Oxfordshire Safeguarding Children Board

Serious Case Review

Services provided for Child M and his mother

Executive Summary

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1. INTRODUCTION

1.1. Between July 2017 and November 2018, Oxfordshire Safeguarding Children Board (the LSCB) conducted a Serious Case Review (SCR) in relation to the services provided for a five year old boy, referred to in this report as Child M, and his mother. Child M died of stab wounds while in the family home with his mother in March 2017. His mother had self-inflicted knife wounds.

1.2. Child M's mother was known to have been a patient of mental health services in Oxfordshire and in two other local authority areas where she had lived during her pregnancy and following the birth of her son in 2012. There were no other members of the household as Child M's mother had avoided contact with his father and other members of her family for some time.

1.3. The SCR was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a '*rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'*. The LSCB is required to *'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'.*[1] This document summarises the SCR findings which are published in full in a separate report.

Reasons for conducting the Serious Case Review

1.4. The circumstances of Child M's death were discussed by the LSCB Case Review and Governance Group on 3 May 2017. At that point the LSCB was informed that:

- Child M had died as a result of abuse
- His mother had suffered from mental illness and been a patient of mental health services or treated by her GP for at least five years
- The family had lived in Oxfordshire since mid 2015; earlier that year Child M had been placed in foster care by another local authority at the request of his mother
- In the months prior to his death Child M's mother had been in regular contact with her health visitor; he had frequently been observed to be a happy, contented boy; he had started to attend his local primary school and there had been no concerns about his care or presentation
- In the weeks before the death, Child M's mother showed no signs of serious mental illness
- She had been assessed by the psychological service because of her anxiety and her reported fear of using public transport; arrangements

[1] *Working Together to Safeguard Children* (2015), 4.1 and 4.7

were being made through the school to provide practical and emotional support to his mother.

1.5. The group decided that the circumstances met the criteria for a SCR and Paul Burnett, the Independent Chair of Oxfordshire Safeguarding Children Board confirmed the decision on 02 05 17.[2]

The focus and scope of the Serious Case Review

1.6. The review team decided that the SCR should consider events between mid 2014 (when the mother's mental health problems became known to services in Swindon) and the death of Child M in March 2017. As the work of the SCR progressed it focused on the following:

- The services provided for Child M and his mother
- Whether or not professionals could have identified the risk of Child M suffering serious physical harm
- The nature of the risk assessments that took place and in particular whether they were informed by a full knowledge of the mother's history of mental illness
- The effectiveness of working between professionals in services for children and those in adult mental health services
- Transfer of responsibility when the family moved from Swindon to Oxfordshire in 2015
- Decisions relating to the involvement of the mother's own family and Child M's father

In addressing these the SCR has taken account of the findings of the internal NHS serious incident investigation carried out by Oxford Health NHS Foundation Trust and considered their particular implications for work with parents who have a mental illness.

1.7. As well as identifying aspects of the case history that point to weaknesses in service provision, the SCR has identified examples of good, diligent individual practice and systems that worked effectively.

Agencies involved

1.8. The SCR considered the work of the following agencies and contracted professionals:

Oxfordshire

- Primary school and preschool
- Oxford Health NHS Foundation Trust (mental health services and health visiting service)

[2] The criteria for a SCR are in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, 5 (2) (a) and (b) (1)

- Children's centre in Oxfordshire (managed at the time by Action for Children under contract to the County Council)
- General Practice
- Oxfordshire County Council (children's social care)

Swindon

- Swindon Council (children's social care)
- Avon and Wiltshire Mental Health Partnership Trust
- Primary care and health visiting services

How the review was undertaken

1.9. Details of the principles underlying the approach to review and the steps taken to carry it out are set out in Appendix 2.

1.10. Child M's mother, his father and maternal grandmother were informed about the SCR in January 2018. This action was delayed because of reports of the mother's mental illness and also because of the parallel police investigation into Child M's death. Other family members had little or no contact with professionals during the period under review.

1.11. In May 2018 the independent lead reviewer held meetings with Child M's mother and with his maternal grandparents. Their views are summarised in Appendix 1 and are reflected at a number of points in the report.

Parallel investigations and proceedings

1.12. The death of Child M was investigated by Thames Valley Police. Child M's mother pleaded guilty to causing his death by manslaughter on the grounds of diminished responsibility and was made the subject of an indefinite hospital order under the Mental Health Act.[3]

1.13. There have been two other reviews of different aspects of the services provided to Child M and his mother conducted under health service procedures. The full report describes their remit and considers whether the commissioning of three separate professional inquiries in relation to the death of a child in these circumstances would in future be the best way of learning from such an incident.

2. KEY EVENTS AND SCR FINDINGS

Key events

2.1. Child M's mother suffered episodes of mental illness as a young adult and during her pregnancy. There were also long periods when she was free of obvious symptoms, usually when she took prescribed medication. Her parents date the development of her psychiatric problems to her early 20s,

[3] Sections 37 and 41 of the Mental Health Act 1983

but say that for many years they were not consistently diagnosed or treated. She had no history of violence.

2.2. Child M was born in 2012. There is no evidence to suggest that his mother had any difficulties in her care of Child M during the first three years of his life. In mid 2014 she moved to Swindon, found Child M a place in a nursery, registered with a GP who continued to prescribe her medication and kept in touch with her health visitor.

2.3. The first risk to Child M was identified in January 2015, when his mother attended the Emergency Department in Swindon with signs of delusional thinking. Her symptoms focused on perceived threats to Child M or her fear of losing him and on a small number of occasions over the following days she reported thoughts of killing Child M, which she believed would prevent others harming him.

2.4. On this occasion Child M's mother had sought help when her mental health deteriorated, the professionals involved responded quickly and sensitively and as a result Child M was not harmed. He remained in foster care for seven weeks and support services were provided when she resumed his care.

2.5. Child M's mother moved to Oxfordshire in June 2015. After this there was a lengthy period during which the family had regular contact with a children's centre, pre-school and a health visitor. All the professionals who had contact with Child M found him to be a calm, happy child who was developing normally and there were only ever minor concerns about the mother's care of Child M, none of which related to her mental health.

2.6. Whilst the family was living in Oxfordshire major concerns about the mother's mental health abated. She was assessed by the community mental health team in September 2015 and briefly had support from a care coordinator. The mental health service ceased its involvement in February 2016 when prescribing and monitoring her medication became the responsibility of the mother's GP.

2.7. In June 2016 Child M's mother approached a number of the professionals to report her fears about having to seek work when her son started school and her phobia of public transport, a problem that she had experienced in the past. This led her briefly to have suicidal thoughts.

2.8. A number of agencies made additional visits and Child M's mother was referred to a primary care level counselling service and then to the mental health trust psychological service. Her suicidal ideas ceased and the mother's mental health was judged to have stabilised.

2.9. Child M (who was already attending preschool) started full time primary school in September 2016 without any significant concerns. Professionals thought that social isolation was a continuing risk factor for Child M's mother and this was addressed by encouraging her to be able to work

closely with staff at the primary school and by having a named worker with whom she could discuss any concerns.

2.10. In early 2017 Child M's mother experienced another deterioration in her mental health without signs or symptoms being apparent to professionals. Unlike the episode in Swindon in 2015 Child M's mother was not aware that her mental health was deteriorating and did not make contact with professionals to seek help.

Knowledge of the family history and perceptions of possible risk to Child M

2.11. A mental health homicide review has been published in parallel with this report.[4] This report evaluates in detail the involvement of mental health services with Child M's mother throughout her life, including her diagnosis and treatment. It concludes that mental health professionals could not have predicted or prevented the death of Child M.

2.12. The Serious Case Review has identified a number of areas in which practice could be strengthened to reduce the likelihood of a future, similar death.

2.13. The deterioration in the mother's mental health in January 2015 posed a significant risk to Child M, but he came to no harm because she sought help at an early point and professionals ensured that Child M was safeguarded.

2.14. After this episode the knowledge that professionals had of the mother's history of mental health problems and (in due course) of this incident itself diminished, leaving those who were working with Child M and his mother with a limited understanding of possible risks to Child M. At no point after the family moved to Oxfordshire did any professional have a comprehensive knowledge of the mother's mental health history.

2.15. Over this period there were a substantial number of changes in the professionals working with Child M and his mother, most notably when case responsibility was transferred both in the local authority social care service and in the mental health service when the family moved in mid 2015. In Oxfordshire different agencies started to work with the family and in most agencies there was a natural turnover of professionals.

2.16. During the 2015 episode the mother's psychotic symptoms had focused on her child. Details of these indicators of possible future risk to him were not known to those such as the health visitor, children's centre, pre-school and school who undertook assessments or provided care for Child M in Oxfordshire. Case transfer and closure summaries did not contain the full details of the incidents that had placed Child M most at risk and would do so again if repeated.

2.17. By 2017 the mother's mental health was believed to be stable and as far as everyone understood she was complying with a regime of treatment that

[4] Anne Richardson Consulting Ltd (2019) Independent review into treatment and care provided by Oxford Mental Health NHS Foundation Trust. NHS England

had been in place for at least 15 months. There was no evidence of a return of her previous psychosis and she had been assessed and was due to start receiving treatment for a relatively minor mental health concern (travel phobia).

2.18. The main agency working with Child M and his mother at the time of his death was the school. Staff there had discovered minor details of the mother's mental health history fortuitously or from comments made by the mother, but no detailed records had been passed from other agencies. The school had only a general idea that the mother had been mentally ill in the past (by that time over two years previously) and no idea of the most concerning comments that she had made at that time.

2.19. Across all of their contact with the mother, professionals found further, understandable reassurance in their very positive observations of Child M and his interactions with his mother. Both in Swindon and in Oxfordshire Child M was closely observed by a range of professionals (including health visitors, social workers, children's centre, nursery, preschool and school staff). The consistent picture provided was one of warm, positive interaction between Child M and his mother, a child who had reached all of his expected developmental milestones and who was calm and happy. Child M was cherished by his mother who was anxious about how he would mix with other children and settle in at school. At times there were minor, individual signs of neglect, though even had information about them been collated they would not (even with the benefit of hindsight) have merited a referral to social care.

Signs of possible risk in the days before Child M's death

2.20. Review of records gives no indication that any of the professionals involved missed signs of a serious deterioration in the mother's mental health or risk to Child M in the days or weeks leading up to his death. Although it is not possible to be certain about the mental state of Child M's mother when he was killed in March 2017, the circumstances point to a sudden and drastic deterioration in her mental health.

2.21. The professionals working with Child M and his mother in early 2017 had a good level of contact with her and every reason to believe that they had a good understanding of the immediate circumstances. In contrast they had only a very limited understanding of the nature and level of risk that had existed historically.

2.22. It is possible that a fuller understanding of the history might have made professionals more cautious when Child M and his mother moved to Oxfordshire in 2015 or when she reported worries about her mental health in 2016; even if different arrangements had been put in place to coordinate services for Child M at those times they are likely to have been reviewed and relaxed by early 2017. At that point she was cooperating with professionals even if she did not always agree with their opinions. There

was no indication that the mother's mental health was deteriorating, no reason to see the mother's pattern of behaviour as presenting a high level of risk and no reason to think that steps needed to be taken to safeguard Child M.

2.23. The SCR identified a number of aspects of service provision where there were identified weaknesses in practice or challenges for agencies which could have implications in other cases:

- The way in which the needs of Child M and his mother were assessed, including the risk that she might harm him
- Whether assessments were based on a full knowledge of the history of the mother's mental health difficulties and the concerns about the impact of these on the parenting of Child M
- How the family's move from Swindon to Oxfordshire and the transfer of information between agencies affected the understanding of risk and the provision made
- Whether Child M's extended family (and particularly his maternal grandparents) should have been involved.

2.24. Despite its tragic outcome this was a case where agencies with responsibility to work with children were properly focused on the needs of the child. The SCR has identified strengths in professional practice and service provision which would contribute to good outcomes for children in other cases. These included:

- The decision to accommodate Child M in Swindon and the collaborative working between social care and mental health professionals while he was in foster care and after his return home
- The active approach taken by a number of professionals and agencies in Oxfordshire to obtain information from their counterparts in Swindon when the family moved into their area
- Services provided to Child M and his mother by agencies in Oxfordshire (including the health visitor, children's centre and pre-school) which promoted his wellbeing and supported her mental health needs (so far as they could be ascertained)
- The allocation of additional support and resources by Child M's school so that his mother had a point of contact with whom she could raise any concerns about him.

2.25. These are also described in the full SCR report. Agencies involved should consider further what enabled staff to work in this way so that the approaches taken can promoted.

3. RECOMMENDATIONS

Introduction

3.1. The review has made recommendations in the following areas of practice and service provision:

- Establishing the principle and practice of joint assessment of need and risk by mental health and children's social care professionals when a patient with a psychiatric illness has the care of children or close contact with children
- Improving the practice of professionals in accessing and taking account of historical records when undertaking assessments
- Improved transfer of cases of children in need across local authority boundaries
- More efficient review of complex cases where service users have been seriously harmed or killed.

3.2. These recommendations are designed to complement those made by individual agencies in internal reviews of their involvement with Child M and his family.

Recommendation 1

3.3. Oxfordshire LSCB should establish the extent to which professionals in mental health services and local authority social care professionals and others working with children in their areas undertake joint assessments. The LSCB should consider how best to promote joint assessment activity when a patient with a psychiatric illness has the care of children or close contact with children and identify any barriers to implementing this approach. Assessment activity should be supported by multi-agency training which provides a better mutual understanding of knowledge, roles and responsibilities.

3.4. Swindon LSCB should consider the relevance of this recommendation for its member agencies.

Recommendation 2

3.5. Oxfordshire Safeguarding Children Board should consider whether its current threshold of need document places sufficient emphasis on the need to consider previous and historical concerns and might reoccur in the life of a child, such as the re-emergence of a serious parental mental illness.

Recommendation 3

3.6. Oxfordshire LSCB should satisfy itself that mental health service providers and GPs have adequate arrangements in place to identify and assess the needs of the children of patients who are being treated for psychiatric illnesses, by either the GP or the appointed care coordinator.

Recommendation 4

3.7. Oxfordshire and Swindon LSCBs should ensure that member agencies set their staff clear expectations for obtaining and reading case histories and

giving them due weight in assessment. Member agencies should report back to the board on progress and any difficulties in meeting the agreed standards.

Recommendation 5

3.8. Swindon LSCB and Oxfordshire LSCB should identify current approaches to the transfer in and out of their authority areas of child in need cases and others that fall below the threshold of child protection (i.e. under Section 47 investigation or subject to child protection plan or care proceedings). Boards should satisfy themselves that current approaches are satisfactory.

Recommendation 6

3.9. Swindon LSCB and Oxfordshire LSCB should seek reassurance that the implementation of the General Data Protection Regulation (GDPR) has not led to the imposition of inappropriate limitations on information sharing about the welfare of children in need, including those who move in and out of the local authority area.

Recommendation 7

3.10. Oxfordshire Safeguarding Children Board, its member agencies (including health commissioners and the police) and NHS England should consider how in future a more streamlined approach to reviewing complex incidents can be developed. The approach should take account of statutory reviewing processes including Local and National Serious Child Safeguarding Practice Reviews, Mental Health Homicide Reviews and Domestic Homicide Reviews.