
# OVERVIEW REPORT

## SERIOUS CASE REVIEW
## IN RESPECT OF A CHILD

## BDS 10

**Born 15 July 2008**
**Deceased 2 June 2010**
**White British**

**Chris Few**
**July 2011**
**(Revised January 2014)**

# CONTENTS

**INTRODUCTION**

**1 Introduction**

**2 Summary of Circumstances Leading to the Review**

**3 Terms of Reference**

**4 Review Methodology**

4.1 Serious Case Review Panel Chair
4.2 Independent Author
4.3 Serious Case Review Panel
4.4 Review Process
4.5 Parallel Processes

**5 Contributions to the Review**

5.1 Individual Management Reviews
5.2 Health Overview Report
5.3 Summary Reports
5.4 Other Sources
5.5 Family Engagement

**OVERVIEW OF AGENCY INVOLVEMENT**

**6 Geographic and Service Context**

6.1 County Context
6.2 Health Service Commissioning
6.3 Health Visiting
6.4 Mental Health Services
6.5 Care Programme Approach
6.6 Derbyshire Constabulary

**7 Family Background**

7.1 Genogram
7.2 Father
7.3 Mother
7.4 BDS

**8 Agency Involvement**

8.1 Integrated Chronology
8.2 December 2007 to September 2008
8.3 October 2008 to 21 December 2008
8.4 22 December 2008 to 9 February 2009
8.5 10 February 2009 to 20 August 2009
8.6 21 August 2009 to 31 October 2009
8.7 1 November 2009 to 25 May 2010
8.8 26 and 27 May 2010
8.9 28 to 31 May 2010
8.10 1 and 2 June 2010

**ANALYSIS**

**9 Analysis of Agency Involvement**

9.1 December 2007 to September 2008
9.2 October 2008 to 21 December 2008
9.3 22 December 2008 to 9 February 2009
9.4 10 February 2009 to 20 August 2009

9.5 21 August 2009 to 31 October 2009
9.6 1 November 2009 to 25 May 2010
9.7 26 and 27 May 2010
9.8 28 to 31 May 2010
9.9 1 and 2 June 2010
9.10 Diversity Issues

**CONCLUSIONS AND RECOMMENDATIONS**
**10 Predictability**
**11 Preventability**
**12 Learning Themes**
**13 Learning from previous Serious Case Reviews**
**14 Learning from the Individual Management Reviews**
**15 Focus on the Child**
**16 Mental Health**
**17 Support for Carers**
**18 Risk Assessment**
**19 Response to Domestic Abuse Incidents involving Children**
**20 Information Management**
20.1 Information Gathering
20.2 Documentation
20.3 Information Sharing
**21 Recommendations**

**APPENDICES**
A Terms of Reference
B Genogram
C Integrated Chronology
D Family Engagement Summary
E Agency Individual Management Review Recommendations
F Derbyshire Mental Health Services NHS Trust
Service Structure and Remit

# INTRODUCTION

## 1 Introduction

1.1 The Local Safeguarding Children Board Regulations, 2006, require Local Safeguarding Children Boards to undertake reviews of serious cases. Working Together to Safeguard Children (2010) provides statutory guidance on the criteria for undertaking such reviews and on how they should be conducted.

1.2 A Local Safeguarding Children Board should always undertake a Serious Case Review when a child dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the child's death.

1.3 The purpose of a Serious Case Review 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]

1.4 Serious Case Reviews are not inquiries into how a child died or who is culpable. That is a matter for the Coroners and criminal courts, respectively, to determine as appropriate. Nor are Serious Case Reviews part of any disciplinary inquiry or process relating to individual practitioners.

## 2 Summary of Circumstances Leading to the Review

2.1 BDS was the only child of Mother and Father. He lived with his mother and had regular contact with his father.

2.2 On the morning of 2 June 2010 Police Officers were called to the home address of BDS where they found the bodies of Mother and Father, who had apparently died from stab wounds. BDS had also sustained stab wounds and was conveyed to hospital by ambulance. He was pronounced dead by clinicians shortly after his arrival at the hospital.

2.3 The death of BDS was treated as murder by Derbyshire Constabulary although no-one outside of those who died was sought in connection with the killing.

2.4 The Derbyshire Safeguarding Children Board (DSCB) Serious Case Review Committee considered the circumstances of BDS's death on 11 June 2010. On the basis that a child had been a victim of homicide[2] they recommended

[1] Working Together to Safeguard Children (2010) 8.5
[2] Working Together to Safeguard Children (2010) 8.9

to Bruce Buckley, the Chair of the DSCB, that a Serious Case Review be conducted. That recommendation was endorsed on 16 June 2010.

2.5 An Inquest was held by HM Coroner in September and October 2013. The jury decided that BDS and Mother had been unlawfully killed and that Father had taken his own life.

# 3 Terms of Reference

3.1 Terms of Reference for the Review were agreed by the DSCB in accordance with Working Together to Safeguard Children (2010) paragraph 8.20.

3.2 The full Terms of Reference are reproduced as Appendix A to this report.

3.3 In addition to the purposes of a Serious Case Review outlined above it was explicitly stated that the review should establish whether the death of BDS was predictable and / or preventable.

3.4 The subjects of the review are:

- BDS10 (Child) Born 15.7.08
- Mother Born 1971
- Father Born 1966

3.5 The Review covers in detail the period from the conception of BDS to 2 June 2010. Relevant information outside of this period is included in summary form.

3.6 At the outset of this Review the Serious Case Review Committee recognised that an immediate review of the arrangements for responding to domestic violence incidents involving children was required. Derbyshire County Council Children and Younger Adults Department, Derbyshire Constabulary, Derby City Children and Young People's Services Department, NHS Derbyshire County, Derbyshire Community Health Services and NHS Derby City were commissioned to undertake this in parallel with the Serious Case Review.

# 4 Review Methodology

## 4.1 Serious Case Review Panel Chair

4.1.1 The Serious Case Review Panel was independently chaired by Sue Richards; Head of Service Children's Quality Assurance, Derby City Council. Sue Richards is experienced in Serious Case Reviews and chaired the Panel as part of a reciprocal arrangement with Derby City Children and Young People's Services Department.

## 4.2 Independent Author

4.2.1 Chris Few was appointed to write this Overview Report at the outset of the Serious Case Review. He has attended all meetings of the Serious Case Review Panel.

4.2.2 Mr Few works independently as a safeguarding children consultant and as Independent Chair of a Local Safeguarding Children Board. His background as a Police Officer includes safeguarding children policy development as well as leadership of child abuse investigation functions and homicide enquiries. He has chaired Serious Case Review Panels, undertaken agency management reviews and prepared overview reports for a number of Local Safeguarding Children Boards and their partner agencies. He has not previously been involved in a Serious Case Review in Derbyshire and has no personal or professional connection with any agency in that county.

## 4.3 Serious Case Review Panel

4.3.1 The following individuals comprised the Serious Case Review Panel for this Review:

- Sue Richards (Serious Case Review Panel Chair)
  Head of Service Children's Quality Assurance, Derby City Council

- Supporting People Manager
  Derbyshire County Council commissioner of services from Amber Trust

- Assistant Director, Children and Younger Adults Services
  Derbyshire County Council,
  (Represented by Deputy Assistant Director)

- Assistant Director, Quality& Integrated Governance
  Derbyshire Community Health Services

- Detective Chief Inspector
  Derbyshire Constabulary

- Director of Clinical Quality and Nursing
  NHS Derbyshire County
  (Represented by Designated Doctor)

- Head of Patient Safety & Deputy Director of Nursing and Quality
  Derbyshire Mental Health Services NHS Trust (Now known as Derbyshire Healthcare NHS Foundation Trust)

4.3.2 All meetings of the Serious Case Review Panel were also attended by the Independent Author

## 4.4 Review Process

4.4.1 A briefing meeting of the Individual Management Review (IMR) authors was held on 28 June 2010.

4.4.2 Following submission of Individual Management Review (IMR) reports meetings of the Serious Case Review Panel were held on:

- 17 August 2010
- 22 October 2010
- 26 November 2010
- 27 January 2011
- 2 March 2011
- 5 April 2011
- 4 July 2011

4.4.3 On 21 December 2010 the Independent Author met with the author and commissioner of the Derbyshire Constabulary IMR to clarify content of that agency's IMR, its interpretation and analysis.

4.4.4 On 21 December 2010 the Independent Author and DSCB Strategy Officer also met with the author of the Derbyshire Mental Health Services NHS Trust IMR and by teleconference with the Executive Director of Nursing and Quality for the Trust who had chaired their internal review. This meeting was to clarify content of that agency's IMR, its interpretation and analysis.

4.4.5 During the review process the submission of IMR reports which were acceptable to the Serious Case Review Panel was, in some cases, delayed by the process of reconciling these with other parallel processes and the requirements of one agency's internal governance arrangements. In May 2011 the DSCB also commissioned independent legal advice. The planned completion date for the Serious Case Review was accordingly deferred on three occasions by the DSCB and Ofsted were notified.

4.4.6 The Overview Report was presented to the Derbyshire Safeguarding Children Board and signed off on 12 July 2011. The Independent Chair of the DSCB at that date was Lynn Harris.

4.4.7 Following the Inquest verdict in October 2013 this report was reviewed by the Independent Author and amendments made to take into account those proceedings. In a small number of cases there was divergence, mainly on matters of interpretation, between information provided to the Review and that given to the Inquest; For these recourse was first made to contemporaneous records and where this did not provide a resolution, evidence given on oath was regarded as definitive.

## 4.5 Parallel Processes

4.5.1 This Serious Case Review has been conducted in parallel with a number of other review processes:

- NHS Derbyshire County Review of Primary Care management of Father.
- Derbyshire Mental Health Services NHS Trust Internal Investigation into the Care and Treatment provided to Father. Ref: 2010/6677[3].

[3] Derbyshire Mental Health Services NHS Trust anticipates that an independent review will also be commissioned by the Strategic Health Authority under DoH HSG 94/27. That has not to date been commissioned.

- Independent Police Complaints Commission Investigation 010/010331.
- DSCB commissioned multi-agency review of arrangements for responding to domestic violence incidents involving children (see 3.6).

# 5 Contributions to the Review

## 5.1 Individual Management Reviews

Individual Management Review (IMR) reports were provided by:

5.1.1 Amber Trust

- Amber Trust is a registered charity which provides support for people with mental ill health to live successfully in their local communities. It employs approximately 35 staff members in Derbyshire.

- Amber Trust provided Father with support from the 30 March 2009 until 2 June 2010 in connection with his tenancy of a property let by the local housing office.

5.1.2 Derbyshire Community Health Services (DCHS)

- Derbyshire Community Health Services (DCHS), during the period covered by this review, was the provider of community health services for NHS Derbyshire County (PCT).

- The organisation provided health visiting services to BDS and his family from the time of BDS's birth until his death.

- The organisation also managed the local Minor Injuries Unit accessed by Mother in January and May 2010.

5.1.3 Derbyshire Constabulary

- Derbyshire Constabulary first became aware of the family consequent to Father reporting to Surrey Police that Mother was missing in October 2008.

- Subsequent direct involvement was in:
  - October and December 2008 when Mother sought assistance to address Father's behaviour;
  - May 2009 when Father was arrested for theft;
  - August 2009 when assistance was provided in relation to Father's welfare;
  - May 2010 when Mother reported problems with Father.

- The last contact was in connection with the incident on 2 June 2010 leading to this Review.

5.1.4 Derbyshire County Council, Children and Younger Adults Services
(Referred to in the body of this report as Children's Social Care)

- Derbyshire County Council, Children and Younger Adults Services provide statutory children's social care services in Derbyshire County.

- They received information from Surrey County Council in connection with Father having reported Mother and BDS missing to the Police. They also received a referral from Derbyshire Constabulary regarding threats by Father to kill Mother at the end of May 2010.

- No services were provided and the only contact with family members was one telephone call to Father in October 2008.

5.1.5 Derbyshire Mental Health Services NHS Trust (DMHS)

- Derbyshire Mental Health Services NHS Trust (DMHS) provides mental health services to Derbyshire County and Derby City.

- The Trust provided mental health services to Father from April 2008 until his death. They also had contact with Mother in her role as providing support and care for Father and occasional contact with BDS when he was present with Mother.

- The IMR was informed by an internal investigation into the care and treatment of Father commissioned by DMHS in parallel with this review.

5.1.6 NHS Derbyshire County – GP services

- For most of the period under review BDS and his parents were all registered at and received primary heath care from one large GP Practice.

- The IMR was informed by an investigation undertaken by the Medical Director of NHS Derbyshire County (PCT), into the primary care management of all three individuals.

5.1.7 Royal Derby Hospital NHS Foundation Trust (RDH)

- Royal Derby Hospital NHS Foundation Trust (RDHFT) is an acute NHS Trust, serving the population in and around South Derbyshire.

- The Trust provided antenatal care to Mother during both of her pregnancies together with midwifery and routine post natal care in connection with the birth of BDS. They also received BDS and attempted resuscitation on the day that he died.

- The Trust also had one contact with Father when he attended the Adult Emergency Department with mental health issues in August 2009.

**5.2 Health Overview Report - NHS Derbyshire County -**

5.2.1 A Health Overview Report was prepared in accordance with Working Together to Safeguard Children (2010).

5.2.2 Compilation of the report was assisted by a meeting on 26 July 2010 convened by the Designated Doctor, to which all health community IMR authors were invited.

**5.3 Summary Reports**

Summary factual reports were submitted by:

5.3.1 Derbyshire Health United (DHU)

- Derbyshire Health United provides of Out of Hours GP services in Derbyshire County and Derby City. They had telephone contact with Mother on four occasions when she sought assistance in relation to the mental health of Father.

5.3.2 East Midlands Ambulance Service (EMAS).

- On 2 June 2010 EMAS staff confirmed that Mother and Father were dead, attempted resuscitation of BDS and conveyed him to hospital. EMAS had previously conveyed Father to hospital in August 2009 after being contacted by the Police.

5.3.3 NHS Direct

- NHS Direct provided telephone advice to Mother regarding a hand injury in January 2010.

**5.4 Other Sources**

5.4.1 Other documents and sources which informed the Review were:

- Internal Investigation into the Care and Treatment Provided to Father by Derbyshire Mental Health Services NHS Trust – Ref: 2010/6677.
- Independent Police Complaints Commission Investigation Report 2010/010331.
- Derbyshire Constabulary Life at Risk Policy (June 2008).
- FAX Transmission of Section 17 Child Referral, Ref: 6456/10.
- Derbyshire Constabulary Domestic Violence Policy (February 2008).
- Domestic Abuse and Safeguarding Children Protocol Between Derbyshire County Council, Derby City Council, Derbyshire Constabulary, NHS Derbyshire County and NHS Derby City.
- Derbyshire Mental Health Service NHS Trust Visiting Policy / Child Visiting Procedures (December 2005).
- Derbyshire Mental Health Services NHS Trust Discharge and Out of Contact Policy and Procedure (October 2008).
- Telephone interview with Kate Howard, Independent Counsellor by the Independent Author on 20 January 2011.
- Meetings with members of BDS' extended family as outlined in this report.
- Progress Report dated 8 February 2010 by the DSCB Strategy Officer on revising arrangements for the management of Domestic Violence referrals.

## 5.5 Family Engagement

5.5.1 The extended families of Mother and Father were informed that this Review was taking place at its outset. They were subsequently contacted by the Independent Author and offered the opportunity to contribute to the Review. It was agreed with them that this would be most productive once an initial narrative of events had been established following receipt of the IMR reports.

5.5.2 Family members were recontacted at the beginning of November 2010 and took up the opportunity to meet with the Independent Author and the Strategy Officer of the DSCB. The new partner of Mother was similarly met with at that time.

5.5.3 Information provided by the extended family has been incorporated into and considerably informed the content of this report. A summary of the family members' perspective on the events leading to the Review is provided at Appendix D.

5.5.4 The Independent Author is extremely grateful to them for their time and the openness of their contribution to the Review.

5.6 As part of planning by the DSCB for the publication of this Review arrangements will be made for family members to receive feedback on its outcome.

# OVERVIEW OF AGENCY INVOLVEMENT

## 6 Geographic and Service Context

### 6.1 County Context

6.1.1 Derbyshire is a geographically large, diverse county with deprived urban and ex mining communities, and also affluent areas, particularly in the more rural west, but where there may be hidden deprivation and isolated hard-pressed farming communities. The health of people in Derbyshire is generally better than the England average, including many children's indicators.

6.1.2 The tragic event which led to this Serious Case Review took place in a small, quiet rural Derbyshire village. The proportion of children living in poverty in that area is lower than the average for England.

### 6.2 Health Service Commissioning

6.2.1 Health services for Derbyshire, excluding Derby City, are commissioned by NHS Derbyshire County from a number of provider organisations and NHS Trusts.

### 6.3 Health Visiting

6.3.1 Health Visiting services are currently commissioned from the provider arm of the PCT, Derbyshire Community Health Services (DCHS). These services are generally provided by professionals co-located with GPs at their surgeries.

6.3.2 Health Visitors have traditionally provided their service in the family home setting. DCHS guidelines[4] however state that developmental reviews will only be undertaken in the child's home if need is identified. This is in line with many other areas of the UK where home visits by Health Visitors are now targeted only to those families with the highest needs, which would not include the family subject to this review.

### 6.4 Mental Health Services

6.4.1 Mental Health Services are commissioned from Derbyshire Mental Health Services NHS Trust (DMHS). The organisation structure of relevant services provided by the Trust is provided at Appendix F to this report.

### 6.5 Care Programme Approach

6.5.1 DMHS operates the Care Programme Approach (CPA) as the principal vehicle of care assessment and planning for individuals receiving mental

[4] DCHS Corporate Working Best Practice Guidelines (2009)

health care. This is a person centred, whole systems approach to care planning and delivery across the individual's life domains, including housing, employment, leisure, education and other needs.

6.5.2 The CPA operates on a partnership basis to deliver an agreed plan of care. The partnership must, as a minimum, include the service user, any carers and the CPA Care Coordinator. It should also include working relationships with other health and/or social care professionals and relevant organisations.

6.5.3 The Care Co-ordinator's core functions are to carry out a comprehensive needs assessment; risk assessment, crisis planning and management; assessing and responding to carer's needs; care planning and review; and transfer of care or discharge[5]. The Care Co-ordinator is also responsible for identifying and advising on changes in the circumstances which might require review or modification of the care plan.

### 6.6 Derbyshire Constabulary

6.6.1 Derbyshire Constabulary provide policing services throughout the County.

6.6.2 They attend on average 19,000 domestic violence incidents a year. The number of reports has increased by 6% each year since 2005.

6.6.3 Since 2003 Derbyshire Constabulary have had co-located Central Referral Units which collate and coordinate all police responses relating to allegations of domestic abuse and child abuse respectively. Where children are exposed to domestic violence a protocol is in place outlining multi-agency response arrangements.

6.6.4 The Constabulary records and investigates in the region of 150-160 offences of Threats to Kill[6] each year. These involve a range of background circumstances which include those that also meet the criteria of domestic abuse incidents.

## 7 Family Background

### 7.1 Genogram

7.1.1 A genogram of BDS' family, as known to agencies in Derbyshire, is included at Appendix B to this report.

### 7.2 Father

7.2.1 Father was white British, born and raised as a child in the North of England. He described having a happy childhood and left school with 8 'O' Levels and 4 'A' Levels. His parents were in business and affluent, with both Father and

[5] Derbyshire Mental Health Services NHS Trust (2009) Care Programme Approach & Care Management Policies and Procedures

[6] Offences Against the Person Act, 1861

his sister being given everything they could want. His religious affiliation is unknown.

7.2.2 After leaving school Father studied graphic design and thereafter visited a number of countries, undertaking a variety of jobs to support his travel.

7.2.3 It was during this period that he met his first wife, to whom he remained married for 12 years. It is reported by Father's family that his wife was considerably older than him and took all responsibility for running their marriage and business affairs, an arrangement which they believed to have suited Father.

7.2.4 Father had a history of depression, which dated back to at least 1999 when he attempted suicide.

7.2.5 In 2002 Father's mother, to whom he was very close, died. Health service reports suggest that although he was offered bereavement counselling around that time he never recovered from the upset caused by her death. His father and sister, with whom he had irregular contact during the period covered by this Review, still live in the North of England.

7.2.6 Father has been described by mental health professionals as a "moderately resistant patient who avoided emotion" and by other health staff as "cold". Family members also found him hard to engage.

7.2.7 Members of both his and Mother's family have also reported manipulative and egotistical aspects of Father's personality, although he seems to have been able to conceal these from professionals, and Mother, until early in 2010.

### 7.3 Mother

7.3.1 Mother was white British and her religion had been recorded as Church of England.

7.3.2 Mother's father became chronically ill when she was around 12 years of age and she played a significant role with her mother in caring for him. It is believed that this experience had a major impact on Mother, instilling in her a sense of commitment and responsibility for the care of those who are sick. It is clear from the accounts of family members that Mother's relationship with her father meant a lot to her, and that was behind her commitment to maintaining contact between BDS and Father.

7.3.3 Mother left school at 18 having achieved good results. She then had a number of jobs and travelled extensively before moving to Spain.

7.3.4 In 2004 Mother met Father in Spain when she was exhibiting work at his art gallery. A relationship thereafter developed between them.

7.3.5 Around the beginning of 2007 Mother returned to the UK alone. She obtained a job as Personal Assistant to the Managing Director of a stock broking firm.

7.3.6 Towards the end of that year Father also returned to the UK and sought out

Mother. Their relationship was revived and Mother became pregnant shortly afterwards. Mother informed her family that the pregnancy was unexpected but that she welcomed it. Father was reported by family members of Mother to have been "off" regarding the prospect of fatherhood. The mother of Mother has stated that Father urged Mother to have the pregnancy terminated, informing her that he did not think the time was right for them to have a child, but that she refused. Father returned to Spain shortly afterwards.

7.3.7 Whilst pregnant Mother moved to Derbyshire to care for her mother, who had become frail. Father followed her there shortly afterwards.

7.3.8 It is reported by family members that from then on Father did not work. Although he reported that he had a source of income in America and he was receiving benefits in the UK, the majority of his money was used to finance debt repayments in Spain. He is reported to have made no financial contribution to the living expenses of Mother, or BDS once born.

7.3.9 Family members have remarked that Father did not display any form of affection for Mother.

7.3.10 Mother is reported by both professionals and family members to have presented as a happy person who was outgoing, sociable and interested in other people. She was quite tactile in greeting those she knew and would commonly embrace them.

7.3.11 Mother was viewed by professionals as a competent and capable woman, who always placed her child's needs first.

7.3.12 Family members have also commented that Mother would do anything to avoid a scene, expressed by her mother as the vehement view that "her family were not the sort of people who had the Police visit their homes".

## 7.4 BDS

7.4.1 BDS was a white British child.

7.4.2 He was described by health visiting staff as happy and smiling and by the midwifery staff who met him as bright, well behaved and interactive. These views were echoed by family members who describe him as a pleasure to be with, highlighting the sunny disposition evident in the photographs on BDS which were shared with the Independent Author and DSCB Strategy Officer.

7.4.3 Family members also commented that BDS got on well with other children of his age, in particular one of his cousins with whom he had regular contact.

7.4.4 The quality of care provided to BDS by his mother is described by both professionals and family members as being excellent and loving.

7.4.5 It is clear that BDS displayed affection for his father and effective interaction by Father with BDS was noted by some professionals.

# 8 Agency Involvement

## 8.1 Integrated Chronology

8.1.1 An Integrated chronology of agency involvement with those included within the scope of this Review is provided at Appendix C.

8.1.2 The following summary of agency involvement is drawn from the chronology. It is divided into largely arbitrary time periods for ease of reading.

## 8.2 December 2007 to September 2008

8.2.1 On 5 December 2007 Mother booked for her first pregnancy with a Community Midwife at the GP surgery. Mother was recorded as aged 36 years and father aged 41 years at this stage. Little other information was recorded about the couple's history.

8.2.2 Mother's antenatal period was unremarkable, apart from investigation for a maternal heart murmur, which was normal. Mother opted not to attend for a screen to assess the risk of Down's syndrome.

8.2.3 The pregnancy was notified to the health visiting team based at the GP surgery.

8.2.4 On 25 February 2008 Mother attended for her 20 week scan, which was normal. Father accompanied Mother to this appointment but did not interact with the health professionals.

8.2.5 On 29 April 2008, shortly after moving to rented accommodation with Mother, Father sought treatment from GP9. He was prescribed fluoxetine[7] and a referral was made to the North Community Mental Health Team (CMHT). The referral was received on 6 May 2008.

8.2.6 On 15 May 2008 an urgent further referral was made by the GP reporting deterioration in Father's mental health.

8.2.7 On 16 May 2008 Father was assessed by a Community Psychiatric Nurse 2 from North CMHT consequent to the GP referrals. In view of his low mood and suicidal thoughts he was referred to Chesterfield Crisis Resolution and Home Treatment Service (CRHTS).

8.2.8 Father was further assessed by the CRHTS and accepted for short term treatment. The Care Programme Approach (CPA) was engaged and CPN1 was appointed. The CPA formed the framework for all subsequent service provision to Father by Derbyshire Mental Health Services NHS Trust (DMHS).

8.2.9 Father was referred to a Support Worker Anxiety Management & Self Esteem Therapy, operating under the direct supervision of the Care Co-ordinator, for

[7] Fluoxetine is an anti-depressant.

provision of anxiety management and self esteem therapy.

8.2.10 A FACE[8] risk profile completed at this time indicated a significant risk of suicide and self neglect. Father was assessed as posing no risk to children or others.

8.2.11 On 14 June 2008 Father contacted Derbyshire Health United (DHU) with concerns about the side effects of his new medication. He was advised to stop taking it and see his GP the following Monday. His GP was notified of this contact and the advice given.

8.2.12 On 15 June 2008 Father was admitted to the Hartington Unit, Chesterfield, for a 3 week period of assessment and treatment. This followed a worsening of his depression. Father was assessed to be at low risk of suicide and self-harm and was started on Mirtazepine[9]. He was discharged following some improvement in his symptoms.

8.2.13 Whilst Father was at the Hartington Unit Mother was identified as an informal carer for him, although no formal assessment of her needs in connection with that role was conducted.

8.2.14 After his discharge Father was followed up in the community by the North CMHT. He was also put onto a waiting list for psychotherapy.

8.2.15 On 15 July 2008 BDS was born, weighing 2990g (between 9th and 25th centiles). Father was present at the birth. Mother sustained a post partum haemorrhage after the delivery, and Mother was admitted to the High Dependency Unit with her baby. BDS was breast fed. Both were discharged on 17 July 2008 to BDS' maternal grandmother's address, moving back to Mother's address some time afterwards.

8.2.16 BDS was noted to have positional talipes[10] in relation to which Mother was given advice about massaging his foot. Otherwise, the postnatal period was uneventful. Post natal Midwifery contact was provided in line with accepted practice.

8.2.17 The Health Visitor undertook a post natal family assessment using the Framework for Assessment of Children in Need and their Families[11]. On the basis that the family were meeting BDS' needs and had no identified unmet need themselves the family was assessed as "low need[12]" The Health Visitor

[8] Department of Health (2007) Best Practice in Managing Risk: Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services describes Functional Analysis of Care Environments (FACE) as "a portfolio of assessment tools designed for adult and older people's mental health settings. It includes both screening and in-depth levels of assessment and contains specialist forms applicable to areas such as substance use, mental capacity, perinatal services and forensic services. The tools meet both CPA and Health of the Nation Outcome Scales requirements. Risk is assessed using the FACE Risk Profile. This may be used either as a stand alone tool or in conjunction with other FACE or local tools. Five sets of risk indicators are coded as present or absent and then a judgment of risk status (0–4) in seven areas (including violence, self-harm and self-neglect) is made. Scope for service user and carer collaboration is built into the system through tailored forms, including feedback on services.

[9] Mirtazepine is an anti-depressant.

[10] An abnormal position of the foot which would be expected to self correct

[11] Framework for Assessment of Children in Need and their Families (2000) HMSO

[12] As defined in Derbyshire Community Health Services Practice Guidance 'Health Visiting Service Contribution

recalls that she would have asked a general question about health problems in the family, but was not told of Father's history of mental illness or his recent hospital admission. The Health Visitor therefore agreed future contacts in line with the Core Programme for Health Visiting Services. Mother is reported to have engaged well with the Health Visiting Service and brought BDS to 18 clinic appointments.

8.2.18 When the lease on the Mother's rented property ended in the late summer of 2008 she moved to her mother's address with Father and BDS. There is reference in agency records to Mother looking for child care so that she could return to work. She also secured an arrangement with her employer that would allow her to largely work from home after the birth of BDS. When she did have to work in London a neighbour cared for both BDS and Mother's mother.

8.2.19 On 3 September 2008 BDS was given his first course of immunisations a week early, at 7 weeks old. This was at the request of Father to accommodate a planned visit to Spain. The Health Visitor sought advice from her manager, who in turn sought advice from the public health Consultant on this.

## 8.3 October 2008 to 21 December 2008

8.3.1 On 24 October 2008 the family were on a visit to Surrey when Father reported to Surrey Police that Mother was missing with BDS. The reported circumstances were that father woke that morning to find Mother packing with the intention of visiting her brother in Berkshire. She was said to have not waited for Father and to have left whilst he was in the shower. A missing person enquiry, also involving Derbyshire Constabulary and Thames Valley Police, was initiated.

8.3.2 Mother had gone to her brother's address in Berkshire as planned and arrived there around lunch time. She informed her brother that whilst out the previous evening Father had argued with her and referred to her in a derogatory manner to her friends. She stated that in the morning Father had refused to get up and she had gone to her car with BDS. At that point Father came into the car park, argued with her and threw BDS' pushchair across the car park towards her. She stated that she was upset by these events and frightened for her safety.

8.3.3 The Police tried to contact Mother throughout the remainder of that day but she did not answer either the telephone or door, fearing that Father had followed her. Thames Valley Police (on behalf of Surrey Police) did make contact with Mother late that evening and visited to speak with her the next morning. Mother informed them that she and Father had argued over the previous few weeks about living arrangements and financial difficulties due to her being on maternity leave.

8.3.4 Mother did not inform the Officers of Father's actions with regard to the

---

to the Healthy Child Programme' (2009) and on the basis of Derbyshire Safeguarding Children Board practice guidance "Meeting the needs of children in Derbyshire (2006)"

pushchair or report that she had been assaulted by him. That aspect of the incident did not therefore feature in the information passed to Derbyshire Constabulary for inclusion in the closure of their incident record, or in the information later passed to other Derbyshire agencies.

8.3.5 Mother then returned to her mother's address in Derbyshire with BDS and informed her mother of the events in Surrey. She stated that she had been frightened by what had happened.

8.3.6 From her family's perspective the relationship between Mother and Father as a couple ended at that point and it is reported that from then on Mother never left BDS alone with Father, even if she was only getting out of her car to visit a shop. She is also reported to have hidden both her own and BDS's passports at her mother' house and later at neighbours house fearing that Father might take BDS and return to Spain with him.

8.3.7 Notwithstanding this Mother did indicate to her family that she felt responsibility for looking after Father. She was particularly conscious that Father was the father of BDS and wanted her son to have a relationship with him in the future.

8.3.8 On 26 October 2008 Father arrived outside of Mothers' mother's home and having been refused entry, banged repeatedly on the door. Both Mother and her mother were worried about what he might do if admitted. Mother rang Derbyshire Constabulary and reported that Father was outside her address causing a "real disturbance"; and that she was there with BDS and did not feel safe. Mother stated that she had been assaulted by Father in Surrey a few days earlier and that this was being dealt with by Surrey Police. As noted above the Derbyshire Constabulary records held no details of such an assault.

8.3.9 An incident log was created with an opening incident category of 'Nuisance'. Police Officers attended and persuaded Father to go to a friend's house in another area of Derbyshire for the night. He was transported to that address by the Police Officers.

8.3.10 The address given by Father was that of Mother's cousin whom Father had met on one previous occasion. He informed her that he had tried to obtain accommodation at a local budget hotel but they had been full. She reluctantly allowed Father to stay the night at her home. When Mother was informed, the next day, that Father had gone to her cousin's address she was angry at him for imposing himself and collected him from there.

8.3.11 On 28 October 2008 a fax was received by Children's Social Care in Derbyshire from Surrey County Council Children's Social Services Department. This contained a police referral regarding the incident in Surrey. In this it was reported that Father had stated he was not concerned about Mother's care of BDS but wanted advice regarding obtaining custody. The Surrey Police assessment was that there was no evidence of domestic abuse and no safety concern for the child, but that Father appeared to be using the incident to try to gain custody of BDS.

8.3.12 A Duty Social Worker attempted to contact Surrey Police to gain further

information but was unable to obtain a reply and left a message requesting that they make contact. No response was obtained. The Social Worker then telephoned Father, who informed her that Mother and BDS had returned, that they were reconciled and reported that BDS was safe and well. The Duty Social Worker recorded no further action and closed the Initial Contact.

8.3.13 At the end of October 2008 Father started a 10 week course of emotion focused psychotherapy.

8.3.14 On 14 November 2008 the DCHS Named Nurse received a copy of the Surrey Police notification. This was passed to the Health Visitor with a request that it be discussed in their next safeguarding supervision session. It was subsequently agreed that the Health Visitor would speak with Mother regarding the notification. In the interim BDS had been seen in clinic and the Health Visitor waited until she could talk to Mother alone to discuss it, which she did in December 2008.

8.3.15 Following the end of the relationship between Mother and Father he returned to Spain, albeit transiently, in December 2008. Additional support was offered to Father by his Psychologist. This included giving him some coping strategies for after the relocation. Father was then discharged from the CMHT.

8.3.16 On 15 December 2008 a routine review of BDS was undertaken by the Health Visitor.

### 8.4 22 December 2008 to 9 February 2009

8.4.1 By 22 December 2008 Father had returned from Spain. He had been put on a plane to the UK by acquaintances there owing to his deteriorating mental health. Mother was contacted by these acquaintances who informed her that Father would need to be collected from the airport. Mother did so and took him to her mother's address.

8.4.2 Mother contacted a CPN at the South CMHT and reported that Father's mental health had deteriorated. The CPN thereafter contacted Father's GP and advised that a referral would need to be made via the Crisis Resolution and Home Treatment Service (CRHTS). The CRHTS declined to accept the referral of Father from the GP. This was on the basis that he did not present with enduring mental illness and should therefore be dealt with by the South CMHT.

8.4.3 On 26 December 2008 Mother took Father to the Hartington Unit, stating that she could not cope. She was asked to take him to the Emergency Department of Chesterfield and North Derbyshire Royal Hospital (CNDRH).

8.4.4 At the hospital Mother requested help with Father's mental health and stated that this made her feel uncomfortable having him at her home. Father refused to get out of Mother's car, stating he had nowhere to go. Hospital staff contacted Derbyshire Constabulary and reported the situation. The report included that BDS was with Mother, that she was very distressed, and that she did not feel safe driving any further with Father in the car.

8.4.5 Police Officers attended and Father agreed to be assessed by the hospital based Mental Health Liaison Team (MHLT). The Derbyshire Constabulary incident was recorded as one involving mental health issues.

8.4.6 Father declined intervention from mental health services and denied any current thoughts of suicide or self-harm. He stated that he intended to visit his father. The records indicate that BDS' welfare was considered and that Mothers' concerns regarding Father and of him being near the baby were explored with Mother. The professionals had no concerns for BDS' safety.

8.4.7 Later on 26 December 2008 Father contacted Derbyshire Constabulary and stated that he was not doing very well. The Officers who spoke with him identified no concerns for his safety and directed him to the nearest Salvation Army hostel in Nottingham. Father subsequently returned to the hospital Emergency Department. He was regarded as being homeless and given assistance by Derbyshire County Council to access overnight accommodation.

8.4.8 On 27 December 2008 Father travelled to stay at his sister's address. He was asked to leave there by his brother in law; who woke to find Father standing at the end of his bed staring at him. This caused the brother in law concern for Father being in the house with his niece. Father thereafter stayed briefly with his father before returning to Derbyshire.

8.4.9 A few days later Father contacted a CRHTS CPN. He stated that he had been sleeping rough and had been to the Emergency Department with panic attacks. He was advised that his care would be picked up once a referral was received.

8.4.10 On 1 January 2009 Mother contacted the CRHTS, informing them that Father had reported being mugged and expressing concern for him. She was told that a GP needed to assess him.

8.4.11 Mother contacted Derbyshire Health United (DHU) and Father, described as 'delirious, restless and confused' was seen at home by an Out of Hours GP. Mother thereafter stayed with Father until he could be seen by his own GP the following day.

8.4.12 On 2 January 2009 Father registered with the same GP surgery as that of Mother and BDS. Father was seen by a GP 2 a few days later and stated that his depression was worsening.

8.4.13 Father thereafter contacted a CPN in South CMHT and asked that contact be made with his previous Psychologist for information. Father was told to attend an appointment with a Consultant Psychiatrist to facilitate his transfer to that CMHT.

8.4.14 On 20 January 2009 Father attended an appointment with a Consultant Psychiatrist 2 for the north area with a view to his care being transferred to South CMHT. Father was assessed as depressed with no thoughts of suicide. On 26 January 2009 a transfer letter was sent by the Psychiatrist 2 to the Consultant Psychiatrist 1 at the south area in respect of Father.

8.4.15 Between 29 December and 24 February, both Father and GP 9 contacted mental health services on a number of occasions to ask about transfer of Father's care. Neither was able to obtain information on when Father would be seen by the South CMHT.

## 8.5 10 February 2009 to 20 August 2009

8.5.1 On 10 February 2009 Father contacted a Counsellor in private practice and sought assistance with worsening depression and suicidal feelings. He explained that he was attempting to access treatment through DMHS but was frustrated at the time it was taking for an appointment to be offered. He provided an outline of his previous treatment history and his social circumstances. This included that he had an infant son.

8.5.2 The Counsellor did not feel able to take on Father as a client but was concerned at the impact his condition may have on BDS, as well as for Father's welfare. She sought Father's consent to liaise with DMHS and did so the following day. The CPN who was contacted arranged for Father to be assessed on 24 February 2009. Father subsequently emailed the Counsellor to thank her for the intervention.

8.5.3 On 24 February 2009 Father had an initial assessment by CMHT CPN 4 South. Father was at that time homeless. He was assessed as having an objective low mood with signs of anxiety; thoughts of suicide and active, but undivulged, plans of self harm; and presenting no risk of violence to others. This information was sent to a Consultant Psychiatrist 1 and to a Senior Clinical Psychologist.

8.5.4 Father was reviewed by the Consultant Psychiatrist a few days later and thought to be suffering from a moderate depressive episode. Father's prescription for mirtazepine was increased and input from the CPN was continued.

8.5.5 On 26 March 2009 Mother contacted DHU and stated that she was concerned about the withdrawn behaviour of Father who was again staying with her. She asked how to access the mental health crisis team if things deteriorated as she was going away for the weekend. She was advised to contact a CPN in the morning (which she did), or to call back if worried.

8.5.6 On 30 March 2009 a Support Worker from the Amber Trust first met Father consequent to a referral from DMHS. The referral was accompanied by details of the DMHS risk assessment. The Support Worker provided Father with assistance to move into a house provided by Amber Valley Housing and maintain the tenancy. Mother acted as guarantor for this tenancy. Regular support visits by Amber Trust staff commenced on 15 April 2009.

8.5.7 BDS continued to have regular Health Visitor clinic contacts for weighing. No concerns for BDS were identified other than an episode of nappy rash.

8.5.8 On 1 May 2009 Amber Trust first had contact with Mother, in this case a telephone call in relation to the support that Father was receiving from Amber

Trust.

8.5.9 On 13 May 2009 there was evidence of improvement in Father's mental health and he was placed on "Open Contact"[13] by Consultant Psychiatrist 1. Fortnightly CPN input was continued. Father's Mirtazepine was reduced.

8.5.10 Over the following weeks concern regarding self neglect by Father was raised with DMHS professionals by the Amber Trust Support Worker and Mother. Assessment by the CRHTS identified low mood, after hearing that his father had suffered a stroke, but low risk of self harm, suicide or risk to others. There is reference to him having nightmares about his son. Visits from Father's CMHT Support Worker were stepped up and a CPA review was arranged. Father was given contact details for the CRHTS.

8.5.11 On 22 May 2009, Father was detained for shoplifting in a supermarket. Police officers attended and the incident was resolved using the Restorative Justice Model.

8.5.12 Following this Father informed Mother and her mother that he had had a panic attack whilst shopping. He stated that the shop had made him agree not to return as his collapse had frightened other customers. On this basis Mother and her mother agreed to accompany him to out of town supermarkets whenever he subsequently wanted to purchase food. Such trips took place late in the evening as Father expressed worry that he would have a further panic attack if the shop was busy.

8.5.13 On 2 June 2009 the Amber Trust Support Worker contacted Father's sister regarding his mental and physical health. The sister stated that she wanted no further contact regarding Father.

8.5.14 On 12 June 2009 BDS' case, which had been open to supervision between the Health Visitor and Named Nurse following the Police referral of the previous November was closed to supervision.

8.5.15 On 17 June 2009 CPNs from the CRHTS and South CMHT visited Father at home. He was discharged from home treatment due to his relative stability and a lack of acute mental illness.

8.5.16 On 26 June 2009 BDS had his routine one year assessment. This was delegated by the Health Visitor to a Community Nursery Nurse.

8.5.17 On 30 June 2009 a CPA Review meeting was held in respect of Father. Along with the Amber Trust Support Worker this meeting was attended by Mother, with BDS. It was agreed that Father would commence therapy with a Senior Clinical Psychologist who would, from that date, undertake the role of Father's Care Coordinator. The CMHT CPN would accordingly withdraw input and Father was continued on "Open Contact" with Consultant Psychiatrist 1.

[13] Open Contact" was an arrangement whereby a case was not formally open to a clinician but the client could access an appointment directly without referral. Whilst common practice in 2009 this practice has been discontinued by Derbyshire Mental Health Services NHS Trust as a consequence of their internal review into this case.

8.5.18 The Senior Clinical Psychologist's initial formulation of Father's issues was that he had difficulty accepting life transitions and processing issues emotionally, with an over-reliance on practical problem solving. Further emerging issues were distress intolerance and anxiety.

8.5.19 Into August 2009 Amber Trust support visits to Father increased due to concerns for his well being as his mental health declined.

8.5.20 On 13 August 2009, following a home visit, South CMHT Social Worker 2 referred Father to the CRHTS because of deterioration in his mental health. He was lethargic, preoccupied with losing a property in Spain and having panic attacks. Father had stopped taking his anti depressant medication.

8.5.21 Father was assessed as at significant risk of self-neglect and as presenting a low risk of suicide. A diagnosis of moderate depression and anxiety disorder, with secondary adjustment reaction to change in social circumstances was made and daily CRHTS contact offered. Diazepam was prescribed for symptoms of anxiety.

8.5.22 Mother was contacted by CPN 4 South and asked to provide care for Father by shopping. Consideration was given by the CPN to whether Mother qualified as an Informal Carer. It was decided that she did not meet the criteria for this and she was not acknowledged by healthcare professionals as such in the year before her death.

8.5.23 On 18 August 2009 Father's neighbour contacted Derbyshire Constabulary and expressed concern for his health. Police Officers found Father unwell and summoned an ambulance to take him to hospital. Father was seen by a CPN from the CRHTS in the Emergency Department. He presented as flat with retarded speech and attributed his condition to anxiety after stopping taking his prescribed medication. He expressed a preference not to be admitted and denied thoughts of self harm or suicide. He was escorted home by the CPN who observed him taking his prescribed medication.

## 8.6 **21 August 2009 to 31 October 2009**

8.6.1 On 21 August 2009 Father was assessed at home by GP 1 and Locum Consultant Psychiatrist 1 for admission under the Mental Health Act 1983. This resulted from his presentation with symptoms of severe depression and significant retardation, lack of insight into the need for medication and refusal of hospital admission. The application was not completed because Father agreed to be voluntarily admitted to the Radbourne Unit, Derby.

8.6.2 In an assessment conducted following Father's admission a low risk of violence to others was identified. There was some concern that Father may harm his child or Mother. This arose from Father's marked preoccupation with his son and his ability to provide for him. This responsibility, together with financial difficulties, was identified as significant stressors for Father. Protective factors were identified as Mother being supportive, Father's engagement with community services and his hospital admission.

8.6.3 Further assessment over the next few days on the ward did not identify these risks again and the view was reached that Father posed no risk to others.

8.6.4 Mother was identified as providing significant care for Father. During his stay on the ward, Mother and BDS visited him and it is recorded that these visits took place in the Family Visiting Room although he also had day leave from the ward in Mother's care.

8.6.5 On 1 September 2009 Father was discharged from hospital. He was prescribed Duloxetine and provided with daily input from the CRHTS, ongoing psychotherapy and anxiety management input.

8.6.6 A discharge letter was sent to the GP, highlighting that Father was deemed as posing no risk of harming himself or others but that there was a significant risk of self neglect.

8.6.7 After short term daily involvement from the CRHTS, Father was discharged from that service to the care of the Senior Clinical Psychologist. Thereafter, for a period of nearly 5 months, Father's mental health improved and stabilised.

## 8.7 1 November 2009 to 25 May 2010

8.7.1 On 8 November 2009 Mother and BDS attended a visit to the Senior Clinical Psychologist with Father. Mother tried to support Father to plan contact with his sister and a visit to his father but Father put up barriers to this. Mother is recorded as expressing the view that Father had a dependent personality.

8.7.2 The Senior Clinical Psychologist arranged for a Support Worker to undertake some exposure therapy[14] with Father as an adjunct to the work being done by the Clinical Psychologist.

8.7.3 During 2009 Mother met with a former boyfriend from her school days on a number of occasions. By January 2010 they had formed a close relationship and he moved in with Mother. Mother was no longer working and spent her time caring for BDS. She also visited her mother on an almost daily basis and on most days combined this with a visit to Father.

8.7.4 The relationship with Mother and her partner was known to members of Mothers' family although they were not made aware that he was living with her. Father was not informed of the new relationship at that time and there is

[14] Exposure Therapy is a treatment often used for anxiety disorders. The aim of exposure therapy is to enable a person to reduce their fear and anxiety, with the ultimate goal of eliminating avoidance behaviour, for example, drinking alcohol to prevent recurring upsetting memories. Exposure Therapy can be implemented by having a person exposed to thoughts, feelings, or situations that he fears, without avoiding them. This may be done by directly exposing someone to a fearful object, image, or situation (for example, introducing the individual to using public transport, or going shopping) or through the use of the imagination. By being exposed to fear and anxiety, the person can learn that anxiety and fear will decrease on its own, eventually reducing the extent with which specific thoughts, feelings, and situations are viewed as threatening and fearful. Exposure therapy may also be combined with teaching a person different relaxation skills, in order to build coping strategies to facilitate management of anxiety and eliminate avoidance behaviours.

no indication of him being informed until May 2010.

8.7.5 On 2 January 2010, following contact with NHS Direct the previous day, Mother attended the Minor Injuries Unit. She reported having trapped her fingers in a loft ladder and a small wound was treated.

8.7.6 On 26 January 2010, during a home visit, the Senior Clinical Psychologist noted a dramatic deterioration in Father's self care. Father continued to receive weekly input for anxiety management, daily telephone or face-to-face contact with his Amber Trust Support Worker and fortnightly contact with a psychotherapist.

8.7.7 At this time exaggeration in the information provided by Father regarding his background was identified by professionals; for example Father had claimed that his property in Spain was a 20 room villa when according to Mother it was a 3 bedroom house.

8.7.8 On 10 February 2010 Mother spoke with Father's Amber Trust Support Worker regarding his well being. Mother had concerns about Father's ability to look after BDS as he was not able to look after himself. She continued to not leave BDS in the sole care of his father.

8.7.9 During February and March 2010 Amber Trust support visits to Father were again increased due to concerns for his well being as his mental health declined.

8.7.10 On 6 March 2010 Father's Amber Trust Support Worker informed the Senior Clinical Psychologist that she had been unable to gain access to Father's house on 24 February and 2 March 2010. She reported that Mother had gained access and found Father with no food in the house, lying on a duvet on the floor and asking to be left alone. A joint home visit with the Senior Clinical Psychologist and CPN was arranged for the following day but no response was obtained at Father's address.

8.7.11 On 9 March 2010 Mother contacted Father's sister and expressed concern for Father's mental and physical condition. They made arrangements to meet the Clinical Psychologist and a CRHTS CPN at Father's address.

8.7.12 Someone was seen in the house but no response was obtained. Keys had been left on the inside of the door locks preventing Mother from gaining access using her key. Mother and Father's sister requested that the Police were called to secure access. They were reportedly informed by the DMHS professionals that to do so would infringe Father's human rights. The professionals then left the address. Mother and Father's sister thereafter purchased some food for Father and left it on the doorstep of his house.

8.7.13 On that date the Senior Clinical Psychologist completed a FACE risk profile of Father, identifying a significant risk of severe self neglect and a low risk of suicide. No risk to BDS was identified.

8.7.14 On 10 March 2010 Father's sister attempted to contact the Senior Clinical Psychologist by telephone on six occasions, leaving requests that he call her.

8.7.15 On 11 March 2010 access was gained by professionals to Father's address. A joint medical recommendation for admission under the Mental Health Act 1983 was completed by an Approved Social Worker from the South CMHT with Consultant Psychiatrist 1 and Father's GP. Father was negative about his current treatment plan. The assessors agreed to give him a further chance to engage over the next 14 days with the South CMHT Support Worker 1.

8.7.16 Mother was present with BDS at the start of this assessment but left after Father attempted to embrace BDS, expressing concern regarding the impact that the situation may have on her child.

8.7.17 On 12 March 2010 Father expressed anger to the South CMHT Support Worker 1 about the events of the previous day. He stated that he felt threatened and that he did not want involvement with CRHTS or his GP.

8.7.18 Over the next three weeks Father was seen by his GP on three occasions and his anger at mental health service provision appeared to have decreased. He was referred by the GP for Cognitive Behavioural Therapy.

8.7.19 Father cancelled an appointment with the Senior Clinical Psychologist on 18 March 2010. His CMHT Support Worker spoke to him offering a further appointment and enquiring after his wellbeing, which was reported as unchanged.

8.7.20 On 22 March 2010 Father met with his DMHS Support Worker prior to an outpatient clinic appointment with the Consultant Psychiatrist. At her encouragement they went for a drink to put him in a social situation. During this activity Father became angry regarding his treatment and his desire to understand his condition; swearing and raising his voice. He then became tearful.

8.7.21 At the subsequent outpatient clinic review with Consultant Psychiatrist 1, Father was angry and dismissive of input from all services. He was recorded as swearing and slamming his hands down. He then "stormed out" of the room. A decision was taken that in view of his anger, CMHT would not see Father at home.

8.7.22 Father continued on his antidepressants but it was speculated that Father may have a Narcissistic Personality Disorder. A plan was made for the Senior Clinical Psychologist to arrange a joint meeting with Consultant Psychiatrist 1 and Father.

8.7.23 The potential diagnosis was further discussed at a multi disciplinary meeting on 23 March 2010 and at a meeting between the Consultant Psychiatrist 1 and the Senior Clinical Psychologist the next day. At that meeting the Consultant Psychiatrist expressed the view that Father's difficulties related to his situation and personality difficulties, rather than depression. The risk of self harm and suicide were discussed but only self neglect was identified as a concern. It was agreed that inpatient treatment would be counterproductive and that long term psychodynamic psychotherapy would be an appropriate treatment.

8.7.24 The above perspective was outlined in a letter to Father's GP, with whom he

had a positive relationship and was continuing to engage. This letter highlighted a strong possibility of Narcissistic Personality Disorder; characterised by a very idealised view of himself, rigidity of thinking up to the point of lacking any empathy and some evidence of trying to control the whole situation which could be reinforced by his sickness role.

8.7.25 On 29 March 2010 Father's GP spoke with Consultant Psychiatrist 1 and the following day reviewed Father. The GP felt that Father was stable with no anger.

8.7.26 On 5 April 2010 the CMHT Support Worker 1 contacted Mother. Mother informed her that she had seen Father 6 times during the preceding month and had been taking him food as she believed he was not eating. She had however found food hidden in the house and expressed anger that Father may be manipulating her. Mother stated that she did not want to visit Father further.

8.7.27 The Senior Clinical Psychologist was informed about Mother's wish to withdraw from Father's care by the CMHT Support Worker 1.

8.7.28 On 6 April 2010 the GP referred Father for Cognitive Behavioural Therapy. This was on the basis that there had been only a partial response to medication and no response to supportive counselling.

8.7.29 On 13 April 2010 Mother, again pregnant, attended a booking visit with the Community Midwife involved in her previous pregnancy. She stated that the unborn child's father was her new partner of some 7-8 months. An enquiry was made about domestic abuse and no concerns were disclosed. Mother told her Midwife that she had stood by Father and done her best to support him, but there had been no progress and she wanted a life for herself and BDS. Mother said that the pregnancy was planned and that she was the happiest she had been.

8.7.30 Father was reported to be unaware of the pregnancy at this stage and they discussed telling him after the 12 week scan. The Midwife asked about contact between Father and BDS, and Mother reported no concerns.

8.7.31 Notification of Mother's pregnancy was forwarded to the Health Visitor with an expected delivery date of 26 November 2010.

8.7.32 On 19 April 2010 the Amber Trust Support Worker contacted CMHT to discuss difficulty in securing Father's engagement. She was informed of Father's anger on 22 March 2010 together with the CMHT decision regarding home visits.

8.7.33 On 20 April 2010 the CMHT Support Worker 1 made a number of unsuccessful attempts to visit Father. She informed the Senior Clinical Psychologist of this. He wrote a letter to Father, challenging him over his lack of engagement over the previous few days and about his lack of engagement with services in general. The letter also included reference to the potential change in diagnosis and highlighted the need for further assessment.

8.7.34 On 27 April 2010 a further home visit to Father was attempted by the CMHT

Support Worker 1 but although he spoke to her she was refused access.

8.7.35 On 4 May 2010 a CPA Review meeting was held by the Consultant Psychiatrist and Clinical Psychologist. Father had been invited but did not attend. It was recorded that Father's GP was arranging treatment for him through Improved Access to Psychological Therapies (IAPT)[15]. Father was discharged by the Consultant Psychiatrist 1. The Senior Clinical Psychologist remained as Father's Care Co-ordinator. It was agreed that the Clinical Psychologist would write to Father and ask him to contact the CMHT if he required their services; otherwise he would be discharged to the care of his GP.

8.7.36 On 14 May 2010 Mother had a scan at the Royal Derby Hospital, confirming that she was 12 weeks and 5 days pregnant.

8.7.37 On the 20 May 2010 a letter was sent from the Amber Trust to Father. This explained that if Father did not re-engage with the support on offer his period of support from the Trust would be ended.

8.7.38 Around this time Mother visited Father and informed him that she was in a relationship with her new partner. It is reported that Father had little reaction to being informed of this.

8.7.39 On 24 May 2010 Father rang his GP with complaints of headaches and nightmares. He was concerned that if he stopped his medication, he might relapse. An appointment was arranged for 28 May 2010.

8.7.40 During a home visit by his Amber Trust Support Worker on 24 May 2010 Father expressed dissatisfaction with the treatment that he was receiving. Father also stated that he felt isolated and did not know anyone except Mother and BDS. Further, that as Mother had met someone else he was worried about losing contact with BDS and another man taking his role. Father wanted the Support Worker to speak to Mother about his contact with BDS. It was explained to him that this was outside of the Worker's remit.

8.7.41 On 25 May 2010 Father's GP contacted Father by telephone and reassured him that the side effects of his medication would be discussed at their appointment.

8.7.42 On 25 May 2010 Father was discharged by the CRHTS as he was not engaging with them.

8.7.43 On that date Father met with Amber Trust support staff and attended an allotment project run by the Trust with service users. Father is described in case records as 'very sociable and chatty' during this support visit.

8.7.44 Also on 25 May 2010 Mother attended the Minor Injuries Unit with pain in her left hip and bruising to her right thigh caused when her car door was hit by a

[15] The Improving Access to Psychological Therapies (IAPT) Programme is a NICE initiative which aims to improve access to evidence based talking therapies in the NHS by implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

bus. There was no serious injury. She was referred to the GP for review of her hip and the pregnancy.

## 8.8 26 and 27 May 2010

8.8.1 Around 1530 hours on 26 May 2010 Mother contacted the Senior Clinical Psychologist and informed him that Father had been calling her earlier in the day. Father was reported to have said that he had slept rough, had written a suicide note and stated that his life wasn't worth living without his son. Mother stated that she had picked Father up and he had refused to get out of her car. The Clinical Psychologist urged Mother to be firm with Father and if necessary call the Police. BDS was with Mother at this time.

8.8.2 In a subsequent text message Mother informed the Clinical Psychologist that she had told Father of her new relationship and that she was pregnant. She wanted the Clinical Psychologist to be aware that Father may need support from the CRHTS. The Clinical Psychologist discussed these events, but not the information that Mother was now pregnant by her new partner, with a CRHTS CPN 4 South and with a Locum Consultant Psychiatrist 1. It was agreed that a joint assessment should take place the next day.

8.8.3 Father maintained his refusal to leave Mother's car and she drove him to a Police Station. Mother outlined events that day to Police Officers and informed them that Father had a history of depression and a Personality Disorder.

8.8.4 When officers went to speak to Father he initially refused to leave the vehicle, stating that his life was not worth living without his son and broke down in tears. He then began to walk away. Owing to these comments and the information shared by Mother, Father was detained under Section 136 of the Mental Health Act, 1983[16]. He was thereafter taken to the Radbourne Unit, Derby for assessment.

8.8.5 Once at the Radbourne Unit he was assessed by the on call Consultant Psychiatrist 3 and the on call Approved Mental Health Practitioner. The assessment concluded that Father presented no evidence on interview of a major mental illness. Further, that having denied suicide ideation or intent he did not require compulsory admission to inpatient psychiatric care. Father accounted for his behaviour as arising from difficulty in arranging access to BDS. The Police Officers were informed that Father was mentally stable. Father was then released from detention and taken home by the Police.

8.8.6 Staff at the Radbourne Unit stated to the Police Officers that they would inform Father's GP of the assessment. This was done by fax that evening.

8.8.7 The professionals assessing Father were also recorded by the Police Officers

[16] Section 136 of Mental Health Act 1983 provides a power for the Police to remove a mentally ill person from a public place to a place of safety, in order for them to be assessed by a doctor or by an approved mental health professional. The person cannot be detained for more than 72 hours, and any necessary care or treatment should have been arranged within this period.

as having stated that Social Care would be informed, although it is unclear whether this related to Children's Social Care or to services for Father. Within DMHS there is no record of this intention.

8.8.8 On 27 May 2010 Father was discussed within a CRHTS meeting. Attempts were made to reach the Senior Clinical Psychologist to engage him in the discussion but these were unsuccessful. On the basis that Father would not engage with services and that Father was making arrangements with his GP to manage his mental health needs it was decided not to accept Father for home treatment. The planned joint appointment was not pursued on the basis that Father had been assessed under Section 136 Mental Health Act 1983 in the interim.

8.8.9 On the morning of 27 May 2010 Father telephoned Mother to discuss seeing BDS. During the call he abused Mother, resulting in her putting the phone down on him. Later that morning Father again called Mother stating he was outside her house and asking to be let in. Mother contacted Derbyshire Constabulary and informed them that Father was at her address but stated that she did not require Police attendance at that time.

8.8.10 Mother later reported that she let Father in to play with BDS and that they spent the rest of the day together. Mother stated she agreed to this as she didn't want Father creating a scene again. Whilst at the park together Mother stated that Father said to her *"You're a fucking bitch for abandoning me and getting together with someone else and getting pregnant. I've given up everything to be with you, if you're going to make it difficult, I'll make it more so, you've no idea what I'm capable of, I'll kill you and take him with me."*

8.8.11 Following this threat Mother collected her partner from his work and together they dropped Father at his home. Mother informed her partner that she had been worried about getting away from Father if she was alone with him and BDS.

8.8.12 Mother is reported by her partner to have taken the threat made to her seriously and attended a Police Station, with him, at 17:13 hours to report this. It is also reported by Mother's partner that the officer speaking with Mother informed her that Father could either be warned or arrested and sought her views on this. Mother preferred that a warning be given, although her new partner preferred that he be arrested. A witness statement was obtained from Mother.

8.8.13 Over the following hours Father made 23 attempts to contact Mother by telephone, although none of these calls were answered. These were not reported to Derbyshire Constabulary.

8.8.14 Around 20:00 hours on 27 May 210 the investigating Police Officer contacted the Duty Bleep Holder[17] at the Radbourne Unit to discuss the outcome of the Section 136 Mental Health Act 1983 assessment of the previous day. She was informed that there was no record of such an assessment. The reason for the enquiry was not requested by the Radbourne Unit bleep holder. On

[17] The "bleep holder" is the senior member of staff on duty, responsible for the out of hours management of the Radbourne Unit as a whole.

the basis of a definitive statement that the information sought was not available the Police Officer did not share the reason for the enquiry.

8.8.15 After consulting with her supervisor and checking the Police National Computer the Officer formulated a plan to issue a harassment warning to Father.

8.8.16 At 22:10 hours that day two Police Officers visited Father's home address with the intention of issuing him with a harassment warning[18] to prevent any further unwelcome behaviour towards Mother. Father was unco-operative and his demeanour was considered strange. This led the Officers to conclude that he should be arrested and they did so for the offence of Threats to Kill.

8.8.17 Following the arrest of Father, the arresting Officers obtained details from Mother as the basis for completing an electronic Form 621 Domestic Violence Risk Assessment. The risk assessment indicated that Mother was at High Risk of homicide[19].

8.8.18 Father was seen by a Forensic Medical Examiner (FME) at the Police Station to assess his suitability for detention and interview. The FME asserted that Father was fit to be detained and interviewed but recommended that an appropriate adult should be made available during interview.

## 8.9 28 to 31 May 2010

8.9.1 Father was dealt with on 28 May 2010 by a Detective Officer who conducted two interviews with him under caution. Father had a Solicitor and Appropriate Adult[20] with him during the custody process. During the interviews Father denied the threats using such terms as *"That is absolutely nonsense, that is absolutely nonsense, I'm sorry, that is just pathetic"* and went on to say *"I would never hurt her, I would never hurt her and I would never hurt (BDS), in fact I've never hurt anybody in my whole life."* He also gave an account that differed to that of Mother regarding the events of 27 May 2010, most particularly in relation to events which had not been included by Mother in her witness statement.

8.9.2 Following the interviews the investigating Officer discussed the case with the Custody Sergeant. It was agreed that there was insufficient evidence available to ask the Crown Prosecution Service to make a charging decision. Further enquiries were required and it was agreed that these could not be completed within the available detention period. The Custody Sergeant decided that Father should be bailed for the enquiries to be progressed.

---

[18] Under the Protection from Harassment Act 1997 a warning used by a Police Officer as a means of formally indicating to an individual that their contact with another is unwanted and should cease immediately. Non compliance with such a warning would make the individual liable to arrest and prosecution.

[19] The Derbyshire Constabulary Domestic Violence policy (2008) explicitly identifies the Form 621 assessment as relating to risk of homicide.

[20] The appropriate adult who attended the interviews and custody process to represent the interests of Father was supplied by the Derbyshire Appropriate Adult Scheme (DAAS). This is an independent scheme provided by a registered charity that can be contacted by custody staff when no other appropriate adult is available to allow compliance with the Police & Criminal Evidence Act.

8.9.3 Father was released from Police custody at 14:50 hours on 28 May 2010 with a requirement that he return on 18 June 2010. The terms of Father's bail included a condition not to contact Mother either directly or indirectly other than through a solicitor to arrange access to BDS. This was explained to Father in the presence of his Appropriate Adult.

8.9.4 Mother was informed of Father's release. She stated that she intended to deliver some property from her home to him. This is reported by Mother's partner as being with the intention of removing any need for Father to visit her address. The investigating officer explained that this was not appropriate given the bail condition and that someone else should deliver the items. Mother's partner subsequently delivered the property to Father. When doing so he was invited to enter Father's house to discuss things. He declined to do so.

8.9.5 The Detective Officer progressed some of the outstanding enquiries soon after Father's release by speaking with Officers involved in previous incidents. Arrangements to obtain a further statement from Mother and to interview her partner, consequent to the information provided in Father's interview, were made for the following week.

8.9.6 On 28 May Father missed an appointment with GP 1 because he was still in Police custody at the time of the appointment. Father attended later, apologised and made an appointment for 1 June 2010.

8.9.7 The Amber Trust Support Worker visited Father's address on 28 May but getting no reply left a message stating that she would call again the next day.

8.9.8 In parallel with the ongoing investigation on the morning of the 28 May 2010, the "Form 621" risk assessment was viewed by staff in the Derbyshire Constabulary Domestic Abuse Central Referral Unit (DACRU). The assessment of risk was confirmed as "High".

8.9.9 Copies of the risk assessment were sent to the investigating Detective Officer and their supervisor.

8.9.10 On 28 May 2010 a fax message headed "Section 17[21] Child Referral" which included a copy of the risk assessment together with details of the incident record was sent to Children's Social Care. The precise time that the fax was transmitted has not been established.

8.9.11 The referral concluded with confirmation of the Police action that Father had been arrested. The referral was sent prior to Father being granted bail and therefore did not include details of this.

8.9.12 On the evening of 28 May 2010, Father's neighbour called Derbyshire Constabulary. She reported that Father was very upset at being told by the Police that he must not contact Mother or BDS and that he had mentioned feeling like grabbing his son.

8.9.13 Police Officers made attempts to contact Father without success. They also

[21] Section 17 Children Act 1989

contacted Mother to check on her welfare and establish whether Father had been in touch with her.

8.9.14 At 01:45 hours on the morning of 29 May 2010 Father answered the door to Police Officers then immediately climbed back into bed. When the Officers went to his bedroom to speak with him he said he was missing his son and had been suffering from depression. He refused any help, including an offer of transportation to the Radbourne Unit. He denied any thoughts of self harm and the Officers found no indication of him intending to do so or to harm anyone else.

8.9.15 Over the weekend of 29/30 May 2010 Father made a large number of telephone calls to his sister during which he is described as having been agitated. Father informed her that he had been arrested for threatening to kill Mother after she had told him she was pregnant by her new partner. He stated that he had not done this and that the Police had let him go as they believed him. Father's sister contacted Mother who provided her own account of events on 27 May 2010.

8.9.16 On Sunday 30 May 2010 Mother informed her mother of events on 27 May 2010. She also informed her mother that Father had taken to walking to the village where she lived and loitering in the vicinity of her house. She said that she kept the door locked in case Father attempted to enter. Neither Mother nor her partner reported these actions of Father to Derbyshire Constabulary.

8.9.17 Mother also told her mother that she had seen her cousin on Friday 28 May 2010 and had warned her to keep her house doors locked and not let Father in if he called there.

8.9.18 On Monday 31 May 2010 Father again had telephone conversations with his sister. In these he expressed annoyance that Mother had not brought BDS to see him and stated that he intended going to Mother's address. His sister attempted to dissuade Father from doing so but it was apparent that he was not convinced in this regard. Father's sister then contacted Mother to inform her of Father's agitation and the likelihood that he would call at her address. Mother stated that she would lock the door and not let Father in. She also agreed to contact the Senior Clinical Psychologist regarding Father's condition and request that he telephone Father's sister.

8.9.19 It is reported that Father did visit the vicinity of Mother's address on that day and walked up and down outside the house saying "He's living here, he's living here". Father was seen by a neighbour to knock on the door of Mother's house whilst the occupants were out. Neither of these events was reported to Derbyshire Constabulary.

**8.10 1 and 2 June 2010**

8.10.1 The fax referral to Children's Social Care was dealt with on 1 June 2010, the Tuesday after the Bank Holiday weekend. On that date a summary was made by a Business Service Officer within an Initial Contact record. This highlighted that the case had been deemed as High Risk by Derbyshire Constabulary and that the child's father had been arrested for Threats to Kill.

8.10.2 The Initial Contact record was passed to a duty Community Care Worker who created a Referral and Information record. This reiterated the information from the Initial Contact and added that Mother was still meeting with Father and there were concerns regarding the child's safety and domestic violence issues. The recommendation was that an Initial Assessment[22] was conducted.

8.10.3 A Children's Social Care visit was planned for 8 June 2010. A letter was prepared to inform Mother of this visit and placed in the post tray on 1 June 2010.[23]

8.10.4 The Referral and Information record was passed to the Children's Social Care Service Manager to confirm the action recommended. The Service Manager did so and passed the referral to the Reception and Assessment Team Service Manager incoming work box to await allocation.

8.10.5 On 1 June 2010 Mother sent a text message to Father's sister informing her that she had spoken with the Senior Clinical Psychologist and that he would be contacting her later that day[24].

8.10.6 On 1 June 2010 Father spoke with GP 1 on the telephone. He was distressed, stating that Mother had withdrawn access to his child and that he wanted help. Father also complained about lack of visits from the CMHT and that he had not had any ECT[25].

8.10.7 The GP agreed to contact the CMHT and suggested that Father contact the Citizen's Advice Bureau for legal advice about access.

8.10.8 Later that day Father again telephoned the GP. He complained of severe headache and stated that he wanted to stop his treatment. He was advised to attend the surgery the following day.

8.10.9 On 1 June the Amber Trust Support Worker called at Father's address but got no reply. She spoke with Father by telephone later that day. Father informed her that Mother had said he could not see BDS, that she had a new family and that he would never see BDS again. Father was described as very upset and anxious.

8.10.10 The Support Worker thereafter contacted Mother who recounted events over the previous week. Mother stated that Father wanted unsupervised contact with BDS but that that scared her. She also stated that she had an appointment to see a Solicitor on 9 June 2010. Mother was concerned that Father would see this as too long a delay and be seen as her being awkward. Mother requested that the Support Worker contact Father and inform him that seeking legal advice had been advised by the Police. When the Support

---

[22] Working Together to Safeguard Children (2010 5.38-47)

[23] This letter was never sent, having been retrieved by a Service Manager following notification of the deaths of Mother and BDS.

[24] It has since been established that Dr R was on leave that week and that Mother had in fact left a message for him rather than speak directly with him.

[25] Father had previously been informed by DMHS professionals that ECT was unlikely to benefit him.

Worker recontacted Father he kept repeating “I need to see my little boy”.

8.10.11 Around 21:30 hours on 1 June 2010 Father’s sister contacted Father by telephone. During this conversation Father reiterated concerns about contact with BDS. In contrast to previous contact he was however not agitated; being described by his sister as very calm.

8.10.12 On 2 June 2010 Father was seen by GP 1. Father was distressed. He focussed on his perceived lack of input for his mental health problems, access to his son and the importance to him of ongoing involvement in his son’s upbringing.

8.10.13 At the start of the consultation, Father made what was perceived by the GP to be a verbal threat, stating “This is going to be one of the most important days of your career”. The GP challenged this, saying "that sounds like threat to me. What do you mean?” Father immediately retracted his remarks.

8.10.14 The GP was very concerned that the issue of access to his son could cause significant deterioration. He planned to talk to Father’s Psychiatrist.

8.10.15 A management plan was agreed with Father, including that Father would be reviewed by a different GP the following week, when Father’s GP was on annual leave. The GP also referred Father back for Cognitive Behavioural Therapy.

8.10.16 As Father was leaving, he came back into the room to confirm the arrangements and to thank the GP for the time he had spent with him. He also apologised again for the threat.

8.10.17 Around 07:30 hours on the morning of 2 June 2010 Mother’s partner left Mother’s address for work leaving Mother and BDS at the house. He locked the door behind him and posted his keys through the letter box.

8.10.18 That morning Mother contacted her mother by telephone and arranged to reschedule a planned shopping trip until the following day as it was raining.

8.10.19 Around 11:00 hours that morning a neighbour of Mother heard a female screaming. She looked into Mother’s house through the lounge window and could see the head and shoulders of Mother. Mother shouted to the neighbour to call the Police. The neighbour called 999 at 11:03 hours. This call was graded as requiring an immediate response and Officers were dispatched to the address, arriving at 11:15 hours.

8.10.20 The Police Officers found all doors locked from the inside and all ground floor windows closed. They immediately forced entry to the premises and found Mother, Father and BDS apparently deceased upon the lounge floor. BDS was lying upon his back on the floor having received 16 stab wounds; Mother was kneeling on the floor having received 32 stab wounds; and Father was slumped over on top of Mother having received 18 stab wounds. A knife was recovered from Father’s lap.

8.10.21 An ambulance was summoned at 11:17 hours and the first paramedic arrived at 11:30 hours. Attempts were made to resuscitate BDS at the scene, en

route to the Royal Derby Hospital, and then in the Emergency Department. These were however unsuccessful and BDS was declared dead at 12:16 hours.

8.10.22 Mother and Father were confirmed to be dead at the scene at 11:50 and 11:53 respectively.

8.10.23 Both sets of keys for Mother's house and her mobile telephone were found by Police in Father's pocket.

8.10.24 The death of BDS and Mother were treated as murder by Derbyshire Constabulary although no-one outside of those who died was sought in connection with the killing. An Inquest was held by HM Coroner in September and October 2013. The jury decided that BDS and Mother had been unlawfully killed and that Father had taken his own life.

# ANALYSIS

## 9 Analysis of Agency Involvement

### 9.1 December 2007 to September 2008

9.1.1 When Mother booked for her antenatal care with the Community Midwife on 5 December 2007 (see 8.2.1) an effective social and family history was not recorded. No information was recorded in respect of Father at that time or in subsequent contacts. Further, although Father attended a number of appointments, neither this nor observations on his role in relation to the pregnancy were documented.

9.1.2 National guidance[26] requires a holistic and family based approach. The importance of recording a full history of both parents was also highlighted by a previous Serious Case Review in Derbyshire[27]. It would be expected that information about the father, including his health, would be asked at the first appointment.

9.1.3 That this did not take place is attributed by the RDH IMR and Health Overview author to the documentation used and accepted practice in the Midwifery Department at that time.

9.1.4 Improved documentation combined with a culture of professional curiosity would present opportunities to gain a fuller picture of parenting capacity and the environment into which the child would be born. This is addressed in the recommendations of the RDH IMR.

9.1.5 Throughout the period under review both the Midwife and Health Visitor remained unaware of Father's mental health problems. Mother had a number of contacts (e.g. 8.2.18; 8.5.14; 8.7.29) with professionals during which she had opportunity to inform the professionals of this aspect of her life and discuss its impact on her and BDS. She never did. A number of possible reasons for Mother deciding not to do so present themselves but this issue remains unresolved.

9.1.6 Mother is reported to have had a very warm relationship with her Midwife, to the extent of embracing her when they met. She is described by the Midwife in unusually glowing terms. The Health Overview highlights that while the nature of this relationship in part reflected Mother's nature, it could potentially implicate the Midwife in a culture of over familiarity. The DCHS IMR also highlights evidence that the nature of Mother's relationship with the Health Visiting team may have blurred professional boundaries.

9.1.7 There is no evidence that this impacted on the gathering of information from Mother but it risked making objective questioning and assessment more difficult. The DCHS IMR makes an appropriate recommendation regarding training in this area.

[26] Nursing and Midwifery Council Guidelines for Records and Record Keeping (2008)
[27] Derbyshire Safeguarding Children Board Serious Case Review in respect of Baby R (March 2007)

9.1.8 Notification of Mother's pregnancy to the Health Visiting team (see 8.2.3) did not result in an antenatal visit being conducted as required by the local Core Programme for Health Visiting Services[28]. There were no identified additional needs and the Health Visitor, incorrectly perceiving her workload to be high[29], decided not to undertake the visit. This undermined the intended benefits of the Core Programme; to promote contact with families, the identification of vulnerabilities within them and provision of appropriate services. The Health Visitor's manager was not made aware of this decision. The issue is being addressed by DCHS.

9.1.9 On 29 April 2008, Father was seen by his GP (see 8.2.5). It is unclear how aware the GP was of Father's history at the time of making the referral to DMHS. A discharge letter from mental health services in Surrey was received by the GP shortly afterwards. That included a self assessment questionnaire completed by Father which was an effective practice initiative.

9.1.10 The deterioration in Father's mental health which led to his GP making a further referral to DMHS on 15 May 2008 appears to have been associated with a period when Mother was away from Derbyshire, working in London. This association between the periods of decline in Father's mental health and the absence of access to Mother is a recurring theme during the period under review.

9.1.11 The DMHS response to Father's needs following the referral made by the GP on 15 May 2008, (see 8.2.6 to 8.2.10), including engagement of the Care Programme Approach, was appropriate. The assessment conducted identified no risk to children but it would have been appropriate to make the health professionals concerned with Father's unborn child aware of his situation. Had this occurred it would have enabled a more holistic view of the family to be taken and prompted at least completion of a pre assessment checklist. This is designed to help a practitioner decide if a Common Assessment Framework (CAF) assessment is indicated.

9.1.12 Neither the GP nor the DMHS professionals did so. This lack of focus on the child and the potential impact of parental mental health problems by professionals is a theme that is discussed further in section 15 of this report.

9.1.13 On 15 June 2008, when Mother was 8 months pregnant, Father was admitted to the Hartington Unit (see 8.2.12) for a 3 week period. There is no evidence that the impact of Father's mental health on his unborn child was considered. The admission was not shared with any professional focussing on that child.

9.1.14 It was identified and recorded (see 8.2.13) that Mother was an informal carer for Father. The National Carer's Strategy (2008) defines a carer as "someone who spends a significant amount of their life providing unpaid support to family or potentially friends, caring for a relative, partner or friend who is ill, frail or disabled or has mental health or substance misuse problems". The Trust Care Programme Approach and Care Standards Policy and

[28] Derbyshire Community Health Services Core Programme for Health Visiting (2007)

[29] It has been established that the Health Visitors workload was in line with 50% of Health Visitors in England and that she was supported by a part time Community Nursery Nurse.

Procedures[30] state that informal carers providing support for mental health service users will be identified and supported appropriately. It was recorded that Mother had no identified needs. There is no evidence that this position was based on a formal assessment or that Mother was consulted.

9.1.15 The role of Mother as an Informal Carer is a theme discussed further in section 17 of this report.

9.1.16 Information on Mother's intentions following the birth of BDS (see 8.2.15) was appropriately shared by the hospital with relevant health professionals.

9.1.17 The post natal family assessment (see 8.2.17) undertaken by the Health Visitor did not elicit from either parent information regarding Father's mental health problems. Routine enquiry at antenatal and new birth contacts regarding parental mental health was included in the Health Visiting Programme until 2009[31].

9.1.18 The Health Visitor had also, as outlined above, not been informed of Father's mental health issues by either DMHS professionals or the GP. The Health Visitor was based in the surgery of Father's GP and had access to his records. There would however have been no expectation that the Heath Visitor would access these records or have an awareness of them unless alerted to the issue.

9.1.19 The approach to future Health Visitor contacts agreed with Mother was appropriate to the level of need identified and in line with relevant policy[32]. Had the Health Visitor been aware of Father's mental health issues, an enhanced programme of contact might have been put in place, to support the family and to review the impact on BDS.

9.1.20 Father's request in September 2008 that BDS receive his immunisations a week early (see 8.2.19) was unusual owing to Father's determination that this take place and the pressure that he exerted to achieve it.

9.1.21 The DCHS IMR suggests that this indicates that he was not prioritising the child's needs. It could be equally argued that he was trying to protect BDS prior to a trip abroad.

9.1.22 The Health Visitor appropriately escalated and sought advice on the request. It would also have been appropriate to seek advice from the GP. More effective communication arrangements within the GP Surgery would have facilitated this. It is probable that had the GP been consulted the Health Visitor would have been alerted to Father's mental health issues.

## 9.2 October 2008 to 21 December 2008

[30] Derbyshire Mental Health Services NHS Trust Care Programme Approach and Care Management Policies and Procedures (2009). This has since been superseded by the Derbyshire Mental Health Services NHS Trust Policy for Assessing the Needs of Carers (2010) which states that carers who provide substantial and regular care for an individual, for which they are not paid a salary or fee, are legally entitled to an assessment of their caring, physical and mental health, leisure, educational and employment needs.

[31] With the adoption of the "Tynedale Health Needs Assessment tool" at antenatal and new birth contacts

[32] Derbyshire Community Health Services Core Programme for Health Visiting (2007)

9.2.1 The response provided by Surrey and Thames Valley Police on 24/25 October 2008 (see 8.3.1 to 8.3.4) was appropriate. Mother did not report the incident involving the pushchair being thrown by Father as an assault. The reason for Mother subsequently (see 8.3.8) informing Derbyshire Constabulary that she had been assaulted and that this was being dealt with by Surrey Police is unknown.

9.2.2 The referral of information regarding the missing person report to Derbyshire Children's Social Care and to the DCHS Named Nurse by their corresponding agencies in Surrey (see 8.3.11 & 8.3.14) was effective practice. That Mother had not reported the alleged assault however undermined both the potential for the referral to enhance professional understanding of the family situation and the significance attached to the notification.

9.2.3 The referral was appropriately recorded by Children's Social Care (see 8.3.11-12). It was identified that further information was required from Surrey. The record should not therefore have been closed without obtaining that information. Further, the suggested motivation for the report by Father was to gain custody of BDS. Although no concerns for the safety of BDS were identified in the referral this should have prompted contact with Mother rather than relying upon an assurance from Father that all was well. At the very least Mother should have been notified that a referral had been received in respect of BDS. The rationale for the decisions taken has not been established.

9.2.4 The case was not subject to oversight and sign off by a manager. This militated against these shortcomings being identified and addressed.

9.2.5 Within DCHS the referral was discussed at supervision (see 8.3.14). It would also have been good practice for the Health Visitor to discuss the referral with the GP. BDS had been seen to be safe and well since the incident and the referral did not identify concerns for his safety. The plan to discuss it with Mother at the next opportunity to see Mother alone was therefore appropriate. The outcome of that conversation was not recorded prior to the case being closed to supervision (see 8.5.12) as it should have been.

9.2.6 When Mother contacted Derbyshire Constabulary on 26 October 2008 (see 8.3.8-10) the recording of the incident as "Nuisance" was inappropriate. The reported situation, that Mother reported feeling unsafe and her reference to being assaulted two days previously should, have prompted recognition that the incident met the criteria for domestic violence[33]. That Derbyshire Constabulary had no record of such an assault should not have affected this. The incident was also not recognised as involving domestic abuse by the attending Officers.

9.2.7 The approach to dealing with such incidents encompassed by the force's Domestic Violence Policy was not engaged. The circumstances would not have presented the basis for a different immediate approach or met the

[33] Defined in the Derbyshire Constabulary Domestic Violence Policy (2008), in accordance with ACPO Guidance, as "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional between adults, aged 18 or over, who are or have been intimate partners or family members, regardless of gender".

criteria[34] for referring them to any other agency. Having the incident recorded as Domestic Abuse would however, as identified in the Derbyshire Constabulary IMR, have put the circumstances on the radar of officers dealing with subsequent events. It is unclear why this recognition as domestic violence did not occur.

### 9.3 22 December 2008 to 9 February 2009

9.3.1 In December 2008 Father was appropriately discharged from DMHS in anticipation of a long absence in Spain (see 8.3.15).

9.3.2 When Father returned shortly afterwards, following deterioration in his mental health, the process of his re-engagement with mental health services was uncertain and protracted (see 8.4.1-15). Neither Mother nor Father's GP were clear on or able to effectively negotiate the pathway to accessing services over the following weeks.

9.3.3 The DMHS response to the Father's situation is highlighted by the DMHS IMR as not following agreed procedure in line with the Care Programme Approach standards of good practice. As Father had been discharged only recently he should have been able to resume his engagement with DMHS, rather than being treated as a new referral. It appears that a significant factor in this not happening was that Father was staying with Mother in the one CMHT area whereas services had previously been provided by another CMHT. It would have been appropriate and in accordance with CPA standards for the two CMHTs to have arranged a joint visit to coordinate resumption of service provision to Father. The DMHS IMR does not clarify why this did not take place.

9.3.4 A consequence of the difficulties in Father's re-engagement with DMHS was that there was no plan of care for him in place over the Christmas 2008 period. On 26 December 2008 Mother contacted the Hartington Unit at Chesterfield to say she could not cope and was advised to take Father to the Emergency Department (see 8.4.3-8). The Derbyshire Constabulary response to Father's refusal to leave Mother's car, facilitating Father's assessment by the hospital Mental Health Liaison Team (MHLT), was properly dealt with as relating to Father's mental health issues. It seems likely that having handed matters over to the MHLT there was an assumption, reasonable in the circumstances that all issues including consideration of the impact on Mother and BDS would be picked up by those professionals.

9.3.5 Appropriate regard for BDS' welfare was taken by the MHLT staff (see 8.4.6). On the basis of the information provided, the MHLT assessment of minimal risk seems reasonable, although it should have been more fully recorded.

9.3.6 Neither the mental health professionals involved in these events, or Mother, informed the Health Visitor of the incident. Although no immediate risk to BDS had been identified it should have been recognised that the Health

[34] Domestic Abuse and Safeguarding Children Protocol Between Derbyshire County Council Social Care and Derbyshire Constabulary

Visitor had a need to know of such an incident involving BDS' parents.

9.3.7 Following his registration at the Amber Valley GP Practice (see 8.4.12) Father was seen mainly by one GP. That doctor has indicated, although this was not effectively documented, that risk to BDS had been considered throughout the following period but that Father was not considered to present a significant risk. There is no evidence that this consideration extended to the impact that caring for Father would have on Mother and her ability to prioritise the needs of BDS.

9.3.8 Given the established relationship between parental mental illness and increased risk to children[35] it would have been appropriate for the GP to discuss this with the family Health Visitor; and following Mother booking with her second pregnancy, with her Midwife. This did not happen and both of these professionals remained unaware of Father's mental health issues throughout the period covered by this Review.

## 9.4 10 February 2009 to 20 August 2009

9.4.1 The difficulty in accessing mental health services for Father continued into 2009 and it was February before he was assessed (see 8.5.3-4). This was shortly after a private practice Counsellor contacted by Father intervened (see 8.5.1-2) with DMHS. There is no indication that the concerns for BDS' welfare expressed by the Counsellor were addressed in the DMHS assessment process. The relevant sections of the assessment record were left uncompleted.

9.4.2 Over the following months the service provided by DMHS was appropriate to Father's level of need and diagnosis.

9.4.3 From April 2009 the Amber Trust supported Father consequent to a referral from DMHS (see 8.5.6). The referral was accompanied by details of the DMHS risk assessment and Amber Trust relied upon this rather than utilise their own risk assessment process as they should have done. The Amber Trust Support Worker thereafter demonstrated commendable commitment to addressing Father's needs and engaging with others who featured in his life, particularly Mother.

9.4.4 Mother continued to play a key role in caring for Father and in identifying changes in his condition to DMHS professionals (e.g. 8.5.5 & 8.5.10). There is no evidence that any professional considered the impact that this might have on Mother or BDS. Her role as an Informal Carer for Father was not revisited.

9.4.5 By the end of May 2009 significant concerns for Father were being reported. The DMHS IMR identifies Father had developed a pattern of deterioration in his mental health in response to events or changes that were a source of stress to him. This manifested as refusal to go out, low mood, withdrawal and self neglect.

---

[35] National Institute for Clinical Excellence (NICE) Guidance "When to Suspect Child Maltreatment" (2009)

9.4.6 Information provided by Mother's family indicates that manipulation of Mother and her mother by Father became an increasing feature of their relationships from this time. This was most notable in Father securing their involvement in late evening shopping trips (see 8.5.11-12) on the basis of a distorted account of his exclusion from a local supermarket. There is no record of this development or its purported basis being shared with DMHS or Amber Trust professionals.

9.4.7 At the beginning of June 2009 father informed a DMHS professional that he was having nightmares about his son (see 8.5.10). The record of this was unsigned and there is no evidence of any action being taken as a result. This represents a missed opportunity to consider specifically the role that BDS played in the mental health of Father, especially as contact and access to his son featured commonly in Father's conversation.

9.4.8 In June 2009 BDS had a routine one year development review (see 8.5.16). This was delegated by the Health Visitor to a Community Nursery Nurse and the assessment did not include a family health review. This was not in accordance with the Core Programme for Health Visiting. Any proposal to deviate from the Core Programme should have been discussed with the Health Visitor's manager. This did not take place and the practice was not recognised by the management oversight arrangements in place. Enhanced supervision and case audit arrangements have since been introduced in March and September 2010, along with training for Health Visitors on the Core Programme.

9.4.9 A CPA Review meeting was held at the end of June 2009 (see 8.5.17), when the Senior Clinical Psychologist took over the role of Care Co-ordinator. Thereafter Father engaged with a number of mental health professionals and accessed some therapies offered. He chose his preferred therapeutic modalities, e.g. preferring not to have medication and stopping it on a few occasions. He also requested ECT on a number of occasions. It was properly made clear to Father some of these therapies were not appropriate to his condition.

9.4.10 Contrary to DMHS policies there was no documented CPA Care Plan in place for Father from this point onwards. The DMHS IMR states that the Care Co-ordinator did have a plan, that the involved professionals were aware of their roles and responsibilities and that care reviews were recorded. At the inquest it was reported that day to day communication within the team immediately responsible for the care of Father was good.

9.4.11 The absence of a documented plan would make service provision difficult, particularly in an organisation such as DMHS with many different teams and where professionals from other agencies were involved. It was also likely to affect the ability of professionals providing responses to future crises in Father's mental health to understand the overall context of his condition and care.

9.4.12 This would undoubtedly have been exacerbated by the disparate record systems operated by DMHS, with seven separate sets of notes on Father held. Some of the records contained duplicated, undated and inaccurately dated documents which were not filed chronologically; along with plan

elements which were not 'SMART'[36]. This did not comply with the DMHS record keeping policy[37]. The DMHS IMR rightly recognises the need to resolve this systemic issue and makes an appropriate recommendation in that regard.

9.4.13 Putting Father on "Open Contact"[38] with the Consultant Psychiatrist (see 8.5.9 & 8.5.17) was permissible and normal practice within the policies operating at that time. It was however likely to undermine clarity regarding ownership of Father's care and it is appropriate that DMHS has now discontinued the practice.

9.4.14 By the middle of August 2009 Father's mental health had again deteriorated, leading to a further period of active involvement by the CRHTS (see 8.5.20-21). In connection with this the issue of Mother being an Informal Carer for Father was specifically considered by a CPN (see 8.5.22). A plan was made to establish if Mother qualified as such and to offer a carer's assessment.

9.4.15 The CPN decided that Mother did not meet the criteria for being an Informal Carer as she was not a "formal (sic) or regular carer". This decision was not consistent Mother being the key person supporting and caring for Father. She had provided him with accommodation at her mother's house, ensured that he had food and intervened when there was deterioration in his wellbeing. This represented a missed opportunity to assess the impact of caring for Father on Mother (and BDS) and to make appropriate support available to her. This issue was not considered again by any professional within the period under review.

9.4.16 Father's deteriorating mental health and self neglect was accompanied by deterioration in his physical health.

9.4.17 On the evening of 18 August 2009 the service provided to Father by all agencies in response to the neighbour's concerns for his welfare (see 8.5.23) was appropriate in relation to his mental health. The physical wellbeing of Father should have been given equal consideration and action taken to ensure that this was addressed. A referral to Father's GP would have been appropriate.

9.4.18 At the Emergency Department Father's role as a parent was not identified by hospital staff and no consideration was given to the impact that Father's condition might have on his child. The RDH IMR highlights that the constraints of the Emergency Department recording system may have contributed to this but that embedding a "Think Family" practice culture would avoid the necessity of relying upon such prompts.

---

[36] Specific, Measurable, Achievable, Realistic, Time-bound.

[37] Derbyshire Mental Health Services NHS Trust Minimum Standards for Clinical and Practice Records (2008)

[38] [38] "Open Contact" was an arrangement whereby a case was not formally open to a clinician but the client could access an appointment directly without referral. Whilst common practice in 2009 this practice has been discontinued by Derbyshire Mental Health Services NHS Trust as a consequence of their internal review into this case.

## 9.5 21 August 2009 to 31 October 2009

9.5.1 On 21 August 2009 Father was admitted to the Radbourne Unit for assessment (see 8.6.1). Consideration had been given by his GP and a Consultant Psychiatrist to formal admission under the Mental Health Act 1983 but this was not pursued after Father agreed to be admitted voluntarily. This was appropriate, as was the decision to keep the issue of compulsory admission under review.

9.5.2 At the beginning of this admission a risk of harm to Mother and BDS, albeit a low one, was identified (see 8.6.2).

9.5.3 Father engaged well during the admission and subsequent risk assessments indicated a rapid reduction in his preoccupation with BDS. The assessed level of risk was accordingly reduced. Notwithstanding this the risk should have been addressed, particularly in relation to the contact that Father was having with BDS during visits to the ward with Mother. It would have been appropriate to have discussed this within the multi-disciplinary team, including Father's Care Coordinator, and with the Trust's Named Safeguarding professionals.

9.5.4 Consideration should also have been given to informing Mother of the assessed risk and notifying Father's GP. Communication to those involved in his care that when Father's mental health had deteriorated he had been assessed, even transiently, as posing a risk to BDS would have raised awareness of a potential risk during future similar episodes.

9.5.5 BDS' visits to the Radbourne Unit (see 8.6.4) took place within the Family Visiting Room and he was accompanied by Mother as required by the DMHS Visiting Policy and Child Visiting Procedures[39].

9.5.6 There is no indication that the visits were subject of the multi-disciplinary team assessment required by the DMHS policy, which should have included consideration of the risk issues identified on admission. The policy also requires that contact be made with Children's Social Care and the family Health Visitor to inform the assessment. This did not take place. The DMHS IMR attributes this to a lack of awareness of the policy by staff. This represents a significant missed opportunity to share relevant information which would have alerted both agencies to Father's mental health issues. It is uncertain whether this would have led to the responses provided to the referrals received from Surrey at the end of 2008 being revisited or to an active response at that time. It would have led to the response provided to future contact with the family being better informed.

## 9.6 1 November 2009 to 25 May 2010

9.6.1 Although Mother had started a new relationship by January 2010 (see 8.7.3)

[39] Derbyshire Mental Health Services NHS Trust Visiting Policy / Child Visiting Procedures (December 2005). These procedures were withdrawn in March 2010 and the procedures subsumed into the Trust's Safeguarding Children Policy. They were however in force in August 2009.

all indications are that that Father was not aware of this at that time. It is unclear when Father did learn of Mother's new relationship although she had certainly informed him of this by the latter part of May 2010.

9.6.2 Father had seen a range of GPs prior to March 2010, with little continuity. In March 2010, GP1 saw Father and made a deliberate effort to engage him and become involved in his long term management, with some success. It was good practice for the GP to actively work with an individual who was sceptical to encourage engagement and provide some continuity of care. The PCT Medical Director's review of the medical management by the GP identifies that this was appropriate.

9.6.3 The GP was aware of BDS, having seen him at Father's home with Mother. He was also aware that although the parents lived apart Mother was keen for Father to maintain contact with his son and facilitated frequent, but supervised, contact.

9.6.4 The GP has stated that he explicitly considered risks to BDS, although this was not recorded. He did not identify a cause for concern and decided not to inform the Health Visitor or Midwife of Father's mental health problems. It would have been appropriate to do so given the extent of professional involvement with Father and the potential impact on BDS and on Mother's parenting capacity.

9.6.5 On 9 March 2010 Mother and Father's sister requested that DMHS professionals call the Police to secure access to Father's address (see 8.7.11-12). The rationale for them declining to do so was not recorded. It is clear they intended to take further action in relation to Father's condition but this could have been more effectively communicated to Mother and Father's sister.

9.6.6 The completion of a FACE Risk Profile in respect of Father (see 8.7.13) was appropriate as was the plan for a joint assessment under the Mental Health Act 1983 the following day. That the profile was undated undermined its ability to enable professionals accessing the records in the future to understand Father's mental health at that point in time.

9.6.7 On 10 March 2010 the calls made by Father's sister to the Clinical Psychologist (Dr R) (see 8.7.14) were not returned. The DMHS IMR states that the Psychologist attributes this to an oversight and has apologised to Father's sister for this. This represented a missed opportunity to obtain input and possibly a fresh perspective from a family member, notwithstanding that the psychologist would not have been in a position to discuss Father's case with her.

9.6.8 On 11 March 2010 a joint medical recommendation for hospital admission of Father under the Mental Health Act 1983 (see 8.7.15-16). Mother was visiting Father when the health professionals arrived. She left shortly afterwards expressing concern regarding the impact of Father's reaction on BDS. There is no evidence that this prompted professional consideration of the impact on BDS' welfare of Father's condition.

9.6.9 Although angry at the action taken by professionals on 11 March (see 8.7.17

& 8.7.20-21) Father did engage with the Support Worker. By 23 March 2010 (see 8.7.23) it had in any event been decided that inpatient treatment for Father would be counterproductive.

9.6.10 Amber Trust was informed of the DMHS decision not to conduct further home visits on safety grounds (see 8.7.32). Amber Trust staff had seen Father since his outbursts with DMHS professionals and he had not been aggressive towards them. The Amber Trust Support Worker did not therefore consider changes their service delivery were required. This should have been the subject of risk assessment within that organisation.

9.6.11 In March 2010 Father's condition was discussed by DMHS professionals, including consideration of whether he may have a Narcissistic Personality Disorder or Dependant Personality Disorder with narcissistic traits (see 8.7.22-24). Following the meetings Father's GP was advised that there was a strong possibility of Father having a Personality Disorder.

9.6.12 Notwithstanding that there was not then or subsequently a diagnosis of Personality Disorder, this new perspective on Father's condition was not accompanied by a review of his risk profile as it should have been.

9.6.13 The possibility of a Personality Disorder contributing to Father's condition is discussed further at section 16 of this report.

9.6.14 When Mother booked with the Midwife for her second pregnancy (see 8.7.29) an effective family and social history was not recorded. No information regarding the unborn child's father apart from his name was obtained. The analysis in respect of Mother booking for her first pregnancy (see 9.1.1-4) is equally relevant to this.

9.6.15 Mother's reference to having stood by Father and now wanting a life for herself was not understood by the Midwife. She questioned whether this related to financial or career issues and was advised that it did not. Had this been fully explored it is likely that a greater understanding of the relationship with Father of Mother and BDS would have been gained. It is uncertain whether this would have included Father's mental health issues even if this had been subject of a direct question.

9.6.16 At the start of April 2010 (see 8.7.26-27) Mother informed Father's CPN that she did not wish to have a role in caring for him any longer. The Senior Clinical Psychologist was informed of this. There is no indication that it was shared with Father's GP. As Mother had not been identified as an Informal Carer for Father this information had minimal impact on the way the DMHS were responding to Father's condition or Mother's role in this. Mother continued to be in contact with the Care Coordinator over the succeeding days regarding the provision of services to Father.

9.6.17 In parallel with Mother discovering that Father had lied to her, professionals also identified a number of discrepancies in the information given by Father. This dated as far back as December 2008, when he informed Emergency Department staff that he had had no previous mental health care. That this had not been detected earlier is attributable to the previously noted inadequacies of the DMHS documentation, making triangulation of

information problematic.

9.6.18 During April 2010 there was an increasing disengagement by Father from services (see 8.7.33-34) although his mental health and, through self neglect, physical health were declining. This was accompanied by moves towards disengagement by DMHS professionals.

9.6.19 Key decisions were made at the CPA Review meeting on 4 May 2010 (see 8.7.35) attended only by the Consultant Psychiatrist and Clinical Psychologist. Other potential invitees, including Father's GP, his Amber Trust Support Worker and Mother were not invited and no arrangements were put in place to facilitate them contributing to the review. Father's CPN has stated that no others were invited to avoid intimidating Father with a room full of people. The Clinical Psychologist attributes this to an oversight.

9.6.20 At the meeting Father was discharged by the Consultant Psychiatrist. This was not conducted in line with DMHS procedures, which would require a planning meeting attended by Father and significant others including his GP. As Father had effectively ceased engaging with the psychiatrist, a phased discharge was not practicable.

9.6.21 Father's Care Coordinator also seriously considered complete discharge from DMHS services, with responsibility for Father's mental health care being transferred to his GP. This was not enacted and the Senior Clinical Psychologist remained as Care Coordinator. Responsibility for management of Father's condition was however effectively delegated to his GP1 with treatment arranged through Improved Access to Psychological Therapies (IAPT)[40]. The Senior Clinical Psychologist has stated that this approach was made in recognition of a reasoned decision by Father to access treatment through his GP.

9.6.22 In the context of an emerging view that Father's condition may be contributed to by a Personality Disorder this delegation was not advisable without robust arrangements being in place to provide advice and support to the GP (see 16.7).

9.6.23 The approach by DMHS was mirrored by Amber Trust (see 8.7.37) later in May 2010, when they wrote to Father advising that they would discharge him if he did not engage with their services. Engagement by Father with this service thereafter showed signs of improvement (e.g. 8.7.43).

## 9.7 26 and 27 May 2010

9.7.1 Mother contacted the Clinical Psychologist on 26 May 2010 and informed him that Father was refusing to leave her car (see 8.8.1). The advice given, to be firm with him and if necessary call the Police, was appropriate. There is no

[40] The Improving Access to Psychological Therapies (IAPT) Programme is a NICE initiative which aims to improve access to evidence based talking therapies in the NHS by implementing *National Institute for Health and Clinical Excellence (NICE)* guidelines for people suffering from depression and anxiety disorders.

evidence that Mother disclosed that BDS was with her. Had she done so it is unlikely that the advice would have been different as there was no indication of any immediate risk to BDS.

9.7.2 The content of the subsequent text message to the Clinical Psychologist (see 8.8.2) was properly identified by him as an issue which was likely to impact adversely on Father's mental health. The DMHS IMR argues that, based on past behaviour, the impact of this change in social stressors would in all likelihood be withdrawal, rapid deterioration in mood and self neglect. The Clinical Psychologist believed that Father had accepted that his relationship with Mother was over and therefore did not think the development would increase risk from Father.

9.7.3 That the degree and likely permanence of Mother's estrangement from providing attention to Father and access to BDS might impact on Father in a qualitatively different manner from previous social stressors should have also been considered.

9.7.4 Discussing the development with DMHS Colleagues was appropriate, as was arranging for a joint assessment of Father the next day. The potential effectiveness of this was however undermined by not sharing the information regarding Mother's pregnancy.

9.7.5 Not informing Father's GP of the situation undermined the ability of the GP to provide Father with appropriate support in dealing with the development and assess any risks arising from it. Similar considerations apply to the Amber Trust Support Worker not being informed.

9.7.6 The failure to share relevant and significant information is not addressed in the DMHS IMR and the reasons behind it have not been established.

9.7.7 When Mother took Father to the Police Station on 26 May 2010 his detention under Section 136 of the Mental Health Act 1983[41] and taking him directly to the Radbourne Unit (see 8.8.3-4) was both appropriate and in line with relevant policies. The Derbyshire Constabulary IMR rightly identifies that while the circumstances may have met the criteria for a domestic violence incident the main presenting issue and concern of Mother was Father's mental health.

9.7.8 Had the incident been classified as one of Domestic Violence it would have engaged the recording and assessment processes applicable to such incidents[42]. Within these the circumstances would not have led to Mother being assessed as at High Risk of homicide. BDS' age and Mother's pregnancy would have triggered a referral to Children's Social Care. The circumstances did not however meet the criteria for engaging child protection procedures.

9.7.9 The incident classification did not impact on subsequent Police action. The

[41] Section 136 of the Mental Health Act 1983 is an emergency power allowing the Police to remove a person who is in a public place and appears to be suffering a mental disorder and to be in need of immediate care or control to a place of safety. The person can be held for 72 hours to allow assessment by mental health professionals.
[42] Derbyshire Constabulary Domestic Violence Policy (February 2008).

officers who dealt with Father on the following days (see 8.8.12-16 & 8.9.1-14) were aware of the events on 26 May by virtue of the second incident being recorded on the same computer record. This was also included in the referral made to Children's Social Care (see 8.9.10).

9.7.10 The assessment at the Radbourne Unit by two mental health professionals who did not know him concluded that that Father did not have a major mental disorder or present a risk of suicide that required inpatient psychiatric care (see 8.8.5).

9.7.11 Given the previously noted lack of a unified set of medical notes and the absence of a documented care plan it is unlikely that the assessment considered full information about Father's background. It would have been robust practice to liaise with Father's Care Coordinator to obtain an informed perspective on Father's mental health and the services that were engaged with him. This, in turn, may have led to greater scepticism in their interview with Father. It is also likely that the assessors would have been informed of Mother's pregnancy and thereby have had a greater understanding of the stressors impacting upon Father at that time.

9.7.12 The DMHS IMR argues that had the assessment been conducted by the DMHS professionals involved in Father's care the outcome of the assessment would have been the same. The rationale for this is that they had not applied to detain Father under the Mental Health Act 1983 when they had assessed him in March 2010 (see 8.7.15 & 8.7.23). By May 2010 there were significant recent developments in Father's life which impacted on his mental health and may have changed the view taken by the professionals.

9.7.13 A fax notification of the assessment to Father's GP (see 8.8.6) was effective practice. This did not identify any risk of violence or to children.

9.7.14 A significant omission by all professionals involved with Father on 26 May was consideration of the impact of his mental health on BDS. There were no indications that BDS was at immediate risk of harm from Father but BDS was exposed to Father's behaviour in Mother's car. The incident was also triggered by issues connected with BDS. These factors should have been recognised as having implications for at least the longer term welfare of BDS and, for those aware of Mother's pregnancy, the unborn child.

9.7.15 On 27 May 2010 a decision was taken not to pursue the plan for a joint assessment or provide a service to Father from the CRHTS (see 8.8.8). This was on the basis that Father would be unlikely to engage, was seeking treatment from his GP and had had a mental assessment in the interim. No contact was made with the Clinical Psychologist, Father's GP or with Father. The decision could not therefore have taken into account the full impact of development's in Father's life on his mental health.

9.7.16 The intervening assessment under the Mental Health Act 1983 only indicated that Father did not meet the criteria for compulsory in-patient care at the time of assessment. The assessment should not have been regarded as a substitute for the more holistic assessment of Father that developments in the professional view of his mental health condition and changes in his social circumstances merited. It also did not obviate the potential for Father to be

engaged voluntarily.

9.7.17 On the afternoon of 27 May 2010 Mother visited the Police station to report threats made against her and BDS (see 8.8.9-12). This was treated from the outset as involving domestic abuse. The response provided was therefore within the framework of the Derbyshire Constabulary Domestic Violence Policy[43].

9.7.18 The incident was also appropriately recorded as one of Threats to Kill. This should have triggered the robust risk assessment and management procedures, with senior manager involvement, specified by the Derbyshire Constabulary Life at Risk Policy[44].

9.7.19 The Derbyshire Constabulary IMR identifies that the underlying purpose of the Life at Risk Policy is to ensure that such threats are subject to an effective risk assessment. This was served by the risk assessment processes engaged under the Domestic Violence Policy. Engagement of the Life at Risk Policy would not have led to a different approach to management of the risk identified. Nevertheless it is appropriate that the action outlined in the Police IMR is taken to ensure that the Life at Risk Policy and Domestic Violence Policy of Derbyshire Constabulary provide a cohesive approach to incidents which fall within the scope of both.

9.7.20 Contact was made with the Bleep Holder[45] at the Radbourne Unit regarding the Section 136 Mental Health Act 1983 assessment of the previous day (see 8.8.14). This was effective practice by the Police Officer.

9.7.21 The Officer was not informed that the assessment record was only unavailable to the Bleep Holder because it was held by the clinicians involved. No advice was given on how access might be obtained. This effectively closed down the likelihood of productive information sharing. Providing access to information regarding the assessment would have been beneficial to the Police. An equally important element of the communication would have been discussion of the reason for the enquiry. This was not sought by the Radbourne Unit Bleep Holder or, in light of a perceived definitive statement regarding availability of the information sought, shared proactively by the Police Officer.

9.7.22 If communication had been better it is likely that assessment and management of the risk that Father presented would have taken place in a multi-agency context. DMHS professionals however remained unaware of the events on 27/28 May 2010.

---

[43] Derbyshire Constabulary Domestic Violence Policy (February 2008). This specifies that response requirements for officers dealing with Domestic Abuse incidents as to:

- Take positive action to ensure the safety of the victim and any children present
- Take measures to prevent an immediate recurrence
- Identify all evidence gathering opportunities and ensure that evidence is preserved and secured
- Ensure that the victim and children are provided with appropriate care and advice
- Ensure that positive action is taken to arrest and convict the offender. *(Emphasis in original document)*

[44] Derbyshire Constabulary Life at Risk Policy (July 2008).

[45] The "Bleep Holder" is the senior member of staff on duty, responsible for the out of hours management of the Radbourne Unit as a whole.

9.7.23 The need for DMHS to improve the means by which other agencies are able to access information held by them is addressed within and subject of a recommendation from that agency's IMR.

9.7.24 While the Derbyshire Constabulary Domestic Violence Policy provided the overall framework for the Police response to Mother's report there were aspects to the response which did not adhere to that policy.

9.7.25 Issuing Father with a harassment warning[46], as intended by the officers who attended his address (see 8.8.15-16) on the evening of 27 May 2010, would have been inappropriate. The rationale for adopting this approach, only rectified when Father was arrested on the basis that he was uncooperative with the officers, has not been established.

9.7.26 Completion of the "Form 621" Domestic Violence Risk Assessment by the arresting officers (see 8.8.16) was in line with relevant policies, although it incorrectly states that BDS was not present at the time of the incident and does not provide his details. It also refers to Mother by her middle name on a number of occasions, creating a potential source of confusion.

9.7.27 The assessment appropriately classified the risk as High. This was confirmed by all of the relevant staff interviewed in preparation of the Derbyshire Constabulary IMR.

9.7.28 It is noteworthy that the "Form 621" risk assessment tool is specifically identified by the Domestic Violence Policy[47] as assessing the **risk of homicide** *(Independent Author's emphasis)* to the victim, in this case Mother. This is however not made explicit on the form itself. It is also apparent from discussion of the Serious Case Review Panel that this understanding is not shared by professionals within Children's Social Care (and the DCHS Safeguarding Team) who are in receipt of referrals arising from this risk assessment.

9.7.29 Whilst the presence and details of BDS should have been recorded, the tool does not specifically assess risk to any children. This is the responsibility of the Child Abuse Central Referral Unit on the basis of the recorded information. In this regard Derbyshire Constabulary are to implement the ACPO "DASH[48]" risk assessment tool, which includes an additional focus on children, for use in cases of domestic violence.

## 9.8 28 to 31 May 2010

9.8.1 The Police interviews of Father on the morning of 28 May 2010 (see 8.9.1) were conducted in accordance with relevant legislation and statutory guidance. Under the "PEACE"[49] interview model it is identified as good

[46] Under the Protection from Harassment Act 1997 a warning used by a Police Officer as a means of formally indicating to an individual that their contact with another is unwanted and should cease immediately. Non-compliance with such a warning would make the individual liable to arrest and prosecution.
[47] Derbyshire Constabulary Domestic Violence Policy (February 2008).
[48] Association of Chief Police Officers Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment model (2009).
[49] The interview model included in Police training programmes.

practice to for two Officers to conduct an interview. The reason for a second interviewing Officer not being present is not explained by the Derbyshire Constabulary IMR. Notwithstanding this the interview, reviewed as part of the IPCC investigation, was concluded to have been thorough.

9.8.2 The decision to release Father on bail following the interviews (see 8.9.2) was consistent with the view taken by the Custody Sergeant at the time that the further enquires required and any consequent further interviews of Father could not be completed within the time limits on keeping Father in custody. The Derbyshire Constabulary IMR identifies that Father completely denied making the threats to Mother and that there was very little evidence available to support Mother's allegation. That which was available is identified by the Derbyshire Constabulary IMR as confused and requiring substantial clarification. It is unclear whether the further planned enquiries would have provided sufficient evidence to enable the case to subsequently be put to the Crown Prosecution Service for a charging decision.

9.8.3 An internal investigation by Derbyshire Constabulary has established that the intention of the Custody Officer in granting conditional bail was to act in the best interests of Mother.

9.8.4 The "Form 621" risk assessment formed the basis for consideration of further action by both the Domestic Abuse and Child Abuse Central Referral Units (see 8.9.8-10). Forwarding details of this and the incident records to Children's Social Care was in accordance with the relevant protocol[50] in place at that time. Making the referral urgently was appropriate and identified by the Derbyshire Constabulary IMR as in line with the assessed risk.

9.8.5 Two practice issues undermined the potential effectiveness of the referral to Children's Social Care. First, as noted above, the form was not fully and accurately completed. It does not immediately identify that BDS was present at the time of the incidents on 26 and 27 May 2010.

9.8.6 Second, the Domestic Violence Officer's assessment and confirmation of the risk categorisation had not been completed when it was forwarded to Children's Social Care. More significantly, as the form was sent before Father was granted bail this was not included. This information was not elicited by Children's Social Care consequent to their receipt of the referral.

9.8.7 The referral should have also been forwarded to the DCHS Safeguarding Team. Not doing so was attributable to individual practice and has been addressed by Derbyshire Constabulary. If it had been forwarded it is unlikely to have been dealt with prior to 2 June 2010 unless the need for an urgent response was specifically prompted.

9.8.8 Aside from the above practice issues, the domestic violence protocol itself mitigated against the effectiveness of the referral to Children's Social Care. Key to this is that the process is explicitly, albeit inaccurately, specified on the referral documentation as being directed at the needs of children potentially requiring services under Section 17 of the Children Act 1989. This however

[50] Domestic Abuse and Safeguarding Children Protocol Between Derbyshire County Council, Derby City Council, Derbyshire Constabulary, NHS Derbyshire County and NHS Derby City

only reflects a number of underlying issues which are discussed in section 19 of this report.

9.8.9 The Police risk assessment identified Mother as at High risk of homicide. The focus of the risk assessment was on Mother and the degree of risk may have been different for BDS. Mother was BDS' main caregiver and any contact between Mother and Father would almost invariably involve BDS. The assessed risk to Mother must therefore have involved a risk of significant harm to him.

9.8.10 It is the Independent Author's view that this should have led to BDS being the subject of a referral to Children's Social Care under Section 47 of the Children Act 1989. That it did not is attributable to the domestic violence protocol arrangements as outlined at 9.8.9 above and in Section 19. The application of thresholds for referral and intervention should be specifically addressed as part of the current review (see 3.6) of arrangements for responding to children exposed to domestic abuse.

9.8.11 The Derbyshire Constabulary IMR asserts that BDS should not have been considered at risk of significant harm. This is on the basis that the phrase used by Father "I'll kill you and take him" could be open to differing interpretation in relation to risk to BDS; that Father had always shown a caring attitude to BDS and that he had no previous convictions indicating a predisposition to harm his son. There is no evidence that these factors or a lack of confidence in the validity of the risk assessment impacted on the decision making by the Police staff involved. It is the Independent Authors' view that they do not therefore provide an appropriate basis for believing such risk to be negated.

9.8.12 Derbyshire agencies have Multi Agency Risk Assessment Conference (MARAC) arrangements in place for domestic abuse cases[51]. The Derbyshire Constabulary IMR identifies that this case could have been considered at a future planned MARAC meeting, although it did not meet the criteria for referral on the information known at 28 May 2010. The arrangements do not include provision for convening an emergency MARAC meeting to discuss a specific case, irrespective of how high the risk is assessed to be. This is considered appropriate. The professional operation response to such cases should already have engaged all relevant partner agencies.

9.8.13 Notifying Mother of Father's release on bail (see 8.9.4) was appropriate. It was concluded that implementing further security measures was not required. This was on the basis of Mother's view that she was safe in her home and a number of positive aspects of her home security, including that she was not

[51] *The use of a MARAC will be specific to adults who are at high risk of homicide or serious harm.* If a child is living in a household where the risk to an adult has been identified as serious and a MARAC is to be held, the impact of this level of domestic violence on the child should be assessed and a referral to Children's Social Care should be made. Children's Social Care will be invited to the MARAC. (Derby and Derbyshire Safeguarding Children Board Procedures, 2008). Risk for the purposes of deciding whether a case should be referred to a MARAC is assessed by Derbyshire Constabulary using a quantitative assessment tool separate to the Form 621 Risk Assessment, scoring risk out of a potential 24. The threshold for referral is 14 although there is discretion to refer with a lower score.

living alone. Better practice would have also considered measures to address risks when Mother was outside of her home.

9.8.14 It was identified that Mother's mindset was one of wanting to help Father. This was viewed as a risk factor and she was advised not to return Father's clothing to him (see 8.9.4). It is apparent from the actions of Mother in keeping her door locked and warning her cousin to do likewise that she considered him to pose at least some risk to her and her family. It is however clear that Mother was not fully convinced to avoid all contact with Father and to report any attempt by him to contact her (see 8.9.16-19). Her rationale for not reporting Father's actions over the following days to the Police is not known.

9.8.15 The Derbyshire Constabulary response to the call from Father's neighbour on the evening of 28 May 2010 (see 8.9.12-14) was generally appropriate and proportionate. It is unclear if Mother was informed of the remark made by Father and it would have been good practice to do so.

9.8.16 In the absence of Father's subsequent actions being reported nothing further could reasonably have been done by the Police to address the risk from him.

## 9.9 1 and 2 June 2010

9.9.1 There was some delay within Children's Social Care, in recording the Police referral on their systems and agreeing the course of action to be taken (see 8.10.1-2). The Children's Social Care IMR identifies that this was within the applicable procedural timescales, which require that a decision be taken on how to progress a case within 1 working day. This is technically correct. It would be more robust practice to have arrangements in place to conduct at least an initial risk assessment of incoming referrals prior to weekends. This is particularly so where a bank holiday introduces further potential delay in responding.

9.9.2 Once the decision had been taken that the case required an Initial Assessment (see 8.10.4) placing the referral in a queue for allocation, with no further action being taken until that occurred. This led to no response being given prior to the death of BDS. The circumstances outlined in the referral should have prompted at least contact with relevant health professionals and seeking further updated information from the Police.

9.9.3 The Children's Social Care IMR appropriately identifies the referral processing system issues behind this as requiring attention. A recommendation is made in that regard. Notwithstanding this it is apparent that three other factors contributed to the lack of a swifter response by Children's Social Care.

9.9.4 First, resource capacity within the team concerned significantly impacted on their ability to maintain effective standards. The Children's Social Care IMR makes an appropriate recommendation in this regard. Second, the referral was one of 291 notifications received from Derbyshire Constabulary that month in relation to domestic violence issues and all were headed as referrals under Section 17 Children Act 1989. This level of such referrals is typical.

Third, as previously noted, there is a lack of understanding by Children's Social Care staff of the Police risk assessment process. In those circumstances it is perhaps inevitable that the default position would be other than to conduct the checks with other agencies which would provide a context for effectively risk assessing and prioritising such referrals.

9.9.5 Had the situation of BDS been subject of a referral under Section 47 Children Act 1989, a more urgent response by Children's Social Care may have been provided. In all likelihood this would have involved a strategy discussion with the Police and at least telephone contact with Mother and the health professionals involved with Father.

9.9.6 A significant consequence of the approach taken was that it did not provide the potential for Father's GP to be aware of the recent events when he spoke with Father on 1 June and saw him on the morning of 2 June 2010 (see 8.10.6, 8.10.8 & 8.10.12-16).

9.9.7 On 1 June 2010 the Amber Trust Support Worker learned of events the previous week (8.10.9-10). She took the view that Father's threats had been made in an attempt to manipulate Mother on the issue of contact. The circumstances should have been discussed with the Worker's manager and advice taken on how to respond. It would have been appropriate to include contact with DMHS and preferably Children's Social Care in this.

9.9.8 That this did not take place reflects an approach to risk that was earlier evident when decisions were taken to rely on the DMHS risk assessment following acceptance of Father as a client and in response to the decision by DMHS not to visit Father at home. The Amber Trust IMR appropriately makes recommendations in relation to both the recognition of concerns for children and risk assessment.

9.9.9 When Father spoke with his GP on 1 June 2010 (see 8.10.6-8) the doctor was aware of the mental health assessment carried out on 26 May 2010. He was not aware of Mother's pregnancy or of the subsequent threats and Police intervention. The GP has indicated that risk to BDS and Mother was considered but that Father was not felt to pose such risk. No enquiry was made to ascertain why contact by Father with BDS had been withdrawn. The absence of specific indications of such risk from the professionals who assessed Father on 26 May 2010 was likely to have contributed to the view taken.

9.9.10 When Father saw his GP on 2 June 2010 the perceived threat against the GP seems to have been appropriately explored by him and nothing in Father's response to this or in their subsequent conversation gave any hint of intended violence.

9.9.11 The response provided by both Derbyshire Constabulary and East Midlands Ambulance Service to the neighbour's call on the morning of 2 June 2010 was both timely and wholly appropriate. The decision to convey BDS to hospital whilst attempting resuscitation, although not identified as such by the Ambulance Service summary report, was in accordance with the applicable

JRCALC[52] guidelines. At the Royal Derby Hospital the continued attempts at resuscitation were also timely, appropriate and involved staff of the correct seniority.

9.9.12 It is clear from the circumstances found by Derbyshire Constabulary on that date that, for unknown reasons, Mother had granted Father admission to her home, following which Father had taken action to prevent her leaving.

## 9.10 Diversity Issues

9.10.1 The requirement to consider diversity issues in relation to the subjects of this Review is included in the Terms of Reference. It is also encompassed within the requirement to prepare IMRs in accordance with Chapter 8 of Working Together to Safeguard Children (2010).

9.10.2 Many of the IMRs do not provide a discrete commentary on their treatment of diversity issues and those that do are largely confined to statements that there were no issues which had a bearing on practice

9.10.3 Ethnicity was generally recorded appropriately by professionals. In addition a number of assessment tools which included identification of other diversity issues were completed. There is little evidence that the impact of such factors on the needs of family members was actively considered. Notwithstanding this, it is apparent from both the content of the IMRs and information provided by those family members interviewed that none of the review subjects had particular needs relating to their ethnicity, gender, sexual orientation, religious identity, linguistic ability or other disability.

9.10.4 The one significant diversity issue in this case was Father's mental health problems. These were central to the practice of those agencies engaged directly in providing services to him. They were also appropriately considered on each occasion that Father came into contact with staff of Derbyshire Constabulary.

9.10.5 With hindsight, there was also a cultural issue within Mother's family of avoiding the creation of attention, most succinctly put by her mother that "her family were not the sort of people who had the Police visit their homes". This is likely to have impacted on the way that Mother approached professional intervention. There is no indication that this was recognised by any professional, the view generally being taken that she was a strong and capable person. This is considered by the Serious Case Review Panel as likely to have led to underestimation by professionals of her vulnerability.

[52] Joint Royal Colleges Ambulance Liaison Committee's (JRCALC) Ambulance Service Clinical Practice Guidelines (2006)

# CONCLUSIONS AND LEARNING FROM THE REVIEW

## 10 Predictability

10.1 Hindsight represents a valuable tool for understanding events in reviews such as this and for the analysis from which learning may be achieved. It is however important to apply this with caution, particularly when reaching conclusions on whether events could have been predicted or prevented by the professionals and their organisations. Care has been taken to reach such views on the basis of information which was known at the time, placed within the relevant organisational context.

10.2 Taken at face value the threats reported to the Police as having been made by Father on 27 May 2010 are believed to have been carried out by him on 2 June 2010. The question is therefore whether Mother's report, in the context of other information available to professionals, provided a basis on which the eventual outcome could have been reasonably predicted. There are a number of factors which suggest that this would not be the case.

10.3 Derbyshire Constabulary receive in the region of 150-160 reports of Threats to Kill" each year (see 6.6.4). Their IMR identifies that this is the only one of those reports over at least a three year period which has been followed by enactment of the threat. The Police had no information from their contact with Mother and Father (see 9.7.17, 9.8.2 & 9.8.17) or regarding Father's mental health issues (see in particular 9.7.10-12 & 9.7.20-21), which would have effectively discriminated this case from any of the other "Threats to Kill" reports.

10.4 The Police were not informed, and remained unaware, of Father's actions subsequent to his release from custody, in particular his visits to the locality of Mother's address (see 9.8.16).

10.5 DMHS professionals, who had most knowledge of Father, remained unaware of the events on and subsequent to 27 May 2010. Other agencies and professionals had at most partial information regarding these events.

10.6 More widely, research[53] indicates that the incidence of murder-suicide is stable both over time and throughout the Western world at 0.2 to 0.3/100,000 of population each year. This may seem to present a not uncommon scenario. It is important to recognise that only a small proportion of these, around 6%, involve the murder of a child and still less the annihilation of a family. This equates to less than one such incident every 15 years in a county the size of Derbyshire. That such occurrences may appear to be more frequent is undoubtedly a facet of the media attention which they attract.

10.7 Father and the context of the events which led to this Review share many of

[53] SH Friedman et al (2005) Filicide-Suicide: Common Factors in Parents Who Kill Their Children and Themselves, Journal of the American Academy of Psychiatry and the Law, 33:4:496-504
S Eliason (2009) Murder-Suicide: A Review of the Recent Literature, Journal of the American Academy of Psychiatry and the Law, 37:3:371-376

the characteristics of others in which a parent has killed their child and themselves. These include depressive mental illness and involvement with mental health professionals, withdrawal or estrangement of a partner and absence of a prior criminal offending history. It should however be emphasised that only an extremely small number of those individuals sharing these characteristics do commit such acts.

10.8 On this basis the Review has concluded that no individual or agency could have reasonably predicted that Father would kill BDS and Mother, thereafter taking his own life, as is believed to have occurred on the morning of 2 June 2010.

## 11 Preventability

11.1 Although the actual events on 2 June 2010 were not predictable the risk assessment conducted consequent to Mother's contact with Derbyshire Constabulary on 27 May 2010 did indicate that he posed a serious risk to her.

11.2 Whilst the focus of the risk assessment was on mother and the degree of risk may have been different for BDS, this must be regarded as involving a risk of significant harm to him, Mother was BDS' main caregiver and any contact between Mother and Father would almost invariably involve BDS.

11.3 For this and the information available to professionals consequent to the events on 27 May 2010 to have potentially prevented the death of BDS would however have required one or more of the following interventions by agencies, either singly or in collaboration:

- Restricting Father's liberty, to the extent that he could not get access to Mother and BDS (either in connection with criminal proceedings or on the basis of his mental health).
- Surveillance, with an on hand intervention capability, of Father, or Mother and BDS.
- Mother being convinced that she should actively and effectively protect herself and BDS from any contact with Father.
- Intervention which would compel Mother to adopt the above approach on the basis of risk posed to BDS
- Removal of BDS from Mother.

11.4 Derbyshire Constabulary did advise Mother not to have contact with Father following his release from custody. This did not however convince her of the risk that Father posed, to completely avoid contact with him or to report his subsequent actions to the Police.

11.5 The other contingencies at 11.3 above were not legally and proportionately available to the agencies and professionals involved with the family on the basis of information known to them at the time.

11.6 Notwithstanding the above this Review has identified better practice which could have been applied by agencies and professionals between 27 May and 2 June 2010:

- Sharing by the Clinical Psychologist of information that Mother was pregnant by her new partner, and the potential impact of this on Father, with other relevant health professionals (see 9.7.4-5).
- DMHS professionals pursuing the assessment of Father planned for 27 May 2010 (see 9.7.15-16).
- Availability and utilisation of better arrangements for accessing records within DMHS; together to more effective communication with Derbyshire Constabulary on the evening of 27 May 2010 (see 9.7.2-23).
- Derbyshire Constabulary Officers making a referral to Children's Social Care under Section 47 Children Act 1989 outside of the domestic violence protocol procedure (see 9.8.10-11 & 9.9.5).
- Children's Social Care processing the Police referral more swiftly, conducting lateral checks with other agencies and providing a more urgent and robust response (see 9.9.1-4). In this regard it is clear that even if child protection procedures had been engaged there would not have been immediate grounds for removing BDS from the care of Mother.
- The Amber Trust liaising with DMHS and / or Children's Social Care on the content of the communication with Mother and Father on 1 June 2010 (see 9.9.7).

11.7 Prior to the afternoon of 27 May 2010, with the exception of the risk assessment in August 2009 (see 8.6.2 & 9.5.2-3), there were no occasions when professionals could reasonably have predicted that Father posed a threat of serious physical harm to Mother or BDS.

11.8 It should have been identified by those professionals providing services to Father that his mental health problems were likely to impact on the welfare and development of BDS. Key issues were Father's behaviour, self neglect and suicide ideation, together with Mother's role as a carer for him. That should have led to engagement of both Mother and the health professionals providing services to BDS in assessing and addressing these issues.

11.9 In this connection some of the IMRs contributing to this Review have not placed sufficient emphasis on the potential for multi-agency arrangements to add value to that of agencies acting in isolation.

11.10 A more robust approach to the impact on Mother herself of acting as informal carer for Father may also have facilitated Mother disengaging from Father's life. It is unknown what impact this may have had on the eventual outcome.

11.11 In early 2010 DMHS professionals identified that Father may have a Personality Disorder, possibly in conjunction with the depressive illness for which he was being treated (see 9.6.11-13). This Review has not established whether earlier recognition of this possibility or a different response might have impacted on the events under review.

## 12 Learning Themes

12.1 Underlying the above issues are six themes, albeit in many cases inter-related, within which the main learning from this Serious Case Review is

identified:

- Focus on the child.
- Mental Health.
- Support for Carers.
- Risk Assessment.
- Response to Domestic Abuse Incidents involving Children.
- Information Management.

12.2 These are explored more fully in sections 15 to 21.

## 13 Learning from previous Serious Case Reviews

13.1 A previous Serious Case Review in Derbyshire[54], resulting from events which bear a number of similarities to those of this case, identified some of the areas where services should be improved which are reiterated here. A second, earlier Serious Case Review[55], whilst arising from somewhat different circumstances also made recommendations on assessment and documentation issues which are relevant to the findings of this Review.

13.2 These Serious Case Reviews led to the implementation of action plans which included:

- Review of DMHS policies with consideration of including provision for joint assessments with GPs in cases where a patient is reluctant to engage with mental health services.
- Development of a joint assessment tool for use by Health Visitors, CPNs, Social Workers and primary health care professionals in assessing the needs of children of parents with mental health problems.
- Inclusion in training and prompts to GPs and DMHS staff that children should not be considered a protective factor for parents who feel suicidal; and of the impact of parental behaviour on children.
- Inclusion in training provided by the DSCB and to GPs of the need to share information (*with Health Visitors and Midwives*) regarding parental mental health issues.
- Highlighting the need to ensure effective information recording and develop systems to monitor compliance.

13.3 The action plans developed have been completed. The underlying learning from these reviews was not however translated through the recommendations into "SMART"[56] actions which were likely to embed the intended changes in professional practice. Further, the monitoring arrangements did not ensure that the action taken had impacted on practice and led to improved outcomes for children and their families.

13.4 Consequently some areas for development identified by those reviews remained evident in the way that agencies approached the needs of BDS and

[54] Derbyshire Safeguarding Children Board Serious Case Review in respect of Child K (July 2008)
[55] Derbyshire Safeguarding Children Board Serious Case Review in respect of Baby R (March 2007)
[56] Specific, Measurable, Achievable, Realistic, Time-bound

his family.

13.5 It is therefore recommended that:
***Monitoring by Derbyshire Safeguarding Children Board should ensure that changes recommended by Serious Case Reviews have been fully embedded in practice and have had the intended impact on outcomes for children and their families. The Board should consider what further action may be required to reassure them that the plans from Serious Case Reviews completed during the last four years have met these criteria.***

## 14 Learning from the Individual Management Reviews

14.1 In addition to the themes outlined at sections 15 to 21 the IMRs which contributed to this Review identified a number of other areas where services should be improved. These include:

- Delivery, Management and engagement with the Care Programme Approach.
- Delivery of the Health Visiting Core Programme.
- Avoidance of "Professional Dangerousness"[57].
- Delivery of a 'Think Family' approach in urgent health care settings.
- Electronic inter-agency referral arrangements.

14.2 Recommendations arising from these areas of learning are included in the IMR recommendations detailed at Appendix E.

## 15 Focus on the Child

15.1 The voice of BDS was not well heard in this case and reports of him as an individual are limited.

15.2 Although too young to talk, more detail of BDS' presentation could have been recorded and analysed.

15.3 Mother was committed to Father remaining part of BDS' life, even after her relationship with him ended.

15.4 She was sufficiently concerned about Father's ability to care for BDS that he was never left in the unsupervised care of his father. Despite this those organisations providing care for Father lacked focus on the needs and development of BDS.

15.5 There were isolated examples of BDS' welfare being considered, for example when Mother took Father to the hospital on 26 December 2008 (see 9.3.4). The risk that Father's health problems might pose to BDS welfare and development, both directly or through their impact on Mother's parenting

[57] CALDER M (2008) Professional Dangerousness: Causes and Contemporary Features in *Contemporary Risk Assessment in Safeguarding Children.* Russell House, Dorset.

capacity, was however never properly professionally assessed. A significant factor in this was a concentration on Father's risk of self harm and of immediate physical harm to others. This was to the exclusion of considering the wider impact of Father's condition and behaviour.

15.6 Further, no action was taken to share information regarding Father's mental health issues with any professional who had the relevant remit and expertise to focus on the interests of BDS. This was also the case in relation to the risk to BDS identified August 2009 (see 9.5.2-3). In some cases conscious decisions were taken not to share information. Those professionals mainly involved in BDS' life, the Health Visitor and Midwife, therefore remained unaware of Father's mental health issues.

15.7 The lack of focus on BDS was also contributed to by the perception of the professionals involved with Father that through Mother's capability as a carer she was able to effectively manage such impact.

15.8 Even more concerning was that BDS was on occasion viewed by professionals as a stabilising and protective element of Father's context, serving to reduce his risk of self harm. This view was inappropriate and demonstrated a serious disregard for BDS' interests.

15.9 These issues featured in a previous Serious Case Review in Derbyshire (see 13.2). They have also been well rehearsed in the biennial analyses of Serious Case Reviews[58], which have identified this as a form of "Silo" practice.

15.10 National guidance on safeguarding addresses and provides guidance on these issues[59]. Working Together to Safeguard Children (2006) is the version available during most of the review period. It clearly states that although mental illness in a parent or carer does not necessarily have an adverse impact on a child's developmental needs, it is essential always to consider its implication for each child.

15.11 It is clear that these messages have not led to the requisite focus on the potential impact that adult mental health problems may have on children being embedded in the practice of those professionals working with these adults.

15.12 It is therefore recommended that:
***Derbyshire Safeguarding Children Board should ensure that all partner agencies working with adults who have mental health problems consistently share information with child health professionals and engage them in assessment and planning processes. This should be in respect of any child with whom the adult has frequent contact, or is likely to have such contact with an unborn child. The default approach to these circumstances should be assessment of the child's needs under the Common Assessment Framework. This should not be seen as an alternative to referring the child to Children's Social Care where a***

[58] For example, Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-7, M Brandon et al (2009)
[59] For example, Think Parent, Think Child, Think Family. Social Care Institute for Excellence (July 2009)

***risk of significant harm is identified.***

15.13 *It is also recommended that:*
***Derbyshire Safeguarding Children Board should ensure that the need to assess and address the potential impact on children of adult mental health problems is embedded in professional consciousness and practice. The Board should emphasise that children must not be considered a protective factor for adults who are self harming or experiencing suicide ideation.***

## 16 Mental Health

16.1 Throughout the period that Father was engaged with DMHS he was treated for and his care plan focussed on depressive illness. The treatment and management of his condition was in accordance with NICE Guidelines[60] for that type of condition.

16.2 In March 2010 it was speculated that Father may have a, possibly co-existing, Narcissistic Personality Disorder or Dependant Personality Disorder with narcissistic traits (see 9.6.11-12). The DMHS IMR identifies that if a Personality Disorder was present this would have explained why his treatment (under the NICE guidelines for depressive illness) appeared ineffective. There was not however, then or subsequently, a firm diagnosis of this and it remains a matter of debate whether such a diagnosis could be sustained.

16.3 A Consultant Forensic Psychiatrist who contributed to the DMHS Internal Investigation is of the view that there were signs of Personality Disorder from Father's early contact with DMHS in June 2008. There were occasions when his response to treatment did not fit with the pattern of a biological illness and the pattern of his behaviour was often controlling, rather than suggestive of depression. It was acknowledged that there was evidence of Father being depressed and that the two conditions can co-exist.

16.4 Conversely a Consultant Forensic Psychiatrist commissioned by HM Coroner concluded that *"The primary diagnosis, in my view, is a severe and recurrent depressive illness and on the evidence available it is not possible to make a diagnosis of Personality Disorder."* The most, in his opinion, that could be said was that *"…personality attributes may well have been excessively exacerbated by the depressive illness."*

16.5 Neither professional gave evidence at the Inquest and their differing perspectives therefore remain untested.

16.6 Identification and diagnosis of Personality Disorder is not straightforward and may rely on identification of characteristics that develop over time, often

[60] National Institute for Clinical Excellence CG 90 Depression in Adults: NICE Guidance on Depression (2009); National Institute for Clinical Excellence CG 90 Depression in Adults: NICE Guidance on Depression (An update) (2010)

requiring recognition of discrepancies between different sources of information. To do this effectively requires coherent and clear recording of information together with triangulation from significant sources other than the service user. It therefore seems likely that the shortcomings of the documentation systems and recording practice within DMHS contributed to possibility of Father having a Personality Disorder not being considered earlier. The DMHS IMR makes an appropriate recommendation for improvements in this area.

16.7 Once the possibility of Father having a Personality Disorder was raised, the investigation of this was undermined by the effective delegation of responsibility for Father's care to his GP (see 9.6.19-22); albeit this was in recognition of a decision by Father, which he had both the capacity and right to make, to access treatment through that route. It is questionable to expect that the GP would be able to effectively explore the potential diagnosis and, if necessary, develop an appropriate treatment and care regime in the context of normal GP practice without considerable support and advice from mental health clinicians. The DMHS IMR makes recommendations which are likely to ensure that such support is provided.

## 17 Support for Carers

17.1 Caring for a person with mental health problems may be at considerable personal cost. This is recognised within the National Carer's Strategy (2008) which defines a carer as someone who spends a significant amount of their life providing unpaid support to family or potentially friends, caring for a relative, partner or friend who is ill, frail or disabled or has mental health or substance misuse problems. It is also reflected in Derbyshire Mental Health Services NHS Trust Care Programme Approach and Care Standards Policy and Procedures[61].

17.2 It was known to DMHS and other professionals that Mother was the key person supporting and caring for Father. Assessment of her role as an Informal Carer was considered on two occasions by DMHS professionals (see 9.1.14 & 9.4.14-15). Despite this she was never afforded the benefit of a Carer's Assessment by DMHS as the lead agency providing mental health services to Father.

17.3 The impact on Mother of caring for Father was also not recognised by his GP or within Amber Trust, although both were equally aware of the extent to which she was undertaking this role. While DMHS had lead responsibility in this regard it would have been good practice for these professionals to have prompted DMHS to offer an assessment.

17.4 That Mother herself did not request a Carer's Assessment is likely to have

[61] Derbyshire Mental Health Services NHS Trust Care Programme Approach and Care Management Policies and Procedures (2009). This has since been superseded by the Derbyshire Mental Health Services NHS Trust Policy for Assessing the Needs of Carers (2010) which states that carers who provide substantial and regular care for an individual, for which they are not paid a salary or fee, are legally entitled to an assessment of their caring, physical and mental health, leisure, educational and employment needs.

been contributed to by two factors. First, there is no indication that Mother was aware of the organisational approach to supporting informal carers. Second, her family report that Mother inherently presented as a strong capable woman and is likely to have viewed making such a request as appearing weak.

17.5 Had an assessment taken place there is no guarantee that Mother would have accepted any services offered and it is unknown how these may have impacted on subsequent events.

17.6 Such assessment would however have provided an opportunity to explicitly distinguish between the carer role of Mother and that of a mother who wanted her child to maintain contact with his father.

17.7 In this connection recognition as an Informal Carer would have provided a mechanism through which she could explicitly withdraw, in a supported way, from the expectations placed upon her by professionals and Father. The opportunity to do this may have been taken by Mother, particularly in the spring of 2010 when she had started her new relationship, was again pregnant, identified the extent to which she was being manipulated by Father and informally stated that she would no longer provide care for him.

17.8 The conclusion of the DMHS IMR that anyone providing informal care should be offered a Carer's Assessment is appropriate, although it is considered that conducting such an assessment should be the default position. Further, ensuring it takes place should extend to all agencies providing services to those with mental health problems. Even if the carer declines to participate the impact of undertaking that role should be assessed and regularly reviewed.

17.9 In addition to its impact on the carer it is clear that undertaking such a role will inevitably impact on the carer's children. Any assessment of the carer's needs should therefore also take into account the needs of any children involved.

17.10 It is therefore recommended that:
***All partner agencies of Derbyshire Safeguarding Children Board providing services to those with mental health problems should arrange for the impact on and needs of those providing informal care to be assessed. Such assessments should be reviewed at least annually. The arrangements should also provide for assessment of any child likely to be affected by the caring role through the Common Assessment Framework.***

## 18 Risk Assessment

18.1 DMHS had in place appropriate risk assessment arrangements and utilised the FACE Risk Profile for the assessment and management of clinical risk. The FACE Risk Profile is a properly validated tool. Such tools are however only as good as their application and the risk management plans that they lead to. The DMHS IMR makes an appropriate recommendation for action to address deficiencies in their risk assessment practice. When implementing that recommendation it should be ensured that all of the following issues are

addressed.

18.2 There was an over concentration on assessing risk of self harm and suicide by Father. It is unclear whether Father's passive aggression in refusing to leave Mother's car or his angry outbursts in May 2010 were given appropriate weight. This was accompanied by lack of consideration of the longer term impact on BDS of Father's withdrawal, self neglect and thoughts of suicide, together with the indirect impact through Mother's role as his carer.

18.3 There was a less than robust response to the, albeit transient, recognition of risk at the start of Father's August 2009 hospital admission, accompanied by a failure to comply with the risk assessment processes for child visitors (see 9.5.2-6).

18.4 On a number of occasions there were inadequacies in completion of the risk profile documentation.

18.5 In formulating risk profiles there was an over-reliance on self reported information without adequate attention to triangulating this from other sources. This, together with the disparate record systems in place within DMHS undoubtedly delayed recognition that Father had provided self serving misinformation, identification of which should have led to review of his risk profile.

18.6 Finally, Father's risk profile was not consistently reviewed when his circumstances and presentation changed. In particular the last FACE Risk Profile completed was in March 2010. There were missed opportunities to revisit and update this as the presentation and view taken of Father's mental health condition, his social context and his behaviour changed.

18.7 It is clear that the risk posed by Father was considered by the GP, most particularly on 1 and 2 June 2010. Where an adult's mental health problems may impact on a child it would be appropriate to involve those primary health care professionals with a focus on the child in this process. The arrangements outlined in the recommendation at 21.2 of this Review are considered adequate and appropriate to facilitating this.

18.8 The Amber Trust also had available a risk assessment tool. It is however apparent that risk assessment within that organisation was not robustly incorporated into practice, most clearly demonstrated when they were notified of the DMHS decision to discontinue home visits (see 9.6.10). The remit of the Amber Trust for management of risk associated with their clients is somewhat more limited than that of the other professionals and the statutory agencies involved in the care of Father. Nevertheless these issues should be addressed and the action recommended by the Amber Trust IMR is appropriate.

## 19 Response to Domestic Abuse Incidents involving Children

19.1 The risks to the safety and welfare of children associated with domestic

abuse are well established[62] and it is commonly a factor in families where serious harm to a child occurs[63]. Such risks may be of direct physical / sexual harm or from the longer term pernicious effects of exposure to such violence. These are recognised in the Adoption and Children Act 2002 as including impairment suffered from seeing or hearing of the ill treatment of another.

19.2 Exposure of children to domestic abuse is also pervasive. Lord Laming[64] highlighted that some 200,000 (1.8%) children in England lived in households where violence is a known risk. Owing to under reporting of such violence the actual number is likely to be significantly higher.

19.3 Responding effectively to cases where children are exposed to domestic abuse requires arrangements to be in place which engage relevant agencies in assessing and cooperatively addressing both risk to the child and their welfare and developmental needs. Responses may thereby be appropriately targeted and prioritised within the resources available.

19.4 In many cases this may be the provision of support services by statutory or third sector organisations on the basis of an initial assessment or engagement of the Common Assessment Framework. In the case of children at risk of significant harm this should however be in accordance with Local Safeguarding Children Board Child Protection Procedures.

19.5 In relation to BDS the Police risk assessment on 27/28 May 2010 did not lead to the engagement of child protection procedures, but was dealt with under the multi-agency protocol between key statutory agencies for responding to children exposed to domestic abuse (see 9.8.5-12).

19.6 Within this there were individual practice issues. That child protection procedures were not engaged however stemmed from operation of the protocol itself.

19.7 It was recognised at the outset of this Review that the protocol arrangements were flawed and the Derbyshire Constabulary IMR identifies that deficiencies in the arrangements had been known for some time previously.

19.8 Significant underlying issues include:

- A lack of understanding and shared ownership across agencies of the aims behind the protocol. This was exacerbated by the impact on its application of resourcing and defensibility considerations.
- Screening which involves a risk assessment model that is adult focussed, on which there is no shared understanding across agencies of what is being assessed and which gives too many false indications of high risk.
- A mechanistic approach to risk assessment and referral that does not involve consideration of the nature of a child's needs or the service expected from the recipient agencies.
- Referral processes which conflate risk with the welfare and developmental

[62] Working Together to Safeguard Children (2010) 9.17 et seq.
[63] For example, Understanding Serious Case Reviews and their Impact. A Biennial Analysis of Serious Case Reviews 2005-7, M Brandon et al (2009)
[64] The Protection of Children in England: Progress Report, Lord Laming (2009)

needs of children.

- At a practical level, the use of fax arrangements which tend to introduce delay in the referral process.

19.9 In that regard the decision of the Derbyshire Safeguarding Children Board at the outset of this Review process (see 3.6) to commission an immediate review of the current domestic violence protocol by the Children's Social Care departments, Police and Primary Care Trusts in Derbyshire and Derby City was entirely appropriate.

19.10 This work must ensure that the multi agency arrangements for responding to children exposed to domestic abuse are underpinned by appropriate application of thresholds for referral and intervention. The review should specifically address this issue.

19.11 Significant progress has been made with that review and led to positive current or imminent service improvements:

- Children's Social Care Child Protection Managers and health professionals have been collocated with the Police Child Abuse Central Referral Unit to improve opportunities for advice, support, consultation and information sharing. This should ensure that all referrals contain appropriate information.
- It has been agreed that all child referral information from the Police to Children's Social Care should be transferred electronically (replacing current fax systems) and that the Derbyshire County Council Call Centre will then distribute referrals to the appropriate district offices. This includes agreement to pilot secure email software that meets the requirements of both organisations.
- A senior practitioner grade Social Worker will work in the Derbyshire County Council Call Centre to decide the threshold and route for all children's referrals. All those directed to Children's Social Care will receive an Initial Assessment; those requiring use of the Common Assessment Framework will be directed to the multi agency teams or to the practitioner most closely involved with the child.
- The ACPO "DASH[65]" risk assessment tool for use in cases of domestic violence, and which includes an additional focus on children, is being implemented by Derbyshire Constabulary.

19.12 It is essential that the impact of the developments arising from the review is assessed to gauge whether additional work is required.

19.13 It is recommended that:

***Derbyshire County Council, Derbyshire Constabulary and NHS Derbyshire County should specifically address the application of thresholds for referral and intervention in their review of the multi agency domestic violence protocol. They should jointly report to Derbyshire Safeguarding Children Board in November 2011 on the outcomes of the review and the impact of the measures implemented as a result.***

[65] Association of Chief Police Officers Domestic Abuse, Stalking and Harassment and Honour Based Violence risk assessment model (2009).

# 20 Information Management

20.1 This Review, in common with most similar reviews, has identified deficiencies in the management of information by the agencies involved with BDS and his family.

## 20.2 Information Gathering

20.2.1 Details of both parents health, background and social circumstances, even if not living together, are crucial pieces of information required to inform any assessment of a child's situation, including the risk of harm. With the exception of within DMHS this information was not comprehensively gathered or collated (e.g. 9.1.1; 9.1.17). The most significant consequence of this was that Father's mental health condition remained unknown to the Derbyshire Community Health Services and Royal Derby Hospitals NHS Trust professionals engaged with Mother in connection with BDS and latterly her second pregnancy.

20.2.2 Use of the Framework for Assessment of Children and their Families[66] by these professionals should have ensured that this information was gathered as part of their assessment of parenting capacity and environment. However it was not, even following the oblique remarks made by Mother to the Midwife regarding her relationship with Father in April 2010 (see 9.6.15).

20.2.3 This, in combination with the failure of all professionals engaged with Father to recognise that information regarding his mental health should be shared with the Midwife and Health Visitor severely undermined the assessments on which service provision to Mother and BDS was founded. It seems likely, and would have been appropriate, that possession of this information would have triggered engagement of the Common Assessment Framework.

20.2.4 The DCHS IMR effectively addresses these issues, together with that of potential professional over-familiarity which may have contributed to the practice applied. Recommendations on this area of practice are made by both the DCHS and RDH IMRs. These must however be accompanied by robust audit arrangements, as also recommended by the DCHS IMR, in both Trusts. This is addressed by the recommendation at 21.1 of this Review.

20.2.5 A lack of effective information gathering to inform assessments and decision making was also evident within Children's Social Care in October 2008 (see 9.2.3) and on 1 June 2010 (see 9.9.1 & 9.9.5). In both cases obtaining further information from the referrer and conducting lateral checks with other agencies would have enhanced the quality of the decisions made. The Children's Social Care IMR makes an appropriate recommendation for improvement in this area of practice.

## 20.3 Documentation

[66] Framework for Assessment of Children and their Families (HMSO, 2000)

20.3.1 A number of organisations have identified deficiencies in the recording of information by professionals around demographic and contextual information. These included the omission of individuals attending a contact, the identification of professionals (both those completing records and those consulted) and detail of conversations.

20.3.2 These issues have made the gathering of information for this Review difficult. More crucially they will have impaired information sharing between professionals and the quality of any resultant analysis and planning.

20.3.3 All agencies have policies on record keeping standards. Maintaining compliance with these standards seems, however, to represent an enduring problem, perhaps inevitably in systems which involve human factors.

20.3.4 This is a recurring theme in cases which are subject of Serious Case Reviews locally[67] and nationally.

20.3.5 A key strategy to address this must therefore be to have effective audit and supervision arrangements in place. Many of the IMRs recommend action in this area. This is not however universal.

20.3.6 It is therefore recommended that:
***Derbyshire Safeguarding Children Board should obtain assurance from all of its partner agencies that they have in place arrangements for the routine audit of recording systems and are effectively addressing practice which falls below expected standards.***

20.3.7 The DMHS IMR appropriately identifies that their current case file system (see 9.4.12) is a barrier to such records to effectively supporting practice. Most significantly, in conjunction with the failure, from August 2009 onwards, of Father's Care Coordinator to ensure that a properly documented CPA Care Plan was available (see 9.4.10), this severely undermined the ability of professionals dealing with Father to readily and effectively understand his former and current circumstances (e.g. 9.7.11). It was also detrimental to identification of discrepancies between elements of the information held (e.g. 9.6.17).

20.3.8 The recommendation of the DMHS IMR for development of a single integrated electronic patient record system is therefore considered appropriate and this should be prioritised by that Trust.

## 20.4 Information sharing

20.4.1 Safeguarding the welfare of children requires effective information sharing across and within agencies. In this case there were significant failures in information sharing between professionals and agencies providing services to Father and those concerned with BDS. The IMRs appropriately identify that enhancements to the communication arrangements within primary health care

[67] Including in, for example, Derbyshire Safeguarding Children Board Serious Case Review in respect of Baby R (March 2007)

settings and for providing access to information held by mental health professionals are required. Recommendations are made to address this.

20.4.2 The most significant issue in this case was not however the absence of information sharing arrangements, or the policies and procedures associated with this. It is clear that these were in place and supported by appropriate guidance[68]. It was the lack of focus on BDS and consequent recognition that information ought to be shared. This has been addressed above. No additional recommendation is therefore made in respect of information sharing.

[68] Derbyshire Safeguarding Children Procedures (2008)
Information sharing**:** Guidance for practitioners and managers; Department for Children Schools and Families (2009)

## 21 Recommendations

***21.1*** ***Monitoring by Derbyshire Safeguarding Children Board should ensure that changes recommended by Serious Case Reviews have been fully embedded in practice and have had the intended impact on outcomes for children and their families. The Board should consider what further action may be required to reassure them that the plans from Serious Case Reviews completed during the last four years have met these criteria.***

***Timescale: 6 months***

***21.2*** ***Derbyshire Safeguarding Children Board should ensure that all partner agencies working with adults who have mental health problems consistently share information with child health professionals and engage them in assessment and planning processes. This should be in respect of any child with whom the adult has frequent contact, or is likely to have such contact with an unborn child. The default approach to these circumstances should be assessment of the child's needs under the Common Assessment Framework. This should not be seen as an alternative to referring the child to Children's Social Care where a risk of significant harm is identified.***

***Timescale: 6 months***

***21.3*** ***Derbyshire Safeguarding Children Board should ensure that the need to assess and address the potential impact on children of adult mental health problems is embedded in professional consciousness and practice. The Board should emphasise that children must not be considered a protective factor for adults who are self harming or experiencing suicide ideation.***

***Timescale: 6 months***

***21.4*** ***All partner agencies of Derbyshire Safeguarding Children Board providing services to those with mental health problems should arrange for the impact on and needs of those providing informal care to be assessed. Such assessments should be reviewed at least annually. The arrangements should also provide for assessment of any child likely to be affected by the caring role through the Common Assessment Framework.***

***Timescale: 3 months***

***21.5*** ***Derbyshire County Council, Derbyshire Constabulary and NHS Derbyshire County should specifically address the application of thresholds for referral and intervention in their review of the multi agency domestic violence protocol. They should jointly report to Derbyshire Safeguarding Children Board in November 2011 on the outcomes of the review and the impact of the measures implemented as a result.***

***Timescale: November 2011***

***21.6 Derbyshire Safeguarding Children Board should obtain assurance from all of its partner agencies that they have in place arrangements for the routine audit of recording systems and are effectively addressing practice which falls below expected standards***

***Timescale: 4 months***

21.7 Implementation of the action plans arising from the above recommendations and the IMRs will be monitored by the DSCB Serious Case Review Committee. Progress will be reported to the DSCB Board annually and on completion of the action plans. This activity will be reflected in the DSCB annual report.