SERIOUS CASE REVIEW

CHILD G

Date of Incident: Summer 2016

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CONTENTS

1. Introduction:
1.1. The circumstances leading to this Serious Case Review Page 2
1.2. Family Composition Page 3
1.3. Methodology Page 3
1.4. Contribution of family members Page 7
1.5. Child G Page 7

2. Summary of the case and agencies' involvement Page 7

3. Appraisal of Practice and Analysis Page 12

4. Concluding Comments Page 23

5. **Recommendations for the Boards** Page 23

References Page 25

Appendix A: Individual Agency Actions Page 26

1. INTRODUCTION

1.1 The circumstances that led to undertaking this Review

1.1.1 In the summer of 2016 the mother of Child G received a text message from 6 year old Child G's father, which gave her reason to be seriously concerned. Child G's father had recently moved out of the family home, but had regular contact with Child G and was caring for her while her mother was at work. The mother called 999 and on arrival at the family home, the police discovered Child G who appeared lifeless. Attempts to resuscitate Child G were made by the police, paramedics and medical staff at A&E, however shortly after midday she was confirmed to have died. The father was also found dead in the house when the police arrived, as were the family's pet dogs. Information provided to this Review was that it appeared that the father had killed Child G and the two dogs before killing himself.

1.1.2 The case of Child G was referred to the Serious Case Review Sub Group of the Isle of Wight Safeguarding Children Board the day following her death. An initial meeting which took place the following month identified that other statutory reviews were likely to be required as the father had been in receipt of NHS services. This was confirmed at a subsequent meeting and it was established that the following reports would be required.

- Serious Case Review,
- Serious Incident Requiring Investigation Report (SIRI) regarding NHS Primary Care Services (Level 2)
- Serious Incident Requiring Investigation Report (SIRI) regarding NHS Mental Health Services (Level 2)

1.1.3 It was agreed by all the services that these Reviews should work closely together to minimise repetition and ensure the best learning for all. This SCR therefore, as far as possible, acted as a joint agency review. However, the threshold was also met under the NHS Serious Incident Framework[1] for a separate 'Level 3' Independent Investigation which would be completed within 6 months of the completion of the Level 2 SIRI. It was also agreed that although the criteria for a Safeguarding Adult Review had not been met, there was likely to be learning for the Safeguarding Adults Board, who would also contribute to the process. The purpose of this one Review was therefore, as far as possible to:

- meet the statutory requirements for a Serious Case Review
- Identify appropriate learning for the Safeguarding Adults Board
- Incorporate the learning identified within the two NHS Serious Incident Requiring Investigation Reports

1.1.4 The Serious Case Review Sub Group which met on 20th July 2016 recommended that the Reviews be undertaken on this basis. The

[1] Serious Incident Framework NHS England March 2013 (p42)

Independent Chair of the Isle of Wight Safeguarding Children Board then formally made a decision to undertake the Serious Case Review and informed the Department for Education the following day. Child G's case had met the criteria for a Serious Case Review as identified in Working Together to Safeguard Children 2013[2], in that there was information that:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.1.5 An Independent Reviewer was identified at an early stage and attended the meeting at which the process for achieving a joint review was discussed. This allowed for a timely start to the Serious Case Review Process and the Review was completed in 6 months as a result.

1.2 Family Composition

The family members referred to in this review are as follows:

- Subject – Child G
- Mother
- Father of Child G
- Paternal Grandmother

1.3 Methodology

1.3.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

> *Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children. (Working Together, 2013:66)*

1.3.2. The statutory guidance requires reviews to consider: "*what happened in a case, and why, and what action will be taken*". In particular, case reviews should be conducted in a way which:

[2] Working Together: HM Govt 2013

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings.*

1.3.3. The methodology used for this Review was underpinned by the principles outlined in Working Together, including the need to use a systems approach. The author of this report is familiar with a systems based methodology. In particular this approach recognises the limitations inherent in simply identifying what may have gone wrong and who might be 'to blame'. Instead it is intended to identify which factors in the wider work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely. A central purpose therefore is to consider not only the individual circumstances but to consider what can be learnt from this family's experience about safeguarding practice more widely.

1.3.4. The Review was Chaired by the Independent Chair of the Safeguarding Children Board, Maggie Blyth. The Independent Lead Reviewer was Sian Griffiths who is independent of all the agencies involved. Sian Griffiths has significant experience in undertaking Serious Case Reviews.

1.3.5. A Review team was established and made up of Senior Safeguarding representatives from the following agencies:

Service	Representative
Isle of Wight NHS Clinical Commissioning Group (CCG)	Director of Quality and Clinical Services and Executive Lead for Safeguarding
Isle of Wight NHS Clinical Commissioning Group (CCG)	Head of Safeguarding and Designated Nurse
Isle of Wight NHS Trust	Executive Director for Nursing
Isle of Wight Council, Children's Services	Assistant Director, Children and Families Service Manager, Children and Families
Hampshire Constabulary	Serious Case Review Team
Isle of Wight Safeguarding Adults Board	Board Manager
Isle of Wight Safeguarding Children Board	Strategic Partnerships Manager Hampshire and Isle of Wight LSCBs

The Isle of Wight Safeguarding Children Strategic Partnerships Manager and Business Coordinator also provided support to the Review.

1.3.6. The review process included the following written information:

- Production of a comprehensive chronology provided by the following key agencies:

    - Isle of Wight NHS Trust (Adult Mental Health)
    - University Hospital Southampton NHS Foundation Trust
    - Isle of Wight Council Education and Inclusion Service
    - Isle of Wight NHS Clinical Commissioning Group (for GP practices)
    - Hampshire Constabulary
    - Isle of Wight Childrens Services
    - YMCA

- Initial Scoping Documents from the agencies which provided chronologies
- Isle of Wight NHS Trust Serious Incident Investigation Report
- Isle of Wight Clinical Commissioning Group Serious Incident Investigation Report.
- Other documents as requested by the Lead Reviewer, including the DASH risk assessment form (risk assessment document regarding domestic abuse.) & IAPT assessments

1.3.7. The Independent Lead Reviewer met with the following professionals who had direct involvement with key members of the family:

- 4 Family GPs and GP Practice Manager (joint meetings with the Clinical Commissioning Group investigator)
- Police Constable (telephone conversation)
- Mental Health Practitioner, Registered Mental Health Nurse (joint meeting with the Isle of Wight NHS Trust investigator)
- Mental Health Practitioner, Therapist at IAPT, Improving Access to Psychological Therapy service (joint meeting with Isle of Wight NHS Trust investigator)
- Adult Social Care Safeguarding Consultant Practitioner (telephone conversation)
- Head Teacher and Class Teacher

Notes of the following meetings with professionals undertaken with the Isle of Wight NHS Trust investigator by herself were provided to the Lead Reviewer:

- Mental Health Practitioner (Single Point of Access)
- Mental Health Practitioner (Clinical Lead for Single Point of Access)

The Lead Reviewer also spoke to a number of other relevant professionals.

1.3.8. A practitioners' event was undertaken involving 8 practitioners who were directly involved with the family, managers from key organisations and

members of the Review Team. The purpose of the event was to ensure information included in the report was accurate and to contribute to the analysis and learning.

1.3.9. The **timeframe** under consideration for this Review was:

March 2015 – Summer 2016

The starting point was chosen as it was identified that at this point the father had sought help from his GP for depression and been referred to the primary mental health care service, IAPT. The end point is the date at which Child G and her father were discovered.

1.3.10. Terms of Reference encompassing the three parallel reviews were produced and are included in Appendix A of this Review. The areas of consideration specific to the Serious Case Review were as follows:

1. *Was there sufficient awareness, understanding and application by the agencies involved of the 4LSCB Joint Working Protocol for safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress - with particular emphasis on Part 3 of the protocol?*

2. *Was sufficient priority given to the needs and safety of the child by the agencies involved and were the risks to the child effectively assessed in the context of the father's mental health issues? Was there a perception by involved agencies that the child could be seen as a protective factor?*

3. *Were there missed opportunities by the agencies involved for interventions to have been put in place to minimise risks to the child and promote protective factors.*

4. *Should a referral have been made to CSC by the agencies involved when the father was expressing that he might harm himself?*

5. *To explore the links between adult safeguarding and child safeguarding procedures and pathways including how the MASH assesses referrals for linked cases on the IOW*

6. *Was the male identified as an 'at risk' adult within the terms of the Care Act 2014*

1.4 Contribution of family members

1.4.1. The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Both the mother of Child G and the paternal grandmother of Child G agreed to meet with the Independent Lead Reviewer. Their contributions to this review are summarised below and included throughout the report.

1.4.2. The willingness of both the mother and grandmother to contribute to this review, given the highly distressing nature of Child G and her father's deaths, was particularly appreciated and has provided an important perspective that would otherwise have been missing.

1.5 Child G

1.5.1. What has been striking throughout this review is the incredibly vivid picture that has emerged of Child G. She is consistently described as a bubbly, friendly child, although she could also be quite shy and was very much a 'mummy's girl'. Child G loved her pet dogs and also had a favourite toy dog, who she always liked to have with her and was her comfort toy. Child G loved dancing and singing and she was in the school choir. She liked to join in to any activities that she could and was described by her teacher as a child who would '*get excited at the tiniest of things'*. She was obviously viewed as a delightful child by her teacher. She was a very kind, caring child who would always think about others. One of her regular games with her mother was for them to list all the things they had to be grateful for.

2 SUMMARY OF THE CASE AND AGENCIES' INVOLVEMENT WITH THE FAMILY

The following is a chronological summary of what is now known about the family and their involvement with agencies. The summary, as far as is possible, will identify what was or was not known to the relevant agencies at the time the events were taking place.

2.1 Background information

2.1.1. Child G lived throughout her life with her parents and was a pupil at her local primary school. Both parents, who were married, were involved in her care and all the information available prior to her death draws a picture of a much loved child. Prior to the time period covered within this review the father had been in full time work and therefore the mother, who also had part time work, was the main carer during the day. Information provided by the mother is that she had a particularly close relationship with Child G and remained the primary carer throughout her life. Child G's mother chose to undertake two parenting courses at the local Children's Centre because she was keen to provide the best care for her child and enjoyed attending these courses.

She was clear that Child G loved her father and believed he loved her, but his involvement in his daughter's care was a less active one, a description that was echoed by her school's experience of both parents.

2.1.2. Both parents had some history of depression linked to their own early life experiences as well as current life stresses. Information from the family was that Child G's father had regular episodes of depression throughout his life, that he found it difficult to talk to people and was almost exclusively reliant on his wife for emotional support. Child G's father was described by some professionals as having a Learning Disability, however there is no evidence of any formal diagnosis, or evidence of assessment since he was a young child. Child G's mother confirmed that he had particular difficulties for example with reading and writing and lacked confidence in this area.

2.1.3. Prior to the timeline under review Child G had limited contact with agencies other than for universal services, specifically education and health. Child G had had some physical health problems for which she received the appropriate care, but which are not directly relevant to this Review. Child G like her parents was born and lived on the Isle of Wight and was white British.

2.2 Events between March 2015 and the summer of 2016

2.2.1. In the spring of 2015 Child G was attending her local school and was in the reception class. Her attendance was something of a concern to the school, it was 82% in March 2015, but all the absences were accounted for and checked by the Attendance Officer. Child G had had mild heart problems as a younger child and had been under the care of a paediatrician. She was discharged from that care in March 2015. Child G had also had two childhood infections that kept her off school earlier in the year. The paediatrician had referred Child G to the YMCA for counselling in 2014 and again in March 2015 as she had been quite badly affected by two deaths in the family and her mother was also worried about how she would react when her much loved elderly dog died. The mother bought a puppy for Child G hoping that it would make this easier when the time came.

2.2.2. Child G's father had attended at the family GPs in March 2015, he was known to have had a history of depression and had in recent years suffered 3 significant bereavements. He was referred to IAPT (Improving Access to Psychological Therapies), the Primary Care Mental Health service. It appears from his notes that his depression was linked to some degree to having lost his job. At the time he was identified as being a medium risk of harm to himself. It was noted that he had literacy problems but was given reading and asked to produce a diary. After two appointments he did not attend further and there is no note about the reason for his non-attendance.

2.2.3. In September 2015 Child G moved into Year One. The school staff knew Child G as a kind, caring child, a child that her teacher never needed to tell off. At the start she had been quite anxious and always wanted her cuddly toy dog with her, but they encouraged her to leave it at the door and she settled in. Her mother was very supportive and always concerned about her.

She was an only child and her mother described her as a '*miracle child*' as she had also been premature. Mother was very supportive of Child G in school, but would perhaps over worry about her sometimes. Child G consistently described herself as happy and would skip into school. The school knew that Child G loved her two dogs, particularly the puppy which she regarded as her dog.

2.2.4. Child G's school attendance did continue to cause some concern, but all the absences were authorised due to illness, and so she was not referred to the Education Welfare Service. The attendance officer reviewed her attendance and was satisfied. The school felt that sometimes Child G's mother could be over concerned about her health, although this was understandable.

2.2.5. In November 2015 Child G's mother visited her GP with symptoms of anxiety linked to a recent bereavement and the stress of managing two jobs. The GP was aware of a history of anxiety, prescribed her an anti-depressant and referred her to the primary mental health team, although she did not appear to have taken this referral up. The following month Child G told the school she had experienced a physical health symptom which they felt needed to be followed up. They informed Child G's mother who immediately took Child G to the doctor for a consultation. Child G's mother talked to the GP about the stresses at home, particularly as a result of the father having lost his job, and felt that it might be that Child G, who was upset about this, was seeking some attention. The GP was confident that there was no other cause for concern and suggested that she get some support from Barnardo's. The GP believed that Child G's mother was quite capable of referring herself to Barnardo's as she had been to their children's centre before and enjoyed it. At around the same time the school noted that Child G was not her usual 'bubbly' self. Child G's mother talked to the class teacher about the father being depressed and described it as '*like looking after two children'.* Child G's father would often collect her from school as her mother was now working. He occasionally came to school events, but was quiet and said little to staff.

2.2.6. In March 2016 Child G's mother again made appointments for herself with her GP and described stress at home. She said that she was thinking of leaving Child G's father. Soon after this meeting the police received a call from Child G's mother saying that Child G's father had been angry about her having text contact with another man and had left home, saying he would not come back. She told the police she was worried as the father suffered from depression and had previously had suicidal thoughts. The attending police officers located the father at his mother's address, they did not identify concern about his mental wellbeing and saw no evidence he was at risk of harming himself or others. This was therefore identified as a period of 'absence' rather than of his being missing.

2.2.7. Child G's father went to see his GP the next day. The GP he saw was not his designated GP and had no previous knowledge of his home situation. She was not aware that his wife had also sought help from the same practice for anxiety. The GP was '*moderately concerned'* about the father and arranged to see him for a follow up appointment in a week, rather than her

usual practice of a fortnightly follow up. She took into account that he had thoughts of deliberate self-harm, but that these had been longstanding. The GP prescribed an anti-depressant and talked to him about counselling, but he was not keen on this because when he had gone the previous year he struggled with the expectations on him to read and write. The GP spoke to him about his relationship with his wife and child and encouraged him to talk to his daughter more. She assessed that his relationship with Child G was a protective factor.

2.2.8. In early April 2016 the police were called by Child G's Mother, because Child G's father had left saying that if he committed suicide it would be her fault. The police officer spent some time with the mother taking a history. The officers then found Child G's father at his mother's home. The father was in bed and did not want to speak. The police officer felt confident that his mother would take care of him and she said that she would take him to the GP in the morning. Child G was seen to be safely asleep in bed and her mother, although upset, was not concerned for their safety.

2.2.9. There was nothing about this incident that stood out for the police officers as being very different from many other similar cases that they routinely attended. The officer did not feel she had any reason to invoke Section 136 of the Mental Health Act in order to take the father to a place of safety and thought that it was likely to be better for the father to go to the doctor the next day with someone he trusted. The officer returned to the station and completed a DASH form to assess the risk of domestic violence. She did this as it is routine part of the police force's practice in any situation that has a domestic component, not because she had any specific reason to be concerned. She also completed a CA12 (Safeguarding Referral form for adults) and a CYP form (Child and Young Person at Risk) used to notify Childrens Social Care when a child could be considered at risk, again as part of standard practice. These forms were forwarded to the Adult Safeguarding teams and the MASH (Children's Services Multi Agency Safeguarding Hub) respectively in line with established policy.

2.2.10. The next morning, which was a Monday, the Adult Social Care Safeguarding Team received the CA12 form into their 'reporting abuse' e-mail inbox, a system for any referrals which might relate to neglect or abuse of an adult who may have care and support needs. The Adult Safeguarding Team had an informal local agreement to triage all these forms (there could be up to 30 after the weekend), including those intended for the mental health team, which did not have a means to receive the forms directly. In line with the team's normal practice, an experienced social worker reviewed the form. She identified nothing to suggest that the father would be considered an adult at risk within the criteria of the Care Act[3]. She was clear that the fact of an adult having suicidal thoughts in itself would not meet the criteria. The father had the support of his own mother, who he was staying with and who

[3] *The adult safeguarding duties under the Care Act 2014 apply to an adult, aged 18 or over, who: has needs for care and is experiencing, or at risk of, abuse or neglect; and as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect*

was going to take him to the GP that day. Having reviewed the form she uploaded it onto the PARIS computer system for the Mental Health Team's information.

2.2.11. The referral form from the police was also considered by the MASH. It was concluded that the appropriate action had already been taken and therefore no further action was required by Children's Social Care.

2.2.12. The Adult Safeguarding referral (CA12) was received and processed by the Single Point of Access (SPA) within the Mental Health team. The SPA is the first point of contact for all referrals for Secondary Mental Health Services in the Community. It was decided to refer it to the father's GP and the CA12 was forwarded to the GP. The GP contacted the father by phone and arranged for him to come in for an appointment. When the father attended the GP surgery a couple of days later, the GP contacted the IAPT service and an appointment was made for the father with the therapist.

2.2.13. Child G's father attended the IAPT service in early summer 2016 for his assessment and was seen by the therapist twice more over the following weeks. The therapist established that the father had suffered depression for most of his life, he felt isolated and had few friends. His immediate problem was that he had separated from his wife who he said had been talking to other men online. The main goal he could identify was getting back to work and the therapist was concerned to encourage him in greater activity. The father was living with his own mother, but was still seeing his wife and daughter with no evidence of there being any conflict.

2.2.14. After the therapy sessions at IAPT had already begun, Child G's father again attended his GP (he had now transferred to a different GP practice as he was living at his mother's). Child G's father spoke about the self-harm attempt when the police were involved the previous month and the GP, who was not aware the father was already being seen by IAPT, made a referral to Mental Health. The GP spoke to a Mental Health practitioner at the Single Point of Access. The Mental Health practitioner in turn spoke to the IAPT therapist and agreed with his assessment that there were no high risks identified and it was appropriate for him to continue with therapy and not at this point be moved to secondary mental health services. A second Mental Health practitioner spoke to the father later that day. They arranged to speak after the father had picked up his daughter from school, demonstrating to the worker an appropriate focus on the child. When they spoke he appeared almost '*jovial*', feeling hopeful about his situation and not presenting any information that suggested a risk. Child G's father was very happy with his therapist and did not want to see someone new. This Mental Health Practitioner had previously been a Child Protection Social Worker, as such she was practiced and confident about referring to Children's Services, but saw no reason to in this case.

2.2.15. Because of Child G's father's recent attempts at self-harm the IAPT therapist assessed his risk to himself as moderate, noting that there had been a gap and he was not expressing active thoughts of suicide. There was no information that led the therapist to believe he was a risk to his wife or

daughter. Child G's father did describe a nightmare in which he killed his wife and daughter. The therapist explored this further with Child G's father, and he was reassured that the father did not have any actual intention to act as these were the two people he most cared about. The therapist was familiar with people having all sorts of seemingly strange dreams and judged that this was likely to be a reflection of the Father's sense of loss, rather than something to be taken literally. The therapist spoke to Child G's mother who was supportive and wanted the father to get help. The therapist understood from the mother that she had not ruled out reconciliation. The father did not present in an angry or aggressive way and there were some signs of slight improvement over the three weeks he was involved with IAPT.

2.2.16. At 10am on the day that Child G died, the police received a call from Child G's mother. Child G's father was caring for their daughter while the mother was at work. She had received a text from him saying he would "*only leave her with memories".* When the police arrived at the house, Child G, her father and the two pet dogs were found apparently dead. Child G was taken to hospital where further attempts were made to resuscitate her, but these were unsuccessful.

2.2.17. The inquest into Child G's death, which took place when this Review was near completion, concluded that she had been unlawfully killed and that her father had committed suicide.

3 APPRAISAL OF PRACTICE AND ANALYSIS

3.1 Introduction

3.1.1. This Section will appraise the most significant aspects of the multi-agency practice with Child G and her family. It will identify what multi-agency learning there may be and respond to the questions outlined as Areas of Consideration within the Terms of Reference.

3.1.2. Where individual agencies have already established appropriate learning and taken action within their own agency, this will not result in further recommendations within this Review. Learning identified within the two NHS SIRI reports will be noted (Appendix B) but not analysed in detail here unless there is an impact on the wider multi-agency safeguarding partnerships. The analysis has been considered under two broad headings: The **Links between Adults and Childrens Services** and **Assessing the risks posed by the Father**. Inevitably, however, there will be a degree of crossover between these two.

3.1.3. Child G and her family were known mainly to universal services, particularly education and health. Up until the last few weeks of her life, there was no information to suggest that she was a child at risk of harm, or was anything other than loved or cared for within her family home. She had experienced loss in her life, with two significant bereavements; however, she was well supported by her mother and provided with child focussed bereavement counselling. Child G had never had any direct contact with Children's Social

Care, whose only involvement was in receiving a routine referral from the police two months before her death. This episode will be considered further in due course.

3.1.4. We cannot know for sure what motivated Child G's father to kill himself and Child G. However during this Review a number of indicators have emerged that suggest the most likely explanation lies in the father's separation from the mother and a resultant desire by him to cause her significant suffering. Child G's mother has no doubt that the father killed his daughter in order to punish her, the mother, and to make her suffer. The paternal grandmother also suggested that her son's motivation was linked to his unwillingness to accept that another man might take his place with the mother and Child G, although this was not actually part of the mother's thinking at this time. That he killed the two family pets, who the mother also loved dearly, and sent her a text message making it clear he wanted to take away the things she loved most, supports her view of his motivation. The father's state of mind as it impacts on how agencies could have responded will be considered in section 3.3.

3.1.5. The predominant focus for the majority of this Review is, unusually, on those services which were working with the father, as the risk to Child G lay with him alone. The conclusion of this report, which will be detailed later in this section, was that the nature of the risk the father posed could not have been identified by professionals in the very short period of time that they were involved with him. Overall the evidence is that agencies and individual professionals provided the appropriate services to Child G's family. There is evidence that professionals who came into contact with the family fulfilled their roles with proper care and there are no points of significant concern in terms of professional practice or access to services. There is, of course, potential for learning where practice could be developed or improved and some occasions where there were chances to understand more about what might be developing within this family at this time. However, there are no evident actions or inactions by professionals which could reasonably be expected to have halted the chain of events that did eventually occur.

3.2 The links between Adults and Childrens Services: Think Family

3.2.1. It was evident from the outset of this Review that a significant area for consideration would be the degree to which there was an effective relationship between children's and adults' services[4] and a proper understanding of the need to consider any concerns for the wider family when responding to the needs of individuals within it. Both the Safeguarding Adults Board and the Safeguarding Children's Board had identified this as a possible area of weakness in practice on the Isle of Wight and were concerned that it appeared to be a feature within Child G's case.

3.2.2. Developing a holistic approach to the needs of children and families is well recognised as good practice and was formalised by government policy in 2008 in the concept of 'Think Family'. This was defined as: *'securing better*

[4] "Adults' services" is intended to include all relevant statutory services for adults including health and social care.

outcomes for children, young people and families with additional needs by co-ordinating the support they receive from children's, young people's, adults' and family service'.[5]

3.2.3. There have been two key strands highlighted by Child G's case which are significant from a Think Family perspective. Firstly, at an organisational level, structures and processes, particularly in relation to information sharing, did not always support a strong 'Think Family approach'. Secondly the review has highlighted that the level of professional focus on the needs of children across adult services also needs strengthening.

3.2.4. **Structures and processes**: When, in the spring of 2016, the father was experiencing a period of depression and was expressing suicidal thoughts, the key agencies that responded to him directly were the family GPs, the Mental Health services and the Police. Following his second contact with the Police the attending officers completed and sent notification forms to the Adult Social Care Safeguarding team and Children's Social Care, as well as completing a Domestic Abuse Risk Assessment (DASH). What this meant in practice was that different forms were sent to different agencies by the attending police officers despite the fact that, with hindsight, it is clear that the information may also have been useful to other agencies. As a result Children's Services did not receive the Domestic Abuse Risk Assessment form; Adult Safeguarding did not know that a CYP notification form had been completed; the primary mental health team, IAPT, did not receive the Police CA12 and so on. That this was the case should not be interpreted as a criticism of individual police officers, who were following established processes.

3.2.5. What has been recognised by services during this Review, and reflects existing concerns, is the risk that key information is not being effectively shared with all the relevant agencies. At a minimum there is a lack of any clear process to ensure that all agencies are made aware of each other's involvement with the family. Referral processes have historically been designed to deal with one issue of concern, for example domestic violence or adult safeguarding, and sometimes there will be links between processes. But what appears to be missing here is a clear strategic position about the way in which all information about risks and vulnerabilities identified for an adult should and can be shared with Children's Services and vice versa.

3.2.6. Suggestions have already been made for some simple solutions to some of the gaps identified, for example: an identifier on a CA12 that an adult has caring responsibilities for a child: routine forwarding of a DASH form to Children's Social Care along with the CYP form. However, the longer term solution is likely to require a more considered approach and a strategic consideration of the way in which adults and children's services can work more collaboratively. The Review has been informed that discussions are taking place as to the viability of combining the various forms into one form. In the interim this Review recommends that the Boards seek an early agreement regarding a means for sharing Referral information and risk

[5] HM Govt (2009:4)

assessments regarding vulnerable adults and children across the relevant agencies. (**Recommendations 1 & 2)**

3.2.7. The system that was in place at this time for processing Adult Safeguarding Referrals (CA12s) does appear to contain some weaknesses although there is no reason to conclude that these would have impacted on the outcome in this case. The CA12 forms are sent directly to the Adult Social Care Safeguarding Team whose role is to assess whether the adult concerned meets the criteria for identification as an Adult at Risk or to forward the information to Mental Health services if concerns about mental health have been identified. The latter is effectively the Adult Safeguarding team acting as a conduit for Mental Health who do not currently have any other way to receive this information within their own systems. The Review has been informed that this system is now under consideration. Plans are being developed for all mental health referrals to go to the Adult Social Care First Response team for triaging. This team's role is as the first point of contact for all other referrals and to assess individual's eligibility for social care services. Such a change would therefore allow routine consideration of an individual's support needs, as well as any risks after these have been considered by the Adult Safeguarding Team.

3.2.8. What has further been highlighted is that at the point an adult referred to the Adult Safeguarding team is assessed as not meeting the 'at risk' criteria, there is no linked system to assess whether that adult might nevertheless be able to access services or support through Adult Social Care or other systems. If the father had been referred to the First Response team after his referral was considered in terms of safeguarding, this would have been an opportunity to assess his wider needs. It is not the assumption of this report that the father would have been deemed eligible for support from Social Care or that he would have taken advantage of any support offered. Even if he had been linked into some support services, whether statutory or otherwise, it would be unreasonable to conclude that any such support could have pre-empted the risks presented to his child. Nevertheless there is evidently an opportunity here to assess need and to link adults into appropriate services.

3.2.9. **The professional focus on children within adult services**: Practitioners working within adult services rightly have as their prime focus the adult who is accessing that service, whether in mental health, adult social care services or other sectors. These professionals are required to manage their work with adults whilst keeping in mind the statutory expectation[6] that all professionals have a role to play in safeguarding children. What has been apparent from all the meetings with the professionals who had direct contact with the father is that they were very aware of their responsibility to raise any safeguarding concerns about Child G. All were alert to aspects of the father's problems that could lead them to make a Safeguarding referral, and this will be considered further in section 3.3.

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[6] Working Together 2013

3.2.10. What was less obviously at the forefront of professional thinking was whether, in the absence of a specific safeguarding concern, there was an equally clear understanding that Child G might also benefit from a wider assessment of her needs, or the offer of Early Help[7] given the pressures that existed in the family. Whilst discussions about Child G took place in most consultations, this was generally in the context of the father's perspective, for example, how he felt about her and how this affected his frame of mind.

3.2.11. There is less evidence that there was a consciousness of what Child G's needs might be, how she might be experiencing the father's mental health problems and whether there was any wider responsibility to her arising out of the service that was being provided to the adult. Child G was not always directly mentioned by the father and one of the GPs acknowledged that he did not proactively ask about whether the father had any caring responsibilities, but would now change his practice. More than one of the GPs also reflected that it could be difficult to appear to be raising concerns about an adult patient's child without a very clear reason. Two different GPs in one practice saw the two parents separately; they were not aware that this was the case and as a result were not in a position to understand the perspectives of the 'other person in the relationship'. It was the case that the mother was presenting a less positive picture of the potential for a reconciliation, however, it is difficult to imagine any significant impact this could have had on their response. Nevertheless the SIRI report in relation to primary care (GP practices) has recommended a flagging system within the GP records to close this gap in potential information sharing.

3.2.12. A key tool developed locally for professionals working with adults who have caring responsibilities for children is the 2014 Joint Working Protocol on behalf of 4 Local Safeguarding Children Boards, including the Isle of Wight, entitled: "*Safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress.*" The purpose of this Protocol being to provide information and guidance for relevant organisations working with adults in these categories. The father of Child G was identified as experiencing a level of depression that required primary mental health care intervention and as a result this Protocol would apply to Child G's family.

3.2.13. Consistently the reviewers were told by the professionals who worked with the father, that they were mostly aware of the Protocol but had not read it. Despite this it would appear that the practice largely met the basic expectations of the Protocol. That they had not read it reflects not on their commitment to their practice but, in the view of this author, reflects the reality of their working lives and the inaccessibility of documents of this nature in that context. The Protocol, which has clearly been completed by well informed and knowledgeable authors, runs to a total of 50 pages, with some quite dense content and some references that would not be familiar to the

[7] Early Help is provided to children, young people and families who are struggling and feel in need of some additional support. See https://www.iwight.com/Residents/care-and-Support/Childrens-Services/Support-and-Advice-for-Families/About-Early-Help

non-specialist reader. It is intended to be read by a wide range of professionals and volunteers from A&E departments to Fire and Rescue Services. Whilst it is an interesting and informative document, it is unrealistic to think that many of those professionals, whose day to day job is not primarily concerned with children's safeguarding, would have the time to read this Protocol, amongst all the other policies and guidance from their own agencies and others. And more importantly, to then have the capacity to absorb and translate these key messages into their routine practice. What is apparent is that a different approach needs to be taken when trying to engage those not directly involved in child safeguarding in order that they can be reasonably expected to have understood and embedded key practice messages.

3.2.14. The professionals concerned unanimously recognised that there was useful learning for them which they would welcome. Examples they gave include knowledge about mental health and parenting capacity as well as skills and confidence in bringing the child into the conversation with an adult patient. They also felt there needed to be a more focussed and role specific way for the Board to communicate policy or practice guidance, such as shorter documents identifying Key Practice points or training workshops linking these messages to their particular work setting. This issue has been made subject to a recommendation in the Isle of Wight Trust NHS SIRI report and is also reflected in **Recommendation 3** of this Review

3.2.15. The experience of the professionals in this case was very clearly that they took seriously the requirement on them to be responsive to safeguarding issues for children. However, this would inevitably for most represent one of many different concerns they needed to keep at the forefront of their minds in any contact with an adult, and often during very limited periods of contact. Typically for example a GP has 10-12 minutes for each consultation. Developing a culture where the child is always in the mind of the professionals is a crucial contributor to safeguarding, but requires an explicit multi-faceted approach championed by leaders in the organisations concerned. **(Recommendation 2)**

3.3 Assessing the risks posed by the father

3.3.1. In order to judge the quality of the assessments that were made about any risk posed by the father and the responses to any concerns, two essential factors need to be considered. Firstly what information was available to those making assessments; secondly what is known from research and practice about assessing risk and dangerousness.

3.3.2. As has already been identified, none of the agencies who had regular direct contact with Child G had any specific reason to consider that she was at risk of harm from her father or anyone else within her family. The school knew both parents and had a good understanding of the broad family situation within the legitimate remit of their role. They had no information to identify that the father had any history of violence or that the family breakdown was other than a sad but familiar feature of family life. Similarly no other professionals who had known Child G earlier in her life - including health

professionals and counsellors at the YMCA - had identified anything unusual or concerning about Child G's relationship with her father or his behaviour within the family. When the police officers were called due to concerns about the father's mental state, what they saw did not present as particularly unusual in their experience. One of the officers described it as follows:

> *"It definitely didn't stand out…we deal with things like this on a daily basis…. ….his wife was very pro-us, wanted to get him help…(other) people we see where there is drinking, violence, the house is dirty…there was nothing like that here"*

3.3.3. The Police Officer concerned completed both a CYP notification form and the Domestic Abuse assessment form (DASH) in line with Hampshire Constabulary policy where the circumstances might include domestic abuse. The Police Officer spoke for some time to Child G's mother who was upset about the father's actions and about the breakdown of the marriage, but did not say anything that suggested domestic abuse was in fact a feature of their relationship. Neither did the Police Officer have any evidence that Child G was at risk. The conclusion of the Domestic Abuse form was that it was a medium risk, because certain categories were identified as a positive. However, having considered the form carefully, it is evident that the mother's fears were related to the father's risk to himself, not to her or Child G.

3.3.4. There were a small number of other occasions when there were references in the mother's GP records to what might be indicators of 'coercive control', the emotional and psychological aspect that is often present in domestic abuse, even when physical violence is not a feature[8]. That the mother was able to speak both to school staff and the GP about the stresses of her relationship with the father however suggests a positive relationship with these professionals. Similarly, following the Police's contact with the family in April 2016 and the resulting DASH assessment, a safety plan was undertaken in line with Police policy. The mother was subsequently visited by a Police Community Support Officer who discussed the plan with her and provided her with a Domestic Abuse information pack.

3.3.5. The mother of Child G was however clear in her contribution to this review that she was never afraid of the father, she did not consider his behaviour as threatening, although it was very difficult to live with, and if anything she felt that her husband was more like a second child, not a threatening dominating figure in her life. She described him as someone who never really demonstrated any strong emotions, positive or negative, including anger. The paternal grandmother did talk to the reviewers about her son having angry outbursts in the context of her relationship with him, but this was not something that the mother had herself experienced.

3.3.6. Despite the fact that the mother is not identifying to this review that she experienced domestic abuse, it is nevertheless important for agencies to be

[8] Controlling or coercive behaviour does not relate to a single incident, it is **a purposeful pattern of behaviour** which takes place over time in order for one individual **to exert power, control or coercion over another**. Home Office (2015:3)

alert to possible signs of domestic abuse in their work with families. The support offered to the mother by professionals, irrespective of whether there was any explicit disclosure of domestic abuse, was therefore appropriate.

3.3.7. The forwarding of the CYP form by the police to Children's Social Care in April 2016 potentially created another opportunity to assess any risk to Child G. When the CYP form is received by Children's Social Care, and where no immediate safeguarding concerns have been identified, checks are made to see if the family is known to the service and a decision overseen by the Assistant Team Manager as to whether this should become a 'Referral'. This results in it being passed up to a social worker, who would make other relevant checks, for example with schools or health services. In the case of Child G, with no immediate safeguarding concerns identified and the family not being previously known to Children's Services, the decision to take no further action is a justifiable one.

3.3.8. What has been highlighted during this review is that the DASH forms are not routinely made available to the staff in Children's Services when making these assessments. Theoretically had the DASH form been with the CYP form, this might have led to it being treated as a referral and from there an offer to the family of Early Help being made. However, given the additional information that this could in fact have provided, it is still unlikely that it would have met the thresholds for progressing further.

3.3.9. The points at which there was some greater opportunity to consider the father's mental state, whether that be in relation to mental health, or other features of his personality, was when he sought help from the GPs for depression and was referred to the primary mental health service, IAPT. The father was seen by a number of different GPs at two practices, he was provided both with anti-depressants and referrals for talking therapies. It is evident that at times GPs had a somewhat raised level of concern about the father's risk to himself, most particularly when he was referred to the Community Mental Health Single Point of Access and the referring GP marked this as 'urgent'.

3.3.10. In making their assessments about any risk that the father posed to himself both the GPs and mental health staff practice reflected established assessment processes for assessing suicide risk. Research[9] and research based Clinical Guides for assessing the risk of suicide (eg The Centre for Suicide Research[10]) identify key factors in order to help professionals assess the presenting risk. The various assessments undertaken during GP and other consultations were in line with current understanding of risk and protective factors. None of the GPs undertook an assessment in relation to risks of violence, because none identified any information that would lead them to do so.

3.3.11. One of the protective factors in relation to suicide risk that has been identified in research and was on more than one occasion identified in relation to the father is that of having caring responsibilities for children.

[9] Eg National Confidential Inquiry into Suicide and Homicide by People 2016

[10] University of Oxford

Whilst this was a legitimate feature of the GPs' risk assessments, it has nevertheless highlighted the complex nature of risk assessment, particularly where a child is identified as a protective factor. It therefore raises two issues of potential concern for the future, although there is no evidence that in this case these issues impacted on the professional response to the father's potential risk. Firstly, risk assessments need to be continually updated because of the dynamic nature of risk indicators and protective factors. As such all professionals should be clear that risk assessments are only valid at the time they are undertaken, and any change in circumstances could mean a change in the level of risk. Secondly a child should never themselves be understood as a protective factor against risk. Rather it should be clearly understood that it is the adult's response to their relationship with the child that could be a protective factor. The Review particularly identified the risks for misinterpretation that this second issue could lead to and as a result a specific recommendation has been made in this regard. **(Recommendation 4)**

3.3.12. Reflection with the GPs concerned also drew attention to the difficulties for non-specialist workers in assessing parenting capacity. For those GPs who talked to the father about his relationship with Child G, there was a broad awareness that they should consider parenting capacity. However, this to some extent sat uncomfortably with them and they were aware of the limitations of their professional knowledge in this area. There was no lack of awareness of links between mental health and potential concerns for children. However, Child G's situation did not, based on what they knew at the time, trigger a safeguarding concern.

> *"we can't refer every child living in a house with mental health issues – there are so many"*

The GPs described having significantly high numbers of adults with mental health problems in their practices. One of the GPs estimated that 20% of the patients she saw had depression or other mental health issues. Another spoke of "*deeply entrenched chronic mental illness*" for many of their patients. What emerges from the experience of this group of health professionals are the real difficulties of managing the impact of these problems on their patient lists within the constraints of their time and given the nature of their professional role. A number of recommendations intended to support GPs further in this context have been made by the Clinical Commissioning Group SIRI report.

3.3.13. A cause of concern raised by the GP who referred the father to the Single Point of Access for the secondary mental health team is that they had expected a full assessment of the father to be undertaken by the SPA, rather than a telephone assessment. The Standard Operating Practice for the SPA however is to conduct an initial assessment by phone. If the individual is assessed as likely to meet the criteria for secondary health services, a full assessment is then undertaken, although due to demand current waiting times are approximately 6-8 weeks. This was the process that was followed with the father of Child G. This episode has also led to further learning about potential problems arising out of an overlap between referrals to IAPT and to

SPA and these have been made subject to a recommendation in the Isle of Wight NHS SIRI.

3.3.14. Whilst there may be different professional perspectives on the needs of an individual patient for urgent treatment, there is no basis for this Review to conclude that the decision taken by the SPA for the father to remain in treatment with IAPT was misjudged. Whilst it is impossible to say whether there would have been any impact on the outcome had a full assessment taken place, it is of course possible that it may have reached a different assessment of his risk. However, based on what is known about the father, including his reluctance to talk about his own problems and what he had previously told professionals, considerable caution needs to be exercised in any assumption that an assessment by the secondary mental health team would have reached fundamentally different conclusions. Nevertheless, identified learning has resulted from these events regarding the need for better understanding between referring GPs and mental health services about their practice and thresholds. This has been recognised by the SPA team in discussion with the author as an area of communication they could develop with GPs. A resulting recommendation has therefore been made for the Isle of Wight NHS Trust working with the CCG. **(Recommendation 5)**

3.3.15. Child G's father attended for his first assessment at the IAPT service three weeks before Child G's death. At each subsequent treatment session, the therapist reviewed his assessment. The therapist's assessments are properly documented and clearly identify the risk indicators that have been discussed. He was concerned about the risk of suicide, but noted that the father was not currently having active thoughts or planning for suicide. He identified that the relationship between the father and his wife did not appear to be likely to end suddenly, but nevertheless put in place, with the father, a Risk Management plan if that were to happen. Both the therapist's records and his reflections on his work with the father are coherent and well considered. It appears that he was beginning to establish a working relationship with the father, and was particularly conscious of the difficulties that the father had with reading and writing which had blocked his contact with IAPT the previous year.

3.3.16. The therapist specifically considered risk to others during his assessments, but concluded that at that time this was not a factor. During the course of the assessment the father described experiencing a nightmare in which he killed his wife and daughter. Armed with the knowledge of what did ultimately take place, this may appear to be a significant cause for concern, but such a conclusion would be misconceived. It was evident that the therapist had asked further probing questions about this, as a result of which he assessed that there was nothing to indicate that the father had any intention to act on this. It seemed to him likely that the nightmare was indicative of the father's feelings of loss in relation to his family.

3.3.17. Research and practice knowledge in relation to intrusive bad thoughts clearly identify that there is no simplistic link between experiencing bad thoughts

and any intention to act them out.[11] Baer identifies that everyone occasionally experiences bad or distressing thoughts (in this case, dreams), but only in some limited circumstances are these thoughts indicative of dangerousness. In particular Baer identifies these key indicators:

- *If you do not feel upset about the thoughts instead find them pleasurable*
- *If you have ever acted on violent or sexual thoughts or urges in the past*
- *If you hear voices, think people are against you or see things that others do not see*
- *If you feel uncontrollable anger and find it hard to resist urges to act on your aggressive impulses.*

In the father's case none of these features applied, and as is well established the greatest predictor of future behaviour is past behaviour. There was, and still is, no evidence of violence in the father's history. It should also be noted that although this Review has paid considerable attention to the father's depression and the professional response to this, we do not know to what degree his mental health, rather than underlying personality traits, may have played a part in his subsequent actions.

3.3.18. A limited body of research is available about the phenomenon of parents who intentionally kill their children, and sometimes themselves, in the context of parental separation. What is known is that this is a rare occurrence although one which takes place with a steady frequency from one year to the next. A major study by O'Hagan[12] identified 128 cases of filicide over an 18 year period which would translate to 7 or 8 such cases each year. Analysis of the available statistical information by Berry et al[13] in 2013 highlighted that in England and Wales there was an average of 4 parental homicides followed by suicide annually. Whilst the persistent nature of these deaths over time is of serious concern, the very small numbers involved mean that it is extremely difficult to develop a means to identify those parents with the potential to kill their children in this manner. Whilst similarities have been identified between those who kill, thousands of others who share the same traits or indicators do not follow the same path.

3.3.19. Based on the information that was available to the professionals involved with the father, it is not surprising, nor unjustified, that the focus was predominantly on his risk to himself rather than on a risk of violence towards others. In reviewing whether or not professionals could have concluded that the father presented a risk of serious harm to Child G, not only the information provided by the agencies about his presentation has been taken into account, but also the views of his family. Child G's mother clearly remains bewildered that he could have taken the actions he did. She had seen no evidence of behaviour that would lead her to consider he could harm his daughter. She had not prevented him having any contact with

[11] Baer, L 2001
[12] O'Hagan, K 2014
[13] Berry et al, June 2013

Child G after he left the home and had no intention of doing so in the future. She recognised that there were limits to his parenting capacity, but agreed that he should have a significant level of time with his daughter, which she would not have done had she had any indicator of concern. The consistent picture of the father is a man who had periods of depression and was isolated and lonely, that the breakdown of his marriage represented a significant loss for him, but that he showed no indicators such as anger or aggression. Even with hindsight, it is difficult to identify that this was a man who posed such a risk.

4 CONCLUDING COMMENTS

4.1. The purpose of a Serious Case Review is to learn from the case in order that improvements to practice can be put in place to help families in the future. The particularly disturbing nature of the events outlined in this review and the profound impact these events have had on those who loved Child G rightly demanded a careful analysis of what took place.

4.2. What has been evident during this examination of practice has been the depth of professional concern and personal distress for all who have been involved with this family. The events, and the subsequent processes for the 3 linked reviews, have identified areas for learning and improvement and it is evident that there has been a clear desire amongst professionals to reflect and learn.

4.3. Although it is tempting to seek to identify points at which the Father's intentions could have been thwarted, there is little if anything to suggest that this would have been possible during the short time period during which he accessed services. On the basis of the information to them, neither the professionals involved, nor Child G's mother, had reason to believe the father had the capacity to commit such an appalling action.

5 RECOMMENDATIONS FOR THE BOARDS

Recommendation 1: That the systems for sharing information amongst all agencies involved in the assessment of risk to both adults and children are reviewed and effectively aligned.

Recommendation 2: That the Isle of Wight Safeguarding Adults Board and the Isle of Wight Safeguarding Children Board develop a shared strategic approach to 'Think Family' for the Isle of Wight and agree priority areas for development within their annual planning.

Recommendation 3: The Isle of Wight Safeguarding Children Board to work with its partner SCBs to

a) review the current *4LSCB Joint Working Protocol for safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress* with a view to developing a more accessible document with practitioner friendly information for the wider multi-agency partnership.

b) seek assurance from partner agencies that effective means have been put in place for developing staff knowledge and practice as identified within the Joint Working Protocol.

Recommendation 4: That action is taken to ensure that professionals know when undertaking risk assessments with adults, that it is the parental response to any caring responsibilities for children, not the children themselves, that may be considered a protective factor.

Recommendation 5 (for Health partners): A plan to be put in place between the IOW CCG and the IOW NHS Trust to develop the professional understanding between primary health care and mental health services of their roles and operating procedures.

REFERENCES

Baer, L: The Imp of the Mind: Exploring the Silent Epidemic of Obsessive Bad Thoughts (2001)

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Home Office: Controlling or Coercive Behaviour in an Intimate or Family Relationship (2015)

HM Govt: Working Together to Safeguard Children. (2015)

O'Hagan, K: (2014) Filicide-Suicide. The Killing of Children in the context of separation, divorce and custody disputes.

Appendix A: Terms of Reference Areas for Consideration

(a) **IOW Safeguarding Children Board**:

7. Was there sufficient awareness, understanding and application by the agencies involved of the 4LSCB Joint Working Protocol for safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress - with particular emphasis on Part 3 of the protocol?
8. Was sufficient priority given to the needs and safety of the child by the agencies involved and were the risks to the child effectively assessed in the context of the father's mental health issues? Was there a perception by involved agencies that the child could be seen as a protective factor?
9. Were there missed opportunities by the agencies involved for interventions to have been put in place to minimise risks to the child and promote protective factors.
10. Should a referral have been made to CSC by the agencies involved when the father was expressing that he might harm himself?

(b) **IOW Safeguarding Adult Board**:

1. To explore the links between adult safeguarding and child safeguarding procedures and pathways including how the MASH assesses referrals for linked cases on the IOW
2. Was the male identified as an 'at risk' adult within the terms of the Care Act 2014.

(c) **IOW NHS Trust (mental health)**

1. To establish if the process for receiving the CA12 was processed in line with policy, procedure and best practice guidance. To explore and comment on the responsibilities of the relevant organisations when receiving a CA12.
2. To examine if the decision taken on receipt of theCA12 was appropriate to the concerns being raised by the police. Was the decision taken by the clinician at the point of assessing the CA12 appropriate?
3. Was the response of the Mental Health service appropriate for a primary care patient referred into community services?
4. Were sufficient risk assessment and treatment plans in place to safeguard the individual and his family?
5. Could there have been any additional safeguarding steps considered or taken for other members of the household. Should a referral have been made for the child of the household to any other agency?

(d) **IOW Primary Care (for the adult male)**

Communication and information sharing:

1. To examine the mechanisms and processes within primary care for practice based staff to raise, discuss and share safeguarding concerns with each other.
2. To examine the mechanisms and processes within primary care for practice based staff to share information and intelligence regarding different household members, where vulnerability and risk exist.
3. To examine the communication intervals/standards between mental health and primary care services both at the point of urgent referral and during the receipt of any IAPT provision.

Systems and policies:

4. To examine the available mechanisms within primary care, for the flagging of individuals and/or creation of automated alerts regarding known vulnerabilities and risk for individuals, e.g. Domestic Violence, Mental Health, Safeguarding Concerns (CYP & CA12 forms); as well as examine the mechanisms for mapping these alerts and flags to other family/household members.
5. To examine primary care processes for the recommendation and/or referral of parents to Early Help Services for advice and support and the follow up of this.
6. To examine the policies, processes and pathways which enable primary care to access urgent mental health assessment both in and out of hours and what the criteria and response time parameters are for such requests.
7. To examine what the processes are within primary care which support practice staff in access to peer or specialist review of individuals with chronic mental health conditions.
8. To examine the policies and processes across primary care in relation to the transfer of information between GPs when patients deregister from one practice and register at a new one

Workforce knowledge and understanding:

9. To examine awareness, understanding and application of the 4LSCB Joint Working Protocol for Safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress.
10. To explore primary care understanding regarding the risks and vulnerabilities for children of parents with: mental health, substance misuse, learning disability and emotional or psychological distress, to include exploration of understanding in relation to the need for explicit documentation of the consideration of parenting capacity at the point of parental mental health diagnosis and thereafter as appropriate.

11. To review primary care staff training in relation to adult safeguarding and their understanding of what they need to do in the presence of safeguarding concerns.
12. To examine the support mechanisms for practice staff following significant events like a MHH.

(e) **IOW Primary Care (for the child)**

Communication and information sharing:

1. To examine the mechanisms and processes within primary care for practice based staff to raise, discuss and share safeguarding concerns with each other.
2. To examine the mechanisms and processes within primary care for practice based staff to share information and intelligence regarding different household members, where vulnerability and risk exist.

Systems and policies:

3. To examine the available mechanisms within primary care, for the flagging of individuals and/or creation of automated alerts regarding known vulnerabilities and risk for individuals, e.g. Domestic Violence, Mental Health, Safeguarding Concerns (CYP & CA12 forms); as well as examine the mechanisms for mapping these alerts and flags to other family/household members.
4. To examine awareness, understanding and application of the 4LSCB Joint Working Protocol for Safeguarding children and young people whose parents/carers have problems with: mental health, substance misuse, learning disability and emotional or psychological distress.
5. To examine the processes across multi-agency partners which assure the awareness and monitoring of the well-being of children where the parent is known to have issues with mental health, substance misuse, learning disability and emotional or psychological distress.
6. To examine primary care processes for the recommendation and/or referral of parents to Early Help Services for advice and support and the follow up of this.
7. To examine if there are any established processes which assure that the voice of the child is heard and their lived experience elicited when living with a parent with issues with mental health, substance misuse, learning disability and emotional or psychological distress.

Workforce knowledge and understanding:

8. To explore primary care understanding regarding the risks and vulnerabilities for children of parents with: mental health, substance misuse, learning disability and emotional or psychological distress, to include exploration of understanding in relation to the need for explicit

documentation of the consideration of parenting capacity at the point of parental mental health diagnosis and thereafter as appropriate.

9. To review primary care staff training in relation to child safeguarding and their understanding of what they need to do in the presence of child safeguarding concerns.
10. To examine the support mechanisms for practice staff following significant events like a child death

APPENDIX B: RECOMMENDATIONS MADE BY NHS SIRI reports

Isle of Wight NHS Trust

RECOMMENDATIONS

1. There is liaison between the Adult Safeguarding team both within the Council and the Trust, the Police and the SPA team to gain an understanding of CA12 processes within all organisations.
2. Information gathered at the above meeting should be clearly set out for information within the CRHT SOP.
3. The draft CRHT SOP is reviewed and amended to include clear expectations of what referral information will be documented, and where is should be documented.
4. A plan should be put in place with the Clinical Lead SPA, the CRHT Team Leader and the Matron to ensure that protected time to monitor and develop practice within the team is facilitated.
5. A review of what the ‘on hold’ process was achieving should be carried out, so that any positive factors are not lost in removing the system.
6. A written protocol for liaison and referral between IAPT and SPA should be written.
7. Communication should be given to staff regarding the required standards for documenting risk assessments – to include risk formulation.
8. Work is undertaken to ensure that the content of the 4LSCB Joint Working Protocol is embedded within all mental health teams.
9. There should be work undertaken within the Trust in partnership with the Local Authority to ensure timely availability of Safeguarding Children Training Level 3.
10. Planned changes to the PARIS patient record should support the routine assessment of risks to dependents.
11. All teams within the service should have some level of access to other systems used within the Clinical Business Unit. i.e. IAPTUS, BOMIC, PARIS.

Isle of Wight Clinical Commissioning Group (Primary Health Care)

1. GP practices to hold monthly meetings to discuss safeguarding cases

2. Family/household members to be mapped to each other on System One along with their flags to promote dialogue between colleagues within a practice

3. A training matrix to be shared across Primary care identifying level, frequency length and mode of safeguarding training for each staff role

4. Capacity for practice based safeguarding training to be developed via the GP leads for safeguarding, to complement the multi-agency training offered by LSCB

5. There is a need to examine with some urgency whether flags ad alerts have migrated from prior EPRs to System One.

6. Designated GP to review all CA12s received for their patients and summarise for an alert on System One, so that any other GP or primary care practitioner seeing the patient can review, be mindful of and undertake any action required

7. Primary care to agree a standard process for managing new and old flags/alerts

8. An awareness raising exercise in relation to the JWP to be undertaken across Primary care

9. The JWP to be condensed into a small number of key pages and the flowchart it currently includes

10. Capacity for practice based safeguarding training to be developed via the GP leads for safeguarding, to complement the multi-agency training offered by LSCB

11. Need to establish the extent of the issues via:

- Primary care audit into current structure and frequency of safeguarding case discussion
- Early Help Audit into referrals received by Primary Care and feedback frequency & timescales
- Adult mental Health Audit into referrer feedback and feedback to Primary Care in general

12. There is a need for standardisation and compliance across Primary care in relation to:

- Common key policies, procedures and processes
- Safeguarding policies and procedures
- Safeguarding training
- Use of flags and alerts
- Risk assessment and evidencing parenting capacity assessment

13. Need to provide information and/or guidance to increase clinician understanding in relation to these key issues:

- Children as protective factors
- CBT in people with LD
- Information sharing

14. Monthly newsletter to be circulated and to include lessons learned