Hillingdon LSCB Response to the Serious Case Review in relation to Child X & Child Y.

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 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.

3. Lessons Learned

Although the serious case review concluded that the deaths of the two children could not have been predicted or prevented, and there was no

[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.

evidence that any professional could have been aware of mother's state of mind that would have led her to kill herself and her children, there are observations arising from the report.

LSCB Actions

3.1 Hillingdon Local 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.

Hillingdon LSCB and safeguarding Adult Board (SAB) have formed a Case review Sub-Committee that meets quarterly and is chaired by the LSCB business manager. This sub-committee considers recommendations from serious case reviews, serious adult reviews and domestic homicide reviews. The sub-committee has clear terms of reference and reports directly to the operational LSCB and SAB. An annual report will be produced for both boards. The procedures for a serious case review, serious adult review and domestic homicide review are published on the Hillingdon.gov website.

3.2 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.

Hillingdon LSCB has written to the Department for Education and Ofsted and was informed that the current procedures are satisfactory.

3.3 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.

Although there were no indicators within this case to suggest that domestic violence had taken place, the author observed that while reviewing reports from Hillingdon Hospital and the GP at no time had a question regarding domestic violence been asked. The understanding was that any women accessing health services, whether it is A&E or maternity services that a standard question regarding domestic violence would be asked. As there are currently a further two reviews that are focussed on domestic violence, this recommendation will be picked up at the case review sub-committee alongside the domestic homicide recommendations.

3.4 As a point of good practise 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.

There was no evidence to suggest that the additional lessons that Child X & Child Y were having impacted on what happened. This recommendation came from the school that they attended as the school were not aware of any extra lessons any of their pupils were having. The author felt that it would be useful for schools to hold this information in order to advise parents on how they can support their children, and to monitor whether these lessons are excessive, although that was not the case in this circumstance.

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