1st December 2014

Press Statement for SCR 42

Serious Case Review C42 has now been completed by the Torbay Safeguarding Children Board (TSCB). It follows the inquest into the tragic deaths of a mother and her children who were found dead on 12 July 2013. The review examines what happened and why, and explores if any lessons can be learnt.

The conclusion of the review found that these deaths could not have been avoided. However, the review has highlighted a number of findings and as a result has recommended the following actions:

- All partner agencies demonstrate that effective supervision is available for all staff involved in Safeguarding work
- There is a shared approach to assessing and understanding risk
- Closer working between adult mental health and other agencies through joint training
- There is an agreed process for investigating historic abuse allegations
- There is a review of preventative mental health services

The Independent Chair of Torbay Safeguarding Children's Board, David Taylor, said: "This was a very tragic event and I would like to reassure everyone that the Safeguarding Board and all its partners take the recommendations in this review extremely seriously.

"As the review states these deaths could not have been avoided, but we can always improve on what we do. As such, the Board will continue to review and raise the quality of practice in Torbay to ensure partner agencies continue to improve their integrated working.

"The Board and I are committed to keeping children, young people and their families safe and through close consideration of such cases like this we continue to build on the improvements we have already made to offer the best protection possible."