London Borough of Hillingdon Safeguarding Children Board

Serious Case Review

Child X & Child Y

Report Author

Jane Wonnacott
MSc MPhil CQSW AASW

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1. INTRODUCTION

1.1 This serious case review has been carried out as a result of the deaths of two children (age 4 and 9) in April 2013. Both children were found dead at their home alongside the body of their mother. The police investigation concluded that the mother appeared to have caused the death of the two children before taking her own life. Use of poisonous substances was believed to be a factor contributing to the death of the children.

1.2 In October 2014 an inquest into all three deaths concluded that both children had been unlawfully killed and that their mother had taken her own life. Cause of death for Child X, Child Y and their mother was confirmed as phenol intoxication and ligature to the neck.

1.3 A serious case review must be carried out when a child has died and abuse or neglect is known or suspected[1] and this case therefore met these criteria.

2. REVIEW PROCESS

2.1 There was a delay in commissioning this serious case review. The incident was discussed at a serious case review consideration meeting on 27th April 2013 and it was agreed that the decision as to whether a serious case review should be carried out would be taken after the case had been reviewed by the Child Death Overview Panel (CDOP)[2]. In fact, the case clearly met the criteria for a serious case review at this point and there was no need to delay whilst the Child Death Overview Process took place.

2.2 The need for a decision regarding this review was not followed up by the serious case review consideration panel. However, in January 2015 a newly appointed Local Safeguarding Children Business and Development Manager realised that a serious case review had not taken place and instigated this review.

2.3 A review team was appointed to oversee the review consisting of:

- The Local Safeguarding Children Board Business and Development Manager
- Named Nurse Safeguarding Children for Central and North West London NHS Foundation Trust
- Designated Nurse Safeguarding Children, Hillingdon
- Designated Safeguarding Doctor Safeguarding Children, Hillingdon
- Metropolitan Police Representative
- Named Nurse Safeguarding Children Hillingdon Hospital

[1] Working Together to Safeguard Children 2013 updated in 2015
[2] The CDOP reviews each death of a child normally resident within the LSCB's area.

- London Borough of Hillingdon Child Protection Officer, Education

2.4 Jane Wonnacott was appointed the lead reviewer and report author. Jane qualified as a social worker in 1979. She has an MSc in social work practice, the Advanced Award in social work and also an MPhil as a result of researching the impact on supervision on child protection practice. She has over 20 years' experience of carrying out serious case reviews.

2.5 There had been no involvement with this family beyond universal services. Chronologies were received and reviewed from the GP practice, midwifery services and children's school. The Metropolitan Police made available information from their enquiries following the death of the two children and the author listened to an audio record of the inquest into all three deaths. The lead reviewer and members of the review team met with the following people in order to understand in more detail events leading up to the tragic incident:

- The senior investigating officer, Metropolitan Police
- The head teacher and staff who had known the children's mother in her employment as a laboratory technician at a school in Windsor and Maidenhead
- The safeguarding lead at the school attended by Child X.

2.6 The children's father was offered an opportunity to contribute to the review and he met with the lead reviewer. The review team are very grateful for his willingness to participate in this review in such distressing circumstances.

3. CASE SUMMARY

3.1 This case involves a family who moved to the Hillingdon area from Hertfordshire to live with paternal grandparents as they were able to provide support with child care. Child X was born in Hertfordshire and Child Y in Hillingdon. Mother was a professional woman with a postgraduate degree and had obtained employment as a laboratory technician within a school in order to fit in with her children's needs. The family received universal services with both children attending local primary schools and having minimal contact with health professionals.

3.1 Evidence was given to the inquest of some family disagreements including tensions between Mother and paternal grandparents over the pressure that Mother put on the children to do well at school. Mother was also described as not liking Child Y being close to her grandmother. Although Mother left a suicide note saying that she could not "cope with the pressure" no one at the time had believed that she was unhappy enough to take her own life.

3.2 The overall conclusion of this review has been that the deaths of the two children could not have been predicted or prevented and no evidence that any professional could have been aware that her state of mind would lead her to kill herself and her children. Both children were described as happy at school, there was no indication from medical records of any mental health issues, and there was nothing within the mother's work environment that suggested she may be distressed. There are some practice issues that may need further consideration, but it must be stressed that these are not to be regarded as factors that contributed to a failure to safeguard the children.

4. PRACTICE ISSUES

4.1 During the course of the review it became apparent that the older child was part of a group at school whose parents had a high level of academic expectation and were working towards ensuring a place at a grammar school for their children from a young age. Children in this group were engaged in a number of extra-curricular education activities during the weekend. The children's school does not have any means of monitoring the external tuition attended by their pupils and this may be an area for development in order to ensure that they have an holistic view of any family and social circumstances that may be affecting the children at their school.

4.2 Examination of the midwifery records revealed that it could not be said with any certainty that Mother had been asked about domestic abuse at the time of booking. In Hillingdon there has been no note on the records to indicate that mothers have been asked about domestic abuse although documentation is now being updated and will be used from October 2015. It should be stressed that there is no evidence or suspicion of domestic abuse within the family, but the issue of the effectiveness of this aspect of practice is an important aspect in safeguarding and the LSCB may wish to undertake further work in relation to this.

4.3 Following the death of the children, the police investigation included a discussion with the health and safety executive regarding the safe storage of poisons at the school where mother worked in Windsor and Maidenhead. The conclusion was that there had been no breaches of the health and safety regulations and the school was able to describe to this serious case review how poisons were safely stored. Police evidence to the inquest confirmed that their inquiries had established that the school was the source of the poison that killed the children and the review team were concerned that following such a significant incident as this, there had been no formal internal enquiry as to how Mother had acquired the poisons from the school and whether there were any lessons to learn. This concern has been relayed to Windsor and Maidenhead Safeguarding Children Board.

4.4 The review team were surprised that an incident such as this does not reach the threshold for notification to Ofsted, who would not have been aware that a member of staff had committed suicide and substances from the school had been obtained for use in the unlawful killing of the children.

4.5 A key area of learning for the Safeguarding Children Board relates to deciding whether to undertake a serious case review. In this case, the decision to wait for the outcome of the Child Death Overview Panel process caused extensive delay. The Local Safeguarding Children Board was aware of the children's deaths at an early stage and there was sufficient information to indicate that the case clearly met the criteria for a serious case review. In this situation the decision whether or not to conduct a serious case review should have been independent of the Child Death Overview process, although in other situations there would be a link between the two processes as the Child Death Overview panel would refer the case to the LSCB chair where they suspected neglect or abuse may have been a factor in a child's death[3].

5. RECOMMENDATIONS

5.1 Hillingdon Safeguarding Children Board should document, ratify and publicise the serious case review procedures and the serious case review sub group should provide an annual report to the Safeguarding Children Board on compliance.

5.2 Hillingdon Safeguarding Children Board should write to the Department for Education and Ofsted to bring to their attention the gap in arrangements for the notification of serious incidents in school that may have implications for the safety of pupils. The Board should ask that the criteria for notification be set out in an addendum to national guidance[4].

5.3 Hillingdon Safeguarding Children Board should ask health organisations to discuss with their staff any barriers to asking mothers about experiences of domestic abuse and develop a plan for responding to the findings.

5.4 As a point of good practice primary schools within the London Borough of Hillingdon should be asked to consider whether they have systems for encouraging parents to inform them of extra tuition received by pupils outside school.

[3] Working Together to Safeguard Children 2015 p84
[4] Keeping Children Safe in Education 2015