Hillingdon LSCB Response to the Serious case Review in relation to a young person.

1. INTRODUCTION

1.1 In 2015, somewhere in England, a mother and the young person who was her child committed suicide by jumping together in front of a moving train. The Independent Chair of the Local Safeguarding Children Board decided in July 2015 to commission a serious case review. The review started in September 2015.

1.2 This review, which was thorough, found no new learning because there had been little meaningful involvement with professionals since 2009. It concluded that the event that led to the tragic death of a young person and her mother could not have been predicted or prevented.

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 The serious case review panel met on four occasions between September 2015 and May 2016. The overview report was ratified at the local safeguarding children board meeting on 1st July 2016.

2.2 The lead reviewer was Barry Raynes. Barry is a non-executive director of Signis, a company that owns Reconstruct which provides child care training and consultancy to managers and staff throughout the United Kingdom. Reconstruct also supplies advocacy, independent visiting and participation services to children in England

[1] Working Together to Safeguard Children 2013 updated in 2015

2.3 Each agency who had been involved with the family was asked to check their records and produce a chronology of events

2.4 Each chronology compiler was asked to comment upon any learning that arose from their chronology. Some comments were made but none produced lines of enquiry pertinent to learning lessons from the deaths of the two people. These chronologies were integrated to form a joint chronology (running from 2002 – 2015) and, from this, the lead reviewer produced a narrative of events.

2.5 The young person and her mother had both left suicide notes which were in the possession of British Transport police (BTP). The Panel were assured by BTP that there was no information in the notes that would have led to any concerns about professional practice.

2.6 The serious case review took 12 months to complete. This is longer than the time prescribed by Government guidance. Delays were caused by the summer break in 2015 and the timetabling for the report to be signed off at a quarterly Board meeting.

3. Lessons Learned

The serious case review concluded that the death of the young person could not have been predicted or prevented, and there was no evidence that any professional could have been aware of mother's state of mind that would have led her to kill herself and her child.

The decision to hold this serious case review was made because there appeared to be considerable agency involvement with the family and that, along with the unusual nature of the deaths of the mother and her child, meant that the decision to hold the review was reasonable.

It soon became apparent that historical and recent intervention by professionals had been appropriate. The conclusion is that there is no learning arising from this review.

Hillingdon LSCB June 2016.