Kirklees Safeguarding Children Board
www.kirkleessafeguardingchildren.com

A Serious Case Review in Kirklees (027):

Learning Lessons

This briefing has been produced to provide practitioners and managers with the key learning from cases that have been considered and discussed at the Kirklees Safeguarding Children Board Case Review sub group.

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved and it is believed lessons can be learned from the way in which the local authority, their board partners or other relevant persons have worked together to protect the child.

Kirklees Safeguarding Children Board

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

What was the story?
In November 2015 two sisters aged 3 years (Child 1) and 17 months (Child 2) were stabbed to death by their mother within 24 hours of transferring to a women's refuge after a claim of domestic violence by mother against the father.

Background and case summary:

- Father (aged 30 years) was British and had lived in UK until 15 years then moved to Italy to live with paternal grandparents. Mother (aged 24 years) was white Italian and they had been in a relationship since 2011.
- The parents moved to South Kirklees in March 2013 with Child 1 and Child 2 was born in Kirklees in 2014. Father worked full-time and mother was the full-time carer for the children.
- There were no concerns raised by professionals about the health or social needs of the mother or children throughout the mother's pregnancy with Child 2. At Child 1's two-year developmental check there were no concerns raised and parents stated they had a supportive network of friends and family.
- After the birth of Child 2 Health Visitor checks noted no unmet health or social needs and at the mother's 6-week post-natal check with the GP there were no concerns noted including post-natal depression concerns
- In November 2014 parents attended GP with concerns about Child 1's behaviour and speech development. In December 2014 Child 1 was seen by a paediatrician and reported to be difficult to engage and prone to screaming; referred to Child Development Team who six weeks later were unable to carry out an assessment due to lack of Child's engagement; referred to Speech and Language Therapist who devised a Plan for Child 1.
- Parents reported that Child 1's behaviour difficulties started at the birth of Child 2. They did not register Child 1 with a nursery in South Kirklees but did so in North Kirklees after they moved. Child 1 was referred to Early Years SEN Support Services in September 2015.
- In mid-November mother first stated to Early Intervention and Targeted Support Service that she wished to leave the children's father stating she lacked confidence and was isolated. She claimed there was no domestic violence.
- On 16th November, a telephone call was made to West Yorks Police and mother and children were placed in a refuge outside Kirklees. Over the following 27 hours both mother and father contacted agencies repeatedly with concerns about the other parent. At 11.15 on 17th November Mother reported to a Social Worker that she had killed both children.

Overview and Analysis

Strengths and Protective Factors

There was appropriate engagement with health services and other services throughout

Early Intervention and Targeted Support Services were supporting Mother

Child 1 attended Nursery in North Kirklees

Risk/Harm/Danger

The extent to which mother's language led to understanding difficulties and ability to communicate feelings and mental health status was not formally assessed and evaluated

Grey Areas

Paternal family were cited as a source of support but how this stated support was perceived by the Mother was not explored formally or fully

Lack of communication between agencies may have led to delayed intervention and support but it is not clear if this would have made any difference to the outcomes of this case

Domestic violence by Father was alleged by Mother although the evidence of this was scant and when questioned directly, Mother stated there was no DV

Complicating Factors

It was not possible to access the Mother's previous health records from Italy or to determine any inherent risks from the mother's background

The Mother had always demonstrated strong caring behaviours towards both children

Voice of the Child

Child 1's behaviour traits indicated there were unmet needs

Analysis

This case is characterised by:

The fact that no one identified the mother as constituting a risk to her children and the review finding that there is no reason why anyone should have expected her to harm, let alone to kill the children

Conclusion

In this case, the extent to which actual domestic abuse is a contributory factor is unclear however it is clear that for the mother, the abuse and threat of abuse was real. In particular the mother appeared to be fearful of losing her children and this became apparent very soon before the mother took the lives of her children and was not apparent before this. There were some failings in administrative processes (reporting information through letter and through direct telephone calls) however these appear not to have been significant contributory factors in this case.

The children appeared to be well looked after and to be thriving although Child 1 demonstrated additional developmental needs that were in the process of being investigated at the behest of the parents. The parents demonstrated appropriate high levels of care and this was recorded by all agencies who had contact with the family. There were some delays in referral and appointments for Child 1 to investigate and address the additional needs but these were not thought to be significant in this case.

Specific mental health needs (state of mind) of the mother were not recorded or investigated and it is not clear whether this is because of her English language and communication/understanding difficulties or any previous or pre-disposing mental health needs she may have had. It is apparent that the fact that the children were thriving and the parents appeared to be loving and caring did not raise any professional triggers or alerts.

Learning for Professionals and Multi-Agency Working

- In cases of alleged domestic violence, the first consideration should be for the safety of the alleged abused partners and their children and actions should be taken accordingly; however, alongside this there should be consideration of the mental state of the accuser which may or may not be the result of DV.
- Where there may be poor understanding and perceived, not real engagement because of English language difficulties and cultural differences, this should be tested as part of all professional conversations.
- In all cases where DV is cited, meetings to discuss professional issues regarding children should only take place when both parents agree to the meeting taking place.

Relevant Tools & Multi-Agency Responses for this case include:

Learning regarding victims of DA and fear of alleged perpetrators included in training.

The Impact of Domestic Abuse on Cl

For more information about Serious Case Review and this case visit:

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

'Closing the loop'

Actions taken to address the learning

What has improved/changed as a result of the actions taken and how do we know?
What have the audits revealed and what has happened since?
What metrics have been presented in reports and what are the continued trends that are demonstrated?
Are we assured that learning has been embedded across all agencies?

Evidence of impact of these actions

How often is the evidence reviewed?
What happens if the evidence indicates no improvement or little improvement or things slipping back?