noted to be doing well at school. There is no record of any other information being gathered from the GP or police records and no record of any discussion directly with Father. The decision was to close the case as there were "no child protection concerns".

This decision highlights the problem with decisions made simply on the basis of self-report and minimal consultation with other agencies. The original concerns in the referral were worrying and warranted a more in-depth investigation which was possible as Mother had given consent for agency checks. Had these checks been completed, information from the GP about Mother's mental health could have informed the decision although, because of the series of errors outlined above, it is possible that the information held within Thames Valley Police would not have been available unless they had been directly approached.

5.57 Information from the family indicates that during Christmas 2015 Mother was in Ireland, drinking heavily and her relationships with her family deteriorated.

5.58 In January 2016, Mother was contacted by the Cafcass family court advisor from the central intake team. Mother felt Father's "coercive control" had turned the extended family against her. She denied any alcohol or drug issues affecting her or Father but did admit to stress caused by the court proceedings and having panic attacks, which she was getting treatment for. The family court advisor then filed the safeguarding letter to the court which advised that no further action would be taken by Hillingdon Children's Social Care in relation to the referral by Cafcass. The court was asked to give further consideration to the alleged safeguarding concerns and require Mother to file a letter from her GP regarding her alcohol use and state of her mental health.

5.59 Four days later in January 2016 a Detective Sergeant from Thames Valley Police contacted Mother to discuss the fact that her criminal injuries compensation claim appeared to have been rejected due to an administrative error. The officer noted that Mother was "quite intoxicated…confused and rambling in her responses" and requested an urgent welfare check of Mother by Metropolitan Police officers. The Thames Valley officer was reassured by the information received from the Metropolitan Police which was that Mother had been seen and said she was fine and during a subsequent conversation with Mother had the impression from Mother that she was in contact with Children's Social Care. It is important to note that there is no reference in any police record to the welfare of Child X.

5.60 In February 2016 both parents attended court as Father wanted an order to regulate Child X's living arrangements. He felt these were erratic due to Mother's shifts as a nurse. He was pursuing a shared care arrangement but ideally wanted Child X to live with him full time and for Mother to get help. Mother opposed this. The court ordered section 7 report[10] from Cafcass and case was allocated to a family court advisor to prepare this.

5.61 The Cafcass family court advisor saw Child X alone and found him to be quietly spoken, reserved and to have a balanced view regarding both parents. The family

[10] A section 7 report is ordered by the family court and in accordance with The Children Act 1989 requires either Cafcass or the local authority to investigate all the circumstances of the family including the wishes and feelings of a child or young person and send a report to the court.

court advisor had also intended to interview Mother that same day, but she wasn't able to talk with Mother in private as she was not able to bring anyone to sit with Child X. The family court advisor therefore arranged to interview Mother by phone.

5.62 A face to face interview did take place with Father which raised no concerns about his parenting capacity. He did not raise specific concerns about Mother's parenting but said that he wanted her to get help and for there to be some stability in when he could have contact with Child X.

5.63 During the telephone interview with Mother, she said she had been "labelled with alcohol dependency", denied ever having suicidal thoughts and said she had "no history of mental ill health". Mother also said she had received treatment for Post-Traumatic Stress Disorder and had been on medication for this. Mother was not honest about her treatment at the private clinic being related to alcohol use and when confronted about this was very defensive. She also said she was an ad hoc agency nurse and would not disclose the name of her employer.

5.64 Due to inconsistencies in Mother's responses and potential impact of Mother's alcohol use on Child X a further safeguarding referral was made by Cafcass to Hillingdon Children's Social Care on 17th March 2016.

5.65 Meanwhile on 14th March the school welfare officer reported to the head teacher that Mother smelt of stale alcohol when dropping off Child X at school. On the same day a parent told the head teacher that she had received abusive texts from Mother.

5.66 Following the Cafcass referral to Children's Social Care, Hillingdon MASH telephoned Mother and she denied having alcohol issues or feeling suicidal but did say that she did drink occasionally when Child X was in Father's care. She did not feel that she had mental health issues. She added that the relationship ended because of emotional and domestic violence.

5.67 MASH telephoned the head teacher who said that school did have concerns about Mother's ability to look after Child X. His attendance at this point was 84.71%. He could look dishevelled when brought in by Mother and he could be late. When Father brought him he was never late. Father had expressed concerns that Mother could self-harm or harm Child X. This conversation was recorded in the social care records with the comment that the school had "nothing concrete to report".

5.68 Enquiries were made by Children's Social Care to drug and alcohol services and the Domestic Violence Advocacy Service who advised Mother was not known to them. Mental health services advised Mother was known to them, was feeling low with suicidal thoughts and was waiting for assessment to start therapy.

5.69 The decision by MASH was to close the case as "no safeguarding issues had been identified". It was felt that the referral related to contact issues. The heath practitioner within MASH informed the school nurse of the referral, citing Father's concerns about Mother's alcohol use, but there is no record of any further action by the school

nursing service. During the serious case review process CNWL health staff have responded to this identified lack of response by the school nurse and the MASH pathway is being updated to include a pathway for CNWL community children's teams including expectation of how referrals should be managed.

A more appropriate decision at this point would have been to pass the case for a full social work assessment. It is hard to equate the concerns of the school with the comment in the records that they had "nothing concrete" to report. The information that they gave regarding concerns about her alcohol use and worries that she would self-harm or harm the child should have prompted further assessment. No direct contact was made with Father and it seems that too much weight was given to the fact that Cafcass were preparing a section 7 report and the limitations of this process were not understood. In private law proceedings Cafcass only has automatic consent to carry out checks with the police and local authorities in respect of safeguarding concerns and have to seek consent to carry out checks with schools and other professionals such as GPs. It seems that social workers were not aware of this and did not alert Cafcass to the school's concerns. The focus of the work of Cafcass is on the private law application and this is why they refer to Children's Social Care for assessment if there are any wider safeguarding concerns. This is discussed further in Finding Three.

5.70 On 21st March 2016, the Section 7 report filed by Cafcass concluded that Mother's allegations of domestic violence were vague and did not reflect a pattern of power and control. There was concern about level of animosity towards Father by Mother, and Mother's inconsistent accounts of her alcohol use. The in-patient facility Mother attended for treatment of post-traumatic stress disorder turned out to be a facility for those who suffer with alcohol dependency and substance misuse. The family court advisor concluded that Child X would receive good enough parenting with Mother accessing help through the local authority, but with generous shared care arrangements with Father. The family court advisor had not been content with the decision of MASH to close the case and requested that the court asked for GP information to be shared before any order was made.

5.71 Mother responded to the Section 7 report advising she wanted the family court advisor to attend court and she did not feel her concerns had been adequately investigated.

5.72 At a dispute resolution appointment held in court, Mother was directed to provide a letter from her GP setting out her medical history with regard to alcohol use and mental health. Mother had a telephone consultation with the GP to ask for this information to be provided to the court. She spoke of the stress from the court case and asked the GP to sign her off sick from her university course. The information provided by the GP to the court was based solely on Mother's self-report which was

that she had not drunk alcohol for five months rather than the GP records which noted a previous history of alcohol dependence syndrome.

5.73 In April 2016 Child X was absent from school on three occasions. On two occasions Mother did not contact the school and was aggressive when contacted.

5.74 On 17th June a referral was made by Child X's school to Children's Social Care following a parent reporting that she had spent the weekend away with Mother and Child X and Mother was unable to care for Child X as she was under the influence of alcohol both day and night. This had been witnessed by Child X. Child X was not in school that day. The school had not informed Mother of the referral as "*due to her emotional state I believe I could put the child at further risk by informing at this stage*". The school had also not informed Father as they were concerned about how the information could impact on the court hearing. "*This has been reported to me by a third party and not witnessed by a member of staff, if dad informs mum that I am making a referral it could escalate the situation with mum and make the child more vulnerable".* The referral from the school went on to say that they were unaware of the outcome from the MASH referral in March.

5.75 The police report prepared after Mother and Child X's death indicates that Mother spoke to at least one friend in Ireland about her plan to kill herself and her child to get back at Father. The advice to her friend from the Good Samaritans in Ireland was that the only course of action was to consider calling the UK police, but this could put her in danger. They said they could not reach out unless Mother contacted them first.

5.76 Around this time the MASH team called the school to discuss the referral and advised the head teacher that as there were no new concerns apart from third hand information no further action would be taken, and courts were involved. Both parents were contacted by MASH team to advise a referral had been made and the case would be closed. Mother contacted the school the following day upset about the referral made 'behind her back'.

It was not an appropriate decision to close the case. Although the information from the school might be considered to be third party, the information was detailed and consistent with other known information and previous concerns.

It seems that the only health information that was sought was from the alcohol treatment service which confirmed that Mother was not known. A thorough, forensic and more questioning approach at this stage which sought information from a wide range of sources could have challenged Mother's portrayal of her alcohol use and allowed consideration of its potential impact on parenting, her role as a nurse and her own wellbeing.

5.77 A referral was received by Children's Social Care from Maternal Grandmother on 24th June 2016. Maternal Grandmother stated that she had visited Child X the day before and saw her daughter drinking heavily. She had started drinking at 10:00am and Child X found her asleep on the sofa at 2:00pm. Child X had said that he found his mother passed out on the sofa and that when she does this in the evening he goes to bed. Maternal Grandmother said that her daughter was an alcoholic in denial, had bad health and appears fragile. She felt that Child X was being neglected and not fed properly as there was no food in the fridge. She was keeping Child X away from family members was denying Father 50/50 custody. She also referred to Mother as being a serial liar. This information prompted a child and family assessment.

5.78 On the same day Mother contacted school to advise she would be collecting Child X early after a class trip. Father arrived to collect Child X later and was informed Child X had left with Mother. The school asked to be informed of any Child Arrangement Order so they had information on who would be collecting Child X on which days.

5.79 Also, on 24th June Mother called the Metropolitan Police following an argument with Father. Father had also contacted the police as he had been unable to collect his son for contact. A risk assessment was completed (in respect of the domestic incident) and recorded as "standard". Information was shared with Hillingdon Children's Social Care three days later because of the concerns about the impact on Child X of being in the middle of a relationship breakdown.

5.80 The school received a request from a social worker to visit Child X at school for a child and family assessment. The following day the deputy headteacher contacted the social worker to ask if Father had been made aware of the referral and if he was aware that Child X had been spoken to at school. The social worker advised the school that Father had not been informed but would be contacted.

5.81 The Final Judgement at the court hearing on 4th July 2016 was for a Child Arrangement order for shared care. This was influenced by the GP letter which stated that Mother reported to having been abstinent from alcohol for five months.

5.82 The child and family assessment concluded that Child X was not at risk and there was no need for further social work involvement. Additional support could be provided via the school and a Team around the Family (TAF) service. The assessment also recommended that Mother should self-refer to the alcohol treatment service. Advice was sought from the LADO regarding any implications of Mother's alcohol use for her employment as a nurse but there is no note of any response on file. Following the assessment Mother declined to engage with the Team around the Family and there is no evidence of any self-referral to the alcohol treatment service.

This assessment focused primarily on discord between the parents and its impact on Child X's emotional wellbeing taking account of information from the GP that there were no concerns about Child X. The analysis in relation to alcohol use relied once more on self-

report and although it was recorded in the assessment as a danger, Mother's assertion that she did not abuse alcohol was noted to contribute to keeping Child X safe. Her comment that she had been treated at a private facility for anxiety and depression (rather than alcohol use) was not challenged or checked. Her comment that she had never felt suicidal could not be cross referenced with the threats she had made as these remained within the records of Thames Valley Police and the original documents Father completed when making the application to court. There was no contingency as to what the approach should be if she did not receive help with her alcohol use.

One significant gap in this assessment is that Father was not seen face to face and was only spoken to via a telephone conversation. A more detailed discussion with Father may have assisted the social worker in obtaining a more balanced view as to the information given by Mother during the assessment process.

5.83 On 19th October 2016, Father contacted MASH about suspicions about Mother's drinking, sending threatening text messages and 'messing him around' with contact. He wished this to be treated as an anonymous referral but after further discussions decided to withdraw it as he was concerned that Mother would assume it was a member of the family who had made the referral and "things will become uglier". He said that he had not seen Child X being neglected or at risk. Father recalls that he was told by the MASH worker that if there were problems he would need to go back to court.

5.84 The management decision at this point was to speak to Mother and the school. After contact with Mother no contact was made with the school as Mother did not give her consent for further checks. The decision was that there should be no further action as Mother had provided assurance that she did not have alcohol problems and that the referral was malicious and linked to family tensions.

5.85 On 7th November Mother was seen by her GP for a medical complaint; this was the last appointment before her death.

5.86 On 18th November Child X was absent from school and Mother advised the school that he was unwell with sore throat and upset tummy. He was again absent with a sore throat and a cold on 28th November and Mother told the school Child X had told her he had been upset at playtime the previous day. This was confirmed by the school who explained that there had been a problem in the playground, but Child X had settled and returned to class.

5.87 On Saturday 10th December 2016 Mother refused Father access to Child X due to arriving late, having slept through his alarm. The following day Father arrived to take Child X out, but Mother told him he would not be seeing Child X that day.

5.88 Later that evening Mother left a message on the voicemail of the school to advise that Child X would not be attending school the following day (Monday) due to Child X having a bad chest and cold.

5.89 On Monday 12th December as Father had not seen Child X that weekend, he telephoned the school and was advised that Child X was off school due to sickness. Police records show that Mother's mobile phone records indicate that she read a text message at 9.20 that morning.

5.90 Father arrived later that evening to collect Child X as per the court order, however there was no reply and the house was in darkness. Father tried calling Mother, but the phone diverted to voicemail.

5.91 Father called police and 19.24 hours requesting that officers conduct a welfare check in relation to Mother and Child X. He told the police that Child X hadn't attended school that day. He had made repeated efforts to make contact with Mother by calling her mobile and attending her home address. He had received no response. Father told officers that Mother's mental health was deteriorating, and she was misusing alcohol. He was concerned she may be drunk.

5.92 Police officers were unable to attend immediately but attended Mother's address at 20.37 hours and could see a downstairs light on but no response or signs of movement. Intelligence checks were completed, and neighbours were spoken to who said they had not seen Mother. Officers returned again at 01.09 hrs with no signs of change from the previous visit. They spoke at length with Father who explained that this had happened before, but not often and he was concerned this may be malicious.

5.93 As Child X had not attended school on the 13th December, Father visited the school to relay concerns about not being able to contact Mother. The same day Father called the Police twice. The first call was to inform the police that Child X had not been in school and to ask when he could report him missing. He was advised that he could do so at any point. At 12.27 he called the police to make the missing report.

5.94 On the same day Children's Social Care received a telephone call from Maternal Grandmother requesting a home visit and disclosing that two weeks previously Mother had told her cousin that she was going to commit suicide and take Child X with her. She said that Mother was always drinking, and Child X had not been in school that week. This call should have prompted an immediate call to the police; although it must be stressed that in this case even had this happened the sad outcome would have been the same.

5.95 A MERLIN (child coming to the notice of the police) report was completed and circulated. The initial risk assessment by the police was MEDIUM as it was believed that Child X was with his mother and it was felt there was no intelligence to support forced entry.

5.96 An internal Metropolitan Police review of the police response to the missing child report found that the risk assessment as MEDIUM was proportionate but *although it is apparent that supervisors were made aware of the case neither the Duty Officer's risk assessment entry not the supervision of the MERLIN report were completed*

*within the time periods laid down in the risk review protocol.* The review also noted that there was no investigation plan or further actions until the case was reviewed by the Sergeant in the MISPER (missing persons) unit at 07.12 in 14th December.[11]

5.97 On 14th Children's Social Care started to make enquiries following the referral by Maternal Grandmother the previous day. Conversations took place with Maternal Grandmother, Father, the head teacher at the school and the Metropolitan Police missing persons unit.

5.98 On 14th December 2016 at 10.11 hours officers attend Mother's address and forced entry where Mother and Child X were found lying in bed deceased.

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| The sequence of events leading up to Child X and his Mother being found deceased show that both police and Children's Social Care could have responded with more urgency on 13th December. There has been a thorough review within the Metropolitan Police which found there had been no professional misconduct but both organisations will need to continue to reflect on whether their responses in such situations can be improved. However, it should be stressed that there is no evidence that this would have made any difference to the sad outcome in this case. |

## 6 REVIEW FINDINGS AND RECOMMENDATIONS

### Finding 1
**Information sharing within police systems and across police boundaries did not always work well and resulted in information about support for Mother and risks to Child X becoming lost in the system.**

6.1 Thames Valley police carried out a thorough individual management review of police practice in this case and identified where individual administrative errors prevented proper sharing of information within their own systems and would have affected information that was shared with other agencies (see para 5.96 above). Specifically, recording lacked precision and as a result potential risk to Child X was not flagged in the adult protection report. The importance of ensuring that all relevant information is copied onto a child protection or adult protection report is subject of an internal recommendation within Thames Valley Police.

6.2 Considering the Thames Valley Police information alongside that given to the review by the Metropolitan Police, there are two specific points where cross border working

[11] The eventual outcome of the police review was that the case did not meet the criteria for referral to the Independent police Complaints Commission but individual learning should take place at a local level.

between police forces needs to be improved in order to make sure that vulnerabilities of both adults and their children are properly identified and managed.

6.3 The first area relates to victim care. Thames Valley Police victim care arrangements are guided by the Home Office circular[12] which refers to the expectation that the police force where the victim lives is best suited to offer appropriate victim care in cases of child abuse. The Thames Valley Police individual management review comments that this circular *is commonly applied to other serious crimes such as Serious Sexual Assault (SSA)* and that the Detective Sergeant quoted this policy in an e-mail to the Sergeant in the Metropolitan Police sexual offences investigation team. Metropolitan Police records seen for this review do not acknowledge this e-mail and in any event, the force do not use the guidance in this circular to direct their work with adult victims. Their expectation would have been that they would have been updated every 30 days about the investigation by Thames Valley Police. Each force assumed the other was arranging support for Mother and the outcome of this misunderstanding was that there was no victim care plan for Mother for several months and opportunities were lost to understand her mental state during this crucial period. This situation was rectified and after Thames Valley Police took over victim care there was an excellent standard of service.

6.4 The second area is information flow between the two forces. In relation to the initial rape investigation this worked well but following the investigation of domestic harassment allegations the totality of the concerns about Mother's mental state and risks to Child X were not passed via the most appropriate method to the Metropolitan Police. These should have been passed from one MASH team to another, but instead the OBRT system[13] was used and there was no follow up to make sure that the information had been received and acted upon. This was important information which included Mother's threats to kill herself and her child and had this been received by police officers in Hillingdon MASH it could have influenced the subsequent assessments within Children's Social Care, Cafcass and mental health services.

**Recommendation 1a**
The Metropolitan Police and Thames Valley Police forces should review the points in this case where information exchange did not work effectively and ensure that officers involved have been debriefed and relevant learning has taken place across the local system.

**Recommendation 1b**
National guidance from the College of Policing should be unambiguous regarding the expectation that, in cases of sexual assault, a victim care plan should be delivered by the police force where the victim resides.

[12] Home Office Circular 36/2002
[13] See paragraph 5.45 above

**Finding 2**

**Assessments of Mother's wellbeing were too often based on self-reported information and there was a lack of focus on the potential impact of Mother's alcohol use and mental health on her role as a parent and a nurse.**

6.5 Mother's alcohol use is a theme throughout her contact with *all* practitioners but on most occasions, she was able to convince people that this was either in the past or it did not interfere with her care of Child X. This is what lay behind the positive report by the GP to the family court and was likely to be a factor in the police officers not notifying Children's Social Care at the time of the rape allegation. Mother was a nurse and although there is no concrete evidence that this influenced responses this cannot be ruled out. There needed to be far more curiosity by practitioners regarding the impact of alcohol on her life, taking account of the possibility that she was minimising described alcohol intake. Several factors seem to have prevented this happening.

6.6 Generally, practitioners lacked confidence in probing in more detail when Mother made reference to her use of alcohol and there is no evidence of any standardised tools being used to understand the extent of the problem. For example, she told police officers that she was "a drinker" but there was no follow up as to what this meant and GP records in February 2015 noted she had been "drinking alcohol ++". There is no further detail, although the GP did suggest a referral to alcohol treatment services (which Mother did not take up).

6.7 When she had a telephone assessment by IAPT Talking Therapies this also did not refer to any specific analysis of the interaction between mental wellbeing and alcohol intake and the telephone assessment would not have allowed for consideration of any non-verbal cues. Although Mother's mental health did reach a threshold for consideration by the mental health team, they were not aware of the full extent of her threats to kill herself and her child and could not therefore carry out a detailed assessment that would be expected in these circumstances.

6.8 Within mental health practice an understanding of protective factors is an important aspect of assessment. However, where a child is named as a protective factor more thought needs to be given as to what this means for the child. Although a child may give a parent a reason to engage with therapy, or make them a low risk of completed suicide, there must be next stage of assessment which considers both the needs of the child and any potential risk. The voice of the child was missing from the assessment and there was no attempt in this case to use any framework or tool to assess the needs of the child independently from the needs of the parent.

6.9 A study of common factors in parents who kill their children commented that traditional risk factors for violence are different from commonly occurring factors in

cases where parents kill themselves and their child.[14] Where children are deemed to be a protective factor there needs to be a proactive approach to considering risks. More work is needed to support practitioners with evidence-based tools. A UK study of parents who have killed their child [15] concluded that understanding risk factors for filicide (parents killing their children) is far from complete and more work is needed to support the development of effective intervention strategies.

6.10 From the perspective of GPs, they will rely on self-reported information and within a standard seven-minute appointment may not routinely ask for more detail including whether the patient has caring responsibilities. This is an area of practice that could change with an expectation that when a patient is known to misuse alcohol, consideration should always be given to the impact on those they are caring for. A referral can be made to alcohol treatment services, but it is up to the adult whether or not they wish to engage. Their response to offered treatment needs to be understood from the perspective of others in their family, particularly children.

6.11 Mother did attend a private treatment facility for substance misuse but there is no record that this facility considered her role as a mother or liaised at all with her registered GP. There is no requirement for such facilities to do so and this is a gap in the system. If the GP had received information about this treatment episode this could have been taken account of in subsequent appointments.

6.12 Information obtained for this review indicates that Mother was asked to leave a permanent job as a nurse at the end of her probationary period. On at least two occasions whilst working for an agency the hospitals concerned did not wish to use her again.

6.13 There is no indication that professionals questioned whether any steps should be taken to refer Mother to the professional regulator when they became aware of her alcohol use alongside her role as a nurse. The one exception was a social worker who considered discussing the issue with the LADO[16], but this did not result in any further action as it would not have reached a threshold for LADO intervention as Child X was not understood to be at risk of significant harm. Her work practices as a nurse are of relevance since the method by which Mother obtained the insulin used to kill both herself and Child X also remains unclear.

6.14 The problem seems to be that referral to the regulator is felt to be too draconian for fellow professionals, such as GPs, to consider this course of action although there would be no reason why a referral to the Nursing and Midwifery Council could not be made if it was considered that patient safety could be compromised. When Mother

[14] Friedman et al (2005) 'Filicide-Suicide: Common Factors in Parents Who Kill their Children and Themselves' *The Journal of the American Academy of Psychiatry and the Law Online* 33(4) 496-504
[15] https://www.manchester.ac.uk/discover/news/findings-from-most-in-depth-study-into-uk-parents-who-kill-their-children/
[16] The Local Authority Designated Officer is the term commonly used to describe the requirement within government guidance for the local authority to have designated officer responsible for overseeing investigations into abuse in organisations.

failed her probationary period in a hospital the concerns were believed to relate to *conduct* rather than safeguarding issues and arriving at work smelling of alcohol was only reported on one occasion with no further instances after her return to work following the period of suspension. Additionally, work as an agency nurse meant that it was harder to pick up patterns of problematic behaviour, although the agency in question does have a policy of reviewing situations where three separate employers have asked for a nurse not to return. With hindsight, problems with colleague relationships and work practices which did not always put the needs of patients first were a pattern that could have been considered as not meeting professional standards[17] [18]. Expectations on agencies to review situations where complaints have been made should be reviewed to make sure that they are fit for purpose.

6.15 Employment references are an important part of the safeguarding system and in this case it seems that the nursing agency received a positive reference from a member of staff at the private hospital during a period where there were conduct issues being monitored and these had resulted in an extension to Mother's probationary period. Although this professional reference was written on the template supplied by the nursing agency it had not been obtained via the hospitals HR department who would have been able to give a more objective assessment of Mother's practice.

**Recommendation 2a**
All partner agencies must work together to develop an approach to working with adults who misuse alcohol which assesses level of risk, both to the person concerned and their dependents. Specifically, GPs should always ask patients whether they have any dependents when alcohol misuse is a presenting problem and consider discussing any child under school age with the health visitor.

**Recommendation 2b**
The local safeguarding partnership should work with mental health professionals to reinforce the need to use evidence-based tools routinely and systematically where a parent has a mental illness in order to identify any impact on children in their care.

**Recommendation 2c**
The Department of Health should require nursing agencies to have in place a process for reviewing the performance of staff registered with them and undertake a formal review when more than one employer has asked that they do not return.

**Recommendation 2d**
Safer employment guidance for health organisations should make it clear that organisations should only request and accept professional references directly from the HR department of the organisation who previously employed the professional concerned.

[17] https://www.nmc.org.uk/globalassets/sitedocuments/education-standards/future-nurse-proficiencies.pdf
[18] https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

**Finding 3**

**The involvement of the family in private law proceedings diverted attention away from the role of Children's Social Care in carrying out assessments where there are concerns that a child may be at risk of harm.**

6.16 It is noticeable that the family court advisor was the one professional who moved beyond Mother's self-reported information and questioned the impact of her alcohol use and mental health issues on her capacity to parent. The problem arose because although Cafcass made referrals to Children's Social Care and expected safeguarding concerns to be fully assessed, social workers were falsely reassured by the fact that Cafcass were involved and carrying out their own assessment for the private law proceedings. There was a fundamental misunderstanding about the limitations of the Cafcass role in private proceedings and the information that was being considered during a section 7 assessment. This information was gathered with Mother's consent and did not include information from Child X's school.

6.17 The misunderstanding about the role of Cafcass within Children's Social Care is further evidenced by the comment made to Father that if he had concerns about Child X he should "go back to court".

6.18 Cafcass now recognises that it is good practice to ask parents for consent to contact the child's school and this is an important element in allowing schools to understand all the various factors that might be impacting on a child's life. In this case the concerns that had been accumulating within the school could also have been considered by the family court advisor. Asking for information from schools should become embedded in Cafcass policy and practice guidance.

6.19 The family court advisor had expected Children's Social Care to carry out a full assessment and was not happy with the response. This should have led to professional challenge and debate. If differences of opinion could not be resolved, the escalation process[19] should have been used.

6.20 There are some similarities between this case and the findings of a serious case review in Croydon[20] (February 2018), indicating that misunderstandings about Cafcass's role and the need to further develop knowledge and skills in assessing risks in situations of parental disputes applies beyond Hillingdon. Social workers need evidence informed frameworks to help them make sound professional judgements in these complex situations.

**Recommendation 3a**

Cafcass should embed into policy its current practice of asking for information from schools in private proceedings.

[19] https://hillingdonlscb.org.uk/wp-content/uploads/2018/03/Escalation-Policy-January-2018.pdf
[20] http://croydonlcsb.org.uk/wp-content/uploads/2018/02/SCR-Child-J-and-Child-K-publication.pdf

**Recommendation 3b**
Cafcass should encourage family court advisors in family proceedings to be familiar with the escalation protocol in the area where they work and be proactive in bringing to the attention of Children's Social Care concerns if they are not satisfied with the response following a referral.

**Recommendation 3c**
Hillingdon Children's Social Care should work with Cafcass to inform social workers about the Cafcass role in family court proceedings and clarify boundaries and best practice in communication between practitioners and assessing potential risks to children in such circumstances.

## Finding 4

**Information held by friends and family needs to be taken seriously and support given to help them share information relevant to the safety of a child.**

6.21 Although the extended family and social network may hold important information that could help identify where children may be at risk of harm, this might not be available to practitioners or, where it is known, there may be uncertainty how to use the information provided.

6.22 There is, for example, information within police records suggesting that Mother did have more than one conversation with a friend or family member during which she stated that she had a plan to kill herself and Child X. This information only came to light after the deaths. It is also apparent that what friends and family can do with such information is not clear; they may not know who to talk to and/or be fearful that telling the authorities will result in a child being removed. A confidential helpline for friends and family along the lines of Childline may be one way forward.

6.23 Referring to information from family and friends as "third party", although accurate, seems to have the effect of minimising the concerns within the content of the information. In this case information from Maternal Grandmother was important and not properly analysed within the context of all the other accumulating concerns.

6.24 The issue of consent to share information is important but professionals do not need consent to listen to the concerns of another and to record the information to help in further assessment. Assessment practice needs to encourage reflection on all types of information and steps taken to confirm or refute information that cannot yet be seen as fact.

6.25 There are several factors evident in this case that challenge our safeguarding system to develop ways to work with families and friends to protect children, whilst working ethically and within the boundaries of confidentiality.

6.26 Balancing information from all parties who know the child is not easy. In this case Father was in a difficult position as he did not want to antagonise Mother to such an

extent that he caused Child X distress, or his contact with his son became more contentious. He was therefore understandably careful in the amount of information given to Children's Social Care. When Children's Social Care did receive information from the family this was treated as third party information and the decision was no further action, as Mother's account contradicted that of the family member and reassured the practitioner.

**Recommendation 4a**
Hillingdon Children and Adults safeguarding partnerships should consider with relevant national organisations whether a helpline for families concerned that a child is at risk could be developed and publicised.

**Recommendation 4b**
Assessments should always actively consider the meaning of information labelled "third party" and develop the skills of practitioners in listening, recording and exploring any such information further, in order to use family and friends as a positive resource.

### Finding 5

**Although the notion of "Think Family" has been promoted over several years there continues to be a divergence between the intellectual acceptance that the needs of children are intimately linked with the needs of adults in their lives, and the way in which services respond.**

6.27 In this case Mother was known to have problems with alcohol, was described as emotionally vulnerable and referred to mental health services. This information did not sufficiently permeate the system designed to meet the needs of her child. A number of reasons for this have been explored above including; GPs not routinely asking about carers and mental health professionals noting children as protective factors rather than moving to the next step of making sure that the lived experience of the child is understood.

6.28 An additional factor in this case was that Mother accessed a private treatment facility which did not communicate with her GP and seems not to have considered Mother within the context of her family and role as a parent. There is no requirement for private facilities to communicate with GPs. This is a potential gap in the system which prevents a holistic understanding of a patient's health and care needs.

6.29 Information systems also provide further challenges to a whole family approach with records for children being separate from those of their parents and practitioners needing to take active steps to make connections. This can be challenging in a busy GP surgery and police teams need to make sure that issues for children are actively flagged on any records for adults.

6.30 Involving fathers in assessments has been frequently written about in child protection literature, but this case illustrates that this is still an issue that needs active thought. Cafcass, by the very nature of their work in the family court, are compelled to talk to both parents, but other social work assessments may not be proactive enough in giving fathers the opportunity to contribute on the same terms as mothers. In this case in July 2016 Mother and Child X had been seen in the family home but Father was spoken to over the phone with no opportunity to understand where Child X spent 50% of his time.

6.31 The review team has considered carefully the possibility that approaches were influenced by an unconscious bias towards Mothers and presumption that they will not harm their child, even when making threats to do so. It is not possible to say unequivocally that this is the case and indeed the Cafcass worker took a balanced approach. However, there are also other indications that there may have been an unconscious gender bias, in approaches within this case. Even when Mother made threats to kill herself and her child these were not viewed with the urgency and depth of assessment that they deserved.

6.32 In relation to the allegations that Mother had harassed Father, the team considered whether these would have been viewed differently had these been made by a female against a male. Mother showed many of the indicators which show increased risk to the child within in the tool, developed by Barnardo's and set out in the London Child Protection Procedures,[21] to assess the impact of domestic violence on children. For example, she made threats to kill, she tried to control Father's contact with Chid X, there was evidence of harassment via text, mental health issues, alcohol abuse and suicidal ideation. This tool was developed to assess risk to children in situations of male violence towards females and although the London procedures ask practitioners to apply the guidance to all situations of domestic abuse they also acknowledge that the procedures have been written in a context of most domestic abuse being perpetrated by men against women. There is a need for more research and guidance to assist practitioners in working in this complex area.

**Recommendation 5a**
Hillingdon Children's Social Care should expect practitioners to gather information from all relevant adults in the family and make sure that a balanced approach to assessment results in the voice of *both* parents being properly included.

**Recommendation 5b**
Organisations working with adults with substance misuse and/or mental health problems should ensure that care plans for parents always address the care of any children in the family.

**Recommendation 5c**
The Department for Health should ask the relevant health bodies to ensure that when a patient attends a private facility due consideration is given to liaising with the patient's GP.

[21] https://www.londoncp.co.uk/files/supp_sg_dv_app1_riskmat.pdf

**Recommendation 5d**
Hillingdon Local Safeguarding Children and Adult Boards should work with partner agencies to promote a whole family approach and, through supervision and staff development opportunities, develop the confidence and skills of the children and adult's workforce in working with whole families in order to address the inter-relationship between the needs of adults and their children.

**Recommendation 5e**
The gap in evidenced based assessment tools where there are allegations of harassment perpetrated by a mother against a father should be brought to the attention of the Department for Education and this limitation be made clear within the London Child Protection Procedures.

## 7 SUMMARY OF RECOMMENDATIONS

**Recommendation 1a**
The Metropolitan Police and Thames Valley Police forces should review the points in this case where information exchange did not work effectively and ensure that officers involved have been debriefed and relevant learning has taken place across the local system.

**Recommendation 1b**
National guidance from the College of Policing should be unambiguous regarding the expectation that, in cases of sexual assault, a victim care plan should be delivered by the police force where the victim resides.

**Recommendation 2a**
All partner agencies must work together to develop an approach to working with adults who misuse alcohol which assesses level of risk, both to the person concerned and their dependents. Specifically, GPs should always ask patients whether they have any dependents when alcohol misuse is a presenting problem.

**Recommendation 2b**
The local safeguarding partnership should work with mental health professionals (locally and national) to develop evidence based tools to ensure that where children are referred to as a "protective factor" there is always consideration of what this means for the lived experience of the child.

**Recommendation 2c**
The Department of Health should require nursing agencies to have in place a process for reviewing the performance of staff registered with them and undertake a formal review when more than one employer has asked that they do not return.

**Recommendation 2d**
Safer employment guidance for health organisations should make it clear that organisations should only request and accept professional references directly from the HR department of the organisation who previously employed the professional concerned.

**Recommendation 3a**
Cafcass should embed into policy its current practice of asking for information from schools in private proceedings and, with appropriate permissions, make sure that schools receive information that can help them to offer the best possible support to a child.

**Recommendation 3b**
Cafcass should encourage family court advisors in family proceedings to be familiar with the escalation protocol in the area where they work and be proactive in bringing to the attention of Children's Social Care concerns if they are not satisfied with the response following a referral.

**Recommendation 3c**
Hillingdon Children's Social Care should work with Cafcass to inform social workers about the Cafcass role in family court proceedings and clarify boundaries and best practice in communication between practitioners and assessing potential risks to children in such circumstances.

**Recommendation 4a**
Hillingdon Children and Adults safeguarding partnerships should consider with relevant national organisations whether a helpline for families concerned that a child is at risk could be developed and publicised.

**Recommendation 4b**
Assessments should always actively consider the meaning of information labelled "third party" and develop the skills of practitioners in listening, recording and exploring any such information further, in order to use family and friends as a positive resource.

**Recommendation 5a**
Hillingdon Children's Social Care should expect practitioners to gather information from all relevant adults in the family and make sure that a balanced approach to assessment results in the voice of *both* parents being properly included.

**Recommendation 5b**
Organisations working with adults with substance misuse and/or mental health problems should ensure that care plans for parents always address the care of any children in the family.

**Recommendation 5c**

The Department for Health should ask the relevant health bodies to ensure that when a patient attends a private facility due consideration is given to liaising with the patient's GP.

**Recommendation 5d**

Hillingdon Local Safeguarding Children Board should work with partner agencies to promote a whole family approach and, through supervision and staff development opportunities, develop the confidence and skills of the children's workforce in working with whole families in order to address the inter-relationship between the needs of adults and their children.

**Recommendation 5e**

The gap in evidenced based assessment tools where there are allegations of harassment perpetrated by a mother against a father should be brought to the attention of the Department for Education and this limitation be made clear within the London Child Protection Procedures.

## 8 APPENDIX ONE: TERMS OF REFERENCE

This is a serious case review into the murder of a seven-year-old child by their Mother who then died by suicide. The review has been commissioned as a serious case review but will also consider any learning for Adult's Services due to Mother's previous involvement.

### Background to the review

On 14th December 2016, emergency services were called to an address in Ruislip and found a seven-year-old child and his mother deceased. Subsequent investigations concluded that both the Mother and child's death had been caused by an overdose of insulin. A suicide note, written by Mother was found at the scene. The initial conclusions of police investigations were that this was a case of murder/suicide.

A coroner's inquest in June 2018 concluded that the child was unlawfully killed, and the Mother died by suicide.

A review of information known to statutory agencies revealed that Mother had worked as an agency nurse, the child's parents had been involved in an acrimonious separation and that Mother had contact with agencies as a result of alcohol and mental health problems. Mother had also had contact with the Metropolitan Police following a rape allegation and some limited contact with Hillingdon Children's Social Care.

### Decision to carry out a serious case review

At the time of the deaths the Chair of the LSCB and the then assistant director children's social care did not feel that the threshold had been met for a serious case review or a safeguarding adult review. The national panel were notified and did not disagree.
The case was reviewed by CDOP in May 2018 and there was a recommendation that the decision not to conduct a review should be re-considered. Following a consideration meeting on 9th August 2018, a decision was made to commission a local serious case review with consideration of any adult safeguarding issues and this decision was ratified by the new national panel.

### Purpose of the review

The purpose of the review is to improve services and assist in preventing similar events.

Child safeguarding Practice Reviews.

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account.

(Working Together, Chapter 4 para 4:1, July 2018)

## SCOPE OF THE REVIEW

The time period for individual agency chronologies is from the start of the individual agency's involvement until the 14th December 2016.
All relevant information should be made available to the lead reviewer.

The following agencies should be asked submit a chronology of involvement.

- Primary School
- GP for the child and Mother
- CAFCASS
- Central and North West London Community Health
- Metropolitan Police
- Hillingdon Hospital
- Children's Social Care
- Adult Mental Health
- Private alcohol rehabilitation facility

### Issues to be examined

- Were services effective in recognising and responding to any potential risks associated with Mother's alcohol use and mental health?
- Were there any barriers to an effective multi-agency response to the child's emotional wellbeing including the way in which GPs recorded contact with children's social care and the integration of information from the private health facility?
- Did the use of telephone consultations by GPs impact on an accurate assessment of Mother's mental state?

- Was the impact of parental disputes on the child properly considered and safeguarding concerns identified?
- Were there any issues that hampered safeguarding as a result of communication between Thames Valley and the Metropolitan Police?
- What is the process for raising any concerns about the professional practice of agency nursing staff and did this work effectively in this case?
- To what extent did the professional background of the parents in this case influence professional responses?

It is expected that other themes will emerge during the process of review and these will be addressed by the lead reviewer in the overview report.

**Methodology**

The review process is designed to ensure an open and collaborative approach which includes the perspectives and views of practitioners and family members. That there is a focus on *what* happened and *why* practice decisions were made. The review seeks to move beyond a focus on individual practice to an understanding of lessons for the safeguarding system the as a whole.

The process of the review will be:

1. Gathering and analysing written information via chronologies and other relevant reports.
2. Agreeing key practitioners who should be offered an opportunity to contribute.
3. Meeting with practitioners either individually or in small groups. These meetings will be led by the lead reviewer along with a panel representative with professional expertise in the area bring discussed.
4. Meeting with family members.
5. Key themes and earning to be agreed with the panel.
6. Production of a draft report to be agreed by the panel.
7. Sharing of the final draft with all those who have contributed.
8. Production of final report agreed with the panel and presented to LSCB.

**A statement of good practice**

The approach taken within this review should be proportionate: led by individuals who are independent of the case; with relevant professionals fully involved and able to contribute their perspectives without fear of blame; family (and others) invited to contribute.

## Criminal (and other) proceedings

There are no criminal proceedings regarding this case as the perpetrator of the murder committed suicide. There will be reference to civil proceedings regarding custody and access to the deceased, as these are relevant to the review.

## Timescale

The decision to conduct a review was taken on the 20th September 2018. It is proposed that a draft report will be presented to the panel six months from this date.