



Serious Case Review Report Child K

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1. Introduction

- 1.1 The Wolverhampton Safeguarding Children Board (WSCB) agreed to undertake a Serious Case Review (SCR) in respect of Child K in February 2018. They recognised the potential that lessons could be learned from this case about the way that agencies work together to safeguard children in Wolverhampton.¹
- 1.2 Child K was 11 years old when she died. Her great uncle admitted killing her in a violent attack. He has since been convicted of manslaughter on the grounds of diminished responsibility.

2. Methodology²

- 2.1 An independent lead reviewer was appointed to undertake the review³. She had access to the key single and multi-agency documents in the case and met with practitioners involved with the family in a number of reflective sessions where the case was discussed. The pre-disposing risks and vulnerabilities⁴ that were known at the time were considered in order to understand the case. This was followed by the consideration of the opportunities for prevention and protection.
- 2.2 The agencies that had involvement were then asked to reflect on the agency specific learning and their conclusions, and any improvement actions to be undertaken are being overseen by WSCB.
- 2.3 The lead reviewer and a representative of WSCB visited Child K's great aunt twice, she was accompanied by one of her brothers on the first occasion and then with her sister and mother prior to publication. They initially had a telephone conversation with Child K's father, and then met with him prior to publication. They also met with Child K's great uncle's

¹ It was agreed the SCR would consider the professional involvement with Child K and her family from September 2017, taking into consideration any information available prior to then.

² The Government guidance Working Together 2015 states that SCR's should be conducted in a way that 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

This review has achieved these objectives. Consideration has been given to whether it is necessary to 'identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice'. The review has also clearly identified 'what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result'²

³ Nicki Pettitt is safeguarding consultant. She is an experienced chair and author of serious case reviews and safeguarding adult reviews. She is entirely independent of WSCB and its partner agencies.

⁴ Triennial Analysis of Serious Case Reviews 2016, Sidebotham, Brandon et al, Department of Education

daughter and her mother, as they were involved in attempting to get help for Great Uncle prior to Child K's death. The purpose was to discuss the SCR and to ask them to reflect on professional contact with the family during the timeframe of this review. They were also informed of the conclusions of the review, WSCB's response, and the plan for publication.⁵ Their views are included in this report. The lead reviewer spoke to Child K's mother on the telephone. She had not had contact since Child K was a baby, but welcomed the opportunity to be told about the SCR.

- 2.4 Drafts of this report were shared with the professionals who had been involved as well as with WSCB SCR group to ensure collaboration and ownership. The recommendations were written by the lead reviewer along with the SCR group.

3. The Case

- 3.1 For the purpose of this report, the following family members are relevant:

Family member to Child K :	To be called:
Father	Father
Paternal Great Aunt	Great Aunt
Mother of Great Aunt	GGGM
Brother of Great Aunt	Great Uncle
Daughter of Great Uncle	Daughter of Great Uncle
Father's other children	Siblings

- 3.2 Child K was a bright, happy and popular girl. She had a good sense of humour, was able to make and sustain friendships and could be relied on in school to be kind to the more vulnerable children in her class. Her family shared memories of Child K, and it is clear that she was a child who was loved dearly by those who knew her, and she was secure in this knowledge.
- 3.3 Child K's parents were very young when she was born and her care was taken on by her paternal Great Aunt, who later applied for and received a Residence Order. Children's Social Care (CSC) was involved at the time for around 14 months and supported the placement and application, which was not contested. Child K had on-going contact with Father who lived locally. She attended school with Father's children from a different relationship, and clearly identified as being their big sister.
- 3.4 Great Aunt worked shifts and the school were aware that Child K would spend time at the home of GGGM. As a year 6 pupil Child K would come to school and return home independently. Her attendance was excellent and the school had no concerns about her. Great Aunt explained that she was a single parent who relied on the support of her family to care for Child K, and that this involved spending time, including overnights, with GGGM. Great Aunt is clear Child K's home was always with her, although this is disputed by Father.
- 3.5 Child K's Great Uncle had no known mental health history, although he had some health conditions. This included epilepsy and a brain tumour that was diagnosed around 20 years ago.

⁵ It is anticipated that this report will be published in full. It contains only the information that is relevant to the learning established during this review.

- 3.6 There are records of Father contacting children’s social care (CSC) on two occasions. At the time of Child K’s death, CSC were undertaking a completely unrelated assessment of Child K and a number of other children due to an issue identified from outside of the family and not due to any of the adults mentioned in this review.
- 3.7 The day before Child K was killed, members of Great Uncle’s family had made contact with the GP surgery, with 111 and with a hospital mental health service trying to get support for Great Uncle who they described as agitated, confused and hearing voices. These contacts will be considered in more detail in the analysis section below.
- 3.8 The police attended during the night following a violent attack on Child K that resulted in her death.

4. Analysis

- 4.1 To analyse the interventions with the family, consideration has firstly been given to the predisposing vulnerabilities and risks in the case that were known or knowable to professionals involved at the time. This is followed by an analysis of the preventative and protective actions taken by the agencies involved.

Predisposing vulnerabilities:
Child K was a young child who was dependent on her family to care for and protect her.
Child K was unable to live with her biological parents and appears to have had no on-going contact with her mother. It is not known what sense Child K made of this lack of contact, and what impact it had on her identity. There was regular and on-going contact with Father.

- 4.2 It is recognised that the adults predisposing vulnerabilities may pose a predisposing risk to the child. The following additional risks have been identified:

The risks in the case:
Professionals were not made aware at the time, but it appears that at the time of Child K’s death there were concerns in the extended family about GGGM’s memory. Father stated that he was made aware following his daughter’s death that GGGM “may have dementia / Alzheimer’s”. No medical attention was sought for GGGM until after Child K’s death and no professional was aware of any concerns. Great Aunt told the review that the family did not believe there was any risk, and described a close and loving relationship between Child K and GGGM.
On the days leading up to Child K’s death, members of his family were increasingly concerned about Great Uncle’s mental health. He was staying with his mother (GGGM) who often had care of Child K due to Great Aunt’s work commitments.
Great Uncle had a brain tumour around 20 years ago, leaving him with epilepsy. There was a lack of engagement with health professionals, with Great Uncle missing the majority of appointments offered, and not getting prescriptions regularly.

- 4.3 There was evidence of preventative and protective actions by the family when considering the case:

Protective actions – family

Great Aunt provided Child K with a caring and nurturing home. Child K had a secure attachment to Great Aunt, who she called Mum. Great Aunt secured the arrangement with a residence order. Child K had close relationships with a number of members of her extended family who provided her with care while Great Aunt was working, particularly GGGM.

Father was committed to remaining involved in his daughter's life, and she spent time with him and his family, including trips away. He made contact with CSC on occasion, including reporting difficulties with gaining formal contact with Child K, and he was concerned about what he perceived to be the poor standard of physical care of Child K, who he said wore old and worn school uniform. He also alleged, around four months before she died, that Child K was living with her elderly GGGM rather than Great Aunt, sharing this information with CSC. Great Aunt and other family members dispute this, as do the school. They acknowledge Child K spent time with GGGM while Great Aunt worked, but that her home was always with Great Aunt, who was her primary attachment.

Family members attempted to get support for Great Uncle in the days before he killed Child K. His daughter told the MHLT that she was concerned he might hurt her grandmother. She was not aware that Child K was staying in the house.

4.4 There was evidence of and opportunities for preventative and protective actions by agencies involved with the family:

Protective and preventative actions – agencies

CSC were involved at the time that the residence order was made, and had no concerns about the care provided by Great Aunt to Child K.

The school provided support to Child K and liaised appropriately with her carer around any issues that arose. They also provided information to CSC following Father's contact with CSC in September 2017, and provided the family's contact details to CSC early in 2018, when CSC were undertaking checks. (See 3.1.6).

CSC were contacted by Father in September 2017. It is recorded by CSC and school (who CSC then contacted) that Father had stated he was having difficulties seeing his daughter, that she was unkempt, and that was not residing with her Great Aunt who has a residence order, but with 'her grandmother'. The school had no concerns, but agreed that they would speak to Child K. It was agreed between the school and CSC that the school would only feedback to CSC if anything was amiss. Father was spoken to again by the social worker who informed him that the school had no concerns and that his daughter was thriving. School confirmed during the review that they did speak to Child K and she was clear that she lived with Great Aunt and stayed at her GGGM's when Great Aunt was working nights. Father continues to state his belief that Child K lived with his grandmother.

An unrelated CSC assessment was started in January 2018. (See 3.1.6.) Father was spoken to in relation to Child K's siblings. During the interview Father stated that relationships between him and his family were strained as they had taken over care of Child K and excluded him. He did not state during the visit that Child K was living with elderly GGGM or that he was concerned for Child K. The allocated social worker had not read the record of the telephone call from Father in September 2017, so she was not aware of Father's previous concerns. The allocated social worker then spoke to Great

Aunt and an appointment was made to go and speak to Child K, but this did not happen before she died.

The first contact with professionals regarding Great Uncles mental health was three days before Child K died. His adult daughter rang for an ambulance stating that her father was hearing voices and was very paranoid. He then went out and the family told the ambulance service that were not sure where he had gone. The ambulance service stated they could not assess the situation and/or attend the scene if the 'patient' was not there. They suggested that they were called back when he returned or that the police were called.

Two days before Child K died, a family member rang the GP surgery to make an appointment for the same day for Great Uncle. He did not attend. Later the same day the family member spoke to the receptionist at the GP surgery and it was reported by the GP surgery that they said Great Uncle was in a confused state. The receptionist spoke to the GP who advised that the family member be told that Great Uncle should go to A&E. This is considered further below.

The following day Great Uncle's young adult daughter rang 111⁶. She explained that her father was not aware she was contacting them, but expressed concerns about his mental health. She described him as not eating or sleeping for the past three to four days and as agitated, hearing voices, and she was very worried. She spoke initially to a call handler and then to a clinician. This is considered in detail below.

Later the same day (after 9pm) Great Uncle's daughter spoke to the hospital based Mental Health Liaison Team (MHLT). They established that Great Uncle was not known to the service, so they followed their processes and provided advice about how the family could access help for Great Uncle. This is considered further below. One of Great Uncle's brothers was around at the time and he told the review that he thought that there was an improvement in his brother that evening, and felt reassured. He stated that Great Uncle had no known history of violent or aggressive behaviour.

Prior to the death of Child K, GGGM was not seen by any professional regarding the family's concerns about her memory.

4.5. The review has established that the following areas require further analysis and provide us with the learning in this matter:

- **Child K's lived experience**
- **Response to the concerns about Great Uncle**

Each theme is considered here.

4.6. **Child K's lived experience**

4.6.1. Great Aunt and the school spoke of a child who was self-assured and confident, and who was secure within her family. Child K had ambitions to be a doctor and had the potential to achieve this goal. She had completed her practice SATs prior to her death with a pass rate of 97%.

4.6.2. Child K was described by those who knew her as a confident child who appeared happy at home and at school. The only issues that any professional was aware of were the concerns that Father expressed in two contacts with CSC. One about his contact and one where he

⁶ NHS 111 is a telephone medical helpline. It replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours services in 2014. The clinician who may speak to those calling is likely to be a general nurse or a paramedic.

stated that Child K was unkempt and wasn't living with her Great Aunt who had a residence order.

- 4.6.3. The school had no concerns and stated that both Child K and her uniform were clean and that she was happy and thriving. They were aware that Child K spent time with GGGM due to Great Aunt's job, but Great Aunt was their main point of contact and they had no reason to believe Child K was not living with her. Child K herself confirmed this to them in September 2017. Great Aunt disputes that Child K lived anywhere other than with her. Father however states that Child K had been living with GGGM not Great Aunt for some time prior to her death.
- 4.6.4. When a social worker spoke to Great Aunt as part of an unrelated assessment there was no indication that Child K was not living with her. Father had also not explicitly stated this when the social worker visited him at this time to meet with the siblings. He told the review that he assumed the social worker knew this as he had shared it previously.
- 4.6.5. The family members that were spoken to during this review clearly loved her very much and have been devastated by her death. Previous difficulties in the family relationships have been exacerbated however and differences of opinion have been shared about Child K's life and relationships. Professionals need to give consideration to what a child's home life is like and be aware of family dynamics. In this case there was no indication from Child K herself, or from her behaviour in school, that she was unhappy and she was clearly thriving. However when the opportunity arises it is important to ensure that a child's family and living situation is understood by all agencies working with them. In this case CSC has identified learning about the importance of using an up to date genogram when undertaking an assessment.

4.7. **Response to concerns about Great Uncle**

- 4.7.1. Family members had concerns about Great Uncle's mental health and they sought help on four occasions. Firstly by calling an ambulance, secondly by making a GP appointment then speaking to the surgery, then by speaking to 111, and then to the hospital mental health liaison team (MHLT). While speaking to the MHLT, Great Uncle's Daughter stated they would be to blame if he killed his mother. While two of Great Uncle's siblings, including Great Aunt, told the review that while they were concerned for Great Uncle, they had no concerns that he would be a danger to himself or others, including Child K.
- 4.7.2. When they could not persuade Great Uncle to attend the GP appointment a family member rang the GP surgery for help and advice. They could not speak to a GP as they were with a patient, but via an administrator the GP told the family that Great Uncle should attend A&E. The family told the review that they had never rung the GP surgery about Great Uncle before, and that the GP was aware that Great Uncle had a long history of missed appointments and lack of engagement with health services. The review has been told that the advice given was correct in regards to attending A&E, but learning has been identified about the processes that are in place in GP practices of receptionists relaying information to the doctor, the associated documentation of this, and the issues that could occur.
- 4.7.3. Non-attendance for a GP appointment is not uncommon and does not routinely lead to any follow-up. Great Uncle had very little contact with health agencies, despite the serious health issues he had in the past. GPs tend to encourage attendance, but a person with capacity is entitled to choose which services they engage with. Prescriptions for a chronic health condition would not be withdrawn due to lack of engagement.
- 4.7.4. The review considered the telephone call between two members of the family and two of the 111 staff, initially a call handler and then a nurse. The 111 staff were using NHS

Pathways, a clinical tool used for assessing, triaging and directing contact from the public to urgent and emergency care services such as 999, GP out-of-hours and NHS 111. It enables patients to be triaged effectively and ensures that they are directed to the most appropriate service available at the time of contact. Two main difficulties were identified in this case. Firstly the fact that those calling did not want Great Uncle to be aware of the call, and secondly because the focus of the call was largely on whether there was any physical health emergency, rather than considering a mental health emergency. The family members were clear that they were worried about Great Uncle's state of mind, stating that they couldn't tell him they were calling for support because 'he is convinced we all want him sectioned'. The call handler checked whether he had been violent or whether he had a history of mental health problems, neither of which were the case. The family were not asked who he lived with, or if he lived with any children. NHS 111 services use NHS Pathways and Health Advisors have to adhere to the 'Pathways' questions set, and cannot stray from them due to licensing conditions. The Pathways do not enable the Health Advisors to ask these questions.

- 4.7.5. As the nurse who spoke to them was insistent that they needed to be in the same room as Great Uncle, and the family members were clearly worried about this, they said they would have to ring back later after they worked out how to speak to Great Uncle. The call ended at the request of the family, with worsening advice being given to the family; 'if anything gets worse or changes or if there are any other concerns then please call back'.
- 4.7.6. 111 have clarified that it is possible to deal with a person who is not the patient in circumstances such as these. The difficulty in this case was that this usually happens when someone is not calling from the same location as the patient, so this confused the issue. Single agency learning has been identified by 111 that will lead to their staff being briefed about the ability to act if a person of concern is present at the location but consent has not been sought or given. They have also identified the need to emphasize the need for 'active listening' for all new and existing frontline staff. There will be renewed promotion of the 111 mental health pathway that focuses on behavioural change, and which includes questions about hearing voices and whether anyone is at risk. 111 are also providing additional training and support from mental health professionals and education for staff around the importance of assessing a caller's potential personal risk from a patient with behavioural problems or a worsening mental illness.
- 4.7.7. Contact was again made with professionals that evening due to concerns about Great Uncle. He hadn't slept for 72 hours and was clearly unwell. His daughter rang the local mental health hospital switch board and was transferred to the MHLT at the general hospital as there is no emergency or out-of-hours provision at the mental health hospital. The worker they spoke to said that no-one from the mental health hospital would be able to visit Great Uncle or see him at the hospital that night. Advice was given to the family regarding what they could do however, including going to A&E or contacting the police. The record of the contact includes the information shared that Great Uncle was 'acting strangely' and that checks showed he was not known previously to mental health services. They asked who lived in the home and they were told that he was staying with his elderly mother. The written record made of the contact states that Great Uncle's daughter was advised as follows: *'Advice given on routes of referral. Option of GP call-out, 111, ambulance discussed. Also advised her of option of requesting a mental health act assessment. Advised to contact police should he become a danger to self and/or others'*. The mental health worker involved remembers that Great Uncle's daughter was angry and stated that mental health services would be to blame if he killed his mother.

- 4.7.8. The mental health trust have identified learning about the need to ensure that information gained during telephone contacts needs to be more thorough and standardised to ensure that appropriate advice and a management plan is formulated. This will include more information on the person's circumstances and the risks, including considering if there is contact with any children or potentially vulnerable people. This will be followed by clear advice and support.
- 4.7.9. When spoken to as part of this review, Great Aunt and her brother stated their belief that they, as the family members who had responsibility for Child K, were reluctant to call the police as Great Uncle had not committed a crime, and they believed that the police would not attend because of this. It is also understandable that they would have been reluctant to criminalise Great Uncle. They state that they now know that they should have been worried when he was saying he was hearing voices, and believe that this should have alerted professionals that something was very wrong, and that there needed to be a timely response.
- 4.7.10. It is rare for a person to have their first psychotic episode in their fifties⁷. It is not impossible however. It is of course possible that Great Uncle had episodes before that were not observed by others or were thought to be part of his previous health issues. The lack of any history may have been considered by those involved the day before Child K's death, and reassured them that it was not a psychotic episode. This may then have impacted on the family's decision not to take any further action that evening.
- 4.7.11. There were no specific questions asked about where Great Uncle was staying, nor who with, during contact with 111. There is no certainty that Child K would have been mentioned if the question had been asked, as she was not always at GGGM's home and because Great Uncle's daughter was not aware Child K would be staying there that day. 111 have identified helpful learning for their agency and others working with adults which includes the need to have 'situational awareness' including gaining an understanding about who is around, with special emphasis on children and vulnerable adults.
- 4.7.12. While the MHLT were made aware by his daughter that Great Uncle was staying with this Mother (GGGM), no professional involved that day was aware that Child K was staying there.
- 4.7.13. Further general learning for the partner agencies of WSCB has been identified as follows:
1. *When support and advice is sought about an adult's mental health and well-being, agencies should ensure that questions are asked about;*
 - *the wider situation, including whether there is contact with children or other vulnerable people (including regular visitors)*
 - *behavioural changes**and advice is given about;*
 - *if things get worse or don't improve*
 - *options about actions that can be taken, with clear information about what that would involve*
 - *any potential barriers there may be to gaining help*
 2. *Those approached by, or about, someone who may be experiencing a mental health crisis should not assume it is the first on-set, even if there is a negative response to the question 'has the person got a previous history of mental ill health' as previous issues may have been hidden, managed, or not shared. The person seeking support on behalf of*

⁷ <https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml>

another may not be aware of the history. In this case too much emphasis was placed on Great Uncle not having a history of mental health problems.

5. Conclusions and recommendations

- 5.1 Good practice has been identified in this case review. This includes the excellent care and support provided to Child K during her time at primary school, good communication between the school and CSC, and the on-going support being provided to Child K's siblings since her death.
- 5.2 The Triennial Review states that 'good quality SCRs should incorporate particular characteristics. These include lessons learned which are clearly linked to the findings of the review; findings and questions for the LSCB, to promote deeper reflection on the lessons of the review, and leading to a response and action plan developed by the Board to address that learning; specific recommendations where there is a clear case for change, again with a response and action plan developed by the Board; and a strategy for dissemination and learning of the lessons that will reach relevant practitioners and managers within the Board's constituent agencies'.
- 5.3 The main issues that have been identified as learning from this case have been highlighted within the analysis section above. Single agency learning has been identified and a number of recommendations have been made that will ensure that the required improvement action is being taken. The SCR Panel for this case, along with the lead reviewer, have considered the learning and have agreed with WSCB that the following recommendations and question are appropriate.

Recommendation 1 for WSCB:

WSCB to seek assurance from partner agencies regarding how they will ensure that the learning from this review is widely disseminated.

Recommendation 2 for WSCB:

WSCB to seek information on the out-of-hours pathway for people not known to the mental health service, and to ensure all partner agencies disseminate this information to their staff and to the public.

Question for WSCB:

*How can WSCB ensure that professionals within partner agencies are encouraged to **'take ownership'** of situations they are aware of, and **'dig deeper'**?*