# Kirklees Safeguarding Children Board

# Serious Case Review

# Executive Summary

# Child aged 2 years 7 months

# December 2011

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# 1. Introduction

1.1. The requirement for the Kirklees Safeguarding Children Board to carry out a Serious Case Review is detailed in Chapter 8 of *Working Together to Safeguard Children: a guide to Inter-agency Working to Safeguard and Promote the Welfare of Children* (2010)

1.2. The purpose of the Serious Case Review (SCR) as identified in *Working Together* is to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- Improve intra and inter-agency working and better safeguard and promote the welfare of children.

1.3. This executive summary is written on behalf of the Kirklees Safeguarding Children Board and provides an overview of how this review was conducted; key findings; learning for the Board as a result of this review and how it will be addressed across partner agencies.

# 2. Circumstances leading to the Serious Case Review

2.1. The child in this case was aged two and a half years and was found dead in the family home on 19 February 2010. The child's father had not been a member of the household for almost two years and the child had no brothers or sisters.

2.2. The mother had a history of mental health difficulties and was suspected to be suffering from schizophrenia for some years prior to the birth of the child. Over a number of years her mental health was thought to have been stable and she was not a client of mental health services but under the care of her general practitioner. During this time no concerns had been identified about the child and she had access to universal services.

2.3. In the days leading up to the child's death, professionals had identified that the mother's mental health appeared to be deteriorating and concern had been expressed as to the effects this may have on the child's safety and wellbeing. The police attended the family home on 19 February 2010 to support other professionals to assess the mother's mental health.

2.4. On 19 February 2010 when the police and other professionals arrived at the mother's house she refused to let them in and only when they threatened forced entry did she open her door. The police searched the home and discovered the body of the child in the home.

2.5. A post mortem examination showed that the child was well nourished and well cared for. The pathologist's findings were suggestive of, but not diagnostic, of smothering, which is consistent with the mother's account. The time of death was not clear, but the mother reports that it occurred sometime on the evening of 18 February 2010 after 21.00hrs.

## 3. The Serious Case Review Process

3.1. The Serious Case Review Workstream of the Kirklees Safeguarding Children Board considered this case against the criteria provided in *Working Together to Safeguard Children* (2010). The workstream recommended that the Kirklees Safeguarding Children Board conduct a SCR. The chair of the Board agreed and the review commenced in March 2010.

3.2. This SCR was conducted in line with the requirements of statutory guidance *Working Together to Safeguard Children* (2010).

3.3. A serious case review overview panel, with independent chair and independent author, was established to undertake a serious case review. Membership was as follows:

- Dave Herring, Independent Chair
- Assistant Director for Safeguarding Children and Vulnerable Adults, NHS Kirklees
- Assistant Director Practice Effectiveness, South West Yorkshire Partnership NHS Foundation Trust
- Board Manager, Kirklees Safeguarding Children Board
- Chief Inspector Partnerships, Kirklees Division, West Yorkshire Police
- Divisional Manager, Fieldwork, Kirklees Safeguarding and Specialist Provision
- Group Manager for Personalisation and Commissioning, Kirklees Adult Services
- Named Nurse Child Protection, The Mid Yorkshire Hospitals NHS Trust;
- Paediatric Consultant and Designated Doctor, Calderdale and Huddersfield Foundation Trust
- Safeguarding Coordinator for Practice Review and Standards, Kirklees Safeguarding Children Board

3.4. The independent author of the overview report, Mike Harrison, and a Legal Adviser to the Kirklees Safeguarding Children Board attended overview panel meetings.

3.5. The panel met 11 times to discuss the findings of the case and quality assure the reports that were produced. In addition, both panel members and authors of individual management reviews had various meetings with staff that were directly involved with the case.

**<u>Scope and Terms of Reference</u>**

3.6. In scoping the review, the SCR Workstream drafted full terms of reference in line with the requirements of *Working Together to Safeguard Children* (2010). The following issues were considered to be of particular relevance to this case:

- Opportunities for earlier intervention – were there opportunities for earlier intervention that may have prevented this case from reaching crisis point? If so, what can we learn about supporting staff to maximise these opportunities in the future?
- Focus on the child – did agencies providing adults' and children's services give sufficient consideration to the child's daily life experiences and seek to gain an understanding of their welfare, wishes and feelings?
- Engagement with services – was frequent attendance or repeated non-attendance a feature of this family's involvement with agencies? If so, are there concerns around appropriate follow-up, particularly in light of the parent caring for a very young child? Are there concerns about decisions to withdraw services?
- Referral pathways and plans to support adults and children – how robust and well understood are referral pathways? How well understood is the difference between an urgent referral and seeking an emergency response? Were all key professionals involved in the development and monitoring of plans? Were there appropriate contingencies in place (i.e. clear processes and thresholds for re-referral)?

3.7. It was felt that it was important to consider the nature of the mother's mental illness and how this had previously been managed and supported. As such, the timespan for the review was from the mother's first significant psychotic episode (resulting in admission to hospital) to the death of the child, a period of nearly ten years. The SCR Overview Panel agreed that this was a considerable timespan for agencies to gather comprehensive records of their involvement.

**Individual Management Reviews (IMRs)**

3.8. In line with requirements of *Working Together to Safeguard Children* (2010), the SCR Workstream requested that key agencies compile IMRs of their involvement with the child and family. IMRs look openly and critically at individual and organisational practice and at the context within which people were working to see whether improvements could be made and, if so, to identify how changes could be brought about.

3.9. All authors of the IMRs were independent of involvement with the case. They were provided with an outline format for their report and attended a briefing session delivered by the Board prior to drafting their reports.

3.10. Each author produced an individual agency chronology (based on both paper and electronic records) and interviewed relevant staff to produce their reports. The reports were quality assured by the overview panel.

3.11. IMRs were received from:

- Action for Children (commissioned to run children's centres);
- Kirklees Children and Young People Service: Safeguarding and Specialist Provision;
- The Mid Yorkshire Hospitals NHS Trust;
- NHS Kirklees (with regard to primary care and health visiting services);
- South West Yorkshire Partnership NHS Foundation Trust (responsible for adult mental health services);
- West Yorkshire Police; and
- a voluntary organisation that provide supported housing for people with long term mental ill health.

3.12. NHS Kirklees, as commissioners of health services in the area, also wrote a Health Overview Report to assess how health organisations worked together to support the family in this case. This report was considered as an IMR on behalf of the Primary Care Trust and made recommendations to strengthen the learning from health organisation's IMRs.

3.13. Each IMR makes suitable recommendations to address learning for their agency.

## Involvement of Family in the Serious Case Review

3.14. Government guidance indicates that serious case review panels should involve members of the family and other relevant people in order to take account of their view of events which led to the incident under review.

3.15. Accordingly, the overview panel invited family members to provide feedback on the services provided to the child and family.

3.16. The overview panel was not able to speak to the mother given the criminal investigation and her ongoing mental ill-health. The child's father declined to speak to the panel; and the overview panel took the view that it would be inappropriate to approach members of his extended family.

3.17. The child's maternal grandmother, maternal aunts and a maternal cousin of the mother provided valuable feedback on the services provided to the child and the child's mother.

3.18. The family members described the child's mother as very caring and gave numerous examples of her efforts to provide the best care she possibly could for her child including past examples of how she had kept her child safe. The family members interviewed felt that the mother and child had received valuable support from all of the agencies involved up to the few days prior to the tragic death of the child.

3.19. The family members were concerned that they had not been contacted by the agencies involved with the child on or around 17 to 19 February 2010 to enlist their help or to gain information.

3.20. All the family who were interviewed felt that the tragedy may have been avoided if someone had let them know about the concerns and hoped that the review would give answers as to why they were neither involved before nor immediately after the tragedy occurred.

## Parallel Investigations of Practice

3.21. In addition to this SCR, two parallel investigations have been conducted.

3.22. A criminal investigation into the death of the child was conducted by police. The mother subsequently appeared in Crown Court charged with the murder of her child and entered a plea of guilty to a lesser charge of manslaughter due to diminished responsibility. The judge confirmed that this was an appropriate charge and ruled that the only appropriate action was for the mother to be admitted to a secure unit subject to a hospital order under section 37 of the *Mental Health Act* (1983) and a restriction order under section 41 of the Act.

3.23. An inquest into the death of the child was opened by the Coroner. At the time of preparing this executive summary, the Coroner is yet to release his findings.

## 4. Overview of Case and Professional Involvement

4.1. The following section provides an overview of this case, including the family composition, a table of key dates and a narrative of events that occurred during the period under review.

**Family Composition**

Child, born 2007
Mother, born 1980

Father (no longer residing in the family home), born 1969

Maternal grandmother
Maternal aunts
Maternal cousin

**Key Dates**

| Month/Year | Incident/Event |
|---|---|
| October 2000 – January 2001 | Mother admitted to mental health unit in hospital. During this admission it was considered likely that she had schizophrenia. Upon discharge she was supported by specialist mental health services. |
| April 2002 – June 2002 | Mother self-referred to hospital and admitted to mental health unit. Discharged and supported by specialist mental health services. |
| March 2003 | Mother commenced tenancy in supported housing for people with mental ill-health. |
| September 2003 | Mother appears to have commenced relationship with the child's father, another tenant at supporting housing. |
| February 2006 | Mother discharged from specialist mental health services to the care of her GP. |
| January 2007 | Mother's pregnancy confirmed. |
| May 2007 | A staff member from the supported housing provider contacts the Duty and Assessment Service (children's social care) requesting an assessment of risks to the forthcoming child and monitoring after baby is born. Letter advises that couple are moving and have rejected an offer of continuing support from the organisation. |

| Month/Year | Incident/Event |
|---|---|
| July 2007 | Mother and father cease tenancy with supported housing provider. |
| August 2007 | Case allocated to social worker for pre-birth assessment. |
| September 2007 | Child born. |
| October 2007 | Child subject to Child in Need plan – family referred to family centre for parenting assessment and regular home visits undertaken by health visitors and social worker. |
| December 2007 – March 2008 | Deterioration in relationship between mother and father, incidents of domestic abuse. Father leaves family home. |
| September 2008 | Child in Need plan ceased (case closed by children's social care) following no concerns with mother's parenting. |
| January 2010 | Mother sought nursery place for child. |
| 9 February 2010 | Health visitor undertakes home visit and mother reports slight concerns about her mental health. This to be taken up with her GP. |
| 17 February 2010 | Two health visitors undertake home visit and note further concerns with mother's presentation, referrals are made to children's social care and mental health services. |
| 18 February 2010 | Community Psychiatric Nurse and Emergency Duty Worker attempt home visit at 9:00 pm. Mother refuses access. |
| 19 February 2010 | Mental health services attend the family home to undertake Mental Health Act Assessment, children's social care and police also in attendance. Child found dead in home. |

## Synopsis of the Case and Professional Involvement

Mother's Mental Ill-health

4.2. In October 2000, the mother was admitted to a psychiatric unit in hospital after having been found wandering and confused by police. The hospital admission lasted three months, during which the mother reported that she had been hearing voices for three years prior to the admission. Misuse of alcohol and cannabis was noted. She stabilised through use of anti-psychotic medication, and was discharged with a diagnosis of "psychosis triggered by cannabinoids", but it was noted that schizophrenia was likely.

4.3. Following her discharge from hospital, the mother lived with her mother and siblings, who were reported to be supportive, and had regular appointments and home visits with specialist mental health services. There were some reports that she continued to misuse substances and be aggressive and verbally abusive, but these behaviours were not severe enough to warrant professional intervention. She did not always comply with her medication and presented on fifteen separate occasions at the accident and emergency (A&E) department of her local hospital with psychotic symptoms, depression and/or anxiety, and was treated by mental health services and discharged home.

4.4. In April 2002, the mother presented at accident and emergency with escalating symptoms and was admitted to the mental health unit of the hospital for a second time. She reported that she had not taken her medication for several days, and very rapidly deteriorated. She spent a month in hospital. She was discharged from hospital with continued support from specialist mental health services.

4.5. Following this second admission to hospital, the mother appeared to stabilise. She occasionally presented at A&E and there were some issues with medication, but by 2004 she did not report any symptoms and no longer wished to see a psychiatrist. She continued to be supported in the community by a Community Psychiatric Nurse for a further 12 months and did not report further symptoms. She was discharged from specialist mental health services to the care of her General Practitioner in 2006.

4.6. Until February 2010, the mother was stable for an extended period, with no significant psychotic episodes for eight years.

Mother's Relationship with the Child's Father

4.7. The mother moved into supported housing in 2003. She met and commenced a relationship with the child's father, another resident at this accommodation, that year. The couple married in 2006, and the mother became pregnant in 2007.

4.8. The couple decided to move into a larger home before the baby arrived, and left their supported accommodation. They declined an offer of continuing support.

4.9. Following the birth of the baby, the father found it difficult to adjust and the couple began arguing. On three occasions, police attended the family home and recorded incidents of domestic abuse. The effects of domestic abuse were considered at a professionals meeting, and the mother was considered to be acting protectively towards the child.

4.10. The father left the family home in 2008 following the third incident of domestic abuse. The mother made it clear that she would not allow him back into the home after this incident. The father had no subsequent contact with the child.

Pregnancy and Birth of the Child

4.11. The mother's pregnancy was confirmed by her GP in 2007.

4.12. The couple announced their intention to leave the housing project when the mother became pregnant. Staff at the project expressed anxiety to children's services as to how the couple would cope with a baby given their

mental health difficulties and requested a pre-birth assessment. This was considered to be of particular importance as the couple were moving to another address and had declined an offer of continuing support from the supported housing provider.

4.13. The Duty and Assessment Service undertook an initial assessment, which led to a pre-birth assessment. As part of the pre-birth assessment process, the allocated social worker contacted staff in those agencies that had provided support to the parents. However, information from the parent's family doctor was not requested and the information from mental health services was not detailed.

4.14. Following the pre-birth assessment, the child was subject to a Child in Need plan for a period of nine months. The plan closed with professionals across agencies noting good attachment between the mother and her child; that the house was always clean and warm; and that the child's needs were always prioritised. Following the closure of the Child in Need plan, the mother was able to continue to access universal services.

January/February 2010

4.15. In late January the mother visited a family centre seeking nursery provision for the child. The mother advised that she did not have a health visitor. The family centre contacted the health centre to request a health visitor and to progress the request for nursery provision for the child.

4.16. A health visitor went to the family home on 9 February 2010. During this visit the mother revealed that she was experiencing thoughts and feelings which she did not understand. The health visitor advised that these concerns would be discussed with the mother's GP. The health visitor planned to return to the family home in two weeks' time to broaden the assessment of family needs. Following the visit, the health visitor contacted the GP Surgery, and an appointment was made for the mother to see the GP. The mother did not attend this appointment.

4.17. The mother regularly attended sessions at the children's centre during early to mid-February. At this point no concerns about the mother's behaviour and/or her interaction with the child were noted by children's centre staff.

4.18. On 17 February 2010, two health visitors undertook the planned visit to broaden their assessment of family needs. The health visitors noted that the curtains and blinds were drawn, putting the room in darkness and the child was not dressed. The mother did not make eye contact during the visit. Her conversation was out of touch with reality, and she alternated between smiling and scowling.

4.19. The child showed no emotion and seemed unaffected by the mother's shouting. The mother agreed that her medication needed to be reviewed. The health visitors reported that, upon leaving the house, the child held onto the hand of one of the health visitors and they gained the impression that the child did not want them to leave.

4.20. One of the health visitors telephoned the Duty and Assessment Service and the Community Mental Health Team to share their concerns about the mother's behaviour during the visit and the effect it may have on the child. However, these calls was made late in the day. The health visitor was advised to provide this information/referral in writing, and this was faxed the following day.

4.21. On receipt of the faxed referral from the health visitor, a Community Psychiatric Nurse (CPN) called the child's mother to arrange a home visit. The mother reported that she was at nursery with the child and declined a home visit.

4.22. The CPN then contacted the Duty and Assessment Service to advise that no home visit had been made, and that the Community Mental Health Team may make a visit later on that evening. The Duty and Assessment Service advised the CPN to contact the Emergency Duty Service if a home visit was considered to be necessary that evening.

4.23. The CPN contacted the child's mother again early in the evening and noted that she was extremely angry and abusive. The CPN contacted the Emergency Duty Service to plan a joint visit to assess the mother's mental health and the risks to the child, and advised that a different CPN would undertake the visit.

4.24. At 9:00 pm, the CPN and an Emergency Duty Service (EDS) Worker met outside the family home, had a brief conversation through their car windows and then knocked on the door. The mother opened the door but was reported to be very angry and she refused entry to the house and shut the door. The child was not seen. Both workers agreed that any attempt to force entry or undertake a full assessment under the *Mental Health Act* (1983) was likely to inflame the situation and cause distress to the child. They left the home and the EDS worker sent a fax to the Duty and Assessment Service for immediate follow up the next day.

4.25. The following day, the Community Mental Health Team contacted the Duty and Assessment Service to advise that they were making the necessary arrangements to conduct an assessment of the mother under the *Mental Health Act* (1983). It was agreed that Duty Social Workers would attend the assessment in case the child needed to be accommodated and police would also be in attendance.

4.26. The assembled team arrived at the family home and knocked on the door. The mother initially refused entry, but then opened the door to the police. When the mother opened the door, she was very distressed and covered in blood, which was later established to be her own blood from self-inflicted injuries. The mother reported that the child had died. Police entered the property and requested the assistance of a doctor in attendance, who confirmed that the child had died.

4.27. The mother was taken to a medical assessment unit in a distressed state, and was subsequently detained in a secure unit in hospital under the *Mental Health Act* (1983).

## 5. Analysis of Agency Involvement with Family

5.1. The following section provides an analysis of agency involvement with the family. This analysis is shaped by considering the key issues identified in the terms of reference: opportunities for earlier intervention; focus on the child; engagement with services; and referral pathways and plans to support adults and children.

**Opportunities for Earlier Intervention**

5.2. The overview panel considered if there were opportunities for earlier intervention that may have prevented this case from reaching crisis point. It was considered that the pre-birth assessment and the deterioration of the mother's mental health in February 2010 were of particular relevance.

Pre-birth Assessment

5.3. The pre-birth assessment provided an opportunity to bring together the various strands of the mother's and father's mental health problems and to carry out a detailed risk assessment of their parenting ability.

5.4. The pre-birth assessment was flawed because it did not include a detailed history of the mother's mental health. Duty and Assessment staff knew that the mother had previous mental health difficulties but had no detailed information about the nature of her illness. Despite this lack of detailed information, the panel found evidence that professionals involved with the family at the time recognised the potential for post-partum depression/ psychosis in this mother, and would have responded to indications of a deterioration in her mental health if they became apparent.

5.5. The lack of detailed information about the mother's mental health may have resulted in a missed opportunity to fully consider the extent of risk to the child. This learning point is addressed in recommendation 8.16.

5.6. The mother was reported to present well throughout the assessment process and demonstrated good attachment to and care for the child. No concerns were noted about her parenting capacity.

Contingency plans

5.7. The overview panel agreed that the eventual outcome in February 2010 was not affected by the previous history in the case and/or any failure to provide earlier interventions with this family. However, the overview panel also considered that professionals should have considered developing contingency plans to detect and respond to any deterioration in the mother's mental health. This learning point is addressed through recommendation 8.5.

Early indications of the deterioration in the mother's mental health in February 2010

5.8. Health visitors made two home visits in February 2010 and noted a deterioration in the mother's mental health. The panel considered that the decision to make referrals to the Duty and Assessment Service and the Community Mental Health Team was appropriate, although acting on their concerns immediately, earlier in the day and to the correct referral point may have enabled earlier intervention.

5.9. The overview panel also considered if, in the light of the mother's presentation, the health visitors should have considered seeking an emergency response from the Duty and Assessment Service. The panel recognises that the health visitors did not believe that the child was at any immediate risk of harm. However, the health visitors did not appear to consider the impact the of the mother's deteriorating mental health or access supervision as the panel would have considered appropriate. Such supervision may have highlighted the urgency of the situation and supported the health visitors to seek an urgent response from specialist services. This is considered to be an important learning point, and is addressed through recommendations 8.2 and 8.20.

**Focus on the Child**

5.10. It is the panels view that, whilst there is evidence of some good practice throughout the involvement of all of the agencies in this case, in the days

leading up to the tragedy, there appears to have been inconsistent consideration and assessment of the child's welfare.

5.11. The practice of the community psychiatric nurse who first picked up the referral on the afternoon of 18 February 2010 and tried to take appropriate action to safeguard the child is to be commended as there was a clear focus on the potential risk to the child.

5.12. However, professionals who attended the family home on 18 February 2010 to undertake an assessment of the mother's mental health did not gain access to the house, and were unable to assess the nature of her deteriorating mental health and the potential risk to the child. Importantly, the child was not seen during this visit. Whilst the staff who visited the home did not feel that the child was at risk of harm, a clear focus on the child would have led them to ensuring that the child was seen. Furthermore, these staff did not seek management oversight of their decision making, and the overview panel agreed that such oversight would have ensured that the child was seen, and may have led to further consideration of the risk of leaving the child in the home. This is considered to be an important learning point, and is addressed through recommendation 8.1.

5.13. Both workers were aware of a plan, made earlier in the day, that if the mother was grossly unwell and un-cooperative they would embark on more formalised mental health assessment procedures. They did not follow this plan. They could also have used the police to gain entry to the house if necessary. As a result of this the mother's mental health was left unassessed, the child was not seen and an assessment of risk to the child was not carried out. This represents a missed opportunity to safeguard the child.

5.14. One of the reasons the plan was not followed was because the community psychiatric nurse remembered the mother from some years previously and expressed a view, based on that knowledge, that the mother was unlikely to be violent. Both workers agreed that to try to gain entry to the property would inflame the situation further and felt the assessment was better left to daylight hours. The emergency duty service worker fully supported that decision after they had discussed the situation with another colleague on the telephone.

5.15. The emergency duty worker could have consulted the mother's family and enlisted their help to gain entry, but had been given the impression, by another CPN colleague, that she was estranged from her family.

5.16. In not carrying out the assessments regarding the mother's mental health and the child's welfare, staff did not follow procedures or use their professional judgement as the panel would consider appropriate.

## Engagement with Services

5.17. The overview panel considered if repeated non-attendance was a feature of this family's involvement with agencies; and if decisions to withdraw services were appropriate. This is considered to be particularly relevant with regard to the mother's discharge from mental health services.

5.18. The mother was discharged from mental health services to the care of her GP in January 2006 following multiple non-attendances and an absence of psychotic symptoms.

5.19. The consequence of the discharge of the mother from mental health services in January 2006 was that she moved from a service where some proactive visiting to her was taking place through the involvement of the community psychiatric nurse, to a system where no review, support or intervention would take place without an appointment.

5.20. Frequent non-attendance at appointments was a key feature of the mother's behaviour from the commencement of her contact with services.

5.21. It is usual practice for clients with mental health issues to be managed by their GP. However, the overview panel could find no evidence of formal meetings to hand-over management of this case, or develop contingency plans or strategies for re-engagement with mental health services should it become necessary.

5.22. The overview panel considered that more collaborative working between the GP and mental health services would have been appropriate given the mother's history of failing to attend appointments. This learning point is addressed in recommendation 8.26.

5.23. The overview panel recognised that a more thorough discharge process may not have changed the decision to transfer management of the mother's care to her GP given that she chose not to engage with services, had reported no psychotic symptoms for four years, was taking her medication and she was in adequate housing.

5.24. The decision to discharge the mother to the care of her GP was considered to be reasonable and in line with the established care pathway for mental health, from tertiary (highly specialised) care to secondary (specialist) and primary care (GP).

## Referral pathways and plans to support adults and children

5.25. The overview panel considered how robust and well understood referral pathways are.

5.26. The panel notes that there was some confusion about the correct entry point for a referral to mental health services, as health visitors had incorrectly contacted the Crisis Team to assess the mother's mental health (when the referral should have gone to the Community Mental Health Team). This was not considered to be key to the outcome of this case, as the health visitor was given the correct contact number and immediately made the referral through the appropriate team. However, the overview panel felt this should be picked up as a point of learning. Recommendation 8.12 addresses this learning point.

## 6. Conclusions

6.1. The analysis of the events between October 2000 and 16 February 2010 highlights the need for some improvements in professional practice. However, the eventual outcomes of the events which commenced on 17 February 2010 and concluded on 19 February 2010 were, in the panel's view, unaffected by the previous history in the case and not the result of any systemic organisational failures.

6.2. However, in the days leading to the child's death, there were a number of shortfalls in professional practice and professional misjudgements of the risks to the child in the circumstances of mother's deteriorating mental health.

- From the information recorded by health visitors on their visit on 17 February 2010, it is apparent that the mother was significantly unwell and that the situation warranted an immediate referral to mental health services and children's social care.
- There was an initial delay in making these referrals and the urgency of the situation was not sufficiently communicated to and/or understood by receiving agencies.
- The two workers who visited the home on 18 February 2010 did not follow the planned purpose of the visit, which was to assess the mother's mental health and the risk to the child. In doing so, they did not:
    - plan the joint visit and have contingency arrangements in place if they failed to gain access to the family home;
    - follow procedures that require a child to be seen during an assessment of whether they are at risk of harm;
    - contact a senior manager for advice and/or oversight of their decision making;
    - have sufficient focus on the child; or

- consider contacting extended family members for interim support.

6.3. It is recognised by the panel that neither professional thought the child was likely to come to harm and that they believed the situation would hold over night. The Board recognises that, with the benefit of hindsight, this was a professional misjudgement that was not so clear to those professionals at the time, and if either worker thought that there was any risk of harm to the child then different actions would have been taken. Nevertheless, the Board considered that there was not adequate consideration of the cumulative impact of professional attempts to contact the mother and how this may have affected her mental health or risks to the child.

6.4. This case has clearly demonstrated the risks associated with rapid deterioration of a parent's mental health and that a sudden deterioration of mental health can have a significant impact on the safety of a child. This is particularly important in the context of increased professional concern and attempts to contact the family and gain access to the family home.

6.5. The professionals who attended the family home on 18 February 2010 did not consider the situation serious enough to take further action. The Board concludes that, if further action had been taken that evening then the outcome of this tragic case may have been different and, on that basis, that the child's death was possibly preventable.

6.6. Whilst there was evidence of a real commitment by professionals to working with this mother over a number of years, the SCR panel considers that this case did not identify any systemic failures in safeguarding practice or procedures but acknowledged that it has, with the benefit of hindsight, identified some professional misjudgements and that some professionals failed to access management oversight/ supervision as the panel would consider appropriate.

## 7. Lessons from the Review Process

**Risk assessment of parent/carer with serious mental health problems**

7.1. When a parent or carer has serious mental health problems with psychosis and is receiving care or support from either the mental health services or their GP that person must be the subject of a risk assessment. This assessment should include consideration of the safety and wellbeing of the children in the household and be child focussed.

7.2. This learning point is addressed through recommendation 8.14.

## Contingency Planning in relation to parental mental health

7.3. While it is important not to stigmatise those parents or carers suffering from serious mental health problems with psychosis, a balance must be struck that recognises the increased potential risk they could pose to children in their care if their mental health were to deteriorate.

7.4. The lack of psychotic symptoms and the presence of good parenting practice as in this case should not discourage workers from formulating contingency plans to allow for changes in circumstances. This learning point is addressed through recommendation 8.5.

## Referral pathways

7.5. Referral pathways into mental health services should be clearly set out and communicated to ensure they are understood by both professionals and users accessing the services.

7.6. This recommendation is addressed through recommendation 8.12.

## Planning of Joint Visits

7.7. The professionals who attended the family home late in the evening only spoke briefly through their car windows before attempting the home visit. It is the overview panel's view that this lack of planning did not allow the workers the opportunity to consider strategies to gain entry to the home or develop a contingency plan. It should have been apparent (from records of earlier conversations) that the mother would be reluctant to let them in.

7.8. As such, professionals undertaking joint visits should ensure that such visits are well planned. Plans for joint visits should include strategies to engage resistant families, and contingencies in the event of failure to gain access to a family home (which could include contacting police in emergencies). This learning point is addressed through recommendations 8.3 and 8.4.

## Seeking Management Support in Professional Decision Making

7.9. If a parent or carer with serious mental health problems with psychosis has personal care of a child and refuses to allow access to their home to have their own mental health assessed or the care of the child assessed advice should be sought from senior managers in the relevant agencies. The help of the police should be enlisted to gain access if necessary in order to carry out those assessments.

7.10. In this case professionals across key agencies did not seek management oversight and/or specialist supervision when making key decisions affecting the child. This was particularly evident in the days prior to the child's death.

7.11. Management oversight and/or supervision may have provided an opportunity to better understand the mother's presentation, what this suggested about her mental health, and if she posed a risk to the child. The Overview Panel felt that management oversight/supervision could have led to different actions being taken by professionals, which may have changed the outcome. This learning point is addressed through recommendation 8.2.

## Training, consultation and supervision

7.12. Training, consultation and supervision processes must be effective in enhancing the likelihood that established procedures will be followed. Such processes could usefully be developed to include improving negotiating skills for staff in situations where users are reluctant to engage with services and how those users could be supported if they refuse to engage.

7.13. This learning point is addressed through recommendations 8.10, 8.15 and 8.19.

## Professional Failure to Recognise the Increasing Risk of Harm to the child

7.14. On the day before the child's death, professionals from different agencies were trying to contact the mother to make an assessment of her mental health, which was suspected to be deteriorating. It does not appear that all professionals recognised the possible accumulative impact of asking the mother about her mental health and her capacity to provide adequate parental care, and the potential for this to increase the risk of harm to the child.

7.15. It is the overview panel's view that the professionals should have considered the possibility that the attempts to contact the mother (which she rebuffed) were making her increasingly agitated, and, although professionals did consider the risks associated with forcing entry to the home, they did not adequately consider the mother's perception at that point and consequences of leaving the child in the care of the mother. As such, professionals should recognise that repeated attempts to contact families where parental mental ill-health is a feature may increase the risk of harm to children. Professionals should give consideration to the risk of leaving children in the sole care of a parent where there are concerns that mental health may be deteriorating. This is addressed through recommendation 8.1.

7.16. In cases where a child is thought to be in immediate danger normal assessment procedures, such as those under the *Mental Health Act (1983)* should be suspended in favour of using emergency action to safeguard the child, in collaboration with the police as appropriate.

7.17. This learning is addressed through recommendations 8.1, 8.9 and 8.25.

**Focus on the child**

7.18. During any assessment of risk of significant harm to children, the child must always be seen.

7.19. This learning is addressed through recommendations 8.10, 8.15 and 8.19.

## 8. Recommendations

**Kirklees Safeguarding Children Board**

8.1. The KSCB to provide learning opportunities that direct professionals to consider the impact of agencies' efforts to assess parenting capacity, and if parental anxiety over agency involvement with their family increases the risk of harm to children.

8.2. The KSCB to ensure partner agency take practical steps to improve professional take-up of management support in decision making.

8.3. The KSCB to develop guidance to support staff undertaking joint visits.

8.4. Where a parent or carer suffering from deteriorating mental health problems with psychosis refuses to undergo an assessment of their mental health or refuses access to a child for whom there are concerns about the potential risk of significant harm, the police should be contacted for assistance.

8.5. The KSCB to explore options for strengthening contingency plans between adult and children's services in relation to parental mental ill-health.

**Action For Children**

8.6. Action for Children should work with the local authority in Kirklees to consider recording issues. These should relate to the local question of recording referral details prior to an allocation meeting and to the wider question of whether there are ways of making records of all contacts with all service users at the Children's Centre. The outcome of this review and any pilot that follows should inform future good practice alongside other good practice drivers.

**Kirklees Children and Young People Service: Safeguarding and Specialist Provision**

8.7. Safeguarding & Specialist Provision should undertake an audit of the quality of pre-birth assessments.

8.8. Whenever pre-birth assessments are undertaken, the GP should be contacted in all instances.

8.9. In cases where there are significant safeguarding concerns in relation to a child/ren of a parent with a deteriorating mental health condition and home access is denied, consideration should always be given to suspending normal assessment procedures under the *Mental Health Act* in favour of using emergency action to safeguard the child in collaboration with the Police.

8.10. All Emergency Duty Service home visits to conduct assessments in relation to adult or child safeguarding issues, mental health assessments or CIN, should include a requirement that any child in the household is seen as part of that assessment.

8.11. The Unit Manager for Duty and Assessment Service should review systems and processes for receiving information into the Service with a view to ensuring that information is collated together and passed to the Team Manager within the required timescale (24 hours).

**South West Yorkshire Partnership NHS Foundation Trust**

8.12. The South West Yorkshire Partnership Foundation NHS Trust should ensure clarity about access and referral points to all of its services and ensure details are publicised appropriately and understood by partner agencies.

8.13. All staff will be reminded via team brief and a headline on the Trust Intranet of their responsibility to maintain clinical records to the required professional standards and in compliance with the policies of the Trust.

8.14. The Clinical risk assessment policy will be reviewed and make any necessary amendments to make it clear to clinical staff that risk assessments should take place as soon as the first information is received, including that received as part of a referral.

8.15. A focused communication campaign will be undertaken; reminding all staff that the child's welfare is paramount in all situations and circumstances

8.16. Guidelines will be developed for SWYPFT staff to provide guidance on contributing to a pre birth assessment being undertaken by the local authority CHYP service by December 2010.

## NHS Kirklees

8.17. Health visitors must utilise a structure such as the common assessment framework when working with families with identified safeguarding vulnerabilities.

8.18. Further work must take place in NHS Kirklees to strengthen the collaborative work that takes place between health visitors and colleagues in general practice in respect of vulnerable children.

8.19. Child protection training must be delivered to staff working with children and families, to provide direction on identifying a child protection emergency, and the subsequent action that must be taken to ensure the child's safety.

8.20. NHS Kirklees Safeguarding Team must provide training to general practices and Kirklees Community Healthcare Services about the factors which can compromise parenting capacity, and the professional response that is required to ensure that these factors are regularly analysed, and used to inform safeguarding children work.

## The Mid Yorkshire Hospitals NHS Trust

8.21. Clear lines of accountability need to be established between The Mid Yorkshire Hospitals NHS Trust and the South West Yorkshire Partnership NHS Foundation Trust with regards to patients presenting to the emergency department with primarily mental health issues through the strengthening of referral pathways and policy.

8.22. In revising the safeguarding strategy The Mid Yorkshire Hospitals NHS Trust will describe the requirement for commissioners to commission paediatric liaison services.

8.23. Where there are allegations of abuse, all concerns must be fully accounted for including thorough medical assessment, and documentation of decision making processes.

## Health Overview Report

8.24. South West Yorkshire Partnership NHS Foundation Trust should review current policies and procedures to ensure that a clear system is in place and

risk assessments are undertaken when services users fail to engage with mental health services.

8.25. Child protection training delivered to staff working in South West Yorkshire Partnership NHS Foundation Trust must provide direction on identifying a child protection emergency, and the subsequent actions that must be taken to ensure the child's safety.

8.26. General Practitioners and Mental Health Services should develop a clear process for managing clients with mental health issues within the primary care setting and should clarify the roles and responsibilities of General Practitioners and Mental Health Services.