Overview Report on

The SERIOUS CASE REVIEW relating to

Child S and Child R

Contents

1 INTRODUCTION

1.1 Background to the review

1.1.1 In 2012 two children, along with their father, were found deceased at their home in Wiltshire. It is thought that the children had been drugged prior to being suffocated and that the father hung himself. The exact cause of the deaths is still to be determined by the Wiltshire Coroner however the police are not looking for anyone else in connection with them. Prior to the incident there had been involvement with this family from agencies across Hampshire and Wiltshire but there had been no evidence to suggest that father had ever acted violently towards the children prior to this event. The children had been in the care of Hampshire County Council, on a voluntary basis, for seven months. They had been living with their father for the six months immediately prior to their deaths.

1.1.2 The matter was discussed by the Hampshire Safeguarding Children Board (HSCB) Serious Case Review Sub-Committee on 28th September 2012 which considered the criteria for a serious case review (SCR) to have been met on the grounds that 'The Local Safeguarding Children Board (LSCB) should always undertake a SCR when a child dies, and abuse is known or suspected to be a factor in the child's death' and it was recommended that a serious case review should be held. That recommendation was confirmed by the Chair of the LSCB the same day.

1.2 The Terms of Reference

1.2.1 The purpose of a SCR as set out in 8.5 of Working Together (WT) to Safeguard Children 2010 is to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations worked individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons were both within and between agencies, how and within what timescales they would be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

1.2.2 Each Individual Management Review (IMR) author was particularly asked to address the following issues: -

- Identify and evaluate decisions, assessments, plans and services offered by the agency in relation to members of the household and family, with particular regards to:
    - domestic abuse/adult violent behaviour
    - parental substance misuse and mental health
    - the competencies and limitations of the parents in their parenting task
    - the extent to which the children's needs, views and wishes were taken into account.
- Identify and evaluate decisions, assessments and plans and/or recommendations made by the agency in relation to the residence and contact arrangements for the children. To what extent were the children's needs, views and wishes taken into account.

- Identify and analyse key events/opportunities for assessments and decision making in the 3 months leading up to the children's deaths. Were any child care or safeguarding concerns recognised and responded to appropriately.
- Examine and analyse the level and effectiveness of exchange of information and communication between agencies and across areas. Identify any gaps which may have impacted upon assessment, service provision or outcomes.
- Were there any organisational difficulties being experienced within or between agencies? Were these due to lack of capacity within the agency? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Highlight ways in which practice can be improved and make recommendations as appropriate.

1.2.3 Additionally it was agreed that authors of IMRs, SCR panel members and the author of the overview report should give consideration to the areas identified in W.T. 2010 page 245 in their analysis of involvement that were not covered by the above specific issues and should bring to the attention of the SCR panel chair any other matters identified which appeared to fall within the scope of the review if they thought that there were lessons to be learnt either for an individual agency or for the HSCB. Working Together 2013 was produced during the period of this review and this final report was produced in accordance with the requirements for full publication.

1.2.4 It was also expected that authors of IMRs who identified other significant issues not falling within the scope of the review should bring them to the attention of a senior manager within the agency. Finally it was expected that consideration would also be given to the findings of recent SCRs both locally and nationally.

1.2.5 The time frame of the review was from 1st September 2010 until 3rd September 2012 and agencies were asked to provide a detailed chronology for that period. All agencies were also requested to provide a summary of any significant events and relevant family history outside the specific scope and timescale, where this would help to inform the overall analysis.

1.3 SCR Process

1.3.1 IMRs were received from the following sources:

- Hampshire Children's Services Department
- Hampshire Education – Primary School
- Hampshire Police
- Hampshire Probation
- Southern Health NHS Foundation Trust – Hampshire Health Visiting & School Nursing
- Hampshire Early Years
- Borough Council
- Housing Provider
- Solent NHS Trust – Homer Substance Misuse Service
- Southern Health NHS Foundation Trust - Mental Health
- Hampshire Adult Services
- Primary Care (Health) - GP Services
- CAFCASS

- Wiltshire Children's Services Department
- Wiltshire Police
- Wiltshire Probation
- Great Western Hospitals NHS foundation trust – Wiltshire Health Visiting
- South Central Ambulance Service

1.3.2 IMR authors were provided with a briefing session and authors were also asked to attend the SCR panel in order that feedback could be provided on the reports and the panel could ask questions in order to clarify any issues.

1.3.3 Additionally reports were received from a number of agencies who had limited contact with the family during the relevant period but who had information that would assist the review. Reports were received from:

- Hampshire Hospitals NHS Foundation Trust
- HMP Winchester
- University Hospital Southampton NHS Foundation Trust
- Wiltshire Early Years

1.3.4 A health overview report was also produced by the Designated Nurse to enable NHS Hampshire, as commissioners, to review and evaluate the practice of all involved health professionals (including GPs and providers) commissioned within the PCT area.

1.3.5 IMRs and the health overview report were drawn up by officers who had had no previous involvement in the case.

1.4 Family Input into the SCR

1.4.1 Consideration was given to involving the family in the review process and the independent overview author met with the mother, the father's brother and the maternal grandparents. The paternal grandparents lived a great distance away, and had less contact with the children, so the overview author had a telephone conversation with them. The panel is conscious of the distress experienced by family members and is grateful for their significant contribution to this review.

1.5 The SCR Panel

1.5.1 The review group membership was as follows: -

- Ron Lock Independent Chair
- Hampshire Police
- Hampshire Probation
- Hampshire Children's Services (Education and Inclusion)
- Hampshire District and Borough Councils
- Hampshire Children's Services (Children and Families)
- Designated Nurse, NHS Hampshire
- Designated Doctor, NHS Southampton
- Southern Health, Mental Health
- Acting Board Manager
- Wiltshire LSCB

- CAFCASS

Additionally Fiona Johnson, the independent overview writer attended SCR Panel Meetings.

1.5.2 The panel met on eight occasions; four meetings to review individual management reports and four meetings to agree the independent overview report. Dates of review Panel meetings were as follows: -

- 7th January 2013
- 11th January 2013
- 16th January 2013
- 28th January 2013
- 13th February 2013
- 25th February 2013
- 6th March 2013
- 21st May 2013

1.5.3 The chair of the panel is Ron Lock and he has had no direct involvement with any of the professionals' work being reviewed. He is a qualified social worker who has spent his entire career in the field of child protection, for most of that time with the NSPCC, finishing in their employment in 2001 as a Regional Head of Child Protection Services. Since then Ron has been an independent consultant in safeguarding children, is the chair of the Bournemouth and Poole LSCB, and has specialised in SCRs, to date being involved in more than 70, either as independent chair or overview author. Much of this work has occurred for a number of LSCBs across the Midlands and South of England, and has on one previous occasion been the author of a SCR in Hampshire. Ron has not had any professional connection with any of the agencies who provided services to the family who were subject of this SCR.

1.5.4 The independent overview writer is Fiona Johnson, an independent social work consultant. Head of Children's Safeguards & Quality Assurance in East Sussex County Council between 2004 and 2010, Fiona qualified as a social worker in 1982 and has been a senior manager in children's services since 1997 contributing to the development of strategy and operational services with a particular focus on safeguarding and child protection. She is HCPC registered and has previously written overview reports for East Sussex, Brighton & Hove, Portsmouth, Southampton, Kent, West Sussex, Wandsworth, Surrey, Slough, Kingston and Bracknell Forest LSCBs.

1.5.5 As part of the SCR process the overview author, the independent chair and some members of the SCR panel met with front-line professionals and their managers to discuss the early findings from the review process.

1.5.6 Child deaths and their consequences are distressing for staff who have been directly involved with the child and their family. This review has been greatly assisted by the co-operation and commitment of staff from all contributing agencies.

1.5.7 The overview report was completed based on information provided in the IMRs and the additional reports supported by the discussions with the family members and

front-line professionals and their managers. The overview author was also provided with executive summaries from previous serious case reviews held in Hampshire that were considered to be relevant.

1.5.8 The SCR panel considered at all stages how early learning could be shared with relevant agencies and staff. The recommendations and action plans will be shared with staff and implemented immediately where possible. Full publication of the findings of the review will follow on from the completion of the serious case review process.

1.6 Parallel Processes

1.6.1 The children's deaths have also been considered by the Wiltshire Coroner to establish the causes. The Wiltshire LSCB representative on the SCR Panel acted as the link between this review and coronial investigations. The coronial process had not been completed at the time of the conclusion of the serious case review process.

2 THE FACTS

2.1 The Family Background

2.1.1 The children were siblings and until 2010 lived with their mother and father who were not married. After their parents separated the children lived with their mother until they moved to foster carers. After seven months in foster care they moved to live with their father and remained there until they died. Their maternal grandparents and maternal aunt and uncle lived locally as did a paternal uncle. The paternal grandparents lived some distance away.

2.1.2 Both parents are white British and English is their first language.

2.1.3 Maternal Grandparents had regular and close contact with the children until they were placed in foster-care. Once the children moved to live with father their contact was when the children were staying with mother. Mother worked part-time until she was made redundant following a long period of sickness. Mother had worked at this job for thirteen years, returning to work after the birth of both children.

2.1.4 Father was one of four children. Paternal grandmother and her husband saw the children once or twice a year because of the geographical distance, but had regular 'phone contact'. It is reported that father moved south because of debts and problems associated with drug-use. Father worked full-time until he was sent to prison. Mother and father had significant debts. This meant that they became insolvent and were the subject of an Individual Voluntary Arrangement to pay off the debts.

2.1.5 Mother and father met when she was 17 and he was 23 years old, and their first child was born within a year. A history of domestic abuse and violence has been reported by mother that is said to have started when she was pregnant with her first child. The aggression was not continuous and mother described it as being exacerbated by father's use of alcohol and drugs. Mother did not tell professionals about the abuse and when she needed medical treatment for injuries she described them as being accidental. Mother did confide in colleagues at work about the domestic abuse, and her younger sister was also aware; however, she did not share the information with her parents. The police were occasionally involved in domestic disputes prior to 2010 however there was limited involvement from any other agencies apart from universal services such as GP, school and health visitor.

2.1.6 The older child attended school and the younger child was cared for by a child-minder whilst mother worked. Both children suffered from a genetic condition but otherwise they were generally fit and healthy. The older child was doing well academically at school and had appropriate friendship networks. There was no evidence available to any agency that the children suffered significant harm as a result of the alleged domestic violence.

2.2 Agencies' Involvement with the family

2.2.1 There were three main periods of agency involvement; ten months when the children were primarily in the care of their mother; seven months when the children were in foster-care and six months when they lived with their father.

2.3 First Period - Children living with mother

2.3.1 The parents separated after a ten year relationship and father left the family home. Over the next ten months both parents were known by professionals to abuse alcohol and possibly drugs. They both reported mental health problems and were seen by mental health professionals. Each parent was assessed regarding possible suicide risks and in neither case was the risk considered to be high. Support was offered to both parents by mental health services; but father refused it on the basis that his problems were resolved, and mother failed to attend appointments.

2.3.2 Despite living apart the parents continued to be involved in each other's lives and their relationship continued to be conflictual. There was significant police involvement with the parents. Both raised concerns about each other's parenting and both were given advice about seeking legal support in resolving custody and contact difficulties. At this stage only mother had parental responsibility for the children and this was known to all agencies.

2.3.3 Mother made a number of allegations about domestic abuse to a range of agencies and on occasions was seen with injuries. She did not co-operate with police investigations about the domestic abuse allegations and was often observed by the police to have been drinking although she was never considered by police officers to be incapable of caring for the children because of her alcohol intake.

2.3.4 During this period mother was discussed at three multi-agency risk assessment conferences (MARAC). These are meetings where information is shared on the high risk domestic abuse cases between representatives of local agencies. After sharing all relevant information they have about a victim, the representatives discuss options for increasing the safety of the victim and turn these into a co-ordinated action plan. The main focus of the MARAC is on managing the risk to the adult victim but in doing this it will also consider other family members including any children involved and managing the behaviour of the perpetrator. At one of these meetings professionals discussed the risk to the children but as by that time they were in foster care it was agreed there was no need for further intervention to provide additional safeguarding. These meetings discussed the risks to mother and considered that she was placing herself at risk by some of her actions which made it difficult to provide her with sufficient support. Father was also described by a Probation Officer at one of the meetings as having a 'significant drug problem' and being a 'loose cannon'.

2.3.5 Children's Social Care (CSC) undertook two initial and one core assessment regarding the children because of concerns regarding possible emotional abuse resulting from alleged domestic abuse and mother's possible alcohol abuse. These assessments involved consultation with the health visitor and school and mental health agencies but did not include communication with the GP. There was also very limited assessment of father who was seen once during this period at the CSC office. There was evidence of social workers talking with the older child who expressed unhappiness at mother's 'drinking' and said that father provided good care.

2.3.6 There were concerns about the safety of the children when in mother's care at the family home and it was therefore arranged that she should look after them at the maternal grandparents' home. During this time father was arrested for four offences, two involving violence to other adults, one concerned with violence towards mother and one for possession of cocaine. Mother returned to the family home, against the

advice of CSC and her parents, and the police took the children into police protection and they were then placed in foster care. At this point the Local Authority considered it necessary to initiate the Public Law Outline (PLO) process which is a pre-curser to applying to the courts to remove the children from their parents' care. At this point a Public Law Outline (PLO) letter was sent to both parents that set out the expectations on both of them if they wished to avoid the Local Authority applying to the courts for care orders and explained to the parents how they could apply for legal aid. This was followed soon after by the social worker meeting with both parents together to explain the PLO process. Soon after, father was sentenced to three months imprisonment. This sentence related to four offences, three for violence and one for possession of cocaine. The probation recommendation for sentencing was a Community Order with a condition to attend the Integrated Domestic Abuse Programme (IDAP). However, this was not accepted by the court which felt that imprisonment was more appropriate.

2.4 Second period - Children in Foster Care

2.4.1 Soon after the children moved into foster care there was a change in the lead social worker because there was a need for a worker from the long-term team to become involved. The process of handover was managed well and there was a clear case summary produced which identified future work which included mother changing her lifestyle to prioritise her children's needs and father addressing the issues of his drug-use while in prison.

2.4.2 During the period that the children were in care there were two main planning processes in operation. The first was the 'Looked After Children' (LAC) review arrangements and the second was a series of legal strategy meetings which began as a result of the initiation of the PLO process.

2.4.3 There were three LAC reviews held during the seven months that the children were in foster care. At the first review, held within a month of the children moving to foster care, neither school nor health visitor were present. The school attended the next two reviews but the health visitor was not present at any and it is unclear if she was invited. The first two review meeting were attended by mother but she was not at the final LAC review however father was at that meeting. All reviews were attended by social worker and foster carer and the children also attended all reviews with the eldest child contributing fully to the discussions. Much of the focus of the LAC reviews was on immediate planning for the children including health and education issues. The meetings did however give a clear direction about the need for permanence planning and that this should be achieved speedily.

2.4.4 The legal strategy meetings were attended by the social worker, his manager and a representative from Legal Services. The focus of these meetings was to ensure that there was planning in place to ensure that the children were returned safely to either parent's care and if that was not possible to ensure that appropriate plans were made for the children to move to alternative permanent carers. Soon after the children were placed in foster care there was a meeting that involved the paternal grandmother and paternal aunt to discuss possible longer-term care arrangements for the children. It was agreed at this meeting that if it were not possible for the children to return to mother or father's care then placement with the extended family would be the preferred option. Neither mother nor maternal grandparents were at this meeting although it is thought they were invited.

2.4.5 Initially there were plans to return the children to their mother's care. However, there were on-going concerns about her abuse of alcohol and her choice of partners. Mother was unreliable during contact visits and failed to co-operate with the social worker. It was clear from social work contact with the children that the elder child did not like mother's current partner and there were significant professional concerns about him which included his domestic abuse of previous partners and drug misuse. During this three month period mother disengaged from the planning process involving the children and it is unclear how well she understood what was happening.

2.4.6 It is known that during this period father had contact with mother by telephone and she reported to the police that he was threatening her saying that he would 'make her life hell' when he left prison. An investigation was undertaken which resulted in father being 'gate-arrested' on his discharge from prison and charged with harassment. Soon after this mother told the social worker that she was considering allowing father to have custody of the children as she was concerned that he would 'hound' her otherwise.

2.4.7 After the children had been in foster care for four months father was released from prison and immediately indicated that he wished to care for the children. Regular contact was arranged between father and the children supported by the paternal aunt and uncle with whom he was staying. The contact between father and the children was observed to be good and the older child was clearly happy seeing father on a regular basis. It was arranged that the children would spend Christmas with their father and with the support of the social worker he took them to stay with his sister and then paternal grandparents.

2.4.8 At this point mother was failing to co-operate with the social worker who wrote to her advising her that he intended to assess father as a carer for the children. There is no evidence that he told her that he was agreeing to the children being in their father's care over Christmas or that they would be spending Christmas away from Hampshire. At this point father did not have parental responsibility for either child as he was not named on the younger child's birth certificate and although named on the older child's this pre-dated the legislative change that presumed parental responsibility where the father is named. Although the first social worker had been fully aware of the legal position of the children and it had been discussed between agencies prior to the children moving to foster care, there was confusion at a later legal strategy meeting about the children's legal status however it is clear that the social worker was aware that father did not have parental responsibility prior to the children spending Christmas with him.

2.4.9 The social worker undertook assessments of both mother and father however these assessments were not written up until three months after the children had left foster care and so much of the planning decisions were being made on the basis of verbal reports from the social worker to his line manager and to the legal strategy meeting. The recording on the general case records by the social worker was also very limited which meant that there is minimal evidence as to which agencies were consulted during the assessment work. The assessments were therefore dependent on the social worker's direct observations of both parents and their interaction with the children. There is no evidence of formal consultation with the police, probation, mental health or substance misuse services about their perspective on his previous

violence and drug misuse and what its implications were for his parenting. There was also no evidence of contact with the prison service to identify whether he had received any support regarding substance misuse whilst in prison. It is also noteworthy that within two weeks of father's discharge from prison the social worker spoke to the housing department, and confirmed that the children were in local authority care, that he did not have parental responsibility for them but that if father had suitable accommodation, he had been assessed as suitable to care for them.

2.4.10 Maternal grandfather raised concerns about the assessment of father with the social worker saying that the CSC treatment of mother and father in assessing their parenting abilities had, in his view, been unequal. Maternal grandfather then followed this up in writing, a week later, raising concerns that he felt that father was emotionally unstable, was involved in drug abuse and had tendencies to violence and excessive alcohol use. There is no evidence that these allegations were investigated.

2.4.11 Soon after Christmas father approached a solicitor regarding applying for custody of the children and with the assistance of the Housing Department Rent Guarantee Scheme obtained private rented accommodation in Wiltshire. At the same time the foster carer told the social worker that the older child was increasingly distressed by contact, and wanted to move in with father. The social worker then agreed a plan with the foster carer that the children would move to live with father within three weeks. The children immediately started to have overnight stays with father and at a LAC review three weeks later it was agreed that the children would move permanently to his care.

2.4.12 The LAC review date was brought forward because the overnight contact between the children and father was going very well and the older child was asking to move to live with father. Mother was not present at the LAC review and there is no evidence that she was formally consulted about the decision to place the children with father. The meeting agreed a change in the care plan; that the children should reside with their father with close monitoring in place for three months. The children moved to live with their father from this date and effectively left the care of the local authority and from this point forward there were no formal multi-agency processes to monitor the children. It is relevant that at this point, the only person with parental responsibility was mother, who could have at any time, legally, removed the children from father's care.

2.4.13 At this time mother was having limited contact with the children as she had been disruptive in the meetings and had spoken inappropriately to the children. She was also not co-operating with the social worker who was undertaking a separate assessment of her capacity to care as she was pregnant and there were significant concerns about her capacity to care for a child appropriately. Mother sought legal advice for the first time at this point and appeared to understand her legal rights that she could remove the children from foster care and therefore from fathers care. The police had also been involved in a dispute between mother and father about custody arrangements. The day before the LAC review father appeared in court on the charge of malicious communication with mother whilst he was in prison. He pleaded guilty to the charge and the court requested a pre-sentence report. He was bailed to return to court on condition that he had no contact with mother. There were delays in

the pre-sentence report being completed by Wiltshire Probation, due to work pressures, and this report was not completed until 3rd April 2012.

2.5 Third period – Children living with Father

2.5.1 For the first month father seemed to cope well with looking after the children. The only problem reported to agencies by father, at this time, was regarding transport to school as he was living some distance away and was dependent on public transport. The school monitored the older child who seemed happy and well. The younger child was seen during this period by medical staff when father took him for an ophthalmology appointment; and by the health visitor, who undertook an initial assessment and recorded that he was well within age appropriate speech and physical development.

2.5.2 During this period mother's life style was very chaotic and there was police involvement because of domestic abuse incidents between her and her new partner which resulted in him being remanded to prison. A review legal strategy meeting was held which noted that the children were placed with father and that there were no concerns. The major issues discussed were mother, and her relationship with her ex-partner. It was agreed that there would need to be an Initial Child Protection Conference held later in the pregnancy. The only risk associated with the children was the dysfunctional relationship between the parents. It was agreed that the social worker should complete a Section 7 report for the court recommending supervised contact for mother and continued monitoring of father's care of the children.

2.5.3 There was however evidence that mother and father were resuming contact. Within the first six weeks the social worker made an unannounced visit to father and was told by him that the children were at mother's house, and would be having an overnight stay that night. Father explained that he had made this arrangement because he was due in court the following day. There was no evidence that the social worker advised that the children should not stay overnight despite the legal strategy meeting having recommended that mother's contact should be supervised and father's bail conditions precluding contact between father and mother. Four days later during a telephone conversation with the social worker, father admitted that the previous week mother had stayed overnight, and that she was now threatening to inform Probation that he was in breach of his bail conditions. The social worker expressed concern about this, but there is no evidence that he took any other action.

2.5.4 At this time a MARAC meeting was held that discussed the incidents the previous month concerning mother and mother's ex-partner. At that meeting mother's pregnancy was noted and health professionals and CSC identified that pre-birth assessments would be undertaken. The meeting noted that the children were in the care of father and the police informed the meeting that they had intelligence that father and mother had reconciled and that mother was staying with father in Wiltshire. The source of this intelligence was not disclosed; and, it is unclear if the social care representative on the MARAC shared this information with the social worker.

2.5.5 Later that month Wiltshire police were contacted by mother alleging that father had tried to strangle her and that this had been witnessed by the younger child. Mother phoned from outside a local police station and when the police arrived could not be

found. Wiltshire police contacted Hampshire Emergency Duty Service (EDS) who confirmed that father had care of the children and provided background information. Wiltshire police also spoke with the foster carer, who confirmed that the older child was staying overnight with them, because of a football engagement. The police visited father, who denied the assault, but said that mother had been with him all day, and had been drinking, and as she had become argumentative he asked her to leave. There was no sign of an altercation at the address and the child was seen asleep in bed. Mother was contacted again by the police, but refused to co-operate, so the matter was closed without any further action. Wiltshire police informed Wiltshire CSC about this event who failed to identify that there was a social worker in Hampshire working with the family, and therefore did not pass on any information. In reality, however, the social worker knew about the incident because of the contact with Hampshire EDS.

2.5.6 Soon after this incident father mentioned it to his probation officer, and also told him that mother had cared for the children the previous night, and that he was concerned she might not return them to his care. The probation officer asked father what he would do if this happened, and he said that he intended to discuss his options with his social worker, and asked to leave his unpaid work early to allow him to contact him. This was facilitated by the probation officer who also tried to contact the social worker, to advise him of father's contact with mother, and the possibility of friction if she did not return the children. The social worker was not available, but the probation officer left a detailed message with the duty social worker. There is no record of any follow-up by the social worker, either with the probation officer, or by contacting father and seeing the children.

2.5.7 During this period father's application for parental responsibility and residence orders on the children were considered by the courts. As Hampshire CSC were already working with the family CAFCASS had very limited input and the court decisions were made based on information provided by the social worker. He recommended that the father be given residence orders and that their contact with mother should be at his discretion, and should include overnight contact. The court accepted these recommendations. No defined contact order was made, but the court determined that contact should take place up to three days a week, and should include overnight stays. The court also required a further review of the arrangements after three months.

2.5.8 From this point onwards the children's contact with mother was at the discretion of father. It is unclear what direct contact the social worker had with the children from this date onwards as there are few records. A month after the court hearing there was a final legal strategy meeting. The purpose of this meeting was to determine further CSC involvement. It was noted that father continued to co-operate with the social worker. Furthermore the court had granted father parental responsibility and a residence order had been made in his favour, with contact between the children and mother at his discretion. The social worker reported one domestic incident in April that was caused by the parents becoming too close, but said that father had learned from this experience, and that there had been no further incidents. The meeting agreed to end the PLO process, and that social work involvement would cease or transfer to Wiltshire CSC, following the review in court.

2.5.9 In the three months prior to the children's death there was limited contact by any agency with father and the children, although the older child continued to attend school, and was doing well. Both children, when seen by professionals, seemed happy and there were no identified concerns regarding health or development. Father was seen regularly by his probation officer for supervision, and also attended unpaid work. Father did miss some supervision sessions and unpaid work which was ascribed to child care problems. The probation officer offered that the Probation Service would pay for a child minder, and father appeared to make arrangements for this, however it is unclear if the child ever attended; and father continued to attend supervision sessions with the child, inhibiting full discussions. On these occasions father blamed mother for failing to keep to arrangements for her contact with the children. When father met with the probation officer he presented as sober and discussed, rationally, the arrangements he was making for the children's contact with mother. Father also said that he was not drinking, and that he had no debts. When the younger child was seen at supervision sessions, there were no concerns noted. The probation officer also checked regularly with Wiltshire police for any evidence of further domestic disputes.

2.5.10 The relevant district council housing department in Hampshire had some involvement with father during this period. The first matter concerned the rent deposit loan which he was due to pay back monthly. There were delays in this payment being started and he was in arrears resulting in a letter threatening legal action being sent to him. Following receipt of this letter, father started monthly payments which were received regularly up until his death. Father was also nominated for a housing association property close to mother's address. Father visited this property, with mother and the younger child. They presented as a couple, and mother was put down on the application forms as next of kin and a key-holder. She was also heard by the housing official to say that the timing of the possible allocation was good as it would enable her to move in when she was evicted. The child was observed to be content and related well to both parents. In the event father's nomination to this property was refused by the housing association on the grounds of his anti-social behaviour and offences in the last three years. The property was also considered to be too near to mother's house. The social worker was advised that father was refused the property but it is unclear whether he was told of mother's presence at the visit.

2.5.11 Mother's tenancy was in jeopardy because of her anti-social behaviour and significant rent arrears. She was served with an eviction notice and contacted the housing department saying that the older child was living with her and asked for advice to avoid the eviction and made an application for housing benefit claiming that the child was living with her. The benefits officers observed father with the younger child waiting outside for mother whilst she made the application. At this time the police advised the social worker that they had been told that mother and father had resumed their relationship. The social worker telephoned father who denied that this was the case and said that he was aware that mother was about to be evicted and was sad that this would prevent the children having overnight stays with her. Father was adamant that despite mother's potential homelessness he would not resume their relationship. The social worker updated the police following this conversation. Later that month mother went to court and made an application to stay the eviction order, due the next day. This was unsuccessful, so she made a homeless application for herself and the older child, providing a letter awarding her child benefit as proof

that the child was living with her. The housing officer contacted the social worker and advised him about mother's homeless application and the letter showing that she was in receipt of child benefit. The social worker unexpectedly saw father and the two children the next day in town. He asked father about the claims made by the housing department and father explained that he had allowed mother to make the claim for child benefit in order to stop her being evicted. He also assured the social worker that the children were in his full-time care and that he regretted allowing mother to make the claim. The social worker saw both children and observed that they looked well-presented and appeared happy and content. The older child said that living with father was all right but that the area they lived in 'was a bit boring'.

2.5.12 A month later father was arrested by Hampshire police because he was seen by a CCTV camera operator snorting a white substance. He was arrested on suspicion of being in possession of a 'Class A' drug, he had also been drinking. On interview father reported that the substance was a legal high known as 'poke'. This investigation was open at the time of father's death and the white substance has since been identified as methiopropamine (MPA) which is not a controlled drug under the Misuse of Drugs Act 1971. Information about this matter was not passed to other agencies as the children were not present at the time of the arrest. Later in the month Wiltshire CSC received a telephone call from the manager for the flat saying that the rent on the flat had not been paid since the beginning of the year and that the tenant was due to be evicted. This message was taken by an administrative worker and a record made on the case file but it is not clear if it was seen by the social worker or his manager.

2.5.13 A week later father saw his GP because he was having difficulty sleeping. He said that he was experiencing stress regarding the court case for custody of the children and was prescribed medication to assist with sleep, for a limited period. There is no evidence that the GP considered whether this was a suitable prescription for a man having sole care of two children, nor evidence that he investigated father's home circumstances any further. Father failed to attend his appointment with the probation officer at the end of the month which was thought to be because it was the school holidays and he had not been sent a reminder about the meeting.

2.5.14 Three days later, as father was due to be evicted; the lettings agent visited the flat, with a potential new tenant, and found the bodies of father and the children. Wiltshire police then undertook a full investigation for the coroner which has yet to be completed.

2.5.15 The cause of the deaths has yet to be determined. There are indications that the children did not die on the same day. Mother and maternal grandparents have also told the author of this report, that around the probable time of the children's death, father suggested that mother should visit him at his accommodation to collect the children for contact, she refused to do this as she could not afford the travel costs.

3. VIEWS OF FAMILY MEMBERS

3.1 The overview author met with the maternal grandparents, the paternal uncle and his partner, with mother and also had a telephone conversation with paternal grandmother. Detailed reports were made of these conversations which were agreed with them. The key issues from these reports are included below.

3.2 All people interviewed were clear that they did not expect father to hurt the children and that they had not seen or reported to professionals any concerns that he would physically harm the children.

3.3 The paternal grandmother and paternal uncle felt that father was given insufficient support after he had moved to live in Wiltshire and felt that he found it challenging caring for two children alone. They felt that he should have been monitored more closely with more practical and emotional support provided, in particular, they identified assistance with money management and access to other people in a similar circumstance, as they feel he was very lonely as a single parent caring for a young child. The paternal uncle, who cleared the house after the children had died, said it was in a poor state and was surprised that this had not been monitored more closely.

3.4 The maternal grandparents and mother considered that the assessment of father prior to the children moving to his care was inadequate and did not fully address the issues of substance misuse and violence. They also felt that there was insufficient monitoring of the children once they were in the care of father. In particular they were concerned that he had been able to have rent arrears and be facing eviction without any action being taken by CSC.

3.5 Maternal grandparents, paternal grandparents and mother all considered that the arrangements for the children to spend Christmas with their father were arranged hastily and were influenced by a desire to have the children away from Hampshire over the Christmas period.

3.6 Paternal grandparents and paternal uncle considered that the second social worker could be difficult to contact and that assumptions were made by him about the level of support that they as family members would give. Maternal grandparents described him as disorganised and considered that he had a poor relationship with mother. Mother disliked the second social worker and said that she found it hard to work with him. All agreed that the social worker was keen to present the views of the children and was anxious for the children to move from foster care back to live with a parent.

3.7 Maternal grandparents and paternal uncle were both clear that the relationship between mother and father was conflictual and enmeshed and was not in the children's interests. They were both unhappy that the contact arrangements recommended by the social worker and confirmed by the court meant that there had to be on-going contact between the two parents.

4 KEY THEMES IDENTIFIED BY THE REVIEW PROCESS

4.1 The parents' relationship

4.1.1 There is clear evidence that the parents' relationship was enmeshed and that even after they separated there was significant contact which was destructive to both of them and potentially was emotionally damaging for the children. This was most apparent in the period prior to the children being placed in foster care, however, there is significant evidence that after the children moved to live with father there were close links which went beyond that needed for contact arrangements.

4.1.2 The continued contact between mother and father made it impossible for professionals to assist her in protecting herself from further domestic violence and resulted in some professionals doubting the validity of her claims about domestic abuse. Mother also often presented under the influence of alcohol. This affected how some professionals perceived her and contributed to the discrepancies between different agencies' assessments of risk. Mother's behaviour contributed to professionals' lack of confidence in her ability to work with them positively and in the children's best interests.

4.1.3 It is apparent that mother had a problematic relationship with the second social worker and she found it difficult to work in partnership with him. There were some aspects of his interventions which were difficult for her to accommodate as a victim of domestic abuse. His approach was initially to treat both parents equally and to work with them through contracts of agreement signed by both of them. This approach whilst suitable for work with couples experiencing marital difficulties could be experienced negatively by a woman who had experienced domestic abuse. It is clear that mother felt pressurised by father even when in prison and therefore was unlikely to feel that she was an equal partner in these processes. After father's discharge from prison he worked co-operatively with the social worker and increasingly became a partner in planning processes around the children from which mother was increasingly isolated.

4.1.4 Mother was sometimes not involved in making key decisions about the children's future, partly because she would not co-operate with the social worker. After the children were placed with father, he had almost total control over when and how mother saw the children. This situation is not uncommon and research has shown that men with a history of domestic abuse may use custody and contact with the children as a mechanism to control their ex-partner after the relationship has ended. 'In a study of abusive men referred to a parenting group, the use of custody proceedings to control or harass a former partner was a strategy commonly identified by the men themselves' (Francis, Scott, Crooks, &Kelly, 2002). Indeed, threats to obtain custody are often used by abusers as a weapon against the abuse victim to enhance power and control post-separation. Furthermore, research has shown that batterers are more likely to apply for custody and equally likely to be granted it in comparison to non-violent fathers (Liss &Stahly, 1993; Zorza, 1995)'.[1]

[1] Understanding Women's Experiences Parenting in the Context of Domestic Violence - Implications for Community and Court-Related Service Providers Peter G. Jaffe, Ph.D. Claire V. Crooks, Ph.D.

4.1.5 Whilst mother's reasons for remaining involved with the father may be explained by her desire to maintain contact with her children; father's motivations for continuing the relationship are less clear. The paternal uncle was very clear that he considered that the adults were mutually destructive, and that father understood this; which was why, when he was living with them, there was no contact. This position ceased almost immediately after father's move to independent accommodation. It is probable that father understood this was not in the children's best interests as he repeatedly denied to the social worker that he was seeing mother despite evidence to the contrary even when that contact was prohibited by bail conditions. It is also clear that, throughout the period of time that father looked after the children, he was aware of mother's personal circumstances including knowing about her possible eviction. It is obvious that father had not disengaged from an involvement in mother's life as evidenced by him assisting her in obtaining proof of child benefit for the older child as a means of being re-housed.

4.1.6 There was understanding within the wider professional system that on-going contact between the parents was unhelpful and not in the children's interests. On occasions contact between the adults was prohibited such as when father was subject to bail conditions. After the children moved to live with father the assumption by the social worker was that the couple would be able to manage contact arrangements, without the involvement of any other person or agency, and in the best interests of the children. There was however also an expectation that the couple would not resume their relationship as that would not be good for the children. It is unclear if this was ever formalised in a written contract or shared with other agencies. There was however evidence of agencies alerting the social worker to the indications that the couple had resumed their relationship which would suggest that professionals understood the risk of possible emotional abuse that this posed to the children.

4.1.7 The nature of the parents' relationship may be relevant with regard to father's final actions. Research about filicide, (the act of the murder of a child by a parent), has classified six different sets of characteristics of child murder[2]. Of these characteristics, one could potentially apply to the acts by this father; "Spouse Revenge Filicide - where the parent kills the child as a means of exacting revenge upon the spouse, perhaps secondary to infidelity or abandonment"[3]. Mother has certainly suggested that this was father's motivation for the children's deaths and there is some suggestion from her and the maternal grandparents that he might have wished to kill her as well. Research about filicide where the perpetrators then commit a self-destructive act identifies 'a subgroup of men who react poorly to conjugal separation and commit killing in a context of reprisal. In some situations, the children seem to be perceived by the man as an extension of the woman and their death seems to be a way of hurting her…'[4]

4.1.8 There was however no evidence available to professionals that would indicate that father presented a risk to the children and filicides are often difficult to predict and therefore prevent. More apparent would be the potential for on-going parental disharmony or domestic abuse. While the parents continued to have a close relationship there was the potential for incidents of domestic violence that could be

[2] Resnick, PJ, "Child Murder by Parents: a psychiatric review of Filicide. American Journal of Psychiatry (1969)
[3] Sara G West, "An Overview of Filicide". Psychiatry MMC, (February 2007)
[4] Suzanne Léveillée & Jacques D. Marleau & Myriam Dubé, Filicide: A Comparison by Sex and Presence or Absence of Self-destructive Behavior. Journal of Family Violence (2007)

witnessed by the children. Such an incident occurred within the first months of the children living with father although the emotional impact on the children was limited as the older child was staying with the foster carer and the younger child was said to be asleep.

4.2 Multi-agency Working

4.2.1 A significant feature identified in this review was the limited nature of the structured multi-agency working regarding the children once they were placed in foster care. Most of the assessments undertaken largely consisted of professionals in isolation assessing the parents in accordance with their own assessment processes and tools. Thus the probation officer, mental health and substance misuse services all assessed mother and father as adults requiring their services. Some of those assessment processes involved communication to gather information from other agencies but there was no multi-agency assessment. Most of these assessments included an expectation of judging parenting as a part of the assessment but this was always undertaken by the professional alone.

4.2.2 This was apparent in the context of the social work assessment of each parent. The main source of information used by the social worker for these assessments was his own observation of the interaction between the children and the parents and the information he gathered from interviews with them. There is no evidence that he used any specific professional tools such as 'motivational interview'. There is little evidence of the social worker collecting information and evidence in the 'context of an ecological framework based on clearly understood developmental and psychosocial theories.'[5] A good assessment of the father should have included an understanding of his own relationship and history; an assessment of his state of mind and reflective functioning; a perception of the caregiving environment generated by the carer; and, a knowledge of how the children's behaviours matched the environment provided. Using these factors the social worker could have assessed his likely responses to potential stresses, both social and environmental. Whilst there was some evidence that he evaluated the last two areas, there was little recorded about his relationships, childhood or his state of mind and functioning, despite a recent history of violence and substance misuse. An example of this being that there is no evidence that the social worker was aware that father had a complex childhood with different father figures.

4.2.3 The social worker did gather some information from other professionals, mainly school and health visitor, but this was largely focussed on how the children were presenting or whether parents were accessing services. He did not directly involve other professionals in gathering information about the parenting skills. This was particularly important in the context of understanding how their parenting was being affected by their alcohol and drug-misuse. Both parents were said to be abusing alcohol and drugs but there was never any systematic attempt to assess this or to clarify the extent of it and to judge the effect on parenting. There was widespread use of the term 'in drink' by professionals however there was no clarity as to what that meant and professionals understood the term to have different meanings. For the police it meant that adults had consumed alcohol but were not drunk. There was however little testing of the adults by any professional to gauge levels of alcohol

[5] P 67 Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005 Brandon et al DCSF 2008

usage or frequency. Much information about the parents' alcohol and drug-use was self-reported which is notoriously unreliable. Mother's erratic behaviour was clear evidence of her 'binge-drinking' but reports of father's alcohol and drug-use were rarely investigated despite evidence from his conviction of substance misuse and no knowledge of any treatment having been accessed. A recommendation was made by the legal strategy meeting that both parents should undertake drug and alcohol testing prior to contact however there is no record of this testing and it is likely that this did not happen.

4.2.4 There was significant reliance by the social worker in his assessment on the children's wishes and feelings. It is positive to see that the children were listened to and did provide substantial input to planning and reviews. This should also be seen in the light of the generally positive feedback with regards to the children's progress and development whilst in his care. It was unfortunate however that there did not seem to be any acknowledgement that the child's views might be influenced by parental pressure or that the children might prefer 'risky' care with a parent to remaining in foster-care or being passed to the care of the other parent. It is essential that children are consulted and that their wishes and feelings are taken into account however this must be balanced by considered and energetic risk assessment which understands that children's views are partial and influenced by a range of factors.

4.2.5 One effect of the absence of multi-agency assessment was that there was no creation of a multi-agency package of support for father once the children were placed with him. Thus problem areas such as transport to school or child care were addressed separately by individual professionals. The school attempted to resolve the travel arrangements and both the health visitor and probation officer provided assistance with child care. A more co-ordinated approach would have been more effective and might have highlighted better some of the difficulties he may have been experiencing. Visits to the family home after the children were placed were limited and there is no evidence that any professional visited the house after the first three months.

4.3 Failure to revise judgements and plans

4.3.1 A significant feature of all the professionals involved with this family was a tendency to make judgements about the parents that were partial and did not appear to understand that even when one parent seemed more effective than the other there were still risks that needed to be assessed. Thus father was seen either, as a 'bad person' abusing his partner and involved in drug-use, or, a 'good man' who was working hard to care for his children. In reality, he was both, and the risks associated with his former actions needed to be fully assessed.

4.3.2 This is not an uncommon phenomena and recent analysis of serious case reviews found 'a tendency for professionals to adopt what they term 'rigid' or 'fixed' thinking. Fathers were labelled as either 'all good' or 'all bad', leading to attributions as to their reliability and trustworthiness'. [6] The researchers go on to describe how these fathers can be labelled as 'reformed good dad'.[7] After father came out of prison he appears to have quickly established himself in the minds of professionals as a reformed

[6] P52 Understanding serious case reviews and their impact: A Biennial Analysis of Serious Case Reviews 2005-7, DCSF 2009
[7] P53 Understanding serious case reviews and their impact: A Biennial Analysis of Serious Case Reviews 2005-7, DCSF 2009

character and the professional memory of his previous behaviour as witnessed by his criminal record was not given sufficient weight, despite some significant attempts by the maternal grandparents to redress the balance. Mother was similarly defined as 'bad mum' because of her alcohol abuse and erratic behaviour and as such became marginalised from involvement in the care of her children.

4.3.3 The reasons for this approach by an individual professional, has previously been identified, as a human cognition issue. One of the most persistent and important, problematic tendencies in human cognition is a slowness in revising a view of a situation or problem. Once people have formed a view on what is going on, there is a surprising tendency to fail to notice, or to dismiss, evidence that challenges that picture. As Eileen Munro has described it, 'Becoming fixated on one assessment despite an emerging picture that conflicts with it becomes a significant source of cognitive error.' [8] This is further described as a '*Garden path'* problem where professionals find it hard to revise their initial view because 'early cues strongly suggest [plausible but] incorrect answers, and later, usually weaker cues suggest answers that are correct'. [9] In this case the strong and positive relationship between the children and their father appears to have outweighed the information provided by mother and maternal grandparents who were seen as unreliable and biased. Later reports, by other agencies, of father and mother having increased contact, and their collusion to obtain accommodation, continues to be given insufficient weight because father is able to provide believable explanations and the children continue to present as being happy and well.

4.4 Use of legal process to protect children

4.4.1 Another common theme in this work was a lack of clarity and confidence regarding the use of legal process to protect children. This was first evident when the children became the subject of police protection and were placed in foster care. Police protection can last for up to 72 hours however the police officer making the decision has to consider how long such protection is needed and it should only be in operation for as long as is necessary to ensure that the child is safe. In this case the police protection was put in place on Friday afternoon but it appears that mother's consent to the children being accommodated was not gained until Monday morning. The delay in obtaining mother's consent was because she was inebriated and needed time to become sober before she could meaningfully give consent. Police and social work staff did not discuss the timescales for police protection and it is thought that social workers assumed that it would be for 72 hours. Police officers are required to end police protection as soon as a child is in a place of safety unless there are specific concerns that warrant it remaining in place longer. In this case the children needed to remain the subject of police protection until mother had given her consent for their accommodation but this required agreement between police and CSC. In this case this issue did not adversely affect outcomes for the children however it nevertheless is an important lesson for future practice.

4.4.2 There was also confusion as to whether father had parental responsibility for either child; which was of greatest significance for CSC as they needed to be working in partnership with whoever had parental responsibility, and needed to make key decisions about their welfare, only after consultation. The social worker undertaking

[8] P 53 A review of safety management literature. Eileen Munro, London School of Economics. SCIE 2008
[9] P 53 A review of safety management literature. Eileen Munro, London School of Economics. SCIE 2008

the initial assessment clearly recorded that father did not have parental responsibility; however, at the legal strategy meeting, the second social worker assumed that he did have it for the older child. In reality father did not have parental responsibility for either child until after they moved in with him. It is evident that the social worker knew before Christmas that father did not have parental responsibility so it would seem that he chose to place the children with father without any legal framework with the risk that mother could legally remove them from his care.

4.4.3 One explanation for this could be that mother was choosing not to have contact with the social worker and thus forcing him to act without her consent. In this context the most appropriate action by the social worker would have been; either, to facilitate the father obtaining parental responsibility more quickly; or, to consider whether (in the absence of a person with parental responsibility) the Local Authority should apply to the court for an interim care order to enable the parental responsibility to be shared with mother. The local authority had already started this process by issuing the PLO and had previously been confident that the grounds were met for an order. Clearly the circumstances had changed since then; and, it is possible the court would not have supported the application, however such an action would have meant that father could still have been considered as an alternative carer but within a more structured legal framework.

4.4.4 One advantage of this approach would have been to ensure that both parents were legally represented and CAFCASS would have been involved which may have resulted in a greater focus on the children. As was identified in the CSC IMR, it was clear that mother had no real insight into why the children were in foster care and did not understand the seriousness of the PLO process. It was reported by the CSC representative to the review panel that it was very unusual for a parent involved in the PLO process not to have legal representation. It was apparent on a number of occasions that mother was unclear of her rights and did not fully understand the PLO process. If there had been an application made to the court by CSC this might have proved a spur to mother to get legal advice, also her entitlement to legal aid may have been different if the matter had been reviewed under a public law framework. There would also have been separate representation for the children and this might ultimately have been better for them. It must be acknowledged however that the PLO was a legitimate process to be used in these circumstances and there was significant efforts made by CSC to ensure that mother had sufficient information with which to understand her legal rights and responsibilities.

4.4.5 An additional effect of the absence of any formal legal order with regard to the children was that the decision to place them with their father, (and subsequent monitoring of their care) was the sole responsibility of CSC, and the social worker. Once the children were placed with father, there were no inter-agency frameworks in place to review their care. If the children had been the subject of a care order, they could only be returned to father's care via 'placement with parent' processes which require formal consultation with other agencies, including the police. They would also have remained the subject of LAC planning reviews until the order was discharged.

ANALYSIS

5.1 What was the quality of decisions, assessments, plans and services offered by agencies with particular regards to: domestic abuse/adult violent behaviour?

5.1.1 There were positive aspects of the work undertaken by agencies with regard to domestic abuse. There was regular notification of events by police to all agencies including school and health visitor. There was also evidence that police regularly considered children's needs and on occasions spoke to children when appropriate. There was also positive engagement by most agencies in the MARAC process and significant information sharing between agencies.

5.1.2 There were some limitations to the MARAC process in that the absence of clear records produced by one agency meant that each agency recorded what they thought relevant which could lead to inconsistency. The requirement to store records centrally also meant that individual case records did not always include the full detail of discussions. The MARAC process, where central representatives discuss a number of clients, meant that the discussions and decisions reached at MARAC lacked personal knowledge of the families. Also as the MARAC meetings only occur monthly there was sometimes a tendency for events to have overtaken these meetings. There was one MARAC immediately prior to the children being placed in foster care when the MARAC discussion was very focussed on the safety of the children and it is possible that it could have been more appropriate for there to have been a child protection conference which would have allowed those professionals directly working with the children to have contributed. It is probable however that the concerns being discussed would not have met the threshold for calling a child protection conference. This was discussed fully at the professionals consultation event and raised questions about the need for a more formal child in need planning process where there are concerns that do not warrant calling a child protection conference.

5.1.3 Most of the assessments undertaken by CSC whilst addressing the effect on mother of the domestic abuse did not include sufficient contact with father to assess his response to the allegations. Thus they relied on mother's interpretations as to what had happened which did not provide a good gauge of the risk that father posed as often mother minimised or exaggerated the abuse or was too inebriated to judge the effects.

5.1.4 There were two opportunities for father to receive assistance regarding being a perpetrator of domestic abuse. The first was when Hampshire Probation recommended attendance at an IDAP programme but the court gave a custodial sentence. The second was when Wiltshire Probation recommended that father should receive a sentence of 'supervision with unpaid work' in response to his action of making malicious threats from prison. This assessment should have considered recommending attendance at an IDAP programme given the nature of the threats and the fact that they were made when father was in prison.

5.2 What was the quality of decisions, assessments, plans and services offered by agencies with particular regards to parental substance misuse and mental health?

5.2.1 It was unfortunate that neither father nor mother fully engaged with either mental health or substance misuse services. Significant effort was made to engage mother in both but she was in such emotional chaos that she was unable to maintain regular

contact with any professional. It is clear that mother did have mental health difficulties but the extent to which these were clinical or were a learned response to her domestic abuse is open to debate. There is one perspective that describes much behaviour by abused women to be a legitimate response to trauma.

5.2.2 Father was only seen by the mental health services once despite some evidence that when under extreme stress he did have some aspects of suicidal ideation. There are two references to father considering taking his own life; once when the couple had first separated and the second after he has been arrested for assault and possession of cocaine. When he was seen by mental health services he presented very rationally and denied any need for help. In such circumstances it is hard for agencies to intervene further.

5.2.3 It is also unfortunate that there was not a multi-agency approach to the parenting assessments on both mother and father. It was clear that alcohol and drugs played a significant part in the couple's problems and was identified by them both as being a source of the domestic violence. A more co-ordinated approach to the parenting assessment that involved joint working between mental health, substance misuse and social work professionals might have identified more clearly the risks and the actions that needed to be taken to better promote the welfare of the children. It is noteworthy that mother and maternal grandparents were not happy about the assessment of father by the social worker and they raised concerns that the children may have been at risk of harm through neglect because of his alleged alcohol and substance misuse.

5.2.4 There was also very little evidence from most agencies of a knowledge or use of the Hampshire Joint Working Protocol[10]. Health partners whilst they communicated to some degree did not recognise the necessity to share information between health services working with the adults and those working with the children, sharing information in silos. The community mental health services and health visiting services did not communicate directly with each other, as guided by the Joint Working Protocol. This protocol was developed following a previous serious case review that identified issues about how risks were managed in a family where there were significant mental health and substance misuse issues. The expectation is that where agencies are working with adults who are parents and there are such issues that there should be immediate communication with key agencies such as the health visitor to ensure that the parenting risks are addressed. The development of the protocol was an acknowledgement of the difficulties in transferring information between agencies however this review has not identified significant improvement in this area.

5.3 What was the quality of decisions, assessments, plans and services offered by agencies with particular regards to the competencies and limitations of the parents in their parenting task?

5.3.1 As has been clearly stated previously the major limitation in the assessment of the parents to the parenting task was with regard to the possible effects of alcohol or drug abuse on their parenting. The assessment of father undertaken by the social

[10] Hampshire Joint Working Protocol
http://4lscb.proceduresonline.com/pdfs/joint_working_pr_parents_have_problems.pdf#search="Joint

worker was dependent on his direct observation of the children and information provided directly by father. There is no evidence that he gathered information from other sources apart from the school and family centre. An omission was that he did not ask the paternal grandmother how father had cared for the children over the Christmas period despite this being the first long period during which they were in his care. With hindsight the paternal grandmother considers that father found caring for the two children together too much.

5.3.2 There is some evidence that the social worker made judgements very early in the assessment process. Thus two weeks after father had left prison the social worker advised the Housing department that if he had accommodation he would be deemed suitable to care for the children. Mother, maternal and paternal grandparents all reported that the social worker seemed extremely keen that the children should not be in foster care over the Christmas period. The rationale for this is not known and it is clearly an emotive time of year when significant efforts are made for children to be with their families. This should not be a driving force, however, and in this case it seemed to lead to actions that were not technically lawful and caused distress within the wider family. There may also have been some pressure for the children to be discharged from care because of the need for planning for the older child's school place in September and this was mentioned at a LAC review. Whilst it is clearly important that social workers are thinking ahead about children's education this should not preclude proper assessment of risk.

5.4 What was the quality of decisions, assessments, plans and services offered by agencies with particular regards to the extent to which the children's needs, views and wishes were taken into account?

5.4.1 There was clear evidence throughout the work that all professionals worked hard to ensure that the children's views and wishes were taken into account. Many professionals spoke directly to the older child who was articulate and expressed his wishes. Examples of this prior to children being moved to foster care include the social worker seeing the older child alone during a visit when the child said that it was 'fun with father playing on the PlayStation' and that 'it did not feel safe with mother because she drank vodka, beer and wine starting at 5pm'.

5.4.2 There were also examples of the older child contributing fully to the LAC reviews particularly early in the placement when the child clearly stated a desire to remain in the foster placement rather than move to one closer to home and school. There is also evidence that when the older child felt that the move to live with father was not progressing in a sufficiently speedy manner the child made this clear to both the school and the foster carer who informed the social worker.

5.4.3 There is however sometimes a requirement for social workers to be able to differentiate between children's expressed 'wishes and feelings' and their 'needs'. In this case the 'wishes and feelings' were clearly heard by the adults but this may have overwhelmed their judgement about how those 'needs' would be best met. In the author's opinion and based on case recording there is a sense that on some occasions the social worker found it hard to accept the pain that the child was experiencing as a result of the separation from the father and that this had too great an influence on his practice.

5.4.4 There was also sometimes a lack of judgement about 'when' and 'how' the children should be included and involved in decision-making. An example of this was when the social worker spoke with the older child, and advised the child that, in his view, the assessment of mother was not favourable and that he had begun an assessment of father. At this stage, father had been released from prison for seven days, and the only person with parental responsibility was mother. It is not clear if mother had been advised by the social worker that he was assessing father as a carer, or that he considered her to be unsuitable to care for the children.

5.5 What was the quality of decisions, assessments and plans and/or recommendations made by the agencies in relation to the residence and contact arrangements for the children? To what extent were the children's needs, views and wishes taken into account?

5.5.1 As previously stated the decision to place the children with father when he did not have parental responsibility or a residence order depended on mother co-operating with the arrangement. Similarly the recommendation to the court that father should manage the contact with the children was problematic. At best this arrangement meant there was on-going direct contact between two individuals who repeatedly showed that they had difficulty maintaining appropriate boundaries. At worst it was enabling father who had previously abused his partner for thirteen years to have significant power over her. However, it should be acknowledged that the court made this order having considered all of the facts at that time.

5.5.2 It is clear that the social worker was acting in accordance with the children's wishes in enabling their move to live with father. It is also clear that the older child particularly was disillusioned by mother's actions and felt that she was unreliable. In this context it was important to ensure that on-going contact was a positive and enabling experience. It is unclear how this was expected to be achieved given the attitude and behaviour of both parents. The social worker repeatedly asked the parents to work together in a mature way to ensure that the children's needs were being met but there was significant evidence that mother was unable to do this, and some evidence that father also was failing to do so. In these circumstances it may have been appropriate to recommend the involvement of a third party in the handover arrangements which could also have served to monitor the progress of the relations between mother and father.

5.6 What was the quality of assessments and decision making in the 3 months leading up to the children's deaths? Were any child care or safeguarding concerns recognised and responded to appropriately?

5.6.1 There were two significant events that might have prompted agency action in the three months prior to the children's deaths. The first was father's arrest for being in possession of a white substance. This event was being investigated at the time of the deaths and because the children were not present, in line with police policy, it was not reported to the police Child Protection Team. When interviewed father advised that the children were in the care of their mother. The second event was the notice of eviction of father for non-payment of rent. It is clear that this suggested a lack of stability by father in providing accommodation for the children and warranted further examination.

5.6.2 During the three months immediately prior to the children's deaths, there was limited contact by any agency with them. The older child attended school for half the period

and did not show any distress or report anything unusual. Father attended probation appointments regularly but nothing unusual was noted. The housing department and police reported to CSC that mother was having significant contact with father. The social worker did discuss this with him, when he met the family in the street, and on that occasion, he saw both children who seemed happy and well.

5.6.3 During the three months leading up to the children's deaths it is evident that there was some drift in the planning by CSC. There was no decision made regarding closure or transfer but there was equally no active input recorded by the social worker. The supervision record at this time indicates that either transfer to Wiltshire or closure would be appropriate but did not make a decision about which was the most appropriate course of action. It is unclear what the rationale was for the case remaining open to Hampshire CSC at this time. Transfer of case responsibility to Wiltshire CSC may have been appropriate but would have depended on their willingness to accept case responsibility. It is concerning that there was no consideration of consulting with other agencies about this decision or evidence that they would have been informed about the case being closed.

5.7 What was the quality the level and effectiveness of exchange of information and communication between agencies and across areas? Were there any gaps which may have impacted upon assessment, service provision or outcomes?

5.7.1 There was some evidence of good communication between agencies and there were significant levels of information sharing. There was however a tendency for most of the service provision to be undertaken in silos and until the children were accommodated there was no clear multi-agency planning process with regard to them. Even whilst they were looked after the assessment and decision-making was largely undertaken by the social worker with limited involvement of other agencies. Whilst there was regular contact with the school there was limited involvement of the health visitor and minimal contact with the GP. Once the children moved to live with father there was no multi-agency planning and professionals reverted to passing information to the social worker.

5.7.2 There was limited evidence that professionals were aware of and using the Hampshire Joint Working Protocol (JWP) despite both parents having 'complex problems that might impact on their ability to care for children'[11]. Communication between all adult services and CSC was minimal and few agencies linked appropriately with the GP despite that professional being a central hub for information sharing, particularly about the adults. The MARAC process was multi-agency and was well attended by professionals. The effectiveness of the process was however questionable given the recurrence of domestic abuse incidents and earlier in the report are details of reasons why this could be the case.

5.7.3 Another factor that impacted on information sharing was that father moved into accommodation outside the Hampshire boundaries which meant a significant change in the professionals from all key agencies. As the children were not looked after there was no obligation on Hampshire CSC to advise Wiltshire CSC that the children had moved into their area but this clearly could have facilitated communication. It would

[11] Hampshire Joint Working Protocol
http://4lscb.proceduresonline.com/pdfs/joint_working_pr_parents_have_problems.pdf#search="Joint

also have been good practice for the social worker to discuss with Wiltshire CSC whether they would accept case responsibility to provide support for the family particularly given that the possibility of transfer was raised in the LSM.

5.7.4 There were also communication difficulties between Wiltshire police and Hampshire police when Wiltshire failed to contact Hampshire to get more detailed local information. At the front-line professionals group there was a strong view from Hampshire police officers that the move weakened the focus on the family as the Hampshire police force knew both parents well. The issue was that mother reported a domestic violence incident in Wiltshire whilst she was resident in Hampshire. If Wiltshire police had passed the details of this incident to the Hampshire police Domestic Violence Team they would have had a complete picture of the risks from domestic violence to a Hampshire resident and then could have referred her to a Hampshire MARAC if appropriate. It is also noteworthy that information sharing about domestic abuse incidents varied across the two counties so the school was not advised of the domestic abuse incident that occurred in Wiltshire.

5.8 Were there any organisational difficulties being experienced within or between agencies? Were these due to lack of capacity within the agency? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

5.8.1 The Wiltshire CSC IMR clearly identified that workload pressures and vacancies resulted in the delays in responding to the police referral about the domestic abuse incident in April 2012. It is clear however that this delay did not have a significant impact as the Hampshire social worker was aware of the incident although Hampshire police were not.

5.8.2 The main social worker in Hampshire was an agency worker, brought in to cover vacancies in the team. The team was therefore not fully staffed; however caseload data, and feedback from staff, indicate that workload pressures were not greater than in comparable teams. There were also changes in management arrangements but the IMR author did not consider that these affected practice and the social worker when interviewed did not consider that it affected his supervision.

5.8.2 There were workload pressures because of vacancies in the health visiting teams in Wiltshire and this was seen as one explanation for the lack of closer monitoring of the younger child by the health visitor. It is not clear that this would have made a significant difference to the children's safety as the child was seen by a range of health professionals when in his father's care and seemed happy and well.

5.8.3 A resource issue, identified by the school, was regarding support for father with transport in getting the older child to school. The panel agreed with the professionals that continuing the school placement for the older child in his last year of primary school was important, and that the very long journey on public transport would have placed some stress on father, which may have been alleviated, if transport could have been provided. This was also an issue raised by the paternal uncle and his wife, who felt that the daily journey both led to greater contact between mother and father, and, also was a financial pressure.

6. ASSESSMENT OF IMRs and the SCR process

The review ran smoothly, with good participation from most agencies. The quality of management reviews was generally good and agencies kept to timescales. Family members contributed to the review process and frontline staff and managers were also involved. The multi-agency meeting had a significant personal impact on some individual staff. The panel noted the importance of all staff involved with child deaths to be given sufficient support in contributing to serious case review processes which can be very challenging for them. It was also agreed that the methods by which front-line staff can contribute to the review process would be further evaluated.

6.1 Hampshire Children's Services Department

6.1.1 This was a very full report that detailed all of the involvement of CSC staff with the family. It described the three periods of involvement firstly whilst the children were living with their mother, then whilst they were in foster care and then the later period when living with father. The report is robust in its critique of social work intervention and identifies a number of areas for improvement including improved social work record keeping, better recording of MARAC decisions and police checks. It also identifies ways in which the public law outline procedures could be strengthened and rightly identifies that the legal strategy meetings that are a part of the process should be as robust as the child protection planning systems. In the bulk of the report there are other areas of weakness identified that the author either considers to be specific to that worker or are areas where compensatory action has already been taken by the local authority, for example changes in the file audit processes that will present greater challenge to individual practitioners. The panel considered that the report was less robust with regard to the weaknesses of the social work assessment of father, particularly the absence of significant consultation with other agencies, and the limited supervision of the children after their return to his care. It also did not fully address whether the management and supervision provided to the social worker was sufficiently strong.

6.1.2 The original report was scrutinised by the panel who asked for additional information regarding the role and involvement of the fostering service and the foster carer. Otherwise there were minimal changes required and the panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.2 Hampshire Education - school

6.2.1 This report provided an overview of the involvement of the school attended by the older child for the period of the review. Generally the school had provided him a supportive environment when family life was difficult. The school had provided 'a close watch' over the older child for the duration of the review which meant that the class teacher, class teaching assistant and special needs co-ordinator observed the child closely in class and outside of lessons in order to identify any signs of deterioration in behaviour or progress. Most of the school's report focussed on information received from outside agencies as the child's progress within school was uneventful and the child was a popular and successful pupil. The report did evidence good information sharing across agencies. The only real difficulty identified was with regard to the distance travelled by the older child when living with father and the one

recommendation relates to provision of support to children travelling to school from outside the area.

6.2.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendation was appropriate and reflected the issues that were raised in the report. There was no action plan as the issue of transport was incorporated into a CSC recommendation

6.3 Hampshire Police

6.3.1 This report was a very detailed synopsis of the significant involvement that Hampshire police had with the family. It identifies strengths in the police response to domestic abuse but also highlights areas for improvement. It reports on the changes in the police Public Protection Department and the development of the Central Referral Unit as central point of receipt for all notifications of children at risk. The report also identifies the potential for children to be at risk when police are involved in making informal short term care arrangements and identifies checks that need to be made to militate against these risks.

6.3.2 The original report was scrutinised by the panel who asked for additional information regarding the MARAC. Otherwise there were minimal changes required and the panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.4 Hampshire Probation

6.4.1 This report reviews the limited involvement of Hampshire Probation which was concerning the production of a pre-sentence report. The recommendation that father should attend IDAP was not adopted by the court but their decision to impose a custodial sentence was seen as understandable in the context of his escalating violence. There are no recommendations.

6.4.2 This IMR was reviewed by the panel and as the terms of reference had not been formally addressed some minor amendments were suggested. The panel considered that the authorship was sufficiently independent.

6.5 Southern Health NHS Foundation Trust - Health Visiting

6.5.1 This report details the involvement of the health visiting service in Hampshire prior to the children being accommodated. It identified that both children suffered from a medical condition and evidenced the involvement of the service in the MARAC process. Recommendations made relate to operating procedures and recording systems for MARAC.

6.5.2 This IMR was reviewed by the panel and the first draft was felt to need some changes as it was insufficiently critical and did not address the terms of reference. Even after amendment there was a need for additional recommendations which was addressed via the Health Overview report. The panel considered that the second draft was acceptable; the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.6 Hampshire Early Years

6.6.1 This IMR provided an analysis of the involvement of the family centre in providing supervision for contact and the work of the child-minders who care for the younger child at different times. It identified the difficult task child-minders have in maintaining relationships with parents whilst maintaining appropriate professional boundaries and ensuring that children are safeguarded. The report also identified difficulties in commissioning the IMR because of the specific nature of the relationship between the Local authority and commissioned services such as child-minding. Recommendations made relate to the need for improved training and support for child-minders and improved protocols regarding the undertaking of serious case reviews

6.6.2 This IMR was reviewed by the panel who felt that significant changes were needed as the report did not address the terms of reference and needed substantial additional information regarding the role of the local authority as commissioner of services and the actual times that the child attended the child-minder. The panel considered that the second draft was acceptable; the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.7 Borough Council

6.7.1 This report is concerned with the housing and revenue and benefit services provided to the family. There was significant involvement over the period as both mother and father were in receipt of housing benefit and father required re-housing during the period of the review. The lessons learned from the review are mainly concerned with improving the confidence and knowledge of staff to, where necessary, challenge the judgements of colleagues in CSC. The recommendations are therefore relating to how to improve joint working between the two agencies.

6.7.2 This IMR was reviewed by the panel and as the terms of reference had not been formally addressed some minor amendments were suggested. The panel considered that the second draft was acceptable; the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.8 Housing Provider

6.8.1 This report related to the involvement the housing provider had with mother who was their tenant and also a decision made by the agency to refuse to provide accommodation to father who was nominated for a house near to mother after he had custody of the children. The recommendations mainly relate to improving awareness of safeguarding across staff.

6.8.2 This report was reviewed by the panel and additional information was required about involvement with mother. Additionally the report needed to be re-written to address the terms of reference. The panel considered that the second draft was acceptable; the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.9 Solent NHS Trust – Homer Substance Misuse Service

6.9.1 This report provides an overview of the limited involvement the service had with mother when they tried to engage her in addressing her substance misuse problems. The review highlighted good attempts to engage mother and that domestic abuse and child safety were considered in the work. The review also identifies that the recording system did not allow for full records to be made of all the interventions particularly with regard to domestic abuse and safeguarding. The recommendations are directed to addressing this deficiency.

6.9.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.10 Southern Health NHS Foundation Trust - Mental Health

6.10.1 This IMR GAVE an overview of the services provided to mother and father. It identified that the services provided to mother were appropriate and that clinicians involved with her identified the vulnerabilities of the children resulting from her behaviour. It noted that mother failed to engage with on-going therapeutic services despite significant encouragement to access them. It identified that services to father were also appropriate but that a more detailed assessment of him might have elicited information about potential risks and in particular his parenting responsibilities. The recommendations relate to the importance of improving understanding of domestic abuse, better recording and multi-agency liaison.

6.10.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.11 Hampshire Adult Services

6.11.1 This report reported on the very limited involvement the service had in screening referrals and passing them on to the Community Mental Health team. The recommendations relate to improving safeguarding training for staff involved in screening.

6.11.1 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.12 Primary Care (Health) - GP Services

6.12.1 This report reviewed the involvement of GP services with the family. There were three practices involved and primary care practitioners were closely involved in assessing both parents around mental health and substance misuse issues. Primary care practitioners were also aware of domestic abuse problems. The major finding of the review was that there was insufficient focus on parenting capacity when primary care practitioners undertook the assessments and that there were several opportunities where potential risks to the children could have been assessed. The

recommendations relate to increasing awareness of domestic violence, improving assessment of parenting capacity and ensuring that this is recorded appropriately.

6.12.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.13 CAFCASS

6.13.1 This report relates to the limited involvement of Cafcass following father applying for parental responsibility for both children. The report concludes that the actions were appropriate and in line with procedures. The report also identifies the need for improved operational guidance regarding Standard Operating Principles to define and support the standards of practice required in its Work to First Hearing.

6.13.2 This IMR was reviewed by the panel who considered that it was acceptable and that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.14 Wiltshire Children's Services Department

6.14.1 This report provided a very detailed overview of the single period of involvement by Wiltshire CSC. This related to the domestic abuse incident investigated by Wiltshire police. CSC failed to identify that a Hampshire social worker was working with the family and passed the case for assessment. Unfortunately due to pressure of work this was not undertaken and at a later date the case was closed with no action being taken. Recommendations relate to the development of new domestic abuse notifications and the associated changes in procedures and training systems.

6.14.2 This IMR was reviewed by the panel and was felt to need some changes as it was too long and included unnecessary detail. The panel considered that the second draft was acceptable; the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.15 Wiltshire Police

6.15.1 This report related to the one incident of domestic abuse that was investigated by the Wiltshire police. The findings identify some areas for improvement regarding the sharing of information about domestic abuse with other agencies. The recommendations also relate to changes in these systems.

6.15.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.16 Wiltshire Probation

6.16.1 This report details the involvement of Wiltshire probation in preparing the pre-sentence report and then supervising father. The report is critical of the recommendation as attendance at an IDAP programme would have been more

appropriate and the evaluation of the supervision is that it was insufficiently robust. The professional practice was not considered to be representative of general practice but was associated with individuals' practice that was being responded to via competency human resource processes. Recommendations relate to improving consistency of practice across all parts of the service.

6.16.2 This IMR was reviewed by the panel who considered that it was acceptable and that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.17 Wiltshire Health – Health Visiting

6.17.1 This review relates to the period when Wiltshire Health was responsible for monitoring the health and well-being of the younger child. The health visitor saw the child on two occasions, including one home visit. The review concluded that there should have been closer monitoring of the child when full consideration was taken into account of father's history. The recommendations therefore relate to changes in the recording of risk assessment and more training for staff on risk assessment.

6.17.2 This IMR was reviewed by the panel and some minor amendments were suggested. The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

6.18 South Central Ambulance Service

6.18.1 This IMR reports on six contacts with the family during the period of the review and identifies weaknesses with regards to ambulance staff safeguarding responses. The original IMR was not felt to be sufficiently robust and did not fully address the terms of reference so amendments were requested. After significant interventions these amendments were achieved.

6.18.2 This IMR was reviewed by the panel and amendments were recommended. These were implemented and an action plan was received.

6.19 Health Overview Report

6.19.1 This very comprehensive and detailed report appropriately reviewed the key themes from the health IMRs and identified any relevant matters of concern for commissioners. They also evaluated the health IMRs and where necessary made additional recommendations. These were the lack of GP involvement with the children once they were looked after; concerns as to whether safeguarding alerts placed on GP records were seen by clinicians; the lack of risk assessments by the health visitor where there was parental substance misuse, domestic abuse and mental health issues; and the limitations in the ambulance service regarding notification of previous safeguarding concerns when involved in repeat call-outs to the same address. There were six additional recommendations addressing these issues.

6.18.2 The panel considered that the authorship was sufficiently independent; the recommendations were appropriate and reflected the issues that were raised in the report and that the action plan was sufficiently robust.

7 LESSONS LEARNED FROM THE REVIEW

7.1 The review highlighted the need for integrated multi-agency assessment of families where children may be in need but which do not meet the threshold for child protection; particularly if there is evidence of the toxic trio of mental health, substance misuse and domestic abuse. Best practice demonstrates the need to move beyond information sharing, towards a more collective approach to making decisions regarding the care of children. Furthermore, the assessment needs to ensure that there is realistic understanding of parents whole life experience; and, it is important that issues of past substance misuse and domestic abuse are fully evaluated, when making decisions about the future care of children. This was particularly relevant with regard to the assessment of father which did not involve other agencies sufficiently.

7.2 A significant finding from the review is the danger of 'fixed thinking' and the need for challenging management and supervision processes that ensure that professionals involved in safeguarding children have sufficient professional curiosity so as to enable reflective case work even in a context where there is no evidence of direct physical harm to children. This was relevant with regard to the assessments by many agencies of mother where insufficient attention was paid to the impact of prolonged domestic abuse on her mental health. It was also significant with regard to father and it is important that managers should ensure that, where assessments depend on the work of a single person, the evidence base for their decision is robust enough and is appraised via critical analysis. The question that needs to be answered is what would have assisted the professional involved in being able to analyse and identify the effect that their interaction with the client was having on their practice. Clearly a significant factor has to be the nature and type of supervision being provided. This review has shown the importance of the 'critical review' aspect of supervision; there are certain types of erroneous thinking and decision making that will simply not be picked up by the individuals concerned themselves. The systemic issue for the LSCB is the extent to which agencies know how well their supervision provides sufficient 'critical review'.

7.3 The review also showed the importance of ensuring that whilst communicating and consulting with children there are still appropriate adult/child boundaries. Adults need to make the adult decisions, albeit having first obtained children's views, noting that in this case the local authority did not at any stage have parental responsibility for the children and the fact that the court granted residence orders to father.

7.4 A specific aspect of learning was the need for professionals from all agencies to have a greater mutual understanding of the legal framework within which they operate. Where possible, professionals need to enable these legal processes to include consultation and communication with professionals from other agencies. This clearly links to the learning in 7.1 around greater multi-agency involvement in assessment processes. It is important that all professionals feel confident in calling for multi-professional planning meetings to discuss safeguarding concerns. In this case it was apparent that there was no obvious point at which a child protection conference should have been held; but, all the front-line professionals consulted were clear that in the absence of such a need a multi-agency meeting of another kind would have enabled a better understanding of the family's problems.

7.5 The review also showed that the MARAC process, while well established, needs to ensure that it is better integrated with individual agency processes and systems. In particular it is important that any records of discussions about individual children are included in the individual client records and that each agency is confident that systems are in place which ensure that information is passed speedily from the MARAC representative to the individual key worker and it is clear what action is expected. Furthermore the review identified a need for clarity about when it is appropriate for a discussion within a MARAC to trigger a child protection conference, and how this should be initiated.

7.6 The review also identified the difficulties of working across boundaries and how important it is for all agencies to ensure that, when a family moves out of the area, sufficient relevant information is shared with professionals in the new area to enable them to fully understand any safeguarding risks.

8 CONCLUSIONS

8.1 Even with the benefit of hindsight it is clear that the events that resulted in the children's deaths could not have been predicted. Whilst father's violence towards mother had been identified the risks to the children were less tangible. None of the professionals involved with the family anticipated his actions. There is no evidence of physical abuse by father against the children prior to their deaths. No-one, including members of the family, anticipated his actions nor is there any substantive information to suggest that anybody could or should have anticipated the tragic outcome.

8.2 This review has highlighted, however, areas where practice could be improved and has shown that there could have been a better multi-agency assessment of father, before he assumed care of the children. It has also identified that after the children were returned to his care by the court there could have been closer monitoring of their well-being and better information sharing between agencies.

8.3 It is possible that if a more rounded assessment of father had been undertaken that this would have identified further information, but it is equally possible that this would not have provided any additional knowledge. It is therefore not obvious how these deaths could have been prevented.

9 RECOMMENDATIONS

9.1 Hampshire Safeguarding Children Board (HSCB)

9.1.1 That HSCB requires that Hampshire Children's Services Department review their planning processes for looked after children returning to their parents' care, where there have been concerns about neglect or abuse, to ensure that there is a robust multi-agency assessment and rehabilitation plan.

9.1.2 That HSCB requires that Hampshire Children's Services Department review their 'Child in Need' procedures to ensure that there are clear and timely decisions regarding closure or referral to a new authority area (if the family has moved) and that relevant information is shared in a timely manner with involved professionals and where relevant, professionals in the new authority area.

9.1.3 That HSCB requires Hampshire police to review the MARAC process to ensure that all meetings are suitably recorded and that all agencies have systems in place to enable records from MARAC meetings to be actioned and placed on individual case records. This review should include consideration of how the MARAC process interfaces with the child protection conference system.

9.1.4 That HSCB requires all agencies to ensure that their management and supervision processes are sufficiently robust as to ensure that fixed thinking by professionals is identified and challenged.

9.1.5 That HSCB should, via its Learning and Improvement Framework, evaluate the quality of frontline professionals' communication with children; reviewing whether they are sufficiently clear about the balance between responding to children's expressed 'wishes and feelings' and ensuring that their 'needs' are met.

9.1.6 That HSCB should, via its Learning and Improvement Framework, ensure that front-line professionals have a working knowledge of each other's legal frameworks to protect children.

9.1.7 That HSCB re-launches the Joint Working Protocol to ensure that it is understood and utilised across all partnership agencies.

Fiona Johnson
June 2013

Glossary of terms	
SCR	Serious Case Review
CSC	Children's Social Care
NSPCC	National Society for the Prevention of Cruelty to Children
MARAC	Multi-agency Risk Assessment Conferences
CAF	Common Assessment Framework
CAMHS	Child and Adolescent Mental Health Service
GP	General Practitioner
CP	Child Protection
PSW	Parent Support Worker
HSCB	Hampshire Safeguarding Children Board
IMR	Individual Management Review
PLO	Public Law Outline
IDAP	Integrated Domestic Abuse Programme
LAC	Looked After Child
EDS	Emergency Duty Service
CAFCASS	Children and Family Court Advisory and Support Service
JWP	Joint Working Protocol
LSM	Legal Strategy Meeting