

# **SERIOUS CASE REVIEW EXECUTIVE SUMMARY- RD**

## **INTRODUCTION**

### **Circumstances that led to the Review**

Working Together to Safeguard Children 2006, states: "When a child dies, and abuse or neglect are known or suspected to be a factor in the death, local organisations should consider immediately whether there are other children at risk of harm who require safeguarding. Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances, the LSCB should always conduct a Serious Case Review into the involvement with the child and family of organisations and professionals. Additionally LSCB's should always consider whether a Serious Case Review should be conducted:

Where a child:

- Sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect, OR
- Has been subjected to serious sexual abuse, OR
- Their parent has been murdered and a homicide review has been convened, OR
- The child has been killed by a parent with mental illness, OR
- The case gives rise to concerns about inter-agency working to protect children from harm."

Accordingly, on 26<sup>th</sup> April 2006, the Stockport LSCB Serious Case Review Panel met to discuss the tragic deaths of RD and his mother AD and to determine whether a Serious Case Review should be held.

The Panel decided to convene a Serious Case Review and to appoint an Independent Chair in accordance with the requirements of Working Together to Safeguard Children 2006.

The chair identified had wide experience in Child Protection / Safeguarding as a Designated and Named Doctor for Child Protection. She had a special interest in the services for Looked After Children, including Adoption and Fostering. She also had an interest in services for children with disabilities.

### **Terms of Reference**

Working Together 2006 identifies the following key issues to be addressed by a Serious Case Review:

- Information known about the family
- The appropriateness of actions taken and the quality of decision making
- Communication within and between agencies
- Were policies and procedures followed
- Any gaps in service provision and / or resources available
- Quality of records and record-keeping

Stockport Serious Case Review Panel agreed to consider these by asking the following questions:

1. Was the assessment of RD's needs appropriate as a vulnerable child in need?
2. Were multi-agency support arrangements for RD and AD effective?

3. Was there evidence that the support offered to AD to minimise potential difficulties in caring for RD was inadequate?
4. Was there evidence of potential risk of significant harm to RD that was not perceived by agencies?

The panel agreed to review agency involvement from the time of RD's birth in respect of the above questions.

### **Members of the LSCB Serious Case Review Panel**

Independent Chair

Assistant Director, Social Care & Health

Service Manager, Safeguarding Children Unit

Designated Nurse for Child Protection / Safeguarding

Greater Manchester Police

Principal Education Welfare Officer

Designated Doctor for Child Protection / Safeguarding

CAMHS Strategy Manager, Pennine Care Mental Health Trust

GP, Named Doctor for Child Protection / Safeguarding

Acting Council Solicitor, Stockport Legal Department

LSCB Administrator (Minutes)

In addition, RD's father and paternal relatives plus maternal relatives were invited to contribute their perspective to the review.

### **List of Contributors to the Review**

1. Greater Manchester Police
2. Humberside Police
3. Stockport Children & Young People's Directorate
  - Education
  - Children's Social Care
4. Stockport Primary Care Trust
  - Community Services
  - GP Services
5. Stockport NHS Foundation Trust – Paediatric Service
6. Voluntary & Independent Sector
  - Sharecare
  - Independent Options
7. Pennine Care NHS Trust:
  - Adult Mental Health Service
  - Child and Adolescent Mental Health Service
  - Community Mental Health Service

## **Background to the Report**

On 12.04.2006 RD and his mother AD died after falling from or jumping from the Humber Bridge into the River Humber.

RD's body was recovered from the River Humber near Swinefleet, East Yorkshire on 16.04.2006. AD's body was recovered from the Humber River near Welton Waters, East Yorkshire on 29.04.2006. It is believed that they both died as a result of injuries sustained from falling from the Humber Bridge into the River Humber.

The inquest conclusions were that AD committed suicide and RD was unlawfully killed.

RD was diagnosed with Fragile X Syndrome at the age of 4 years. Fragile-X Syndrome is an inherited form of Learning Disability. It causes difficulties with speech and language, plus difficulties in attention span and behaviour. Affected people may experience difficulties in social interaction and relationships plus difficulties in verbal and nonverbal communication, inflexibility of thinking and behaviour. Some of the features of Fragile X Syndrome fall into the Autistic Spectrum of disorders. RD experienced learning difficulties and behavioural difficulties and his behaviour was becoming more challenging as he grew older.

RD's mother AD experienced mental health problems from a young age and was known to mental health services for depression and anxiety. She experienced several periods as an in-patient due to short psychotic episodes. AD was described as a private person who had high standards and always wanted the best for her son.

## **Summary of Chronology of Composite Reports**

RD was born in Paignton, Devon on 26.05.1993. During his first years AD and RD spent time living in Stockport where AD's family lived, and Hull where RD's father lived. During RD's second year of life, close monitoring of his development established that he had delayed development, especially speech and language. He was referred to the Child Development Centre for multi agency assessment.

On 24.09.1997 AD was admitted to hospital with an acute psychotic episode. On discharge, she was referred to the Community Mental Health Team for support but there is no evidence to show that this service was offered. Early in 1998 AD moved to her own home with RD in Stockport. In July 1998 it was confirmed that RD had Fragile-X Syndrome.

By April 2000, Children's Social Care had conducted a needs assessment and appropriate support was commissioned from a provider of independent activities and support for young people with disabilities. AD was sometimes dissatisfied with their inconsistent support because of staff shortages and changes. RD was recognised as having increasingly difficult behaviour.

In September 2002 RD started at a Resourced Main Stream Primary School. RD's challenging behaviour appeared to be having an impact on AD's mental health.

In April 2003, AD was Sectioned and admitted to Hospital. RD was referred to CAMHS for management of his difficult behaviour but he was not seen because there was no Consultant Psychiatrist in CAMHS.

On 30.04.2003, AD was discharged and referred to the Community Mental Health Team for support. The team informed AD's GP that she did not fit their criteria for support. AD was monitored by her GP and the Hospital Mental Health Services.

On 31.03.2004, RD's Consultant Paediatrician noted that he had no imaginative play skills, poor social awareness, no sense of danger and needed constant supervision. He was referred to CAMHS again but could not be seen because there was no CAMHS Psychiatrist.

On 21.05.2004 Children's Social Care completed another needs assessment. They noted that AD was struggling to cope with RD's challenging behaviour and AD's mental health was fluctuating. Children's Social Care agreed to fund more support from the independent provider of support services.

On 15.09.2004 the Consultant Paediatrician telephoned and sent a letter to Children's Social Care requesting a multidisciplinary meeting about RD and AD. There was no response to this request. From 11.01.2005 AD and RD received extra support from the Community Learning Disability Team.

As RD's behaviour became more challenging the amount of day time respite support was increased. In addition a search was undertaken for a respite foster carer who could provide weekend respite. A worker was identified and introductions undertaken in June 2005. This service was appreciated by AD and her family but RD's last visit to the Respite Carer was on 04.10.2005 and a replacement could not be found.

Despite the lack of replacement foster carer, RD's situation seemed quite settled. By December 2005 the regular day time respite and activities were more consistent and RD also attended a Social Skills Group and football practice on Monday evenings. AD still had concerns about RD's vulnerability when he was out on his own.

On 27.02.2006 RD was seen by his consultant and AD reported some improvement in RD's behaviour. In March 2006 Children's Social Care conducted a service review and the level of service provision was maintained.

On 12.4.06 AD cancelled a meeting with her sister and was identified on CCTV footage travelling to Hull with RD and entering the Humber river later that day.

## **ANALYSIS**

### **Community Child Health Services**

- The HV services in Paignton, Stockport and Hull were consistently good and responsive to AD and RD's needs. The communication between the services predominately good.
- There was a 14 month gap from 16.03.1994 to 17.05.1995 when RD was lost to the HV services. It is possible that RD had not registered him with a GP but this cannot be confirmed.
- RD's developmental delay was detected early and he was referred to appropriate services.
- The Speech and Language Service was good.

## **Paediatric Services**

- RD was referred to the Child Development Centre and had multidisciplinary assessments and was referred for diagnostic tests during his 3<sup>rd</sup> year. By age 4 a diagnosis Fragile-X was confirmed.
- Communication within services at the Child Development Centre and with other agencies was good.
- RD was appropriately referred to the CAMHS service for management of his difficult behaviour.
- In September 2004, RD's Consultant Paediatrician contacted Children's Social Care suggesting a multi agency meeting to discuss AD and RD's needs. His attempts to bring agencies together to discuss AD's needs and RD's deteriorating behaviour were not successful.

## **GP Services**

- AD received a consistently good service from her GP practice. There was regular contact between the GP and other health services about AD's mental health and about RD's deteriorating behaviour.

## **Adult Mental Health Service**

- The Hospital Mental Health Services offered to AD were sensitive to her needs. When she defaulted an Out Patient appointment she was offered another or referred back to her GP to ensure that she was consistently monitored.

## **Community Psychiatric Nursing Service**

- AD was referred to the CPN service on discharge from hospital in 1993 and 1997. There is no written evidence to confirm that AD received a CPN service on any of these occasions.

## **Counselling Service**

- In May 1998, AD was referred to the counselling service. When it became apparent that she would not engage with the service, she was referred back to the GP to ensure that she would continue to be monitored.
- AD was referred to the Counsellor again in September 2001. This time she engaged well and attended sessions until January 2002 when she said she was much better.

## **Child & Adolescent Mental Health Services**

- The CAMHS Service were unable to meet RD's needs because there was no Consultant Psychiatrist within the service. Also CAMHS were not commissioned for children with learning difficulties and had no Psychiatrist to advise and to monitor the medication prescribed for RD.

- RD was referred to CAMHS on at least four different occasions when his behaviour deteriorated and AD could not cope with him. His case was screened but no service was provided and he was never seen by a Consultant Psychiatrist.
- There was no Consultant Psychiatrist in the CAMHS Service between the following dates:  
November 2001 to September 2002 (11 months)  
September 2003 to May 2004 (9 months)  
July 2004 to April 2006 (23 months)
- It is reassuring that since mid April 2006, CAMHS has recruited 2.4 WTE Consultant Psychiatrists.

### **Education Department**

- From RD's transition from the Child Development Centre to Nursery School the service offered was geared to meet his educational needs. AD's demands were dealt with sensitively as RD moved on to a Resourced High School placement.
- Communication between the Education Services and other agencies was appropriate.

### **Children's Social Care**

- The standard of service provided to AD and RD was predominantly good and sensitive to their needs.
- The support offered to AD and RD by the independent provider of respite activities and support was sometimes inconsistent due to staff illness and their inability to recruit acceptable replacement staff.
- Children's Social Care were responsive to the increasing challenges presented by RD's behaviour, increasing their commissioning of respite and support for him as his needs increased.
- The standard of record keeping was not always consistent.
- A carers assessment was offered to AD, but she declined it.
- Despite the many services involved with AD and RD, there was never a multi-disciplinary meeting to consider and plan collectively for his needs, although such a meeting was suggested by the Consultant Paediatrician.

### **Greater Manchester Police**

- The contribution of GMP to the review has been invaluable.
- The Police responded to the concerns of the family and to the emerging tragedy with sensitivity.
- The Family Liaison Officer was key to keeping the family informed as the case evolved and in ensuring that the voice of the family was heard.

## **Humberside Police Service**

- The Humberside Police responded to the alert about AD and RD with an exhaustive investigation
- The police are involved and committed to a group chaired by the Humber Bridge Bridgemaster which is working towards preventing such tragedies. They are looking at:
  - Installing safety wires and mesh to the railings thus preventing people climbing onto or over them.
  - Improving CCTV
  - Restricting access to the walkways e.g. gating system
  - Access to a direct telephone link to the Samaritans.

## **Multi-Agency Analysis**

**This analysis seeks to answer the questions asked by the Serious Case Review Panel in considering the terms of reference.**

**Q. – Question**

**A. - Answer**

**Q. Was the assessment of RD's needs appropriate as a vulnerable child in need?**

**A.** Overall the assessment was appropriate.

**Education** - RD received an appropriate educational assessment and placement.

**Children's Social Care** - Appropriately assessed RD's increasing needs as he got older. Respite activities were provided and RD attended a social skills course.

**CAMHS** - His increasing behaviour problems could not be assessed due to lack of appropriate CAMHS expertise.

**Q. Were the multi-agency support arrangements for RD and AD effective?**

**A.** Individual agencies offered good support. However, this was not done in a coordinated way and communication between agencies could have been better.

There were no multi-agency meetings to address RD & AD's needs and so there was no consistent approach.

Communication between Children's Social Care as commissioner and the services commissioned could have been better. There should have been better evidenced reviews of services and clear messages about the needs of RD and AD and outcomes to be achieved by Service Provision.

**Q. Was there evidence that the support offered to AD to minimise potential difficulties in caring for RD was inadequate?**

**A.** Overall individual agency responses were good at times of crisis. There was a lack of preventative support services when the situation was settled. AD was offered a carers assessment, to establish her needs but she declined. Overall support offered to AD was considered adequate based on the information available.

**Q. Was there evidence of potential risk of harm to RD that was not perceived by agencies?**

**A.** There was no evidence of potential risk of harm to RD. No service could have predicted AD and RD's sad end.

## CONCLUSIONS AND LESSONS TO BE LEARNED

The purpose of this Serious Case Review is to establish whether there are any lessons to be learned about how professionals and organisations work together to safeguard and promote the welfare of children.

During the course of this Case Review it has become clear that the tragic deaths of AD and RD could not have been anticipated or prevented by any individual person, service, agency or a fully functional multi agency approach.

It was recognised during the review that safeguarding policies and systems have developed and improved in the last eleven years and some of the issues raised in RD's early life would no longer be cause for concern.

Conclusion	Lessons to be learnt
<ul style="list-style-type: none"> <li>• During his pre-school years, RD was assessed and received services through the Child Development Centre multi disciplinary and multi-agency teams working together to plan and provide services for RD</li> <li>• After he reached school age, RD and AD were linked to and required services and support from several different services. At no time were these services able to sit round a table to plan and review the services required by this vulnerable family.</li> <li>• The evidence available to Children's Social Care as commissioner of support services shows that the review of quality and effectiveness of provision of services was not as effective as it should have been.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Multi-agency Children In Need meetings are essential to ensure all services are clear about their role, are consistent in their plans and work together to support children with disabilities and their carers.</b></li> <li>• <b>Children In Need Framework indicates that children in RD's circumstances should have an allocated lead professional / key worker to co-ordinate services.</b></li> <li>• <b>Planning meetings should involve professionals from all relevant adult services.</b></li> </ul>
<ul style="list-style-type: none"> <li>• The standard of record keeping was not consistently good. Meetings were attended; reviews and assessments were carried out, sometimes without any written records to provide the content, detail and conclusions of these important events.</li> </ul> <p>Some information for this Case Review was obtained by interviewing workers who had no relevant written record to confirm their recollection of events</p>	<ul style="list-style-type: none"> <li>• <b>It is essential that ALL meetings should be minuted and records kept by all those who attended. All entries into case notes must be dated and signed. Supervision of professionals must include checks on record keeping.</b></li> <li>• <b>Recording of service reviews should be extended to include progress against target outcomes and future need.</b></li> </ul>

Conclusion	Lessons to be learnt
<ul style="list-style-type: none"> <li>It has been difficult to obtain some records of the work carried out at the Child Development Centre on RD and AD.</li> </ul>	<ul style="list-style-type: none"> <li><b>All multi disciplinary records from the Child Development Centre must be kept together and stored in a way that will facilitate ease of retrieval. Essential copies should be in the child's continuing health record to provide continuity and ensure that important information is not lost.</b></li> </ul>
<ul style="list-style-type: none"> <li>From 16/03/1994 to 17/05/1997 RD was lost to the HV services although the Stockport HV Service were aware that AD and RD had moved to Hull. There is no written evidence to show that the Hull HV Service were informed that RD had moved to their area.</li> </ul>	<ul style="list-style-type: none"> <li><b>HV services must always maintain their good practice of alerting the receiving HV Service area that a child has moved to their area. The receiving HV must identify the child and family and then request the records from the forwarding HV Service.</b></li> </ul> <p><b>If the child is not found in that area and there are concerns about the child's welfare, a National Alert may need to be issued, to alert all HV Services of the missing child and family. This would have been particularly important in RD's case because his mother had known Mental Health problems and RD's delayed developmental milestones had been identified.</b></p>
<ul style="list-style-type: none"> <li>Although RD's prognosis could not be predicted, it was essential that when he was referred as his behaviour problems fluctuated and worsened, he had access to a CAMHS Psychiatrist to provide a lead to appropriate therapy and support services</li> </ul>	<ul style="list-style-type: none"> <li><b>It is essential that all children and young people in Stockport who require the services of a CAMHS Psychiatrist should always have access to such a service and any recommended services appropriate to their needs.</b></li> <li><b>The Stockport PCT must urgently consider the commissioning of a CAMHS service including a Psychiatrist for learning disabilities.</b></li> </ul>

## **Family Perspective**

During the review, family members were interviewed and invited to contribute their views.

RD's Maternal Aunts views were as follows:

- They expressed disappointment at the failure to recruit another respite carer. This service had been appreciated by AD and the family.

- RD had bouts of anger and his relationship with AD was breaking down. They needed help.
- AD was reluctant to let RD out of her sight. She dreaded periods when RD was not at school. The week AD and RD died was just before end of term.
- There had been a good support group but the leader had moved house and the group folded.
- AD appreciated support from the independent support service but it was inconsistent.
- She had complaints but was afraid to voice them in case she was given less priority for support.
- AD always had high standards and was not seen as needy.
- They felt that professionals worked to individual mandates and did not “see the bigger picture”.
- RD had no sense of danger and no fear.
- One sister had suggested AD should plan for the future and their mother was thinking of moving house.
- RD was getting more violent and AD saw herself and RD as a burden and “found a solution”.
- Just before their disappearance AD had become angry and introspective.

RD’s father and paternal aunts expressed the following views:

1. RD’s father stated that he had kept regular contact with AD and RD. He last spoke to them 3 weeks before their deaths.
2. RD’s father knew that RD was receiving support services but AD had told him that everything was fine. She later said she thought she had taken too much on.
3. RD’s father was not aware of the extent of AD’s mental health problems. He was aware of her anxiety and possible depression.
4. He expressed their anger at what had happened to RD. The family did not consider that his additional needs were “insurmountable”
5. He said he had a good relationship with RD. It was clear that he loved his son.
6. He felt that services involved with RD made no attempts to involve him. He was angry that his role in RD’s life had been ignored.
7. RD’s father last saw RD in August 2004. After that he was not able to travel to Stockport due to ill health.
8. He gave his views of AD’s own need and vulnerabilities which reflected those expressed by her family.

### **The Inquest**

The inquest into the deaths of RD and AD was held on 11.08.2006

The Hull Coroner ruled that AD had committed suicide and RD had been unlawfully killed. The family GP felt that RD’s condition made it possible that RD would have jumped without being pushed. RD’s Consultant Paediatrician agreed that RD may not have appreciated the danger he was subjected to. A post-mortem concluded that both AD and RD died from drowning. In conclusion the Coroner took into account AD’s long struggle with mental illness and their long journey to the Humber Bridge. He felt it was significant that AD did not ask for help from the emergency services and took account of the suicide note (left at her home). He was satisfied that AD had taken her own life. The Coroner felt that the evidence he had heard convinced him that RD’s death amounted to an unlawful killing.

He thanked the family for the dignity they had shown throughout and offered his condolences to all those who had been affected by the tragic deaths of AD and RD.

## **REFERENCES**

1. WORKING TOGETHER TO SAFEGUARD CHILDREN 2006
2. CHILDREN ACT 2004
3. KEEPING CHILDREN SAFE (2003) (DfES, DOH, Home Office)
4. COMMON ASSESSMENT FRAMEWORK FOR CHILDREN & YOUNG PEOPLE 2003 (DfES)