Directorate for Children's Services

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24 January 2023

Dear Mr Wade KC

RESPONSE TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
In the matter of the Inquest re Leighane Redmond and Melsadie Parris

This is a response by Buckinghamshire Children's Social Care ("BCSC") response to HMAC Wade KC Report to Prevent Future Deaths made under Regulation 28 of the Coroners (Investigations) Regulations 2013 dated 12 February 2021. That report arose from an Inquest held between 14th to 30th November 2022 into the deaths of Melsadie Parris and her mother Leighane Redmond

I would like to take this opportunity to add my condolences to both Leighane and Melsadie's families and acknowledge the extremely tragic nature of this case. I would also like to thank the Coroner for his report.

The Report to Prevent Future Deaths identified one matter of concern to the Coroner, namely:
'*that the social work staff in the children's services were informed on 9th January 2019 by two separate persons, Melsadie's father (directly) and Melsadie's grandmother (indirectly by means of written report produced by the 111 NHS non-emergency service, noting the information) that the adult with daily care of Melsadie had spoken to Melsadie in terms of describing her as evil. On checking with the adult carer, that person admitted to the social worker that the reports were true. The social work team knew that the adult carer had previously been referred to them by emergency services as a result of genuine and valid concerns about the carer's mental health such that the carer suffering from psychosis. The team had removed Melsadie appropriately while awaiting a mental health assessment, which was completed without knowledge of the carer's remark and before the remark was known to children's services. The mental health assessment found that the carer was not psychotic, an opinion which was appropriate on the day of assessment. The social work team had earlier conducted an investigation around an older matter of concern involving Melsadie, but this was unrelated to the mental health of her adult carer, and it had arisen two calendar months before the mental health crisis. In respect of that initial concern the social worker had concluded reasonably that there was no evidence to justify the removal of Melsadie nor continuing concern for her safety, but for logistical reasons their file remained open at the time of the new concerns around the carer's metal health.*

However the team based their review on investigations conducted some months before the mental health concerns arose and before the remark about evil was made. The team did not conduct a renewed visit to the home, nor seek up to date information from the family, nor liaise with the mental health team. It is likely that if they had done so they would have discovered more detail of the extent of the carer's mental illness which was indicative of paranoia with depression, linked to concealment of ongoing episodic psychosis. It is possible that a further mental health assessment would have been sought, and arrangements made to remove Melsadie from the custody of the carer.

I found that existing guidance and policy recognised and encouraged the need to engage with family to gather information, to make home visits, to liaise with mental health and to treat assessment decisions and verification of file closure as dynamic processes requiring rigorous scrutiny.

However, despite the existence of this guidance, the team placed undue reliance on the opinion of the mental health professionals and on old irrelevant investigations. Furthermore, although the department commissioned an independent review of the case, this found that the death could not have been predicted (which I accept), but tended to emphasise perceived shortcomings in the mental health professionals work, without acknowledging the above concerns. In addition it contained factual inaccuracies, such as a failure to identify the revelations of 9th January 2019. The review report was withheld, following complaints by the family as to matters of fact, but the council decided nonetheless to publish an executive summary which maintained the partial reflection of the review conclusions. I am concerned that by so doing the department will persist in a view that its team did not fail to adhere to its own guidance and good practice.'

This response therefore covers actions that BCSC intend to take in respect of file closures.

Preamble

Before dealing with my response however I do wish to respectfully clarify one key factual point:

The report states that:
*Furthermore, although **the department** commissioned an independent review of the case, …(and)…. but **the council** decided nonetheless to publish an executive summary which maintained the partial reflection of the review conclusions.'*

The independent review was commissioned by, and the executive summary published by, **the Buckinghamshire Safeguarding Children's Partnership** Home - Buckinghamshire Safeguarding Children Partnership (buckssafeguarding.org.uk) which is a wholly independent and separate legal entity to Buckinghamshire Council, and for the avoidance of any doubt, also completely separate to Buckinghamshire County Council. This is a very important distinction which has been clearly stated already within the evidence and previous correspondence.

Therefore, it would be more accurate for the final paragraph of the reg 28 report to read:
*Furthermore, although **Buckinghamshire Safeguarding Children's Partnership** commissioned an independent review of the case, this found that the death could not have been predicted (which I accept) but tended to emphasise perceived shortcomings in the mental health professionals work, without acknowledging the above concerns. In addition it contained factual inaccuracies, such as a failure to identify the revelations of 9th January 2019. The review report was withheld, following complaints by the family as to matters of fact, but **Buckinghamshire Safeguarding Children's Partnership** decided nonetheless to publish an executive summary which maintained the partial reflection of the review conclusions. I am concerned that by so doing **Buckinghamshire Council Children's Services** will persist in a view that its team did not fail to adhere to its own guidance and good practice.'*

Given Buckinghamshire Council Children's Services were not responsible for either the independent report, or the publication of the executive summary, it is difficult to see how the conclusion in the underlined sentence could logically therefore be drawn and would ask for this to please be amended within the Prevention of Future Deaths Report.

File Closure

I am pleased to note that it is recognised by the Assistant Coroner that our existing policies and guidance are deemed sufficiently robust. We do not therefore propose to re-visit those policies and guidance as a result of this PFD, as this does not appear to be the Assistant Coroner's requirement.

Buckinghamshire Council accepts the Assistant Coroner's view that best practice in employing those policies was not followed when this file was closed and intends to learn from this deeply tragic case and the concern identified by the Coroner.

As a statutory children services department, Buckinghamshire Council are fully focussed upon the safety and well-being of all the children and young people who are referred to us. Given the complexity of this work, the fact that every case is different, and that the Assistant Coroner has confirmed the policies and procedures we have are the right ones, our focus will be on ensuring that our staff properly evidence the rationale and decision-making process that informs their professional judgment resulting in the closure of cases going forward.

Closing a piece of work will remain the action and task of line managers, as this is an appropriate exercise of their professional judgement however, going forward the closing reasons will need to be specifically recorded by that manager and will include an analysis addressing the following matters:

a) confirmation that there are no outstanding tasks, including informing family members and other professionals of this decision, and
b) a commentary on the merits of another visit to the family home,
c) why it is therefore appropriate and safe to close the file

The closure of casework and adherence to the above standard will form part of our Quality Assurance activity which will give senior managers oversight of this area of practice enabling them to monitor future adherence to our guidance and to good practice.

We do consider it important to note for the purposes of our response to the PFD, that in this particular case, the Local Authority consider that the legal test (Threshold) for any further statutory intervention was no longer evidenced and that this is what prompted the closure decision.

The legal Threshold to allow statutory intervention by a Local Authority is set out in s47(1) (b) Children Act 1989, namely that:

47. Local authority's duty to investigate.

(1) Where a local authority—

(b) have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

It is respectfully noted at this juncture that the Assistant Coroner himself confirmed within his Findings that '*Melsadie was not a child in need and was not at risk. In January 2019 Melsadie was well cared for. She was loved. Her mother was in good jobs. Her mother was taking appropriate steps to deal with her debts. Her mother was inter-acting with doctors, employers, a landlord, her neighbours, her ex-partner, her friends, her child's nursery, the child social work team…… in ways which were reasonable, appropriate, reassuring – even impressive. She was in fact interacting with her mother.*'

Finally, we would also take the opportunity to respectfully note that in the event that a manager instructs a further visit to take place in the future and either a) the family do not make themselves available to the social worker or b) refuse such a visit, in the absence of any other new evidence identifying a current safeguarding concern, the threshold to insist upon a further visit will not be met and the case will close in any event as the Local Authority would then have no legal right to be able to investigate any further.

<u>Other</u>

The recommendations from the independent SCR will also be actioned, although the accountable body regarding this will be the Safeguarding Partnership Board.

In conclusion, Buckinghamshire Children's Social Care are determined to learn from this deeply tragic case and do take the Coroner's concerns very seriously. We are focused on continuously improving the service we provide to families and are committed to improving this for all children and young people in Buckinghamshire.

Yours sincerely

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Corporate Director Children's Services