SERIOUS CASE REVIEW

THE ANDERSON FAMILY

Executive Summary

of Overview Report

Independent Safeguarding Leads;

- Bob Cook (Chair of SCR Team)
- Ron Lock (Report Author)

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1. INTRODUCTION

1.1 This Executive Summary reflects the main findings of the Serious Case Review which was conducted in respect of the multi-agency involvement with the Anderson family, for the period of almost 4 years before the tragic deaths of all three children in April 2013 and the subsequent death of their mother on the same day. At the time of her death the mother was 7 months pregnant. The parents of the children were not married and the father of all three children lived separately from the family for much of the period of time of this review. The three children's names were Levina, Addy and Kyden who respectively were aged 3 ¾ years, almost 3 years and just over 1 year old at the time of their deaths.

1.2 The Anderson family were known to a variety of child care agencies from the time of the mother's first pregnancy in mid-2009 up until the deaths of all three children. At the time of writing there has been no coroner's inquest, although current evidence would suggest that the mother took the lives of the children prior to taking her own life.

1.3 There were two periods of time when Child Protection Plans were in place for one or more of the children; for almost a year up until June 2010 and then from October 2011. These Plans identified concerns in respect of possible physical and emotional neglect, and were in place at the time of the children's deaths. There were also legal initiatives to obtain Care Proceedings in respect of the first child and although these were withdrawn, later legal strategy meetings were held to continue to consider if the children met the criteria to seek care or supervision orders. Overall there was very limited success in engaging the mother and the father in professional interventions especially by Children and Young People's Service (CYPS) although other professionals such as health workers and children's centre workers did achieve a limited level of involvement.

2. THE SERIOUS CASE REVIEW PROCESS

2.1 Suffolk Safeguarding Children Board made the decision to conduct a Serious Case Review (SCR) which reflected the government guidance contained in Working Together March 2013. The purpose of the SCR is to "Identify improvements which are needed and to consolidate good practice"[1]. Additionally, SCRS should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed, and

[1] Paragraph 7, Chapter 4, Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – HM Government - March 2013

- Makes use of relevant research and case evidence to inform the findings.[2]

2.2 Suffolk Safeguarding Children Board chose to use a SCR learning model to undertake the review consistent with the principles in the government guidance. An independent Chair, Bob Cook, was appointed to lead the SCR and another independent person, Ron Lock, was appointed to be the author of the SCR Overview Report. Both independent persons have considerable experience in safeguarding children and young people, including involvement in SCRs in other parts of the country. Neither had previously worked in Suffolk in a professional capacity. Senior managers from Suffolk were appointed to be part of the SCR team, whose role was to assist with the scrutiny and analysis of professional practice in the case. In particular, each agency involved with the family were required to complete chronologies of their contact with the family as well as a summary of commentary and analysis of the professional practice by their agency with the family.

2.3 The SCR team met on three occasions with the independent chair and independent author in order to progress the SCR and to provide comment in respect of draft Overview Reports. Members of the SCR team were also very active in their contribution to the two one-day "Learning Events" which were conducted with frontline practitioners and their line managers. These meetings were held in order for as many of the practitioners and line managers who had worked with the family as possible, to contribute to the SCR team's understanding of the detail of the work that had been undertaken with the family and to contribute to the analysis of professional practice. In total 41 professionals attended the first Learning Event and there were 31 attendees at the second.

2.4 The outcome from these Learning Events, which were chaired by the Independent Chair of the SCR Team, was clarification of the factual details of the work undertaken with the family and contributions to the analysis of practice which in turn informed the key lessons learned from the work undertaken with this family. The findings from these Learning Events have been included within the body of the report in terms of both the factual and analysis components. Additionally to ensure greater understanding of particular parts of the work with the family, the Independent Overview Report Author spoke individually with some of the practitioners and managers.

2.5 The father of the children was interviewed by the independent Overview Report author in order to gain an understanding of his experiences of the professional interventions with himself, the children and their mother. His contributions are included in the body of the report. Additionally, the maternal grandparents met with the Chair of Suffolk Safeguarding Children Board and LSCB Manager to discuss the Report and lessons identified. Their views were shared with the overview author.

[2] Paragraph 10, Chapter 4, Working Together to Safeguard Children – A guide to inter agency working to safeguard and promote the welfare of children – HM Government - March 2013

THE FACTS

3.1 In terms of professional interventions with the family, this can be divided into three distinct phases. The first phase began just prior to the birth of the couple's first child, Levina, when there were high levels of professional concern about possible neglect of this child and the parental refusal to accept any professional advice or contact. As a result, the unborn child was made subject to Child Protection (CP) Plans[3] and Care Proceedings[4] were instigated although an application by the Local Authority was not granted by the court in June 2009.

3.2 By the time Levina was approximately 6 months old, the local authority withdrew the Care Proceedings in recognition that the assessment which had been completed did not provide the necessary evidence to substantiate the concerns. Levina nevertheless remained subject to CP Plans for a further 6 months before they were discontinued when it was considered that the family were appropriately accessing universal services and living with the family network which was viewed as a protective factor.

3.3 The second phase of professional involvement was from June 2010 to July 2011 when there were no formal "child protection" or "child in need" inter agency procedures in place to work with the family although some concerns were occasionally raised about possible neglect. By this time, the second child of the family had been born. Health and local children's centre involvement continued throughout much of this time, although this was limited in nature because of the parent's continued reluctance to accept professional interventions.

3.4 The third and final phase of professional interventions occurred from August 2011 until the death of the children when they were all subject to CP Plans under the category of neglect. The third child of the family was born in May 2012 and included in these CP Plans. Although legal interventions via the Public Law Outline (PLO)[5] process were again considered in order to protect the children, the plans for these drifted and ultimately no Care Proceedings were initiated. Although there continued to be considerable concerns about the care of the children, the refusal of the mother particularly to accept any intervention, meant that there was minimal contact with her and the children, and therefore the CP Plans achieved very little. Parental attendance at Child Protection Conferences (CPCs)[6] and Core groups[7] was

[3] A set of Child Protection Plans are set up at a Child Protection Conference of involved professionals and the parents, to address the concerns and identify what needs to happen to reduce the risks and improve the care of the child/children. These plans identify who will action and monitor each specific plan.

[4] Care Proceedings are when a court is asked to consider the care needs of a child or children based on evidence of the care of child concerned provided by the local authority and other agencies involved with the family. A number of court hearings are usually held before a final hearing can hear all the evidence and assessment of the family and a final decision is made.

[5] Public Law Outline (PLO) is a process which requires a local authority to complete all relevant assessments before applications are made to the court. If any pre-proceedings action or assessment has not been taken, the local authority must explain why in the application.

[6] A formal meeting of professionals from key agencies such as Health, Police, Children and Young People's Services and those professionals who have worked with and know the family. The purpose is to decide the level of concerns for any child or unborn child in the family and whether they are at risk of significant harm or will likely be in the future. The parents are invited to attend the full conference.

almost non-existent. Whilst the mother's behaviours and attitudes to her children and to professionals raised concerns during this time, the process of the CP Plans was unable to secure any psychological or mental health assessment of the mother.

Events leading up to the death of the children and their mother

3.5 During the afternoon of the **14th April 2013**, the father reported (via his later statement to the Police), that he had been at the mother's home and had fed the children lunch on that day and had left in the evening telling the mother that she needed to accept that their relationship was over.

3.6 At 8.05 p.m. the father called an ambulance claiming he had been stabbed from behind by an unknown male. As the initial statement by the father had said he had been in the vicinity of the mother and children's flat, in the early hours of **the next morning**, a police officer spoke to the mother at her address through the intercom. The Police also thought the incident might have been linked to a domestic dispute. She said that she had not seen the father for a month and would not come to the door.

3.7 The mother arrived at the father's accommodation later on the same morning (of the **15th April 2013)** just after 6 a.m. and handed her flat keys in for collection by the father.

3.8 Just before 9 a.m. on the **15th April 2013** the mother was found deceased in a public location – it was believed that she had jumped from a nearby multi story car park. Just after 11 a.m. **that morning**, the three children were found deceased at their home.

3.9 **Later that day**, the father informed the Police that it was in fact the mother who had stabbed him following an argument about their separation in which she said he would not be able to see the children again. He also explained that soon after the stabbing incident, when in hospital for a short period of time, he had told the mother via text that he had not told the Police what had happened.

FINDINGS AND ANALYSIS OF PROFESSIONAL PRACTICE

4.1 The predominant feature of this case was the challenge of how to engage this hard to reach family, and especially the mother who specifically avoided professional interventions. Despite some committed interventions by a number of practitioners, no success was ever achieved in effectively engaging the family in interventions by professionals, and this meant that overall the implementation of the CP Plans was significantly compromised. The early application for Care Proceedings in respect of Levina set a tone of an adversarial relationship for the parents, particularly with Children and Young People's Services (CYPS), and this strained relationship changed little for the final period of CP Plans and up until the deaths of the children.

[7] Core Group meetings are held between Child Protection Conferences and should involve the key professionals and the parents in order to initiate and monitor the progress the CP Plans.

4.2 Whilst the child protection process was implemented in line with procedures, it was not ultimately successful in engaging this most challenging of families who were avoidant of professional interventions. It was inappropriate for the CP Plans to continue largely unchanged for a period of eighteen months from August 2011 without some form of review and formal revision of the way forward with the family. Whilst there was a system of senior management overview in place, it did not sufficiently impact on this case. Lack of objective input to the Child Protection Conferences impacted on the ability of the CP processes to create a more challenging and questioning environment in which to monitor and improve the care of the children.

4.3 Although there was much consideration of the need for a legal intervention to secure the safety of the children during the latter phase of involvement with the family, this was never taken forward and unfortunately the process was allowed to drift for a period of over a year. The determination of the mother not to accept help was considerable and unwavering although whether a completed PLO process or an application for Care Proceedings at some stage from August 2011 onwards would have changed this, was never tested. Clearly if the children had been placed in care, this could have avoided the tragic outcome, but there was never any guarantee that an application for a Care Order for the children would have been successful, or that the children would not again return to her care even within the context of successful Care Proceedings.

4.4 It was nevertheless concerning that a clear decision was not made by CYPS in respect of the need for a legal intervention and instead allowed the process to drift in a most unconstructive way.

4.5 Whilst the main professional concern was in respect of neglect from both a physical and emotional perspective, it was the physical neglect which was given most attention when there was also evidence of emotional neglect. Overall the professional interventions and the concerns about neglect were never sufficiently supported by evidence that needed to be collected and collated on a multi-agency basis. Emotional neglect proved especially difficult for professionals to evidence, although a more concerted collation of these areas of concern could potentially have realised greater evidence.

4.6 Other challenges for staff that emanated from the difficulty of engaging the family, was being able to secure appropriate assessments either for the children or for the mother. Although psychological and psychiatric assessments of the mother were proposed and discussed with her, unfortunately these were never achieved because of the mother's reluctances. She had the right to choose not to accept that she needed a mental health assessment and there was no legal order in place to help secure such an assessment.

4.7 There had been no known history of either the mother or the father intentionally causing physical harm to the children, or of any self-harming episodes by the parents themselves. In this respect, the deaths of the children and their mother was completely unexpected and not predictable or thought in any way likely, from what the professionals knew of the family. Without any letter or definitive statement of intent by the mother, it remains

unclear why she took the actions she did. During 2013 there was no new initiative or different sanction which was being utilised at this time which would have generated a significant negative reaction from her. In some respects therefore, the analysis of the professional practice in this case goes little way to understanding the final acts by the mother.

LESSONS LEARNED

5.1 Working with hard to reach and avoidant families is very challenging for professionals and has impact upon the parents in the anxiety it creates for them and for the loss of the benefit of receiving supportive services. Innovative multi-agency interventions and new initiatives are likely to be required to engage parents in a more constructive working alliance. There is considerable research and literature on this subject which can give direction to practitioners and managers on how to attempt different strategies and achieve effective outcomes.

5.2 An effective way to identify whether emotional abuse or neglect exists within a family is to focus on the experiences of the children and identify what the impact of any emotional neglect might be. Practitioners need effective supervision and support to enable them to retain a child focus and assess their behaviours and development within families where the parents have high levels of need.

5.3 To allow CP Plans to continue unaddressed throughout a number of CPCs means that the children will continue to be subject to significant harm whilst still within the child protection process.

5.4 The role of the CPC Chair is a pivotal one in challenging the management of a case which is not achieving CP Plans and by inference it is maintaining children in at-risk scenarios.

5.5 For CPCs to only include those professionals directly working with the family will deprive the CPC of objective input by managers and specialists to help progress the case and reduce safeguarding risks of the children.

5.6 All professionals have the responsibility to challenge inappropriate or ineffectual practice, which has become intransigent and is not protecting children. This does not solely apply to CPCs and should include the need to escalate concerns to senior managers when necessary.

5.7 In demanding child protection cases, robust management oversight of the progress of the case is essential and should be shown to have a direct role and impact on the professional interventions.

5.8 To generate the appropriate response and relevant assessment of parents when there are concerns about possible adult mental health issues will prove to be very difficult when the parent does not see the need for any such assessment and is avoidant of any assessment activity focussed upon mental health. It nevertheless must remain on the agenda for multi-agency discussions in consideration of any changing family circumstances, and whether this might enable pertinent mental health assessments to be newly progressed and offered to the parent in question.

5.9 When cases are not progressing in terms of the protection of children, and the multi-agency process has become entrenched, if there is no separate process utilised to objectively review why the case has become problematic, then the children would continue to be at risk of significant harm, and the multi-agency interventions become further entrenched.

5.10 Background information of a parent's own childhood is essential to understanding their own parenting capacity, and if this information is not collected and shared among professionals, it will limit the accuracy of any parenting assessment.

5.11 Drift of the Public Law Outline process must be avoided by strong management oversight and via an effective working relationship between CYPS and legal services. This can only be achieved if there is a shared understanding and clarity about the separate roles, responsibilities and accountability for decision making.

5.12 If there is a shared understanding by non CYPS agencies of legal processes instigated for children, then they are more able to contribute and challenge the process when appropriate, as part of partnership working.

5.13 To fail to record important discussions and agreements reached between CPC Chairs and managers outside of the CP process, will mean that any actions agreed to ensure that a case is properly progressed, cannot be effectively reviewed or monitored and could enable management drift to occur.

Suffolk Safeguarding Children Board Response to Lessons Learned

NB: Following the presentation of this report to the Suffolk Safeguarding Children Board on December 12th 2013, further work was undertaken as a result of discussions at the Board meeting, to confirm the formal response and actions required to address the "Lessons Learned" identified in section 14 above. This response is attached as an appendix.

Ron Lock

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