Press Release

23 NOVEMBER 2015

Kingston Local Safeguarding Children Board responds to Family 'A' SCR Findings

Today (23 November 2015) sees the publication of the Serious Case Review (SCR) into the case of Family 'A' which involves the tragic deaths of three children through asphyxiation by their mother. The mother pleaded guilty to manslaughter on the basis of diminished responsibility. The prosecution accepted that plea and she was sentenced to a Hospital Order in November 2014.

The report's authors concluded:

• The childrens' deaths could not have been predicted, nor could they have been prevented
• Health and social care professionals across all the organisations involved offered the family appropriate and wide-ranging support and care, which sometimes was difficult to progress with the family
• That despite evidence of much good practice from health and care professionals, there are important lessons that should be learned from this case

The Independent Chair of Kingston Safeguarding Children Board, Deborah Lightfoot, said: "The deaths of the three siblings is nothing short of a tragedy. They could have gone on to lead long fulfilling lives. While the review states that all of the deaths were not predictable nor preventable, it has found that there are learning points for practitioners involved."

The report was commissioned by the Kingston Local Safeguarding Children Board and written by independent reviewers Edina Carmi, from a social work perspective and Nicki Walker-Hall, from a health perspective. Both have considerable safeguarding experience and experience of SCRs. The father of the children and the agencies involved have contributed to the review and read the report.

The report identifies 11 key findings and the LSCB has today published its required responses to the recommendations (all findings and responses are set out in the separate LSCB response document).

Due to the complex health needs of the three children with Spinal Muscular Atrophy Type 2 (SMA Type 2), nine different health and social care agencies were required to be involved with the family, along with the three local authorities in which they lived during the period under review: Merton, Wandsworth and Kingston.

Deborah Lightfoot comments: “In the report the parents described themselves as 'inundated' by the number of professionals involved. However significant efforts had been made to double up on visits, streamline services and visit at times convenient to both parents to help them lead as normal lives as possible."

The report also highlights the importance of early understanding of a family's attitudes towards health and disability, so as to provide the right support and concludes that this needs to take place within weeks of confirmation of diagnosis by an allocated health practitioner. As the diagnosis for Family A occurred outside of the UK, it is not clear whether this was ever offered to the family, or whether they would have been open to such a discussion.

The LSCB acknowledges that the parents' needs can often be overlooked when a child receives a diagnosis of disability or significant illness and the resources for counseling available are now being assessed.

Concerns were raised in the report that professionals were worried over a period of time in relation to the mother’s mental health. As part of the LSCB’s response to this, report members are now encouraged to take up training in relation to the impact of parental mental health on parenting.

The report also highlights distress caused to the family when their regular social worker was moved off the case without allowing them to say goodbye. The LSCB agrees with the findings and that working relationships between families and professionals are crucial and need to be developed appropriately.

Deborah Lightfoot commented: “The report found the commitment by professionals working with this family was high, and many went out of their way to provide appropriate and good quality services for the family.”

However, the report also found many agencies were working without having clear knowledge of who the lead professional was in the case, clarity in hindsight may have assisted in instigating child protection procedures.

The report found that the role of the lead professional is critical in complex

cases. The LSCB will now agree with member agencies a consistent process for identifying an appropriate lead professional in each case.

There were concerns the children in the family may have been subject to a neglect of medical, health and development needs. The LSCB, with the help of local Designated Nurses for Safeguarding Children, will take the learning points from this SCR and incorporate them into their continuing training to help staff to determine neglect.

Deborah Lightfoot added: “We accept the report findings that the parents' laudable aim for their children was a good quality of life which was as painfree as possible. Despite misunderstandings by the parents, this was the goal and view of the professionals too."

Detailed throughout the report is evidence of difficult and challenging behaviour from the mother, she had been referred to her GP for help and counselling but had refused this.

Finally, professionals worked hard to find consensus in this case but this became an obstacle in initiating child protection procedures. Child Protection Procedures would have given a clear time line for parents and professionals and clarified expectations on both sides. There was evidence of escalation of concerns by practitioners, who did feel that child protection processes should have been used.

However, there were moves to go into legal procedures instead to ensure access to medical treatment for the children. Ultimately these weren’t acted upon as it was considered that towards the end of the period of this review there had been an improvement in communication from the parents.

Deborah Lightfoot concluded. “As Independent Chair of the LSCB I will ensure that everyone here will be fully aware of the lead professional in each case to ensure a clearer line of reporting concerns. That said, we now foster a culture in Kingston where every professional understands their own individual responsibility to make a referral to children’s social care if they suspect a child is suffering or is likely to suffer significant harm. I hope that other agencies across the country will also be able to learn from the findings of this report.”

For further information please contact Vivienne White, Kingston LSCB, 07469 100485.

Ends.

Notes to Editors:

The full report is available online at:
http://kingstonandrichmondlscb.org.uk/about-kingston-lscb/serious-case-reviews-168.php

Background: The case was formally referred to the Kingston LSCB and the decision was made by the LSCB Chair Deborah Lightfoot to consider the case under the Regulation 5 of the LSCB Regulations 2006.

Ms Lightfoot found that this case met the criteria for a Serious Case Review (SCR) and agreed the commissioning arrangements to be led by the LSCB as laid out in HM Government "Working Together to Safeguard Children (2014).

Please note the family or family members are not named in Serious Case Reviews. However, the LSCB is aware the name of the family and the case are in the public domain.

The LSCB: Working under the direction of an Independent Chair, Deborah Lightfoot, Kingston Local Safeguarding Children Board's role is to ensure that relevant agencies and professionals work together to protect the borough's children from abuse, harm and neglect.

Kingston Council has commissioned Achieving for Children to provide children's services in Kingston and Richmond since April 2014.

SMA type 2 is a genetic muscle weakening condition. Children are unable to stand or walk without support and it can affect arm, hand, head and neck movement, breathing and swallowing. While it may shorten life expectancy, improvements in care mean that the majority of people with SMA Type 2 can live long, fulfilling and productive lives. (source: SMA Support UK).

Biographies

Deborah Lightfoot has been a qualified social worker for over thirty years mainly working at practitioner and management levels in children's services both in the statutory and voluntary sector. Around 12 years ago she started work as an independent consultant and interim manger working mainly in children's services across the country. She has been an independent LSCB chair in London since 2012 starting out as chair of the Harrow LSCB and then the independent chair of the Richmond LSCB and the Kingston LSCB in 2013.

Edi Carmi: following a career as a social work practitioner and manager in

both local authority and voluntary sectors, Edi has been an independent child safeguarding consultant since 2000. She has chaired or written over 30 serious case reviews in that time as well as writing policy and procedures, including the original London Child Protection Procedures.

Since 2009 Edi has worked with the Social Care Institute for Excellence on the piloting and development of the Learning Together methodology for case reviews, research and development of systems training for neglect and a national safeguarding project with the Church of England. Edi has spoken at national conferences on learning from serious case reviews and safeguarding 5 years on from the Baby P Review.

Nicki Walker-Hall is a registered nurse (RGN) and registered sick children's nurse (RSCN). She has an MA in child welfare and protection from Huddersfield University and an MSc in Forensic Psychology from the University of Lincoln.
Nicki has worked with children and families since 1986 and has extensive experience working within an acute trust, nursing predominantly children and neonates requiring intensive care before moving into more community based roles. Nicki has worked in safeguarding roles within health since the 1990s. Latterly she worked in more strategic safeguarding roles within primary care, mental health and learning disability. Her last post within the NHS was as a Designated Nurse child protection in the North East. Nicki became an Independent Safeguarding Consultant in 2009.

Nicki has worked with Local Government Association as a peer reviewer and has experience of being a serious case review panel member, chair and overview author both in safeguarding children and safeguarding adult reviews.