Briefing on Serious Case Reviews

Child D (published by Sutton LSCB 2016)
www.suttonlscb.org.uk/seriouscasereviews

Child D was aged 6 years and 10 months and living with mother, father and a younger sibling at the time of death. On the day of the incident, an ambulance was called to the family home where Child D was found to be non-responsive and to have a head injury. CPR was administered. Post-mortem results show that Child D died of a head injury. An inquest was opened and adjourned.

A criminal investigation was initiated; father was charged with the murder of Child D. Mother was charged with intending to pervert the course of justice. Both parents have been charged with child cruelty

History

Mother had a difficult relationship with her parents, particularly her father. She is recorded as having a history of depression. She has held various jobs, most recently working as a full-time graphic designer.

In respect of father's health, records describe a pattern of frequent injuries related to alcohol, assaults and fights as well as a history of depression. Police and Probation records show a long history of offending, including a 3 year 11 month prison sentence for armed robbery with violence and witness intimidation, charges of ABH and an assault on a pregnant ex-girlfriend. Many other alleged incidents did not proceed to court as witnesses / alleged victims would not pursue a case against him. He frequently breached community orders and failed to co-operate with Probation staff. He reported a history of being sexually abused as a child by a relative, had a history of self-harm and was referred for psychotherapeutic help. Father appears not to have held employment for many years.

In 2007, child D was taken to hospital and was found to have sub-dural haematomas, retinal haemorrhages and suffered seizures. The child was also discovered to have an unusual combination of a laryngeal cleft and a cyst at the back of the tongue. Children's Services were contacted as the injuries were believed to be non-accidental; discussions with the Police took place and a child protection investigation was initiated.

Father was found guilty of GBH in respect of Child D's injuries in March 2009 and was sentenced to 18 months in prison. In June 2010 the Court of Appeal quashed father's conviction for GBH on the basis of new expert medical evidence which raised areas of doubt.

During 2010/2011 both mother and father were convicted of criminal offences, had numerous health problems (including 16 hospital admissions for mother in 8 months) and a poor record of contact visits.

In 2012 a High Court Hearing concluded in the overturning of the previous Finding of Fact. This meant that the parents were found not to be culpable of involvement in Child D's injuries and had suffered a miscarriage of justice. The reviewing Judge's judgement was based on extensive and complex medical evidence by expert witnesses.

After the conclusion of the Court Hearing the children were not subject to any orders, and Children's Services did not have a formal role with the family as the court had found that the threshold criteria were not met.

The Local Authority was required by the court to send a letter to all agencies who had worked with the family to inform them of Mr F's quashed conviction and exoneration and directing that this letter should be prominently referenced in their files.

Key Learning points:

- All agencies should reinforce the importance, throughout their work, of focusing on the **needs** of the **child at the centre of a case** and good practice in the direct **recording of the child's voice** should be adopted.
- When working with **parents who are resistant and hostile**, professionals should not be deflected or distracted by parental behaviour and should focus on assessing the potential risk posed to children in these families by emotional abuse or neglect. The adequacy of multi-agency training in this topic should be assessed.
- When outcomes from **court cases** occur which are not expected by key agencies, and may have the potential to raise concerns for children, the Local Authority should convene a **multi-agency meeting to share information** arising from the unexpected outcome. This should provide clarity about future actions, roles and responsibilities of various organisations and establish communication channels that can respond to any escalation of concern.
- Given that working with **independent social work agencies** and other **independent professionals** is likely to continue to be a feature of children's services work, there is a need for clarity regarding respective roles and responsibilities and accountability so that it is clear who is doing what in a multi-agency context. The Local Authority should take the lead in defining how commissioning, contracts and communications will be managed.
- The position of the Courts, specifically the Judiciary, in respect of SCRs should be clarified. In this case the request for engagement with the SCR was declined; no other form of report, other than a copy of the Judgement, was provided and there was no representation from the Courts Service (HMCTS) on the SCR Panel**. Given the significance of Court judgements in this case**, this lack of engagement raises questions that require serious consideration at a **national level**. The findings of this SCR should be brought to the attention of the President of the Family Division and the Family Justice Council. They should be asked to respond and to clarify the responsibility of the courts to LSCBs in respect of Serious Case Reviews.

Conclusions:

All SCRs are unique, but this was an exceptionally unusual case and an overwhelming one for many involved. The factors that cause it to be so include:

- The number of agencies and professionals in contact with family members over the period concerned.
- The extreme level of avoidance, deception and resistance from the parents, who were often evasive, contradictory and aggressive and who regularly resorted to complaints and threats. This pattern of behaviours was sustained even after the parents' exoneration and the children were returned to live with them.
- The use of an independent social work agency in the assessment and the management of the reunification of the children to their parents, and the exclusion of the Local Authority Children's Services from this role.
- Despite a significant range of concerns and worrying incidents (albeit below the threshold for statutory intervention) being documented by agencies before and after Child D went to live with the parents, the effect of the court judgement and exoneration, combined with the parents refusal of any voluntary engagement with support services, meant that no intervention that might have made a difference was possible.
- The Judge in the High Court case pronounced with perhaps undue certainty that the parents' previous patterns of behaviour would change. She said "Now they have been unburdened from the shadow of findings against them" "They are going to change". Sadly this did not turn out to be the case.