Addendum to Serious Case Review

Kirsty

Addendum

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1 Background

1.1 At the conclusion of the criminal proceedings of this case. It was clear that there was further learning to be recorded and shared with the partner organisations of the NSCB and other agencies working directly with children and their families.

1.2 To ensure that any learning was gathered, the NSCB contacted father and mother who were now separated to request that we could speak with them to elicit any further learning from the case.

1.3 Both parents consented and were happy to take part in the process. The meetings took place in father and mothers homes in March 2017.

1.4 At the meetings the authors explained the SCR process, the role of the independent author, what the report is based on and stressed that the information was from a variety of multi-agency sources.

1.5 The authors also explained and reassured both parents around confidentiality and that the report would also be placed on the NSCB website for 12 months.

1.6 The authors agreed that NSCB will inform both parents when the report will be published and that they would be given a copy of the SCR and addendum before the publication.

1.7 The authors acknowledged the criminal court outcome and that the independent author had updated the SCR to reflect this.

2 Discussion with father

2.1 This discussion was led by the NSCB Business Manager and a Children's Services Senior Manager for Northumberland County Council following the end of criminal proceedings.

2.2 The NSCB Business Manager explained the serious case review process, the learning points and recommendations

2.3 Father was given the opportunity to reflect on the SCR report and was able to provide insight into his views about the learning.

2.4 He also provided information that supported the formation of the recommendations.

3 Summary of the discussion with mother

3.1 This discussion was led by the independent reviewer and a Children's Services Senior Manager for Northumberland County Council following the end of criminal proceedings.

3.2 The independent reviewer explained the SILP process, the learning points and recommendations. Mother had very little response to this either verbally with comments, feedback or questions.

3.3 Mother was given the opportunity to reflect on the SCR report and was able to provide insight into her views about the learning.

3.4 The independent reviewer and a Children's Services Senior Manager were able to provide reassurance that the focus of the SCR was developing learning and not the apportioning of blame.

4 Key learning points

4.0 Both parents' comments highlight that the focus of the intervention by all organisations was on mother. Father was missing in assessments and interventions. Father's comments during the interview strongly support this view.

4.1 There was also a belief by workers that the father was a protective factor and was able to parent Lydia and Kirsty, at a time of severe stress for the family.

Fathers' comments accurately reflect this;

> *"People seemed to provide loads of help with our first child, but with a second child it seemed like we had proven ourselves and didn't need support anymore because we were experienced parents"*

5 Recommendations

5.0 It is clear that all organisations working with families need to engage with fathers / partners in the household, record their views clearly and assess their capacity to parent and safeguard children.

5.1 NSCB needs to review the commissioning of SCR's to ensure that during the SCR process fathers are involved in the process and interviewed if possible.

It is important that the SCR process does not reflect the findings of the triennial analysis of serious case reviews;

> *"Preconceived ideas about fathers as either "good" or "bad" influences potentially whether they are involved in assessments regarding their children. This means that important information about risks may be lost.*[1]*"*

5.2 All agencies should ensure that when providing support to parents following the birth of a baby, that both parents are offered appropriate support and advice, whether it is their first child or not. All relevant documentation should include evidence regarding on-going assessment of both mother's and father / partner's parenting capacity.

[1] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

Recommendation	Detailed Actions	Person Responsible	Timescales	Desired Outcome
Recommendation 1 All organisations working with families need to engage with men in families, record their views clearly and assess the capacity of fathers to parent and safeguard children.				
Recommendation 2 The NSCB to review the commissioning of SCR's to ensure that during the SCR process fathers are involved in the process and interviewed if possible.				
Recommendation 3 All agencies should ensure that when providing support to parents following the birth of a baby, that both parents are offered appropriate support and advice, whether it is their first child or not. All relevant documentation should include evidence regarding ongoing assessment of both mother's and father / partner's parenting capacity.				