Suffolk County Council

Regulation 28 Response of Suffolk County Council

In respect of Ms. Katie Madden

We write in response to the Coroner's Regulation 28 report, dated 30th May 2024 concerning the death of Ms. Katie Madden on 4th June 2023.

First of all, Suffolk County Council ("SCC") would like to express our sincere condolences to Katie's family and loved ones. SCC are keen to ensure that the family and the Coroner's concerns are listened to and reflected upon.

As the Coroner has already identified, the Children and Young People's team ("CYP") have a statutory duty to safeguard the wellbeing of persons below the age of 18. We concur with the Coroner's observation that there exists no statutory or other national system in place to represent the needs of vulnerable parents facing the prospect of their child/ren being taken into care. SCC welcome any interventions that the appropriate Secretaries of State can offer in this regard, which would assist partnership working, moving forward.

Having viewed the Coroner's Regulation 28 report, the first three points relate to the process of information sharing between the Multi-Agency Safeguarding Hub (MASH), Adult Social Care ("ASC") and CYP, and the system of risk assessments in place for managing vulnerable parents when they are facing the prospect of their children being taken into care.

The "Claire's Law" disclosure scheme is managed and led by the Constabulary. SCC social care staff, working within the MASH, reviewed the manner in which Katie received that disclosure and were content that all procedures had been complied with, in accordance with established practice.

CYP staff were aware of the “Claire’s Law” disclosure recorded having had access to all safeguarding referrals relating to the family. However, SCC accept that if a parent demonstrates that they are in need of additional support as a result of the onset of PLO proceedings then CYP staff should make a referral to ASC by way of a referral to its Customer First Team in addition to any support they may already be receiving from other agencies. This is particularly pertinent, in cases such as Katie’s, where a parent has an established history of rumination and behaving unpredictably during stressful life events. The purpose of the referral would be to determine eligibility for assessment and services in accordance with the Care Act 2014. This activity may result in further signposting, including to primary or secondary mental health services. Any referrals related to safeguarding concerns for a parent would be passed to the MASH who will consider any safeguarding actions required in accordance with Section 42 of the Care Act. A practice note and addition to the Standard Operating Procedure for the MASH will be made to remind MASH practitioners of the need to identify the vulnerabilities of any adults involved in safeguarding referrals in respect of children.

Action is already underway following a Serious Case Review in respect of MANDY for a process of prompts in both children’s and adult Multi Agency Referral Forms. This is for the practitioner to consider, when putting in a referral related to a child, whether there is an adult involved for whom there are also concerns. The practitioner will be prompted at the end of the referral form to direct the practitioner to submit the additional concerns in relation to the adult to the relevant portal for triaging. This process will also be implemented when referrals are received in respect of adults where the practitioner will be prompted to refer any concerns identified in relation to a child to the relevant portal.

Whilst a referral of this type is wholly dependent on the persons consent and may not always result in the aforementioned assessment(s) staff will be reminded that a referral ought to be made, nonetheless. This aspect of identified learning shall become a dedicated focus within our annual PLO training for CYP colleagues working across our operational services to raise awareness of presenting significant MH issues, recognising that SW are not able to undertake specific MH assessments. The voice of parent/carers as “experts by experience” will inform our PLO training programme. We shall work alongside our judiciary partners such as CAFCASS to raise awareness and promote

ownership and responsibility across the wider system. We will ensure that advocate support is accessible and appropriate to the needs of parent/carers where risk assessed. CYP staff will also be reminded that the PLO process should be utilised, wherever possible, as a restorative tool which is approached with compassion and from a trauma-informed place.

In addition, staff at Legal Services, when accepting a new case from CYP, shall be required to discuss with social workers any relevant vulnerabilities relating to the parent(s) and whether a referral or any further signposting is needed.

Finally, a Safeguarding Adults Review Panel (SARP) Meeting took place on 10th July 2024. The SARP is a sub-committee of the Suffolk Safeguarding Partnership, more information in respect of which can be found at https://www.suffolksp.org.uk. As a result of this meeting, a referral has been sent to the Community Safety Partnership for consideration for a domestic homicide review of this case. The SARP would like to explore the opportunities for a joined-up review process as part of this ongoing piece of work. An update regarding the proposal for a domestic homicide review is expected in September.

Prepared on behalf of Suffolk County Council Adult and Children Services
25 July 2024