Serious case review
overview report
in respect of
a young person

Barry Raynes
Director
Reconstruct
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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.

2. METHODOLOGY

2.1 A serious case review panel was convened: their role was to produce terms of reference[1] for the review and oversee and quality assure the work of the lead reviewer and author of this report, Barry Raynes.

Serious Case Review Panel

2.2 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.

2.3 The panel comprised of:

Designation	**Organisation**
LSCB board manager	The safeguarding children board where the mother and young person lived at the time of their deaths
Designated Nurse Safeguarding	A clinical commissioning group
Detective sergeant	The police
Designated Nurse Safeguarding	Clinical commissioning group
Director of Learning	Young person's college
LSCB board manager	The safeguarding children board where the mother and young person had previously lived
Safeguarding manager	Children's social care where the mother and young person had previously lived
Head	Mental Health Services
Head teacher	Young person's school
Assistant director	Children's social care where the mother and young person lived at the time of their deaths

Independence

2.4 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] Guidance specifying how the review was to be managed.

2.5 Barry has thirty five years' experience of child protection social work. He has been involved in over 30 serious case reviews since 2007 – either overseeing the work of Reconstruct's consultants or producing overview reports. He has written web-based child protection and child care procedures for more than 50 LSCBs and local authorities in England, Wales and Scotland. Barry has a Masters degree in public sector management and has researched to a PhD level. Barry attended all panel meetings.

Chronology and narrative

2.6 Each agency who had been involved with the family was asked to check their records and produce a chronology of events. The following agencies produced a chronology.

- Community services where the mother and young person had previously lived
- Children's social care where the mother and young person had previously lived
- Housing department where the mother and young person had previously lived
- SEN services where the mother and young person had previously lived
- The young person's school
- GP
- Children's social care where the mother and young person lived at the time of their death
- Housing where the mother and young person lived at the time of their death
- Schools admissions where the mother and young person lived at the time of their death
- Mental Health Services where the mother and young person lived at the time of their death
- The police
- The young person's college

2.7 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.

2.8 That narrative of events was shared with each agency's chronology compiler and they were asked to comment further upon any matters of practice and no responses were received.

2.9 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.

Family involvement

2.10 The grandmother of the young person was contacted and asked if she wanted to be involved in the review; she declined. There were no details of any other family members available to the Panel.

Timescales

2.11 The serious case review took 12 months to complete. This is longer than the time prescribed by Government guidance[2]. Delays were caused by the summer break in 2015 and the timetabling for the report to be signed off at a quarterly Board meeting.

[2] Working Together to Safeguard Children (2015)

3. FINDINGS

3.1 The narrative identified that there had been considerable involvement between professionals and family members between 2004 and 2007 when the family were known to children's social care. The case was closed in 2007 and was never opened again to a social worker. The involvement between 2004 and 2007 appears to have been effective, proportionate and in keeping with procedures in place at the time.

3.2 The only professional contact with the family from 2009 until the event that ended the young person's life came from the family's GP, the young person's school and the police. The Panel considered three questions:

1. should the child's school (and latterly college) have requested more support for the family?
2. did the family's GP consider whether the mother may have had mental health problems and were there opportunities or circumstances that could have indicated welfare concerns in relation to the young person or her mother?
3. did the police deal appropriately with the contact they had with the mother?

School and college

3.3 The head-teacher of the young person's school attended one of the Panel meetings to discuss the school's involvement with the family. The panel was satisfied that there had been no concerns that warranted any action other than those taken by the school.

3.4 The director of learning at the young person's college attended all Panel meetings. There had been an incident in 2015 where the young person had fallen out with peers and the police had been called. The Panel were satisfied that the action that the staff at the college had taken was appropriate, proportionate, considerate and correctly followed their procedures.

GP

3.5 The Panel and the lead reviewer were aware that there had been contact between the mother and her GP and wondered whether the GP could have noticed any mental health issues or any sign that she was contemplating suicide.

3.6 The lead reviewer, along with the GP chronology compiler, (a named GP for safeguarding working in the area and independent of the practice) visited the practice and had a conversation with the GP and practice manager about the mother. The GP remembered her as an easy going, relaxed woman who was often tired and had problems with her joints. There had never been any difficulty with her behaviour and nothing had suggested that she had mental health problems or was contemplating taking her own life, or encouraging her child to do the same.

3.7 Further examination of the notes indicated that the mother had visited the GP on six occasions in the 12 months before the suicides; this was not considered to be excessive by the Panel.

Police

3.8 There was some contact between the police and the family in 2009 and 2010, then no contact until 2015, caused by the incident at college described above where police had been called. There was discussion at Panel regarding this involvement. It was the view of the Panel that the police intervention was appropriate, proportionate and in keeping with procedures.

4. CONCLUSION

4.1 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.

4.2 Once each agency had provided their chronologies it became clear that the information held on the family was, in the main, from 2005 and 2006 – nearly 10 years before the event that ended the young person's life. Further analysis of those earlier events confirmed that intervention had been appropriate and successful. Discussions with professionals who had been involved with the family more recently and analysis of the case records that did exist, demonstrated that recent intervention, such as it was, had also been appropriate.

4.3 There is therefore no learning arising from this review regarding events before the day of the suicide.

4.4 Records show, just before the suicides, that the mother went to an information desk at the station where they committed suicide and asked a member of staff when the next through train would be arriving. It appears that no action was taken following this request other than to supply the mother with a correct answer. The safeguarding manager of the local safeguarding children board who commissioned this review has been in contact with British Transport police and has discovered that training has now been offered to staff at the station in question.

4.5 There are therefore no recommendations arising from this review.