Executive Summary of Serious Case Review - W Family

Background to the Case

The decision to conduct a Serious Case Review in respect of this family was made in June 2005. The family had previously been the subject of a management review by the Area Child Protection Committee.

This action followed an incident in 2004, when the youngest child in the household, then aged 2 years, was admitted to Hospital with breathing difficulties. At that time the previous history of Fabricated Induced Illness in a sibling and the fact that he and his sister had been placed for adoption was not known to health professionals at the hospital. Tests later revealed the presence of opiates in his urine, thought to have been administered maliciously. Subsequent investigations revealed that this child had no apparent organic reason for the reported breathing difficulties and it was assessed that he also had been the subject of Fabricated Induced Illness caused by his mother.

Purpose and Scope of the Serious Case Review

This Serious Case Review decided to consider the details of the inter-agency involvement with this family between 1997 and 2005, on the basis that the inter-agency practice was felt to be of an acceptable standard prior to 1997. As with all Serious Case Reviews under 'Working Together to Safeguard Children', the Serious Case Review Panel (SCR Panel) wanted to establish what lessons should be learned from this case to inform future practice.

The SCR Panel wanted to focus on what could have been handled differently, and to establish whether the harm to the children in the family could have been prevented. The Terms of Reference included 2 key questions:

1. Why were the children returned to the care of their parents in an unplanned way given the historical concerns about their care of children? and;
2. Where there times when better inter-agency working could have prevented the outcome?

Unfortunately, there was considerable delay in the Serious Case Review reaching its conclusion, having first initiated the Review in 2005. The delay was in the first instance due to the criminal proceedings in relation to the parents, but thereafter due to workload issues for the Overview author. This did not however delay necessary actions being taken to address issues identified during the Review process.

Family History and Concerns

The family are of white UK origin, and the mother has had 5 children. There had been extensive involvement with this mother and her children by Health services, education, the Police and Social Services.

Although the Panel were reviewing the inter-agency work with the family between 1997 and 2005, we had to consider the family history prior to this in order to understand the context.

In 1988, when she was 17 years old, the mother was arrested for Child Abduction after she removed a baby from a local hospital ward. She was subsequently convicted of Attempted Kidnapping and was sentenced to a Probation Order for 12 months. This was her first 'Schedule One' offence.

Her 2 eldest children were the subject of Family Court proceedings in 1990 and 1991 respectively, after she was found to have induced illness in her eldest child and attempted to smother him when he was 7 months old. During these family court proceedings, the mother was assessed by a Consultant Forensic Psychiatrist, who concluded that she was not able to safely care for a child as she was suffering from Munchausen's Syndrome by Proxy (the previous diagnostic term for Fabricated Induced Illness). The same conclusion was reached in relation to her second child, who had been removed from her care at birth.

The mother was the subject of criminal charges in relation to her attempt to smother the eldest child, and in 1991 was sentenced to a Probation Order for 3 years, with a condition that she accepted psychiatric treatment. She had therefore again been convicted of a Schedule 1 offence. The older two children were adopted.

In 1992, the mother began a new relationship and moved to another area of the country. She became pregnant but concealed the pregnancy and subsequent birth. Once the parents and baby were found, family proceedings were issued in relation to the third child and he also was removed from her care. Again, Forensic Psychiatric opinion was sought about the risks she posed to this child and the conclusion was that she could not safely care for the child. He was placed with his paternal grandparents.

In 1993, the mother was pregnant again. She was informed that Social Services would seek to remove this child from her care at birth. She and her husband went into hiding and she delivered her 4th child in another country. Despite significant attempts to conceal their identities, authorities removed the child from their care and she was placed in the care of Social Services in England. This child was subsequently also placed in the care of her paternal grandparents. Following these family proceedings, where again psychiatric opinion had been sought and concluded that this mother could not safely care for a child, the mother sought psychiatric treatment.

The Period Subject to Scrutiny by this Serious Case Review

In 1997, the parents approached Social Services to discuss the likely response were they to conceive another child. At the same time they expressed their wish to increase contact with

the 2 children who had been placed with the paternal grandparents 5 and 4 years previously. Social Services sought the opinion of her Forensic Psychiatrist, and he reported 8 months later, suggesting that contact should increase with these children, and that the assessment of this should inform any decision about their care of future children. No changes took place in the children's living or contact arrangements at this time. By 1999, the mother had completed 4 years of psychotherapy and a further opinion was sought from her Forensic Psychiatrist. His opinion was, that based on his current assessment of the mother, the risk that she posed to her children was low.

In 2000, the parents made an application to the Court to increase contact with their children. Social Services were asked to assess the situation, and in 2001, a social work recommendation was made to the Court to increase contact between these 2 children and their parents. The grandparents opposed this plan and shared their concerns with the social worker and with the Child and Adolescent Mental Health Services who were working with them at the time.

Some time in August 2001, the 3rd and 4th child moved into their parent's care from the grandparents in a manner that was not planned by any of the agencies working with them. However, once this change had occurred, no-one neither sought to remove the children from the parents care nor was a multi agency risk assessment completed. In 2002, the 5th child was born and although consideration was given to convening a child protection conference, there was no conference held.

In the following 2 years, concerns were raised in relation to excessive parental discipline of the older children, and the parents expressed an inability to cope with the behaviour of the 4th child. She was briefly placed in foster care at the parents' request. The mother began presenting the youngest child to the GP and hospital, often with breathing difficulties. This behaviour was remarkably similar to the behaviour that had led to the removal of the mother's oldest child.

The parents' care of these 3 children ceased on 5th August 2004, on the discovery of the presence of opiates in the youngest child. Subsequent investigations by the Police, and expert assessments undertaken in relation to family proceedings, demonstrated extensive emotional abuse by the parents, as well as Fabricated Induced Illness by the mother. All three children are now placed permanently away from their parents. The mother was convicted of offences related to cruelty to the children, and the father was convicted of an offence of assisting the mother to escape prosecution in respect of those offences.

Analysis of Inter-agency Work

The combined chronology and significant events present an extremely concerning history of a highly manipulative, dangerous parent with minimal evidence of change over a long period of time.

However, it was not clear to the SCR panel what information from the history was shared between professionals in each of the key safeguarding agencies – health, education, Police, and children's social care - and within agencies, as the family moved location across the country, and subsequent children were born.

The seriousness of the earlier concerns and the mother's personality issues and criminal convictions was not sufficiently acknowledged in the risk assessment of subsequent children. The social work assessment that recommended a more significant role for the parents relied heavily on the assessment by the mother's psychiatrist, and the views of the children and their grandparents were not sought sufficiently or given due weight. The existing Child Protection procedures and processes were not followed when the children returned to the care of their parents, and this meant that a thorough multi-agency evaluation of the risks was not undertaken. Appropriate safeguards were therefore not in place that could have reduced the risks to the children and prevented further harm.

Learning the Lessons from this Serious Case Review

The panel felt that there were the following key areas where lessons needed to be learned:

- How to effectively conduct a risk assessment of a dangerous parent
- Ensuring adherence to procedures for multi agency assessments following referrals, moves or concerning presentations by the children
- The use of documentation, record keeping and the review of previous records
- Effective supervision, management and training of staff
- The ability of professionals to challenge each other effectively
- The voice of the children is significantly absent from the assessments the panel saw

The Panel made the following recommendations:

1. Children's wishes and feelings must be sought, understood and be integral to any assessment of their needs. This should include analysis of children's behaviours as well as their words. This requirement is included in existing procedures, but measures need to be in place to ensure that this happens and that this requirement is strengthened across agencies.

2. Where children are to be returned to parents who have previously seriously harmed children, a child protection conference must be held. This requirement is included in current procedures, but performance management arrangements need to be in place to ensure compliance in the future.

3. Where a woman who has previously seriously harmed a child is pregnant, a pre-birth assessment and child protection conference should be undertaken. This should also happen if the pregnant woman's partner has been subject to a serious child protection investigation. This requirement is within the existing guidance in relation to Fabricated Induced Illness and compliance needs to be performance managed.

4. Where an expert opinion has been gained about individuals with previous convictions of offences against children, this information should be critically evaluated and shared with child care professionals in at least one other agency when assessing risks to

children. Effective performance management arrangements need to be in place to monitor compliance.

5. When working with families in which Fabricated Induced Illness is an issue, staff need to be made aware that research and practice evidence demonstrate that the level of manipulation by the parent can be considerable, and their subsequent actions must be rigorous to a point of not automatically trusting the information provided by the family. Analysis of the potential risks and assessments of the children involved need to be subject to additional scrutiny in these cases.

6. File audit processes must be strengthened in each Agency, and managers should have systems in place to record when they have been had oversight and review of individual case files. Any poor practice identified through this process must be effectively managed.

7. Managers in all agencies should ensure that in staff supervision of complex cases, risk assessments are critically evaluated and hypotheses are tested.

8. CYPS Team Managers should ensure that where concerns about professional practice exist, the competence framework is applied rigorously.

9. All LSCB agencies should ensure full co-operation with Serious Case Reviews and emphasise the need to contribute if requested.

10. Police CAIT teams and intelligence officers must share intelligence with other constabularies where it is known an offender frequents or moves to, particularly in cases such as this where offences are serious and complex.

11. Police case papers and relevant documents relating to child protection cases must be stored indefinitely.

12. When conducting a child protection investigation, Police should probe the status of anonymous referrers without compromising the confidentiality of the referrer or the other agencies involved. This would assist with testing the voracity of information disclosed and therefore assist the risk assessment overall.

A multi-agency Action Plan was drawn up to address these recommendations. Given the length of time that has elapsed since initiation of this Review, all the aspects of the action plan have been completed or will be completed by April 2008.

Paul Taylor

Chair of the Serious Case Review Panel

Date: 11th February 2008