Serious Case Review

Child R

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1 INTRODUCTION

1.1 Child R, aged seven, died in 2018 at his maternal grandparents' home in Essex. He had been living in the home with his mother and nine-year-old sibling. Mother was arrested, admitted killing Child R and in January 2019 was found not guilty of murder by reason of insanity. She was given an indeterminate hospital order.

1.2 At the time of Child R's death, records showed that Mother had a long history of physical and mental health problems and was an open case to mental health services. As a child had died as a result of abuse by a mental health service user the case met the criteria for both a child serious case review and an independent mental health homicide investigation by NHS England.[1]

1.3 Prior to their move to Essex in November 2016, Mother and the children had lived with her ex-husband in Southend. Much of their contact with agencies had been whilst living in Southend, and Essex and Southend Safeguarding Children Boards discussed who should lead the serious case review process. It was agreed that as the children had resided in Essex at the time of Child R's death the review would be led by Essex, with Southend agencies contributing to the review and joining the review team. Although some of the learning has general applicability beyond the local area, most recommendations focus on either services in Southend or health trusts that work across both local authority areas.

1.4 The decision to carry out a serious case review took place after new statutory guidance came into force in 2018[2] and prior to new partnership arrangements for safeguarding children being in place in Essex and Southend. Arrangements for initiating this review and publishing the report have therefore remained with Essex Safeguarding Children Board but it is important that the final recommendations are considered and responded to by both Essex and Southend Safeguarding Children Boards/Partnerships.

1.5 The focus of this serious case review is Child R. Due to the circumstances of his death many of the recommendations of this review relate to the way in which risks to children can be recognised by practitioners working with adults with physical and mental health problems. This may inadvertently result in the voice of Child R being lost within the review process and this is not the intention of this review. The main picture given though records and from discussion with family and practitioners is of a child who was loved by his extended family and was a happy boisterous child within school. There were ways in which family circumstances can now be understood to have had an impact on him and this is explored here relevant in the body of this review report.

1.6 The investigation by NHS England focusses in more detail on the NHS services provided to Mother and can be accessed separately, however it should be noted that

[1] NHS England Serious Incident Framework (March 2015) https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwork-upd.pdf
[2] HM Government (2018) *Working Together to Safeguard Children*

the two reviewers have worked closely together in finalising the findings and recommendations of this review. It is therefore important that both reports are considered together when planning a response to this review.

Recommendation One
This report and the findings from the NHS England investigation should be considered by Essex and Southend Safeguarding Adult Boards/Partnerships and the expectation is that there will be joint planning in response to this report and the NHS England independent mental health homicide investigation.

2 THE REVIEW PROCESS

2.1 An independent lead reviewer was commissioned to carry out the review on behalf of Essex Safeguarding Children Board. An initial meeting was held by the lead reviewer with the family including Maternal Grandfather, Maternal Grandmother, the father of Child R, Maternal Aunt and Child R's sibling.

2.2 In order to avoid duplication, terms of reference[3] were jointly agreed with the independent investigator from NHS England and the independent reviewers worked together throughout the review. This has resulted in two separate reports that have been informed by the other with continuity in the recommendations made for the health agencies concerned.

2.3 The terms of reference stipulated that the start date for the *detailed* chronology should be the point that Child R started school in September 2015 and finishing on the date of his death. Agencies were asked to identify any significant information prior to this date. This is included in this report and has proven to be important in contributing to the final analysis.

2.4 Agency chronologies were received from:

- Essex Partnership University NHS Foundation Trust (EPUT)
- Essex Police
- Local Council
- Southend University Hospital NHS Foundation Trust (SUHFT)
- NHS Southend Clinical Commissioning Group - CCG (GP services)
- North East London NHS Foundation Trust
- Southend Early Help
- Southend Education
- Open Door
- Southend Adult Services
- Southend Housing
- The Advocacy Service Provider
- South Essex Advocacy Services

[3] See Appendix One for full terms of reference

2.5 Mental Health services also carried out a Serious Incident Review and this was made available to the serious case review. Reports were also received from psychiatrists who provided expert evidence for the criminal proceedings.

2.6 As well as the meeting with family members at the start of the review, the independent reviewers have also met with Mother. The review team are very grateful for the contribution of the family and their views have informed the findings set out in this report.

2.7 The review included discussions with practitioners who had been involved with the family and a list of those who contributed can be found in Appendix Two of this report. A final draft was shared with all those practitioners who had contributed in order to check for factual accuracy and enable a multi-agency discussion of learning from the review process.

2.8 The final report was shared and checked for accuracy with Child R's family prior to publication.

3 CASE SUMMARY

3.1 Mother reported a long history of physical problems associated with fibromyalgia stretching back to childhood. After her marriage and the birth of her two children she is described as spending two years in bed, being unable to leave the home on many occasions and needing to use a mobility scooter. Mother and Father separated in 2012, Father later returned to the home in Southend to care for his children due to the severity of Mother's physical impairments.

3.2 The following table summarises key contacts with the family up until the two weeks prior to Child R's death. This is followed by a more detailed description of the events leading up to the fatal incident

	Services for Mother	Services for Children
Feb 2014	Mother was seen by Therapy for You (IAPT)[4] and scored high on all three assessment tools but was discharged from the service as she did not attend the next two appointments. A subjective interpretation of the scores noted that she was frustrated with her physical/medical condition and perceived lack of support from medical professionals.	
Feb 2014	Six days after the IAPT assessment Mother was seen in the Emergency Department of Southend General Hospital having taken an overdose and was referred for a mental health assessment. She was discharged to	

[4] IAPT is Improving Access to Psychological Therapies and is an NHS service designed to offer short-term psychological therapies to people suffering from anxiety, depression and stress.

	GP care and referred to outpatient psychiatry and psychotherapy services. She was then assessed by the mental health clinical assessment service and the assessment noted no risk to the children. Mother was referred back to the GP as it was considered that she had appropriate help in place via IAPT. There was no further consideration by the GP of any implications for Mother or the children as a result of her disengagement from IAPT.	
Oct 2014	Father referred Mother to Southend Adult Social Care due to her physical ill health and mobility problems. He also mentioned depression. This resulted in an occupational therapy assessment which focused mainly on her physical problems and adaptations needed to the home.	
Jan 2015		Child R's sibling (age six) was referred to Child and Adolescent Mental Health Services with symptoms associated with anxiety. Following an assessment and five sessions, the symptoms were noted to be improved. The assessment was thorough, included a genogram and noted Mother's overdose although there was no communication with the sibling's school.
March 2015		The school referred to Family Action[5] for family support and a support worker started home visits. The school's view is that risks at this time were managed by Father living in the home but would increase if he left.
April 2015	An advocate was working with Mother and made a referral to Southend Adult Social Care for a holistic assessment. After a home visit the social worker recommended direct payments so that Mother could source her own support, but this was turned down by the allocation panel who advised reablement. After visits by the reablement team Mother reported some improvements.	
Sept 2015	Father was planning to move out and the case was closed to reablement in September 2015 as Mother was described as "not compliant with the assessment". The record notes that Mother was given the access teams number for when father moved out as she would need help with the children.	Child R started primary school. Family Action liaised with the pastoral support worker at the school regarding concerns about the family and discussed the possibility of the referral to young carers. The school did not feel this was needed whilst Father was at home.

[5] A voluntary organisation offering support to families.

	Mother continued to receive specialist health services for physical health problems.	During this period there were further signs that Child R was becoming anxious.
Jan 2016		Family Action closed the case. Father was not happy with this outcome, but the school supported the decision and were positive about the children's behaviour and capacity to form friendships.
March 2016	Essex Police received an allegation from a neighbour that she had been assaulted by Mother. The decision was to manage this via a Community Resolution, but this was not progressed as Mother could not be located and engaged with. The case was therefore closed. It is the view of Mother's advocate that this allegation was part of a pattern of harassment by neighbours and that the assault was precipitated by the neighbour. Mother saw the GP and started taking medication for anxiety. Father also visited the surgery to report that Mother might need counselling for depression and panic attacks. He was given contact details for Therapy for You.[6]	
April /May 2016	In an e-mail to her advocacy worker Mother said that she was worried that Child R's sibling's anxiety symptoms had returned. Records from this time indicate that Mother had moved temporarily out of her flat in Southend and was staying with family in Essex due to harassment by neighbours. Her advocate contacted the GP to request support with housing and asked Essex Police (verbally and in writing) to give details of the harassment. After inquiries to establish whether this fell into the category of hate crime the conclusion was that it was not a matter requiring further police attention. Father made a referral to Southend Adult Social Care for another assessment which was passed to the locality team.	Father told the school he was concerned about Child R's "anger issues" in and outside the home and that his sibling was "petrified of him". The school did not recognise this behaviour as there were no problems in school other than normal boisterousness. The next week Mother contacted the school to say she was keeping Child R off school for the rest of the week after a teacher spoke to her about his behaviour as "she was worried it would exacerbate her illness." From the school's perspective they had not raised any significant concerns. A referral was made to Southend Early Help Service with the consent of Father.
June/ July 2016	Mother was back in the home in Southend and an assessment by Adult Social Care confirmed that Mother met the criteria for support under the Care Act 2014.	A social worker from Southend Early Help Team was allocated to the family. In agreement with Mother the visit was deferred until September.
Sept 2016		In September, the early help social worker contacted Mother, but she was living in Essex with her sister. The children were living with their father in

[6] Therapy for You is a free NHS counselling and talking therapies service for people in South Essex.

		Southend. Mother told the social worker that she planned to return to Southend and explained about her mental health problems and being in debt. As Mother was living out of area and Father did not want any support the case was closed to Southend Early Help Service.
Oct 2016	Mother's fibromyalgia improved– she had accessed holistic support via an on-line group. It seems that many of the physical symptoms improved and she was no longer using a wheelchair or in permanent pain.	
Nov 2016	A Southend Borough Council housing worker interviewed Mother with the advocacy worker to assess whether she was homeless. This decision rested on whether it was unsafe for Mother to return to the flat. After obtaining information from the early help worker and the police, the decision was that Mother was not homeless.	Around this time the children moved in with Mother to her parents' home in Essex. They remained at the same Southend school.
Feb-April 2017	Mother made two calls to Essex Police. The first was to report the theft of three vehicle batteries from the side of her parent's house and the second to report a burglary in progress. On the second occasion, the police call taker noted that mother was not making sense and there were concerns about her mental health. Maternal Grandfather commented to police officers that he thought mother was becoming paranoid. There is nothing in police records to indicate that the welfare of the children was considered at this time. There is a note that a referral was made to "social services" for the "mental health team" to make contact with Mother. Maternal Grandmother took Mother to the emergency department at Southend Hospital reporting hallucinations for three years. Mother was assessed by the Rapid Access Interface and Discharge Team (RAID and a referral was made to the Essex Support and Treatment for early Psychosis Team (ESTEP) for a full assessment. Following this assessment, the decision within ESTEP was to carry out a further assessment in order to establish whether Mother met the criteria for the team. Following further contacts from the family expressing concern that mother's mental health was deteriorating, an assessment was organised at home with the Consultant Psychiatrist from ESTEP. As a result, Mother was started on anti-psychotic medication.	

April 2017	Mother was allocated a care coordinator from ESTEP who saw her regularly. The care coordinator told this review that her role was to gather further information, build up a therapeutic trusting relationship and keep medication under review. The care coordinator also worked on relapse prevention. The children were not seen by the care coordinator (at Mother's request) but there was nothing that alerted the care coordinator to any concerns about parenting. There was also no evidence of fibromyalgia. Maternal Grandmother declined a carers assessment.	Father asked the school to keep an eye on the boys as Mother was having problems "hearing things".
July 2017	Mother stopped taking her antipsychotic medication for a short time and her paranoia returned. She commented to her mental health worker that her children were a protective factor influence on her self-harm.	
Aug /Sept 2017	Mother had resumed medication but did not wish this to be increased – some paranoid thinking persisted. Around this time Mother was declared bankrupt. She was also refused a place on Southend's housing register as there was information on file that she assaulted a neighbour whilst living in her Southend flat. This was followed up by the advocacy service who pointed out that the information regarding the assault was wrong. Advocacy support then ceased as this was a Southend service and Mother was living in Essex. Mother was given details of a local advocacy service should she wish to access it.	Mother mentioned to her care coordinator that Child R (age 7) was wetting the bed. The advice from the care coordinator was to talk to the GP about this issue. Father took Child R to the GP and spoke of his violent behaviour and short attention span during the past year. He was described as punching his sibling in the head leading to an A&E attendance. He was also noted as seeing Mother hit Father, and that Mother had severe mental health issues and was thinking of putting him in foster care. This consultation resulted in a referral to children's mental health services (EWMHS)[7]. Following a desktop triage, Child R was deemed not to meet the threshold for a service from EWMHS and advice was given to self-refer to a local counselling service (Open Door) A letter to this effect was sent to the GP and Mother.
Oct 2017	Mother told a psychologist about stressors including Child R's violent behaviour towards his brother and that he was having counselling.	Mother referred Child R to Open Door for counselling.
Nov 2017	Mother had stopped taking her medication and reported no worsening of symptoms. The plan was for relapse prevention work. Maternal Grandmother was monitoring.	
Jan - June 2018	Mother was seen regularly by the care coordinator who focused on relapse	Child R was seen by the Open Door service for counselling. Mother attended the first session and Father the second.

[7] Emotional Wellbeing and Mental Health Service. This part of North East London Foundation Trust.

	prevention work. In April Mother's condition was noted in the records to be stable.	From the school's perspective they thought Child R's behaviour at this time was that of an ordinary boisterous child.

3.3 Mother and her family have described her becoming increasingly unwell in the two weeks before the incident. They describe her pacing up and down at night and saying that "they are all going to kill us". Around this time, Mother also believed that the brakes on her car had been tampered with by the garage who had replaced her windscreen. Maternal Grandmother telephoned the mental health team and described her concerns including that Mother was having the same thoughts as before in relation to conspiracy theories and thinking everyone was against her. As her usual care coordinator was not in, her call was discussed within the team and a mental health worker attempted to call Mother on three occasions, but she did not answer the phone. Maternal Grandmother was informed, and it was agreed that the usual care coordinator would call as soon as she was back at work.

3.4 Three days later Maternal Grandmother called the mental health team to ask whether a scheduled appointment with the care coordinator the next day would go ahead. When informed that the care coordinator was on holiday but someone else could visit, the records note that Maternal Grandmother said that it was not necessary for anyone else to visit. Maternal Grandmother's recollection of this conversation is different: she recalls being told that here was no one else available.

3.5 The family recall Mother feeling very unwell in the evening three days later and asking Maternal Grandmother to take her to hospital. They arrived at hospital just after midnight and were referred to RAID (the Rapid Assessment and Interface Discharge service) who see all mental health patients who present in the emergency department. A student mental health practitioner, who was nearing the end of her training, took a full history and concluded that the main need was for Mother to start her anti-psychotic medication again. In their opinion there were no overt symptoms that required immediate referral for a Mental Health Act assessment or to stay in overnight for consultant review in the morning. As it was night-time no consultant was on site to prescribe the required medication and Mother was therefore advised to see her GP in the morning for a prescription. It was not common practice for GPs to be automatically notified of a hospital attendance although in some cases a call was made if medication needed changing. This was not thought to be necessary in this case.

3.6 The following morning (Friday) Mother booked an emergency appointment with the GP and attended an appointment accompanied by Maternal Grandmother at 8.59am. The records show that she asked for sleeping tablets and anti-psychotic medication. The GP had no information from the hospital to confirm what medication should be prescribed. The GPs examination concluded that Mother was objectively not depressed and there was no evidence of formal thought disorder. The GP told the review that they would never initiate anti-psychotic medication without psychiatric

advice and in the absence of a letter from the hospital they searched for the most recent letter from her psychiatrist which had been received two months previously. Although some GPs may have refused to prescribe without a letter from the RAID team the GP decided to do so as there was a letter on file describing Mother as having "transient psychosis". In the light of this he prescribed her usual anti-psychotic medication plus medication for sleep. He agreed to review in four weeks or sooner of she was unwell. The GP told the review that Mother did not appear unwell and he was reassured that she attended with Maternal Grandmother and had a network of social support.

3.7 The hospital mental health liaison team sent an e-mail to the community early intervention team and Maternal Grandmother called the mental health team the same day, told them about the hospital visit and that they had collected a prescription from the GP and the medication. Maternal Grandmother confirmed that Mother had taken the first dose although Mother has told the review that she did not take any as she did not feel it would work. Maternal Grandmother is recorded as confirming with the team that she was willing to wait for a visit from the usual care coordinator when she returned from holiday.

3.8 On Monday morning Mother killed Child R.

4 REVIEW FINDINGS

4.1 The overarching finding of this review is the disconnect between the help provided to adults and help to children in the same family. Some of this is structural, some is linked to the right of adults to confidentiality and some of the issues stem from knowledge and skill gaps in recognising the impact of adult issues on their children. This latter issue applied to practice in both adults and children's services. In summary:

- The impact of Mother's physical and mental health conditions on her children was not fully explored or understood by those working with her. (Finding One)
- Indications that the children were being adversely affected by their home situation were not fully assessed when concerns about their wellbeing were considered by community health services, child mental health services and practitioners providing early help services to the family. (Finding Two)

4.2 There are also specific lessons regarding the management of Mother's mental health condition immediately preceding the incident. (Finding Three)

4.3 The need for practitioners to "Think Family" cuts across all of the findings. This is an approach which was first articulated in 1998[8] following a study into fatal child abuse

[8] Falcov, A.(Ed) (1998) *Crossing Bridges: Training resources for working with mentally ill parents and their children.* Brighton: Pavilion Publishing

and parental psychiatric disorder[9] and has subsequently been updated, developed and evaluated[10]. It focuses on the dynamic interplay in relationships between adults and their children and calls for joint working between practitioners working with adults and those whose focus is the child. This case demonstrates that challenges remain in putting this into practice from both adult's and children's services perspectives as well as the need to think widely about services that need to operate from a Think Family perspective. In this case the findings below identify that adult advocacy services, housing, schools and early help providers are all important elements of a whole family approach

4.4 Within Southend Borough Council a Family First Protocol has been in place since 2015 and contains a common set of principles which include "*improves the identification of children in need and in need of protection through increased understanding of the impact of adult problems on a child's life"*. Discussion with practitioners indicates that further work is needed to translate this protocol into day to day practice and decision making.

4.5 Training initiatives such as that planned by Southend Adult Social Care in safeguarding young people and new supervision frameworks in children and adult services as well as the work of the Practice Unit[11] could provide a vehicle for developing practice in this area of work. However, given the overarching findings of this review, a thorough appraisal of any barriers to implementing a Think Family across Health, Children's and Adult's Services in Essex and Southend would seem necessary. This must include the role of schools and other early help services for children where parents have mental health or physical health problems.

Recommendation Two
Southend Safeguarding Children Partnership and Essex Safeguarding Children Board should work with practitioners in all partner agencies to:

a) Agree the principles of a Think Family approach and disseminate these to all providers through staff development and training initiatives
b) Identify any barriers that prevent the principles being implemented in practice and take steps to mitigate their impact.

Finding One

The safeguarding system needs to support practitioners who work with adults to understand the impact of parental issues on children and encourage appropriate information exchange and joint working across services.

[9] Falcov A (1996) *Department of Health Study of Working Together Part 8 Reports: Fatal child abuse and parental psychiatric disorder.* London: Department of Health.
[10]See for example SCIE guide (2009) and evaluation report (2012) https://www.scie.org.uk/publications/reports/report56.pdf
[11] The Practice unit was launched in January 2019 and provides support and challenge to social work and social care practitioners.

4.6 There are examples within the records of those agencies working with Mother of situations where more consideration should have been given as to the way in which her mental and physical health problems were impacting on her children. This should have led to a planned approach across services.

Mental Health Issues

4.7 Adult mental health services should have been in a good position to explore whether Mother's symptoms and behaviour could negatively impact on the children and if necessary, liaise with Children's Social Care. There is no evidence that this happened even when there were indications that the children were involved in her delusional belief system and Mother was open about her worries about Child R's violent behaviour, disclosed that he was receiving counselling and that his brother had also been in receipt of help the past. In fact, her children were generally referred to in positive terms as a protective factor.

4.8 When Mother took a significant overdose in 2014 this was six days after her assessment by IAPT (Improving Access to Psychological Therapy) which had noted high scores for severe depression and anxiety, indicating that active treatment was warranted. The mental health assessment by the Rapid Assessment, Interface and Discharge (RAID) team at the point of the overdose identified her children as being a "protective factor" – she loved them too much to attempt suicide again. This assessment concluded that there was no risk to the children although there is little information as to how the impact of her condition on the children was analysed. RAID's assessment assumed that Mother was being seen by IAPT, but this did not happen as IAPT were not notified of the overdose and discharged her from the service as she did not attend. The GP was not aware that she had been discharged from IAPT so could not assess the implications of the whole picture at this stage.

4.9 Mother again referred to the children as a protective factor when working with her care coordinator in the Essex Support and Treatment for early Psychosis team (ESTEP). Where children are understood to be protective in relation to adult mental health, best practice would be to make sure that the assessment includes a second stage which includes an analysis of what this means for the child and consideration as to whether contact should be made with services for children. The need for a more sophisticated assessment of any potential risk is supported by an overview of lessons from previous serious case reviews which comments:

Children should never be considered a protective factor for parents who feel suicidal. In some cases, professionals inappropriately viewed the child as a protective element who could help to reduce the parent's risk of self-harm. This belief significantly increases the risk to the child.[12]

[12] NSPCC 2015 https://learning.nspcc.org.uk/media/1349/learning-from-case-reviews_parents-with-a-mental-health-problem.pdf

4.10 There are indications that Mother's mental health condition was impacting on her children and that they were involved in her delusional belief system but there is limited evidence that this was considered by practitioners. For example, during the eighteen months before the incident she described to mental health practitioners a belief that her children were being "spiked" and that neighbours were trying to kill her and her family. The investigation report by Essex Partnership University Trust also comments that Mother had referred to her 'children not being bullied at school because of her' and that this rather odd statement should have been explored further to assess whether her children were included in her delusional system. It is also of note that Mother told the school that she had kept Child R at home for the rest of the week after a teacher spoke to her about his behaviour as "she was worried it would exacerbate her illness"; again a rather strange comment which might indicate involvement of the children in her delusions and is an indication that Mother's illness was negatively impacting on Child R's education. The problem for the school was that they were unaware of Mother's mental health condition (apart from Father having mentioned that Mother was hearing things) and could not understand this comment in that light.

4.11 One factor that also seemed to have inhibited a fuller assessment of risk to the children was Mother's diagnosis of acute and transient psychotic disorder. The internal investigation report by the mental health trust comments that the ongoing symptoms and delusions described by Mother should have prompted a review of her diagnosis and the differential diagnosis would have been schizophrenia; a diagnosis that was confirmed after the serious incident. Any possibility of psychosis should have included an assessment of risk to children, particularly as in this case they were involved in Mother's delusional system.

4.12 The Essex Support and Treatment for Early Psychosis team (ESTEP) is a service designed to offer psychosocial interventions which help people to understand their illness and for the family concerned to understand the impact on their lives. In this case the dominant approach was a focus on the potentially stigmatising impact on the adult of the mental health diagnosis and too little attention was given to the social circumstances and others involved in family life, for example the children's school.

4.13 Family therapy was offered but the family did not take this offer up and it would have been good practice to reflect on why this was. Reluctance may have stemmed from an earlier experience when Mother first went to the acute hospital with psychotic symptoms. Her sister recalls being very upset as she did not feel that Mother was being honest during the assessment and that the clinician would not listen to her when she said that she believed that mother had paranoid schizophrenia. The notes of the session do record her sisters' views but also extensive questioning of Mother where she described feeling somewhat better since cutting down on her cannabis use and using natural remedies for her physical problems. Her sister was left feeling that the families views were not important. How best to incorporate the views of families into an assessment that also respects the service users' position is a

challenge for all adult services and further consideration needs to be given as to how the families voice can be heard.

4.14 Mother's expressed wish for the children not to be seen was not considered unusual or unreasonable by the mental health worker but this should not have precluded an approach which actively considered the potential impact of delusional thinking on the children's lives. Child R's sibling has told the review that this behaviour impacted on them on a day to day basis for example, by Mother's refusal to let them drink tap water because it could be contaminated and driving fast because she believed she was being followed. There could also have been a more proactive approach with the mental health service regarding contact with others involved with the family such as schools.

4.15 The school had asked the school nursing service to see both children, but the school nurse would also not have been aware of any mental health problems. The school nursing service in Southend receives mental health notifications through the Paediatric Liaison Services for parents who have been admitted to an acute mental health unit and have a child in a Southend school. This system did not work for this family in either February 2014 or March 2017 when Mother was first diagnosed with psychosis as she had not been admitted to an acute unit.

4.16 There are two issues relating to the school nurse notification process. Firstly, school nurses need to be clear as to expectations on them when they receive such information as they cannot share it without permission unless there are concerns that a child may be at risk of harm. They can however use this information to guide their responses if a school raises concerns about a parent; either by seeing the child, advising and supporting the school, or considering the need for a referral to children's social care. Secondly, the review has found that schools may not be aware of this process and would not be prompted to consult the school nurse if they are worried about the mental health of a parent. There are currently plans to provide this information to Southend Schools and its impact will need to be evaluated.

4.17 Adult mental health services are provided by Essex Partnership University NHS Foundation Trust which has an integrated safeguarding adults team. Training is provided to staff aimed at encouraging staff to "Think Family" and consider the impact of adult issues on children. This case illustrates the need to constantly reinforce this message as practitioner discussions indicated that this approach is not consistently embedded into practice. Where there are indicators of an escalation in the severity of mental health, any indicators of delusional thought patterns towards the children, or where a parent expresses thoughts of self-harm, or of harming her or his children, these should be taken seriously and should prompt an urgent consideration of the safety of the child. Also, where parental mental health problems co-exist with other risk indicators, particularly domestic abuse, but also including drug or alcohol misuse, or social isolation, this should prompt a further assessment of the

child's safety[13]. In this case there were reports of domestic abuse perpetrated by Mother, cannabis use, social isolation and mental health problems. The Trust risk assessment which is a tick box form did not adequately prompt further analysis of these issues using any recognised format; even though policies and procedures set out a clear expectation that this should take place[14] .

Physical Health Issues

4.18 In relation to adult social care, there is evidence that when Mother was experiencing acute symptoms associated with fibromyalgia her capacity to care for her children was reduced. The response from adult social care was focused on her physical condition for example an occupational therapy assessment noted that she had two children age six and four but there was no further assessment of the impact of Mother's medical condition on them. Further assessment by a social worker resulted in a plan for reablement but again no consideration of the family as a whole and the needs of the children. There was a reliance on Father as the main carer for Mother and the children but more could have been done to understand the dynamics of the family as a whole and formal joint planning with Family Action when Mother became "non-compliant" with the reablement and it was noted that Father was planning to move out

4.19 An advocacy service for adults provided support to Mother from 2013 to 2017. Much of the focus of this work was support with conflict with neighbours, housing applications, and a referral to adult social care for an assessment. Mother shared information from time to time that should have prompted contact with children's social care in order to make sure that the children's needs were being met. It is important to stress that there were no incidents that would have fallen clearly into the category of child abuse by either parent, but in more general terms there was information that indicated children's emotional wellbeing could be adversely affected including information from Mother that Child R's sibling was self-harming once more. The advocate who worked with Mother confirmed that they had not received any children's safeguarding training.

4.20 There is a code of conduct for all advocacy services which does specify knowledge of adult and child safeguarding. The contract issued by Southend Borough Council for advocacy services required staff to have "safeguarding training" but did not differentiate between adults and children's safeguarding and in practice this training has tended to focus on adults.

4.21 During the process of Mother applying for housing, the housing officer had received long e-mails from Mother mentioning anxiety and saying that she worried about her

[13] Sidebotham et al (2016) Pathways to Harm Pathways to Protection: a triennial analysis of serious case reviews 2011 to 2014. London: Department for Education. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

[14] EPUT Safeguarding Children Procedure CLPG37, April 2017.

boys and had them with her in the car until nine pm in the evening. As far as the housing officer was concerned these e-mails were not out of the ordinary as the housing officers receive many e-mails which often include threats of suicide or killing others. The housing officer thought children's services were already involved so would not have considered forwarding the e-mails to them. This episode highlights the challenges of recognising those situations which indicate potential risk and need further action where there is a high volume of similar allegations and staff may become accustomed to worrying information. There is no guidance specifically for housing officers as to when to refer to Children's Social Care and a housing officer commented on the general need for Children's Social Care and Housing to understand each other more. Although housing officers are managing a high volume of situations involving adults with a range of vulnerabilities that may affect their children, they currently do not receive any supervision that helps them to reflect on their practice. This is an area for development.

Summary of learning and areas for development across services for adults

4.22 A general issue in relation to all adult services is how far staff have the knowledge skills and confidence to speak to children during the course of their work and judge at what point they should engage the adult in a conversation about the possibility of a referral for help for their child. More confidence is needed in assessing who has prime responsibility for care of the child (in this case this varied over time) and when a reluctance to accept help for their children becomes a formal safeguarding concern.

4.23 Staff working with adults with mental health problems are understandably concerned about the possibility of discrimination against people with a mental health condition and parental mental health problems should not be seen in and of themselves as necessarily harmful to children. The same issue might also apply where an adult has a physical impairment. The challenge is to remain open to the possibility that children may be affected in many different ways and prevent the children themselves being discriminated against because they have a parent with a specific diagnosis. This discrimination may manifest itself in children not receiving help early enough, there being an insufficiently coordinated response across adult and children's services and risks not being addressed. In this case the children did receive some services mainly via the school and counselling services but there is no evidence of any conversation by adult staff with Mother as to whether she would be willing for them to work with the school or that there was any assessment that analysed the impact of Mother's physical and/or mental health problems on the children.

4.24 Skills and confidence in asking difficult questions can be developed through training and reinforced through a relationship with a supervisor which promotes critical thinking and reflection on the assumptions and biases that may underpin day to day practice. There is little evidence that either the required training or effective supervision was in place.

Recommendation Three
All mental health providers should communicate the outcome of their assessments including non-engagement back to GPs and mental health trusts must provide assurance that this is now established practice and any barriers to communication are understood and removed.

Recommendation Four
The provider of adult mental health services (EPUT) should revise their clinical assessment model and related training so that it is in line with information in current procedure documents which requires thorough risk assessment of the impact on children where a parent has a mental illness.
Specifically, the tool should:

- Move beyond a description of children as a protective factor for the adult and assess what this means for the lived experience of the child including any risks.
- Support an analysis of situations where children may become part of the delusional thinking of the parent or carer.

Recommendation Five
All organisations providing services to adults should review the quality of staff supervision in order to ensure that it provides the opportunity for reflection and critical thinking that enables a focus on the needs of all family members particularly children.

Recommendation Six
Southend Borough Council should inform schools of the information that may be held by school nurses about the mental health of a parent, clarify expectations on both parties and evaluate the impact of this process on the safety and wellbeing of children.

Finding Two
Practitioners providing services to children, need to take a whole family approach in order to understand children's behaviours within the context of their family circumstances.

4.25 Generally in relation to an understanding of Mothers mental and physical conditions practitioners working with children saw Father and Maternal Grandmother as protective factors. Whilst this was true, there could have been a more structured assessment of the impact on the children's emotional wellbeing and an acknowledgement that at times Mother would be a sole carer.

The School

4.26 The school attended by Child R and his sibling has a very strong pastoral support team of seven staff who work with about 100 children in total at any one time. Each child seen by the team has a named pastoral support worker. Child R was one such child although the school were not unduly concerned about him: generally, their

perception was that the parents were overly anxious. The school were aware that the children had spoken in the past of seeing “mum hit dad”, and that Mother had physical health difficulties; she had been seen in a wheelchair and Child R’s sibling had reported that he was not allowed into her room. The school did contact Children’s Social Care about an incident where Child R’s sibling was described as having a knife but once they realised the family were not known to them, they decided to refer to Family Action. They were not worried when Family Action closed the case as Father was a supportive figure whom the boys worshipped but the school told the review that the boys would however have been described as young carers if Father had not moved back into the home. This analysis of the situation could have informed thinking when Father was no longer living with the boys after her move back to Essex, although it was assumed that Mother’s family would provide the support needed and in the months before Child R’s death the school had an increase in positive contact with Mother.

4.27 When the older sibling had been seen by child mental health there had been no contact with the relevant school. Current operating procedure within child mental health services[15] does provide guidance about issues of consent where there is a need to contact a school or where a school contacts the service. Schools are a vital part of the support system around the child and both guidance and training could be more proactive in positively encouraging a link with schools where a child is being seen by mental health services.

Health Provision – child mental health and the GP services

4.28 Child R and his sibling were referred to child mental health services two years apart.

4.29 GP services, theoretically, are in a good position to consider the whole family and to understand children’s behaviour in this light. In practice, all family records are individual, and links may not be made between children’s behaviour, family patterns and parental circumstances. The episode when Child R’s sibling threatened self-harm for example was not linked with later concerns about Child R’s violent behaviour and Mothers physical and mental health problems.

4.30 The referral to child mental health services in respect of Child R had been made by the GP after Father had expressed concern about Child R’s increasingly violent behaviour and that he had witnessed his Mother being violent towards his Father. The referral also notes Mother’s severe mental ill health. At this stage the GP should have considered whether this cluster of factors indicated potential risk to the child and a safeguarding referral was needed. These factors included a report of Mother’s violence towards Father. Within Southend, there are current proposals to develop a general practice based domestic violence training support and referral programme for primary care staff, this includes signposting for male victims and may have been a helpful prompt to the GP in this case.

[15] Now known within Essex as EWMHS (Emotional Well-being and Mental Health Service)

4.31 This referral was considered (triaged) by the child mental health service and the decision was that Child R did not need a mental health assessment. A letter was sent to the GP and Mother advising self-referral to counselling services. This letter to Mother is an action which did not take account of the whole family circumstances and consider that Child R could potentially be put at risk since Father had described Mother's violent behaviour. The letter should have been sent to Father as the referrer.

4.32 Child mental health services are now commissioned from a different organisation than the one providing child mental health services at the time Child R's sibling was seen. This made it impossible to review the records for Child R's sibling. The previous Trust kept paper records making it a time-consuming process that has not been commissioned from EWMHS as part of the triage process.

4.33 EWMHS also raised the point that automatically accessing a sibling's records would raise Information Governance issues. Electronic patient record systems used by health providers in Essex do not automatically link family members together so a sibling link would only be known about if the referrer made specific reference to this and permission was given to review these records. These factors mean that there is a lost opportunity to understand children's behaviour within their family context at the triage stage and to use all available information to make a reasoned decision as to the most appropriate course of action, including whether a full assessment is needed.

4.34 The triage process has been discussed in some detail with EWMHS to understand what it involved and what EWMHS has been commissioned to provide. This has been important to understand as part of the overall concern that risks to Child R were not apparent due to a fragmentation of information and response throughout the safeguarding system in adults and children's services. It seems that EWMHS have been commissioned to provide an accessible service where professionals and families can refer in a wide range of concerns and the triage process is designed to establish whether EWMHS is the right service or the child's needs could be best met though being signposted elsewhere. There is no detailed information gathering at this stage and the clinician relies on what is written in the referral. For those making referrals, the quality of the information contained in the referral is of crucial importance since this will determine whether a child mental health service is offered. It is not clear how well this is understood amongst the whole professional community, although EWMHS has provided this information to all stakeholders across a range of forums.

4.35 In the case of Child R, EWMHS did not record a clear rationale as to why the referral was not accepted at the point of triage but the rationale given verbally to this review was that there were no clear signs of mental ill health and there was *"a low level need of anxiety and anger which could be managed through a community provider"*. It was believed that Child R's anxiety could be best managed via a community counselling service such as Open Door, a decision in line with commissioning requirements that promote less intrusive intervention at the first stage.

4.36 Whatever the decision about access to child mental health services, it is important that any safeguarding concerns are identified, and the necessary action taken. In this respect the triage process should always involve a risk assessment based on the information received. In this case the combination of severe parental mental health problems, the report of Mother's violence and her wish for Child R to be fostered should have triggered a safeguarding alert and action taken to make sure that a referral to children's social care was made. In this case the GP would have been the most appropriate person and action taken to liaise with the GP to make sure that this had happened.

4.37 If for any reason it was clear that no safeguarding referral was being made, EWMHS could have made this themselves. It should be noted that EWMHS do have a different view about this and argue that the risk factors were based on third party information (what father had reported about Mother) and was historical rather than current. In these circumstances it is the view of EWMHS that they should not make a referral. This is an issue that needs to be resolved and clarified with the Partnership and action taken to make sure all are content with the procedures and the way they are being interpreted.

4.38 The point of referral to the child mental health service was an opportunity to consider whether any help was needed to support the family in meeting the needs of the children. When the decision is that a community-based service is the most suitable, EWMHS commissioning arrangements are such that they do not make a referral but instead ask the parent to self-refer where appropriate. They also do not ask parents for permission to contact the provider and pass on any relevant information. In this case Mother made a self-referral for Child R but the counsellor had no context for the referral and their own assessment at the start of the counselling sessions was based on self-reported information. They could not understand Child R's presentation or comments during sessions in the light of the family circumstances including Mother's mental ill health and there was no reason for them to contact other agencies such as EWMHS for further information. Practice would be improved if procedures within child mental health services included asking parents to inform them when a self-referral had been made and for permission to proactively share relevant information with the provider concerned.

4.39 Since under the current system, the receiving service will only have information given by the parent it is common practice to ask parents' permission to contact other organisations who may have information that will help them to provide the best possible service to the child. The review has been told by Open Door that most parents are happy to give permission, but other agencies often do not respond to requests for information, even where a parent has given written consent. As this case demonstrates, the opportunity to understand the needs of the child within their family context is lost without a holistic approach.

4.40 A recent report by the children's commissioner into children's mental health services commented that where a child suffers from "low level" mental health concerns the

response can be simultaneously everyone's responsibility, and nobody's.[16] In this case, responsibility for responding to Child R's needs *was* picked up by Open Door but this operated in isolation from the rest of the network. A holistic approach should have sat within the early help framework which is well developed in Essex.[17] The cluster of factors described to the GP should have prompted a referral to children's services and consideration of the need for an early help plan alongside assessment of possible safeguarding concerns. A team around the family approach could have brought together all the services working with the family and been an opportunity to understand the experience of the children in the family and target help accordingly.

Recommendation Seven
Southend Clinical Commissioning Group should work with GP practices to ensure that both permanent and locum clinicians have an understanding of the cluster of factors that might indicate the need for a safeguarding referral and that information about how to refer to local Children's Services is displayed in every GP practice.

Recommendation Eight
Child mental health services (EWMHS) should ensure that assumptions are not made about the actions of other professionals in making safeguarding referrals and at the point of triage always consider whether a child may be at risk of harm and a direct referral needs to be made.

Recommendation Nine
Child mental health services (EWMHS) should work with those who refer into the service to make sure that the quality of information received is sufficient to make a triage decision about emotional and mental health needs based on referral information.

Recommendation Ten
Child mental health services (EWMHS) should be asked to identify the barriers to checking records for any previous involvement with siblings of the referred child and discuss with commissioners of the service as to how these can be overcome and be required practice in future delivery models.

Recommendation Eleven
At the close of contact with child mental health services (EWMHS) letters outlining the outcome should be sent to the parents or carers who made the original referral. Information systems should be reviewed in order to facilitate this.

Recommendation Twelve
Southend, Essex and Thurrock Safeguarding Children Procedures should clarify the need for effective two-way information sharing (with appropriate permissions) between statutory and non-statutory providers in order to facilitate the most effective help to children and their families.

[16] Longfield, A (2020) *The State of Children's Mental Health Services,* The Children's Commissioner.
[17] https://www.essexeffectivesupport.org.uk/media/1078/early-help-offer.pdf

Finding Three

The coordination and response of mental health services needs to take account of concerns that a patient with a diagnosed mental health condition is relapsing.

4.41 It is the view of this review that the extent, severity and diagnosis of Mother's mental health was not sufficiently understood by the Mental Health Liaison Team.

4.42 Although the family have described feeling increasingly worried about mother's symptoms in the days before the incident. Their care coordinator was away for longer than originally planned due to sickness and although a visit from another team member was offered it is reported that the family preferred to wait. The Early Intervention Team should have been more proactive in undertaking a home visit given the deterioration in Mother's mental health and missed opportunities to intervene early when there were signs of relapse. This issue is identified in the investigation report from Essex Partnership University NHS Foundation Trust.

4.43 When Mother was taken to the hospital and seen by the Mental Health Liaison Team, it is the view of the internal investigation report that there was an opportunity to recognise the severity of her symptoms and consider admission to a psychiatric unit or request an assessment under the Mental Health Act 1983 to prevent a further deterioration in her illness. Even if this was not deemed necessary there should have been a handover to the Early Intervention Team the next morning rather than relying on Mother to go to the GP and for the GP to prescribe anti-psychotic medication. Procedures do expect that when patients are discharged back to the GP this should be with "a copy of the assessment outcome and personalised advice, information and guidance on re-direction or signposting to other services if required". There are no timescales within which GPs should be notified, and in this case that notification should have been immediate.

Recommendation Thirteen
Essex Partnership University Trust should ensure that where a patient with a mental health condition is seen out of hours and assessed to require medication, a consultation with an on-call psychiatrist is be requested.

Recommendation Fourteen
The Rapid Assessment Interface and Discharge Team (RAID) team systems should ensure that when a mental health patient is seen out of hours, contact is made with any treating team and the registered GP at the start of the next working day.

Recommendation Fifteen
Essex Partnership University Trust should ensure that Early Support and Treatment in Early Psychosis (ESTEP) protocols and practice in respect of patients who are risk of relapse always includes an urgent face to face consultation with the patient when they have been seen by out of hours services.

5 SUMMARY OF RECOMMENDATIONS

Recommendation One

This report and the findings from the NHS England investigation should be considered by Essex and Southend Safeguarding Adult Boards/Partnerships and the expectation is that there will be joint planning in response to this report and the NHS England independent mental health homicide investigation.

Recommendation Two

Southend Safeguarding Children Partnership and Essex Safeguarding Children Board should work with practitioners in all partner agencies to:

a) Agree the principles of a Think Family approach and disseminate these to all providers through staff development and training initiatives
b) Identify any barriers that prevent the principles being implemented in practice and take steps to mitigate their impact.

Recommendation Three

All mental health providers should communicate the outcome of their assessments including non-engagement back to GPs and mental health trusts must provide assurance that this is now established practice and any barriers to communication are understood and removed.

Recommendation Four

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Specifically, the tool should:

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6 APPENDIX ONE – TERMS OF REFERENCE

Serious Case Review

Terms of Reference

(Child R)

1. Subject of Review

Subject: Child R

Family Members:
Mother
Sibling
Maternal Grandmother
Maternal Grandfather

Father:

2. Reason for the Review

Child R, aged seven, died in July 2018 at his maternal grandparents' home in Essex. Child R, his nine year old sibling and their mother had been living at the maternal grandparents' home at the time of his death. It is understood that the cause of death was that Child R was either strangled or drowned in the bath by his mother.

Mother had a lengthy mental health history alongside her physical health issues; she had fibromyalgia and was known to have at times heavily used cannabis to ease the pain. Mother experienced her first psychotic episode in March 2017.

There has been an ongoing Police investigation in respect of Child R's death.

In January 2019, Mother was found not guilty of murder by virtue of insanity. She has been given an indeterminate hospital order.

3. Relevant time period for the review

1st September 2015 (month when Child R started school) to 23rd of July 2018.

4. Organisations who should contribute to the review

1) Essex Partnership University Trust
2) Essex Police
3) Rochford Council
4) Southend University Hospital Foundation Trust (SUHFT)
5) Southend GP services
6) Southend Early Help
7) Southend Education
8) Open Door
9) Southend Adult Services
10) Southend Housing
11) POhWER (Advocacy Service)
12) South Essex Advocacy Services
13) North East London NHS Foundation Trust (EWMHS)

5. Review Team Representatives

1) Adult Mental Health (EPUT)
2) Essex Police
3) Southend CCG Designated Nurse
4) Southend CCG Designated Doctor
5) Southend Children Social Care
6) Southend Early Help
7) Southend Education
8) Voluntary Organisation – Open Door Counselling Services
9) Southend Adult Social Care
10) NHS England

6. Questions to be considered

1) How comprehensive were the assessments and plans undertaken by services involved in the care of Mother, particularly mental health services, in considering her parenting capacity? What assumptions were made based on Father's involvement with the children and the protective nature of the extended family?

2) What do we know about Mother's level of violence during psychotic episodes? Were these so different from what happened when Child R was killed? What, if anything, did the family know and perhaps did not share with agencies? Was there a fear that the children could be taken away from Mother?

3) The children had mentioned to their school that the family had been involved with Adult Social Care; this needs to be further clarified …was this followed up by the school at any point? Was there a "think family" approach to co-ordinating care for Mother and her children? What levels of support were offered by Adult Services, and was this appropriate?

4) What was the school's understanding of both the professional support network and the family support network, especially given Mother's ongoing mental health issues?

5) Were the assessments of Mother's mental health thorough and responses appropriate in the days leading up to the incident? Mother alluded to not being in control of her mental health issues; did professionals involved in her care ask Mother what she meant by that. What did the Continuing Care team make of Mother's presentations and the potential level of risk she posed?

6) What was the quality of the multi-agency safeguarding arrangements in respect of the practitioners working with the family (information-sharing, integrated working, communication between agencies, assessments of risk etc.)?

7) Were attempts made to bridge the gap between Mother's physical health needs and her mental health needs? Mother did not appear to have a big uptake of GP services; were Mother's physical needs being met by the acute trusts?

8) The review should gather information about the housing situation for the family, what priority was given / should have been given to this vulnerable family, given mother's mental health and physical health issues?

9) School referred to the children as young carers; what was meant by this, and how were the children supported as "young carers"?

10) Voice of the children; what was it like to be a child in this family? What was the lived experience of these two children?

11) What significant steps did the family take to manage their situation? The Lead Reviewer is to explore this through family contributions to the review.

12) What was the level of domestic violence in the family? Did professionals ask the relevant questions around domestic abuse; did they get answers; or did they not ask?

13) What was the impact of Mother's relationship with her new partner and the trip to Jamaica?

14) What was the impact of the stresses Mother experienced around the family's housing situation and her reported £50,000 debt; were agencies aware of the debt and was this discussed with Mother?

15) How do we work together to provide families with adequate support in circumstances where Children's Social Care thresholds have not been met?

16) What was the role of MIND with Mother?

17) Were there any multi-agency meetings to co-ordinate support for the family, and if not why not?

18) What, if anything, could agencies have done differently which may have made a meaningful difference?

7. NHS England Terms of Reference

The investigation is to be conducted in partnership with the Children's Serious Case Review into the death of Child R Terms of Reference.

The investigation will examine the NHS contribution into the care and treatment of Mother from her first contact with specialist mental health services following the birth of Child R up until the date of the incident.

- Critically examine and quality assure the NHS contributions to the Children's Serious Case Review
- Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with Mother
- Review and assess compliance with local policies, national guidance and relevant statutory obligation
- Examine the effectiveness of the service user's care plan and risk assessment, including the involvement of the service user and her family
- Examine the communication with the service user and her family in the lead up to the homicide and the responsiveness of services
- Review the appropriateness of the treatment of the service user considering any identified health needs/treatment pathway
- To work alongside the Children's Serious Case Review and Chair to complete the review and liaise with affected families
- To provide a written report jointly with the Serious Case Review report to the Safeguarding Board and NHS England that includes measurable and sustainable recommendations that may be published either with the multi-agency review or standalone

8. Methodology

The review process is designed to ensure an open and collaborative approach which includes the perspectives and views of practitioners and family members. that there is a focus on *what* happened and *why* practice decisions were made. The review seeks to move beyond a focus on individual practice to an understanding of lessons for the safeguarding system the as a whole.

The process of the review will be:

1. Gathering and analysing written information via chronologies and other relevant reports.
2. Agreeing key practitioners who should be offered an opportunity to contribute. Meeting with family members.
3. Meeting with family members.
4. Meeting with practitioners either individually or in small groups. These meetings will be led by the lead reviewer along with a panel representative with professional expertise in the area bring discussed.
5. Key themes and learning to be agreed with the Review Team.
6. Production of a draft report to be agreed by the Review Team.
7. Sharing of the final draft with all those who have contributed.
8. Production of final report agreed with the Serious Case Review Sub-Committee and presented to LSCB.

APPENDIX TWO – PRACTITIONER DISCUSSIONS

- Care Co-ordinator, ESTEP (Early Support and Treatment in Early Psychosis)
- Psychiatrist - EPUT
- Mental Health Practitioner - RAID (Rapid Access Interface and Discharge)
- GP - Southend CCG
- Adult services social worker - Southend Adult Social Care
- Advocacy worker - PoHwer
- Headteacher and Pastoral Worker - Primary School
- South Essex Advocacy Service commissioner
- Locum GP
- Southend Housing worker
- Named nurse for safeguarding EWMHS
- Head of Children's Services EWMHS