**Summary of Serious Case Review (SCR) for Child BW (Died 2010)**

**Background to SCR**

On a school day morning in 2010 the mother of BW and CW (ages 6 and 7) telephoned the police saying the children`s father had threatened to “throw himself and the children in the river”. Mother had attempted to pull the children out of the car, but the father had driven off. Within a few minutes a call from a member of the public reported a car with children in it had been driven into the river and was sinking fast.

The father escaped from the car and CW was rescued by police. BW remained submerged for two hours. CW made a good recover. BW died three days later.

In 2011 Father was convicted of murder and attempted murder and sentenced to life imprisonment.

**Key information recorded in the SCR report :**

* There were no reports of concerns about the daily care of these children, school reported two well behaved children who were settled at school, confident and with a group of friends. Parents were known to have separated.
* The GP had seen both mother and father regularly in practice, recording misuse of alcohol and mental health difficulties. The GP practice did not consider the impact of the parent`s abilities to meet the children`s needs in relation to this. The GP practice did not consult other health professionals about the welfare of the children.
* The police had significant and direct involvement with the family and responded to Domestic incident call outs, leading to notifications to the Domestic Abuse and Public Protection Units. The children were not spoken to by the police on any of these call outs.
* The PCT Health Safeguarding electronic Flagging system to alert GP`s to patient incidents of domestic abuse dealt with by the police was not made use of.
* Children`s Services (CS) were notified about the domestic abuse incidents, but did not have direct contact with the family. They sent standard letters to the mother saying “Children`s Services have been informed about the domestic call out and will not be taking any further action. Five such letters were sent to the mother, in respect of CW and BW.
* Father had first threatened to kill the children and himself in November 2009. An Initial Assessment (which under “Working Together to Safeguarding Children” must be completed by CS within 7 working days from referral) had not been completed 53 days later when the children died.
* At no time did CS, the Police or Cafcass consult with or seek information from Health professionals, therefore they remained unaware of the treatment of both parents for depression and father`s alcohol misuse.

**MISSED OPPORUNITIES**

* 2008: Father tells GP about suicidal thoughts. This should have led to his parenting capacity being considered and internal sharing of information in Health.
* 2008: A domestic abuse incident call out came when father refused to have the children back after a contact visit. A referral to CS should have taken place for Initial Assessment.
* 2009 : Children present for domestic abuse incident – CS referral for Initial Assessment should have happened.
* 2009: Mother reports father`s threat to kill children and himself made on two occasions. An Initial Assessment should have been started and a Section 47 Enquiry carried out to establish the likelihood of the risk of harm to the children. The children should have been seen and spoken to.
* The time frame of the Initial Assessment which did take place had been missed and information failed to be shared.

**WSCB Conclusions:**

* An accumulation of concerns (e.g. the five letters sent about the Domestic Abuse) should have triggered and earlier response by CS.
* Interagency procedures were not followed regarding sharing of information between Health, CS, School, police and others.
* On notification of a threat to kill himself and the children a brief initial assessment and strategy discussion should have taken followed on the same day. The fact this did not take place was down to professional judgement and interaction between police and CS.
* The assessment of risk by Police was not robust enough and the level of risk assessed was wrong.
* Health and school were key agencies who CS failed to consult with.
* **If the agencies had shared information at the points identified and had undertaken appropriate assessments it is likely the event leading to the death of BW and the near death of CW could have been prevented.**

**Lessons to be learnt**

A threat to kill children by a parent must always be taken seriously and must be responded to by an urgent assessment of the circumstances by all agencies.

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