Suffolk Safeguarding Children Board

Lessons from a Serious Case Review

Anderson Family SCR

Published 22nd January 2014

SCR Partnership Review Model

- Suffolk LSCB made the decision to conduct an SCR which reflected government guidance – Working Together 2013.

- Purpose of SCR: ‘identify improvements which are needed and to consolidate good practice’

Suffolk Safeguarding Children Board

SCR Learning Model

- LSCB chose to use an SCR learning model to undertake the review consistent with the principles of WT2013.
- Two consultants appointed
- Review team made up of Senior Managers from LSCB Partnership
- Agencies involved with family asked to complete chronologies, including commentary and analysis of professional practice

SCR Learning Model

- Review Team met with SCR Chair and Author to progress the SCR and comment in respect of draft Overview Reports.
- Review Team facilitated at Learning Events
- Two one day ‘Learning Events’ held in order for as many practitioners as possible to be involved and contribute.
- 41 attended first event 31 second event

SCR Learning Model

- Outcome of Learning Events was the clarification of factual details and contribution to the analysis of practice. This informed the key lessons learned.
- Overview writer met with some practitioners individually
- Findings from events included within the report

SCR Learning Model

- Father of the children interviewed by overview report writer in order to gain an understanding of his experiences of the professional interventions with the family.

- Maternal Grandparents met with LSCB Chair and LSCB Manager to discuss the report and lessons identified. View shared with the overview writer.

Suffolk Safeguarding Children Board

Lessons from a Serious Case Review

Anderson Family SCR

Published 22nd January 2014

Executive Summary

The **Anderson** family:

- 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 in April 2013 and the subsequent death of their mother on the same day.
- Fiona Anderson was 7 months pregnant at the time of her death.
- Awaiting Coroner's inquest although evidence would suggest that Fiona took the lives of her children prior to taking her own life.

Executive Summary

The parents of the children, Craig and Fiona were not married and Craig, the Father of all three children, lived separately from the family for much of the period of time of this review.

The three children, **Levina**, **Addy** and **Kyden** were aged 3 ¾ years, almost 3 years and just over 1 year respectively at the time of their deaths.

The Facts

The first phase of professional intervention 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.

The Facts

The unborn child (Levina) was made subject to Child Protection (CP) Plans and Care Proceedings were instigated although an application by the Local Authority was not granted by the court in June 2009.

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. Nevertheless Levina remained subject to CP Plans for a further 6 months before they were discontinued

The Facts

The second phase of professional involvement was from June 2010 to July 2011. During this time the Addy was born.

No formal 'child protection or 'child in need' inter agency procedures in place to work with the family – although some concerns occasionally raised about possible neglect

Health and local children's centre involvement continued throughout much of this time, albeit limited in nature due to parent's continued reluctance to accept professional interventions

The Facts

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. Kyden, the third child of the family was born in May 2012 and included in these CP Plans.

The Facts

Although legal interventions via the Public Law Outline (PLO) process were again considered in order to protect the children, the plans for these drifted and ultimately no Care Proceedings were initiated.

There continued to be considerable concerns about the care of the children. However, the refusal of Fiona in particular, to accept any intervention, meant that there was minimal contact with her and the children, and therefore the CP Plans achieved very little

The Facts

Parental attendance at CP Conferences and Core Groups was almost non-existent. Whilst Fiona'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

Afternoon of 14th April 2013: Craig reported (via his later statement to the Police), that he had been at Fiona's and the children's home and had fed the children lunch, leaving in the evening telling Fiona that she needed to accept that their relationship was over.

At 8.05 p.m: Craig called an ambulance claiming he had been stabbed from behind by an unknown male.

Events leading up to the death of the children

Early Hours of the 15th April:

A police officer spoke to Fiona at her address through the intercom as Craig's initial statement had said he had been in the vicinity of Fiona and children's flat and the Police thought the incident might have been linked to a domestic dispute. She said that she had not seen Craig for a month and would not come to the door.

Events leading up to the death of the children

Approx 6am 15th April 2013:

Fiona arrives at Craig's accommodation and hands in her flat keys for collection by Craig.

Just before 9 a.m. 15th April 2013:

Fiona 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.

Events leading up to the death of the children

Later that same day 15th April

Craig informs Police that it was in fact Fiona who had stabbed him following an argument about their separation in which she said he would not be able to see the children again.

Craig also shares that soon after the stabbing incident, when in hospital for a short period of time, he had told Fiona via text that he had not informed Police what had happened.

Findings and analysis

The predominant features of this case:

- The challenge of how to engage this hard to reach family, and especially Fiona who specifically avoided professional interventions.

- 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.

Findings and analysis

CP Process was implemented in line with procedures but not ultimately successful in engaging the family. The CP plans continued largely unchanged for a period of 18 months from Aug 2011 without some form of formal review and revision of the way forward with the family

Findings and analysis

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. Senior management overview was in place but it did not sufficiently impact on this case.

Findings and analysis

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**. 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 way that the overview writer describes as ‘a most unconstructive way’.

Findings and analysis

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.

Findings and analysis

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. It was the physical neglect which was given most attention as 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.

Findings and analysis

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.

Psychological and psychiatric assessments were proposed and discussed with Fiona, unfortunately these were never achieved because of the mother's reluctances.

.

Findings and analysis

There had been **no known history** of either Fiona or Craig intentionally causing physical harm to the children, or of any self-harming episodes by the parents themselves. Neither throughout 2013 was there any new initiative or different sanctions utilised which would have generated a significant negative reaction from Fiona

Findings and analysis

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.

Lessons Learned 1

Working with hard to reach and avoidant families has an impact on the parents and professionals in the anxiety it creates and for the loss to the family 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

Lessons Learned 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.

Lessons Learned 3

To allow Child Protection Plans to continue unaddressed throughout a number of Child Protection Conferences means that children will continue to be subject to significant harm whilst still within the child protection process. The *role of the Child Protection Conference Chair is a pivotal one in challenging the management of a case that is not achieving Child Protection Plans and by inference, it is maintaining children in at-risk scenarios*

If there is no separate process utilised to objectively review why the case has become entrenched, then children continue to be at risk of significant harm

Failure to record important discussions and agreements reached between Child Protection Conference Chairs and managers outside of the Child Protection process, means that any actions agreed to ensure that a case is properly progressed, cannot be effectively reviewed or monitored.

Lessons Learned 4

For Child Protection Conferences to only include those professionals directly working with the family deprives the Child Protection Conference of objective input by managers and specialists to help progress the case and reduce safeguarding risks of the children.

All professionals have the responsibility to challenge inappropriate or ineffectual practice, which has become intransigent and is not protecting children and this should include escalating concerns to senior managers when necessary

Lessons Learned 5

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

Lessons Learned 6

It is difficult to generate the appropriate response and relevant assessment of parents when there are concerns about possible adult mental health issues and the parent does not see/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 at any time this might enable pertinent mental health assessments to be newly progressed.

Lessons Learned 7

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.

Lessons Learned 8

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.

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

Next Steps

- Considerable work underway – see full LSCB response document for details
- Action Plan – to be signed off at LSCB meeting in early March
- Roll out of lessons via training and briefing sessions.