Oxfordshire Safeguarding Children Board

Serious Case Review

Services provided for Child M and his mother

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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. There were no other members of the household and 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 sets out the SCR findings in full.

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;

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

arrangements 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 review has taken account of the findings of the internal NHS serious incident investigation carried out by Oxford Health NHS Foundation Trust (see Section 1.13 below) 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 relevant criteria 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. Section 4.8 of this 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. EXECUTIVE SUMMARY

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

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

problems to her early 20s, 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 Child M's 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 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 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 reducing 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

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

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 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.

<u>Signs of possible risk in the days before Child M's death</u>

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. These are evaluated in Section 4 of this report. Section 5 sets out recommendations covering all of these areas.

2.25. Despite its tragic outcome this was a case where the main agencies with responsibility to work with children were 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.

2.26. These are also described more fully in Section 4 of the report. Agencies involved should consider further what enabled staff to work in this way so that the approaches taken can promoted.

3. BACKGROUND AND KEY EVENTS

3.1. This section provides an account of important contacts between Child M's family and agencies with safeguarding responsibilities during the period May 2014 – March 2017. Limited detail is provided in some areas in order to protect the privacy of family members.

3.2. It also includes a brief summary of the involvement of Child M's mother with mental health services before she moved to Swindon on 2014. This provides context for her later difficulties. It is important to recognise that significant parts of this information were not known to most of the professionals who worked with her during 2014-17. The detail and significance of this is dealt with in Section 4.4

3.3. Appendix 1 sets out additional information provided by family members and their views on the services provided.

	London – prior to 2014
2004 - 2010	Between 2004 and November 2010 Child M's mother had nine psychiatric admissions to a number of different hospitals in London (which were part of services provided by two different hospital trusts). The longest admission was for a period of 5 months but most were brief, lasting only a few days. On one occasion she had made detailed suicide plans but not carried them out. Child M's mother presented very differently during the various admissions and she was given a number of different psychiatric diagnoses and treatments. On most occasions she was offered follow up appointments but did not keep them consistently and was lost to services. Follow up was sometimes hindered by changes of address.
2011 - 2012	In late 2011 Child M's mother was voluntarily referred to the perinatal mental health service in South London. She was assessed by and worked with a range of professionals including social workers. Child M was born in 2012 and looked after by his mother. By June 2012 she was judged by the professionals working with her to be able to care for Child M without a child in need or child protection plan.
June 2012 May 2014	Child M's mother looked after him in the community with no apparent concerns from the professionals who were in contact with her.

	Swindon 2014 - 2015
May 2014	Child M (aged 2) moved with his mother from London to Swindon. She registered with a GP, reporting a history of bipolar disorder (a condition affecting mood which can swing from one extreme to another) and continued to take medication prescribed by the GP
January 2015	Child M's mother presented at Emergency Department showing signs of paranoid and suspicious behaviour, some focused on concerns about her son
	She was discharged home and referrals were made for urgent follow up by the mental health service and social care
	With his mother's agreement Child M was placed in foster care by the local authority after it emerged that his mother had threatened to harm herself and him. His mother had a brief inpatient psychiatric admission. Child M spent seven weeks in foster care. Child M's mother was diagnosed with a psychotic disorder and her medication changed to reflect this. Professionals observed Child M to be happy and developing normally.
February – May 2015	Child M was discharged by agreement to his mother's care. He was considered to be a child in need and the family received a coordinated package of services from the social care family support service, health visitor and the mental health service care coordinator. The level of meetings and phone calls between workers in different agencies reduced as the anxiety about Child M declined.
	Oxfordshire 2015 - 2017
May – August 2015	Child M's mother arranged a house exchange and in June 2015 moved to a small town in Oxfordshire. The agencies involved transferred the case to partner agencies in Oxfordshire without there being a coordinated process. The GP obtained the Swindon records and ensured a rapid referral to the local mental health service
	The Swindon social worker referred the family to Oxfordshire social care (through the multi-agency safeguarding hub or MASH) where a manager decided that a child in need assessment was not needed as there was a good package of family support in place consisting of children's centre, GP, health visitor and mental health

	services. No formal 'team around the family' arrangement was put in place and there was no agreed lead professional. Child M was seen regularly by a health visitor and at a children's centre.
September 2015	An Oxfordshire mental health services psychiatrist assessed Child M's mother and a care coordinator was appointed. She remained involved until November 2015. During this period the mother again began to take Lithium, her preferred medication. Child M's mother presented as being in good health and no full risk assessment was undertaken
November 2015	The mental health care coordinator left her post and until February Child M's mother was monitored through her attendance at outpatient appointments and by her GP. She appears to have complied with her medication
February 2016	Child M's mother was discharged from the mental health service. Advice to her GP was that she should continue to take Lithium, with regular blood tests to monitor its level in the blood and that this might need to continue for some years.
	Child M had started preschool in September 2015 and the family continued to attend activities at the family centre. He did well at preschool although a number of minor 'cause for concern' forms were generated by staff, mainly worried about unkind comments made by Child M at staff and other children. None constituted a cause for suspicion of neglect or abuse.
March – May 2016	Child M's mother continued to do well, taking him to the children's centre, having periodic visits from her health visitor and seeing her GP
June - August 2016	Child M's mother became concerned about having to seek work when he started school and fears of travelling on public transport (which she said she had had in Swindon and London) re-emerged. She reported suicidal feelings and ideas to the ambulance service and a number of services, all of whom responded by making additional visits. The MASH allocated the family for a child in need assessment, but after social care staff contacted the mother and other agencies involved they concluded that there was no need for the local authority to become involved. A referral to the local primary care based psychological therapy service 'Talking Space' was turned down because of the complexity of the mother's mental health history.

	Following an assessment visit by the local mental health team the mother secured a referral to be seen by the psychological service. This referral was lost in the system and not acted on until the GP questioned the delay. At this point Child M's mother was being prescribed Lithium and an anti-depressant medication.
September 2016	Child M started school. Over the following months meetings were held with Child M's mother to assist him in settling in. His mother expressed fears about his behaviour and bullying. These did not match the school's belief that he was happy at school, settling in well and had no major problems. No history of concerns had been passed on to the school from the pre-school or other agencies.
January 2017	Recognising that the health visitor would shortly close the case due to Child M's age, a handover meeting was held at the school so that Child M's mother had a named member of staff at the school whom she could contact in the event of any concerns. Mother later agreed to begin attending a 'drop in' session at the school
February 2017	The psychological service assessment took place in February 2017. The service agreed to work on the mother's fears of travelling on public transport and a follow up appointment was offered.
	A Lithium blood level test result showed negligible levels in the mother's blood. The GP took no immediate action because Child M's mother had seemed well at the consultation and follow up appointments were scheduled with the GP and the psychological service
	A further meeting was held at the school with Child M's mother as she continued to be concerned about how he was settling into school. The role of the home school link worker was confirmed. Professionals involved had no concerns about Child M or his relationship with his mother. The health visitor closed her file on Child M on 9 March 2017
March 2017	On 8 March 2017 the school noted that Child M's mother had become anxious about how Child M had been in school, when the school's impression was that he had had a very happy day. The following day she wrote to the acting head teacher alleging that Child M was being bullied and was also bullying other children. Although the school had been observing Child M's interactions closely and had seen nothing about which they were concerned, it undertook to monitor any concerns and meet with his mother in seven

	days. Very detailed records were kept on 9 and 10 March and nothing of concern was noted
	On Monday 13 March 2017 Child M did not attend school. The school phoned his mother three times and visited the home without success. Mother not answering the phone was considered out of character
	Child M was also absent on Tuesday 14 March 2017. Again school staff phoned and visited the home without success. The police were called because mother's failure to report the absence was unusual. The police record of the call noted that *'the school stated that (mother) was known to have some mental health issues but they did not know what this entailed and Child M had previously spent some time in care'.* When police officers forced entry into the home Child M was found dead and his mother had self-inflicted wounds

4. SERIOUS CASE REVIEW FINDINGS

4.1. Evidence of risk to Child M and how it was understood by professionals

Background information and difficulties encountered by Child M's mother in Swindon

4.1.1. Child M's mother suffered episodes of mental illness as a young adult and during her pregnancy in 2011 – 12. There were long periods when she was free of symptoms, usually when she took prescribed medication, either antipsychotics or Lithium (which is typically used for the treatment of bipolar disorder).

4.1.2. Her parents date the development of her psychiatric problems to her early 20s, but say that for many years they were not consistently diagnosed or treated. Child M's mother was diagnosed with bipolar disorder for the first time during her pregnancy. She is understood to have been successfully treated and there is no evidence to suggest that Child M's mother had any difficulties in her care of Child M during the first three years of his life. She had no history of violence. In mid 2014 she moved to Swindon, found Child M a place in a nursery, registered with a GP who continued to prescribe her Lithium and kept in touch with her health visitor.

4.1.3. 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 (hearing voices from his bedroom, suspicion of a man at his nursery, fear of others harming him). On a small number of occasions over the following days she reported her own thoughts of killing Child M, her motivation being, she said, to prevent others harming him. Sometimes her behaviour was described in professional records as a more general fear of '*not feeling able to keep him safe'*.

4.1.4. In the weeks before this episode Child M's mother had stopped or severely reduced her medication with no medical advice or supervision, though this only became apparent afterwards.

4.1.5. 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. The local authority and the mental health service in Swindon collaborated to ensure that Child M was gradually and safely returned to the care of his mother and she had additional help looking after him.

4.1.6. This episode appeared at the time to have been managed very successfully by everyone involved and to have had no negative lasting legacy. Since the death of Child M it has emerged that during this period the mother became suspicious that he had been bullied when he was in

foster care and became convinced that her own parents wanted to take over his care.

4.1.7. Although she did not articulate them the mother seems to have harboured these thoughts and allowed them to shape her response to later difficulties and offers of help from professionals.

The circumstances in which Child M was living in Oxfordshire

4.1.8. 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 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 minor concerns about the mother's care of Child M. For example the family pet was poorly house trained as a result of which Child M sometimes smelt of urine.

4.1.9. During the time 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 gradually resumed taking Lithium which was her preferred treatment. The mental health service ceased its involvement in February 2016 so prescribing and monitoring her medication was the responsibility of the GP

4.1.10. In June 2016 Child M's mother approached a number of the professionals that she was in contact with to report her fears about having to seek work when her son started school and her phobia of public transport, both of which she said were problems that she had experienced in the past. This led her to have suicidal thoughts. 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 which subsequently began an assessment. Her suicidal ideas ceased and the mother's mental health was judged to have stabilised.

4.1.11. 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 involved in the primary school and by having a named worker with whom she could discuss concerns.

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

4.1.12. Between January 2015 and the death of Child M in March 2017 the knowledge that professionals had of the family history 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.

4.1.13. A small number of professionals in Swindon had been aware that in January 2015 Child M's mother had suffered delusions that directly involved him and that she had expressed ideas about killing him. At the time of this incident the local authority obtained some information about the mother's contact with mental health services during her pregnancy and this was shared with the mental health service in Swindon.

4.1.14. Between January and April 2015 case responsibility for Child M and his mother was transferred both in the local authority social care service and in the mental health service in Swindon. When the family moved from Swindon to Oxfordshire in mid 2015 a whole new set of professionals and agencies became involved. The arrangements for the transfer of the case when the family moved are discussed in detail in4.

4.1.15. In Oxfordshire different agencies started to work with the family. For example: the children's centre gave way to the preschool and then the primary school. The health visitor worked closely with Child M and his mother for more than 18 months but closed the case when he started school.

4.1.16. In other agencies there was a natural turnover of professionals: the first mental health care coordinator left her post and it was assumed that the mother's care could be overseen by a psychiatrist through her attendance at outpatient clinics. The mental health service closed the case because the mother's mental health was stable and her GP took over responsibility for her care. Later episodes of care from the mental health trust involved three new professionals community psychiatric nurses (who undertook assessments) and a clinical psychologist.

4.1.17. Some professionals in Oxfordshire were aware that Child M's mother had been ill during her pregnancy in 2011 – 2012, but that there had been no subsequent concerns about her care of her baby.

4.1.18. Details of the mother's treatment during pregnancy and inpatient mental health admissions were only referred to in documents provided to the mental health trust. This incomplete account had been attached to the electronic patient record under a file name that did not highlight their contents, had not been used during risk assessments and was not known to other professionals in Oxfordshire.

4.1.19. During the 2015 episode the mother's psychotic symptoms (described in 3.1.3 above) 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.

4.1.20. Some of the professionals in Oxfordshire who were working with the mother in 2017 knew that she had been ill in January 2015. They understood that the acute episode had ended positively and Child M had been returned to her care.

4.1.21. 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 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).

4.1.22. 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 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 worrying comments that she had made at that time.

4.1.23. 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.

<u>Professional involvement with Child M and his family in the weeks before his death</u>

4.1.24. The psychology service assessment was undertaken on 1 February 2017 and after consultation with other team members it was agreed that treatment for travel phobia would be offered. A further appointment was sent but did not take place because of Child M's death.

4.1.25. In later January 2017 the health visitor and the school held a meeting to confirm support arrangements for Child M's mother as the health visitor would no longer be involved now that Child M had started school. A home school link worker would have occasional phone or text contact with the mother and she would come to a regular 'drop in' at the school.

4.1.26. In later February 2017 a further meeting was held attended by the mother, the health visitor and the home school link worker to discuss concerns expressed by Child M's mother about how he was settling into school.

4.1.27. In mid-February Child M's mother had an appointment with her GP. She told her that she had seen the psychologist and had a further appointment. The GP assessed her mental health as being 'stable' and

arranged to see her in 4 weeks. Shortly after the mother had her regular Lithium level blood test, part of the normal three month cycle of tests that the mother always attended. These showed an 'undetectable' level of Lithium. Taking into account her forthcoming psychological service assessment follow up appointment and her recent surgery attendance, the GP decided to see the mother in three weeks time as she had planned.

4.1.28. The week before his death Child M's mother again became anxious about how Child M had been in school and wrote to the acting head teacher alleging that he was being bullied, did not want to go to school and did not want to stay at lunchtime. The incidents described all related to another child in the class who appears to have had some behavioural problems or been prone to overexcitement and it is highly questionable whether they would have legitimately fallen within even the broadest definition of bullying. On the day in question the school's impression was that Child M had had a very happy day.

4.1.29. Although the school had already been observing Child M closely, had seen nothing of concern and believed that he was very happy at school, the acting head wrote back undertaking to closely observe his interactions with other pupils and meet with his mother in seven days. A very detailed monitoring exercise was undertaken by the classroom teaching assistant on his last two days at school. She described observing Child M and making notes for much of these two days. Nothing of concern was noted and on numerous occasions Child M interacted in a normal and friendly way with the child in question.

4.1.30. The following Monday Child M did not attend school. The school phoned his mother three times and visited the home without success. The failure to report an absence and not answer the phone were both very out of character. Child M was also absent the next day and the police were alerted, sharing the little background information the school had, including that the mother '*was known to have some mental health issues but they did not know what this entailed and that Child M had previously spent some time in care'*. The police found Child M dead soon after the report.

<u>Signs of possible risk in the days before Child M's death</u>

4.1.31. 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.

4.1.32. The mother's Lithium blood level tests should have made the GP question whether Child M's mother was taking her medication. However she had recently seen the mother and thought that she was well, knew that she was in touch with the psychological service, had further GP and

psychology appointments booked (which she had previously kept) and believed that the mental health service would be better placed to identify and act on any concerns.

4.1.33. Other professionals did not know what medication Child M's mother was taking nor would they have believed that it was their role to discuss this with her. No one noted concerns about her behaviour or mood. No one working with Child M at this point was aware that the deterioration in the mother's mental health in January 2015 had been triggered by her refusal to take her medication.

4.1.34. Child M's mother told the SCR that she did not think that his school was taking her concerns about bullying seriously. In hindsight her anxiety about what appeared to everyone else to be quite ordinary and harmless interactions with other children and her distrust of professionals may have been part of the re-emergence of a pattern of psychotic thinking focused on Child M, but there was nothing to point to this at the time. The week before he had attended school and no concerns had been noted. Child M's mother had written a letter to the school and exchanged a series of text messages with a home school link worker. These concerns had been discussed with her in previous meetings. The content of the messages was evidence of the mother's anxiety about how her son was getting on at school, but they gave no one any indication of an emerging mental illness.

4.1.35. The school was worried by Child M's unexplained absence on two consecutive days only because his mother had previously been so diligent in communicating about any absence or concern. Staff attempted home visits on both days and phoned the police on the second occasion which given the circumstances was a reasonable course of action.

4.1.36. 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.

4.1.37. 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.

<u>Further evaluation</u>

4.1.38. The remainder of the evaluation considers the strengths and shortcomings in practice and service provision.

4.1.39. Aspects of good practice and strengths in service provision are highlighted in 4. These should be promoted as ways of working because they will contribute to better outcomes for children in other cases.

4.1.40. The remainder of the report considers a number of areas 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 affected the understanding of risk and the provision made
- Whether Child M's extended family (and particularly his maternal grandparents) should have been involved

In each section information is provided from the narrative and the review seeks to understand the factors that influenced practice.

4.1.41. Section 4.8 discusses why Child M's death triggered three separate reviews and whether or not this was the most effective way of learning from this sad event.

4.1.42. Section 4 sets out the SCR recommendations. It is not always possible to tell from an individual case example whether shortcomings in service provision apply more widely. The LSCBs and member agencies that have participated in the review and member agencies are asked to consider this and to address any identified systemic weaknesses.

4.2. Good individual practice and strengths in service provision

4.2.1. Despite its tragic outcome this was a case where the main agencies with responsibility to work with children were rightly focused on the needs of the child. The SCR has identified the following strengths in professional practice and service provision which would contribute to good outcomes for children in other cases. The agencies involved should consider further what enabled staff to work in this way so that the approaches taken can promoted as ways of working.

<u>Services in Swindon</u>

4.2.2. The decision to accommodate Child M by the local authority was made at the right time and it seems sensitively handled with his mother. There was good collaborative working between mental health and social care

professionals in Swindon throughout the period when Child M was in foster care.

4.2.3. The plan to return him home was a sensible, cautious one and it was carefully implemented by the local authority. There was good sharing of updates with the mental health trust and attendance at looked after reviews and other meetings by relevant agencies. Child M's mother wished to have him home sooner than the professionals believed was right and this was handled respectfully but firmly, taking account of the mother's rights.

Services in Oxfordshire

4.2.4. The GP had no information about Child M or his mother when they presented at the surgery. Although there was no evidence of immediate risk, the GP recognised that the family circumstances were complex and she was active in seeking out background information from colleagues in Swindon. This mitigated against the usual delay in the transfer of GP records and enabled the GP to refer the mother to the Oxfordshire mental health service.

4.2.5. The health visitor also actively sought information from her counterpart in Swindon so that she could make a better assessment of the family's needs. From this point she made regular visits to the family and was active in seeking out information from the mental health service and other agencies.

4.2.6. Prior to ending her involvement with the family when Child M had started school the health visitor alerted the school to the type of difficulties that the mother had experienced and the additional support that had been provided. She arranged for the school to allocate a worker to be a point of contact for the mother. The school had allocated a school home link worker, who was working closely with Child M's mother to help him settle into school and to address her anxieties about that process. The school's response to reported bullying of Child M was sensitive; while not sharing his mother's concerns it recognised that her concern was well-intentioned.

4.2.7. The Action for Children children's centre offered a range of services from which Child M and his mother benefited. The centre worked closely with the family health visitor and preschool. It went to considerable efforts to obtain background information about the family in order to inform its work, though this was not always provided. The organisation recognises that it should have been more persistent in pursuing this information, even though it saw no evidence of serious risk to Child M.

4.3. How were the needs of Child M and his mother assessed, including the risk that Child M might be harmed by his mother?

Introduction

4.3.1. This section of the report evaluates the way in which risks arising from the mother's mental illness were assessed, including possible risks to Child M. It examines the extent of collaborative working which would have brought together knowledge and expertise from different agencies and professional backgrounds.

Information from the narrative

Assessment by GPs and mental health services in Swindon and Oxfordshire

4.3.2. Child M's mother moved to Swindon in mid 2014 and registered with a GP. As is often the case there was a delay of several months in the transfer of medical records from the previous GP practice. The notes covering the period 2009 - 2014 were never linked to the Swindon GP notes and were not located while the SCR was being undertaken.

4.3.3. The Swindon GP practice obtained no detailed history of mental health problems and did not seek records of previous diagnosis and treatment. Standard mental health review questions (to assess general mood, the mother's ability to cope with family or work and suicide risk) were not asked. The mother was treated for her mental health problems on the basis of observation and self-report.

4.3.4. When Child M's mother presented to the local hospital Emergency Department in January 2015 she was seen by two mental health nurses who took advice from a psychiatrist. In making the judgement that it was safe for her to continue to care for Child M, positive and negative factors were taken into account. Protective factors listed were that mother said she would not harm Child M and that she stated that she '*was more concerned about the man going into his room'* than about Child M. Beyond this there is no clear indication as to how risk was assessed and no systematic framework for doing this. The clinicians had no historical records as this was the first contact that the trust had had with Child M's mother.

4.3.5. The liaison mental health staff who saw Child M's mother in the ED made immediate referrals to social care and to the mental health service intensive team for '*home treatment, recommencement of medication, on-going assessment of risk and mental health'.* The intensive team agreed that assessment of mother's risks to herself and to Child M were required.

4.3.6. Between January and July 2015 these assessments were undertaken in a pragmatic way, as a result there is no formal risk assessment in the Swindon mental health records. When care of Child M's mother was transferred to the recovery team in March 2015 the most recent diagnosis was of '*possible paranoid schizophrenia'*. It was noted that she '*was no*

longer having thoughts to kill herself or Child M' but that *'these risks will increase if (the mother) is non-compliant with antipsychotic medication'*.

4.3.7. In July 2015 as part of the process of ending its involvement with Child M's mother the mental health service sent a letter to her GP. Though not explicit about any concerns about the care of Child M it noted again that continuing assessment was required, mother was difficult to engage, had recently stopped taking some of her medication and that she often moved around. These were all significant factors that increased the likelihood of a relapse, but they were not communicated as part of a formal risk assessment.

4.3.8. A similar pattern continued after the mother's care was transferred to the mental health service in Oxfordshire. No formal risk assessment was completed during the mother's initial contact with the area mental health team in September 2015. Child M's mother did not have a risk assessment in her clinical records and there is no mention of specific risks to others (including children) in the outpatient clinical letter to her GP. It had been planned that this risk assessment would be carried out by the care coordinator once one was allocated but the person concerned moved job before it was undertaken. The consultant psychiatrist told the SCR that it would be very unusual for a risk assessment not to be completed so it was not his practice to audit the case records.

4.3.9. In August 2016 when Child M's mother was re-referred to the service a risk assessment document was opened but not completed and the assessor clicked *'not assessed'* for all domains. The brief summary noted that there had been *'no risk identified unless relapses in bipolar. Managing an awful situation very well'.* The trust says that this does not meet its expected standard of practice. Interviews with staff suggest that in comparison to the vast majority of patients Child M's mother appeared to pose a low risk.

4.3.10. In February 2017, as part of her last contact with the mental health service before the death of Child M, his mother completed the first part of the psychology assessment triggered by her anxiety about travelling on public transport. This noted her previous, but not recent, reported history of self-harm and her reports of bullying in previous employment. On this occasion Child M's mother said that she felt it would be better if she were dead. However on further questioning she was clear that she *'did not have plans to harm herself and that her relationship with her son stopped her from doing so…she was not self-harming at the time of the assessment and that she would not hit or harm her son'.*

4.3.11. Professionals in mental health services are expected to undertake risk assessments and did recognise the need for this both in Swindon and Oxfordshire. In Swindon (where possible risks to Child M were current or very recent) the assessments were completed in an informal or pragmatic way linked to changing events. In Oxfordshire (where the mother's mental health was generally very good) neither the mother nor other professionals

articulated an identified risk to Child M and risk assessments were completed partially, or not at all.

Assessment of risk by social care services in Swindon

4.3.12. The first social care assessment took place the day after the mother of Child M attended the Emergency Department in Swindon, in January 2015. An inexperienced social worker was sent to gather information for discussion on return to the office. The outcome was a plan to assist the mother's parenting of Child M by focusing on her social isolation.

4.3.13. The following day the plan changed after the mother made very concerning comments to her health visitor and members of the intensive mental health service, leading to the decision for Child M to be accommodated. The perceived risk to Child M gradually declined so that after seven weeks in foster home Child M's mother was allowed to care for him at home.

4.3.14. The decision to allow Child M to return to the care of his mother was made on the basis that the worst symptoms of her mental illness were under control, she had had regular successful contact sessions and wanted to resume his care. There was no evidence to indicate that she could not care for him safely and no reason or legal grounds to prevent this from happening. The decision was made cautiously and monitored closely. Again the service responded pragmatically to changed circumstances and there was no formal assessment of risks.

4.3.15. The social worker's closing summary (written in August – September 2015) was an opportunity to bring together information about the concerns about the care that had been provided for Child M, the reasons he had been at risk and the actions taken to safeguard him. Encouraged by the social care recording template it emphasised Child M's presentation, development and behaviour (none of which had ever been a concern), the services that had been provided to the family and the steps that had been taken to liaise with professionals in Oxfordshire. All of this was important but it did not emphasise information about risk. The details of the mother's history of mental illness and the specific threats to harm Child M made in January 2015 were not included. This summary was not shared with children's agencies in Oxfordshire (the local authority and the children's centre) until mid 2016 and was never seen by the mental health trust.

4.3.16. The allocated social worker told the SCR that the most significant risk in his mind was the mother's continuing social isolation, which he believed would make her vulnerable to further mental health difficulties. The Swindon records state that he also spoke directly with the Oxfordshire children's centre about '*potential signs of concern with the family, specifically (the mother) disengaging from local services, not attending appointments or stating paranoid thoughts'*.

4.3.17. The Oxfordshire children's centre record of this discussion is much less specific about the possibility of potential deterioration. The centre

understood that there was only a low level of concern about the family's level of need, the mother's mental health and its possible impact on Child M at that point. The decision not to allocate a local authority social worker in Oxfordshire or undertake a child in need assessment was taken as confirmation of this and (despite requests documented in the case records) no more detailed information about the interventions that had taken place in Swindon was provided to the centre.

Assessment of risk by social care services in Oxfordshire

4.3.18. Oxfordshire considered undertaking a children's social care assessment at two points: in mid 2015 when the family moved into the county, and in mid 2016 when the mother had renewed anxieties about her mental health. The local authority decided that on both occasions assessment was not merited by the current circumstances.

4.3.19. The Swindon social worker's intention had been to arrange for the transfer of the work with Child M and his mother as an active child in need case. However by the time of the transfer his focus was on ensuring that the Oxfordshire children's centre knew about the family and that there was a suitable package of support services in place when the family moved. He believed that this had been done and for some time the package of care provided proved to be effective, even though the centre was not aware of key parts of the family history. Child M's mother had made her own arrangements to register with a new GP who in turn referred her to the mental health service. The social worker believed that the mother's mental health had improved: superficially this was correct although the Swindon mental health trust was aware that she had stopped taking some of her medication.

4.3.20. When the social worker contacted the Oxfordshire MASH (the first step in referring to the local authority) it was agreed that there was no need for a social worker to be allocated to assess the family because support arrangements mirroring those in Swindon had already been put in place.

4.3.21. Given the information presented to the Oxfordshire MASH it is easy to understand why the social worker who took the referral and the manager who authorised the decision decided that there was no role for a social worker at that point. The level of risk in Summer 2015 was considerably less than in January 2015 and neither Child M nor his mother had acute problems. There was a network of support in place and none of the professionals involved with the family believed that there was a role for the local authority.

4.3.22. An argument can be advanced that if more information had been obtained, the complexity of the background history might have been recognised (including for example the extent of the mother's history and the detail of the circumstances in which her mental health had previously deteriorated) and the need for a coordinated plan of support might have been identified.

This would have required that the MASH 1) took a view that was at odds with the referrer and local professionals who knew the family and 2) focused not on the current presentation and circumstances of the family but on the potential risk arising from an event that all those involved believed had been resolved successfully. To have identified and collated this information would have required a very thorough assessment, gathering information from agencies in Swindon as well as Oxfordshire. Given the presumption that social care intervention is proportionate to identified need and risk it is not surprising that the case was not taken on as a child in need case in Oxfordshire.

4.3.23. In August 2016 mother experienced a brief period in which she became anxious about the prospect of having to seek work and use public transport when Child M started full time school. She reported experiencing suicidal ideas. The health visitor, ambulance service, children's centre and GP all acted in a timely way, recognising the need for Child M's mother to be seen quickly by the mental health service and for any risks to the child to be identified.

4.3.24. A second referral was made to the MASH which was screened and passed to the local authority team for a child and family assessment. The local assessment team completed checks started in the MASH and there was a lengthy phone conversation with Child M's mother to test whether there were risks that needed further assessment. Neither Child M nor his mother were seen by a social worker.

4.3.25. This has been described by one of the managers involved as being a 'triage assessment' to determine what further involvement was needed, rather than a full child and family assessment. The review was told that this approach was common practice at that time, widely known of by managers in the local authority, because the introduction of the MASH had caused additional workload in the assessment teams. The referral and the information gathered were all couched in relation to the mother's recent financial difficulties, having to find work and worries about her mother, not a serious deterioration in her mental health or risk to Child M.

4.3.26. The manager told the SCR that she did not believe that seeing Child M or the home circumstances would have changed the outcome of the assessment and noted from the records that (as had happened 12 months earlier) none of the other professionals who were working with the family believed that social care needed to become involved.

4.3.27. If social care assessments had taken place on either or both of these occasions it is impossible to know how thorough they would have been, what information would have been obtained and whether different inter-agency arrangements would have been put in place.

4.3.28. It is notable that on both occasions decisions were made solely on the basis of the current presentation of the family with little weight attached to the

exploration of what had been a complex history. On both occasions no specific current concerns were reported about Child M who was developing well emotionally and physically.

Joint and multi-agency assessment of the impact of mental health on care and safety of Child

4.3.29. All of the assessments described above were carried out separately by professionals in different agencies. It was apparent to everyone involved that the only risk to Child M arose from a deterioration in his mother's mental illness. This led to some collaborative working but no joint assessment involving children's social care and the mental health service.

4.3.30. The level of collaborative working was highest in Swindon when Child M was accommodated by the local authority (January 2015) and in the period immediately after his discharge home to the care of his mother (March 2015). During this period social workers and mental health professionals regularly consulted one another and there was some attendance from other professionals at looked after review and child in need meetings.

4.3.31. The pattern changed after Child M was discharged home as a result of which mental health and social care records during March – June 2015 reflect different experiences in working with Child M's mother. There was no final child in need meeting in Swindon so at the point when the family moved to Oxfordshire agencies transferred the case based solely on their own recent experience of working with the family with no agreed assessment of need and risk. Section 4.5 evaluates the transfer of case responsibility to Oxfordshire agencies in detail.

4.3.32. In July 2016 the ambulance service referred Child M's mother to both social care and mental health services at the same time, however neither agency considered undertaking a joint assessment. The MASH made a check with the mental health trust but subsequently the two agencies had no contact. Professionals in the mental health trust saw no evidence of risk to Child M, so did not ask professionals working with him for information. Those professionals occasionally sought information and reassurance from the mental health trust but had no concrete understanding of the mother's mental health or the treatment being provided.

Factors that influenced practice and service provision

4.3.33. No agency was explicit about how it made judgements about the potential impact of the mother's mental health condition on her care of her son. This was particularly relevant in this case because (with the exception of the brief period in January 2015 when she had threatened to harm him) all observations of Child M, indicators of his development and descriptions of his mother's behaviour towards him were positive. After mid 2015 signs and symptoms of mental illness were only mild, and formal risk assessments were not undertaken. Information about past presentations was not

available or not sought. Frameworks for screening children to determine whether a local authority assessment is required place greater emphasis on current presentation and needs.[5]

4.3.34. In relation to Child M this translated into a broader consensus that '*there are no concerns about his care'*. As he showed no physical or emotional signs of impaired development or harm, the only way in which risks to him could have been identified was through a detailed review of his mother's mental health history, taking account of the factors that put her mental health at risk and the reasons why, when her mental health had deteriorated, her child became the focus of her anxiety and symptoms.

4.3.35. A number of professionals documented their thinking about the factors that might signal a relapse or deterioration in mother's mental health (i.e. non-cooperation with services, not taking medication, her continuing social isolation) but at no point was this brought together in a coherent risk assessment that could be shared between professionals in a way that would have formed a reference point when the family moved or when there were new developments.

4.3.36. This could only have been achieved through a joint assessment by social care and adult mental health professionals which would have in turn required an agreed framework of knowledge, procedures and training. In Swindon professionals from mental health and children's social care largely worked well together, but did not formalise this by making joint visits or producing a shared assessment. In Oxfordshire this was not considered by any of the professionals and there seems to be no evidence of such practice being established or mandated by agencies in Oxfordshire, as part of internal or multi-agency procedures.

The national picture and local practice

4.3.37. Over the past two decades much work has been published on the relationship between the mental health of parents and the safeguarding of children. This has confirmed the need for professionals from adult mental health services and services for children to achieve a better shared understanding of the impact of parental mental illness on children and a better mutual appreciation of roles and responsibilities, from which they can develop the ability to work together more effectively.[6]

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[5] Oxfordshire's thresholds of needs, http://www.oscb.org.uk/wp-content/uploads/Oxfordshire-Threshold-of-Needs_Final.pdf when his circumstances are reviewed against the local threshold document Child M would have met only a small number of more than 70 considerations for assessment, for example '*Child has experienced regular moves raising concerns regarding development and safety'*, and '*Concern that caregiver's history impacts on the development/safety of the child'*

[6] This has included summaries of research, overviews of case review findings and training programmes. See for example: H Cleaver, I Unell and J Aldgate, (2011) *Children's Needs –*

4.3.38. Joint assessment is advocated in a summary of national practice guidance suggesting that '*assessment should be a shared task between children's social workers and adult mental health practitioners. This will ensure professionals fully understand how the situation is affecting children and help identify risks at an early stage.'*[7]

4.3.39. However it is less clear how widely this thinking is now influencing practice: for example whether professionals are aware of the risk factors arising from different mental health conditions and are able to judge what the impact of harm might be on a specific child? It is not clear whether professionals working in services for children have a good understanding of the way in which mental health services work, for example the arrangements for the coordination of care in mental health services or the role of GPs in prescribing and monitoring compliance with medication. There is also a need to clarify the responsibilities of mental health professionals and GP practices in relation to adults with mental health difficulties who are known to have responsibility for children.

4.3.40. The Action for Children (children's centre) report recommends improving the training / knowledge of its staff in the signs and symptoms of mental illnesses and their potential impact on parenting. This applies equally to all of the agencies involved.

4.3.41. The Oxford Health Foundation Trust serious incident review contains recommendations on the assessment of the impact of mental illness on parenting ability. These are largely internally focused, touching on the work of health visitors who are part of the same trust, and would not as they stand facilitate joint assessment of children living with parents with mental illness with the local authority or other agencies.

Parenting Capacity (TSO Second Edition); Department of Health (1998) *Crossing Bridges – Training resources for working with mentally ill parents and their children.* This publication consisted of a comprehensive review of currently available research and a training pack. Adrian Falkov (1995) *Study of Working Together Part 8 reports – Fatal Child Abuse and Parental Psychiatric Disorder,* Department of Health. Nationally produced summaries of SCR findings advocate collaborative working and offers general guidance, see for example the most recent DFE overview, Sidebotham, Brandon et al, *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 - Final report* (May 2016).

[7] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

Recommendations

4.3.42. Oxfordshire LSCB and Swindon LSCB should establish the extent of joint assessment involving professionals in mental health services and local authority social care professionals and others working with children in their areas. The boards should consider how best to promote joint assessment activity and identify any barriers to implementing this approach. Assessment activity should be supported by multi-agency training which provides relevant knowledge and a better mutual understanding of roles and responsibilities.

4.3.43. 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.

4.3.44. 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.

4.4. Availability of comprehensive and accurate history to inform assessment of need and risk

Introduction

4.4.1. This section considers the extent to which information about key events (both prior to and during the period under review) was known to professionals and used to inform assessments of the mother's mental health and the needs of Child M.

Information from the narrative

The extent of the mother's earlier mental health history

4.4.2. The Swindon GP practice was responsible for the mother's mental health care between June 2014 and January 2015. There is no evidence that during this period a detailed mental health history was taken and no discharge or summary information was sought from agencies previously involved. When GP records were transferred to the Swindon surgery they omitted significant periods but no further steps were taken to obtain missing records.

4.4.3. The mental health service in Swindon became involved in January 2015 after the mother attended the hospital emergency department. As a result of the assessment visit a decision was made the next day to seek the mother's mental health notes from London; contact was attempted but there is no record that any information was obtained. Some information was obtained from the local authority about social care involvement with the mother in London.

4.4.4. Subsequently some mental health service documents do contain details of the mother's psychiatric history, noting that she had been admitted to a psychiatric hospital at least three times since 2000, twice as a voluntary patient and once while detained under the Mental Health Act. Her diagnoses included schizophrenia, psychotic depression and bipolar disorder. She had contact with a perinatal mental health service in London during her pregnancy and made good progress. Medications prescribed had included anti-depressants, anti-psychotics and Lithium.

4.4.5. This information – which it is now clear considerably understates the number of hospital admissions - was included in discharge summaries and letters prepared by the Swindon mental health service and transferred to Oxfordshire's mental health service in mid 2015. When Child M's mother was assessed by the Oxfordshire service in September 2015 it is indicated that the previous notes from Swindon had been read. However the events identified do not correlate with those reported in the Swindon documents; the Oxfordshire mental health assessment refers only to previous overdoses in 2000 and 2005. The psychiatrist has told the SCR that when the referral was received the community mental health team looked at all of the available material. It is now understood that important information from Swindon was added to the electronic record as a document with a file name that did not indicate its significance.

4.4.6. There are indications in the Swindon social care records that a local authority in South London had been involved with the mother during her mother's pregnancy and that the mother had responded well to the support provided and been able to look after Child M. Beyond this the evidence is that children services in Swindon had no detailed knowledge of the extent or nature of the mother's previous mental health problems, or of the outcomes of professional interventions.

Knowledge of the mother's mental illness and the accommodation of Child M in January 2015

4.4.7. The decision to accommodate Child M in Swindon in January 2015 was triggered by a very concerning series of comments made by his mother. She showed signs of being paranoid, reported hearing voices coming from her son's bedroom and feared he would be kidnapped. She reported concerns about a man at his nursery and, although she initially denied any thought of harming Child M, threatened to `*do away with myself and take him with me'.* These or similar comments were made separately in the presence of the health visitor, mental health professionals and the allocated social worker.

4.4.8. It is significant that none of the records created by professionals in Swindon capture the detail or the seriousness of these comments or note that the mother's psychotic symptoms were focused on Child M, which was significant. The most explicit reference is the health visiting transfer which

stated that the mother had had a '*psychotic episode which resulted in Child M being taken into foster care'*.

4.4.9. Social care professionals in Oxfordshire were aware that Child M had been accommodated by the local authority. The Oxfordshire MASH summary of discussions between the Swindon social worker and the MASH note that Child M had been accommodated because his mother *'reported feeling unwell and raised concerns about whether she could keep Child M safe'*. It was noted that Child M's mother had *'a history of mental health issues'* and that moving to Swindon had left her feeling '*vulnerable and isolated'*. Child M's mother reported being estranged from family members.

4.4.10. The closing summary from Swindon (written shortly after the family moved in 2015) was not available until 2016 when the family was re-referred to the MASH and a social care assessment agreed. This refers to the mother's paranoid episode in 2015, uses the same phrase about 'keeping Child M safe' but gives no more detail.

4.4.11. The mental health service in Oxfordshire received copies of discharge summaries from the service in Swindon that refer to the episode. They describe the mother's symptoms, including references to symptoms involving Child M, but emphasise the clinical mental health diagnosis and treatment, without commenting further on the detailed reasons why Child M was considered to be at risk.

4.4.12. The Swindon GP does not seem to have been aware that the mother was planning to move until the Oxfordshire GP contacted the surgery to obtain details of the case and arrange for speedy transfer of records. When the notes arrived they included the mental health discharge summaries described above.

4.4.13. When the local authority accommodated Child M in January 2015 the professionals involved had a reasonably consistent, shared understanding of events and potential risks. As time passed details of the mother's breakdown in Swindon in Jan 2015 were gradually lost (in particular the comments made pointing to risk to Child M) and may have appeared to be less serious as time passed and new groups of professionals became involved. Shortly before Child M's death the school reported him missing to the police noting that his mother '*was known to have some mental health issues but they did not know what this entailed and Child M had previously spent some time in care',* indicating only a very general knowledge of the history.

<u>Factors that influenced practice</u>

4.4.14. Responsibility for Child M's case was transferred in Swindon both in the mental health service and in children's social care after January 2015. Some case records, including transfer and closure case summaries did not contain a full account of events and previous assessments, placing more reliance on individual workers to communicate information. This may have diminished

knowledge and focus on the circumstances in which Child M was accommodated by the local authority. The lack of formal risk assessments in the records reduced the likelihood that key documents and information would be transferred and highlighted for new professionals becoming involved. Case transfer is discussed in more detail in Section 4.5

4.4.15. To different degrees professionals sought previous records. These were not always available or provided and in some cases they had significant gaps. Interviews with staff in the mental health trust indicated that they often do not have time to review all of the case papers.

4.4.16. Outside of mental health services there was a lack of precision in descriptions of the mother's mental state and a tendency to fall back on terms such as 'mental health issues' or 'concerns', rather than name the psychiatric diagnosis or use terms such as mental illness or psychiatric disorder. Another term used on a number of occasions was '*concerns about whether mother could keep* (Child M) *safe*', which could cover a wide range of situations without communicating the nature and level of risk.

4.4.17. It may be that some professionals (and wider society) favour such terms because they seem less judgemental and negative. Being widely adopted in media discussions about emotional and psychological reactions to life events as well as psychiatric illness, they may minimise the gravity of some mental illnesses for the patient and the risk that his or her behaviour may pose to others.

4.4.18. As the case history progressed assessment of the mother understandably focused on her current mental state and functioning which was almost always good. Less weight was placed on her history, which was increasingly less well known. The loss of information was greatest when case responsibility transferred between professionals.

<u>Recommendations</u>

4.4.19. The Oxford Health Foundation NHS Trust review recommends that risk assessment and discharge summaries should clearly identify any risk including historical risks and be clear and factual in description of mental health conditions and their possible impact on others.

4.4.20. However the trust's feedback to the SCR notes that historical information is often not provided about patients especially when families have moved from one provider to another and notes that clinicians' capacity to obtain records is made more difficult by lack of time and capacity.

4.4.21. The SCR recommends that the 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.

4.5. Transfer of case responsibility when the family moved from Swindon to Oxfordshire

Introduction

4.5.1. This section of the report considers how the transfer of responsibility for work with the family was handled and the impact that this had on subsequent service provision.

Information from the narrative

4.5.2. Child M's mother moved from Swindon to a small town in Oxfordshire in June 2015. The agencies most closely involved with the family in Swindon had been the family GP, a children's centre, the mental health service, the health visiting service and the local authority social care service. Although only a few months before this Child M had been accommodated by the local authority for seven weeks when his mother's mental health deteriorated there was no coordinated transfer of the case with agreed objectives or a plan and each agency made its own transfer arrangement.

Mental health

4.5.3. In March 2015 responsibility for the mental health care of Child M's mother transferred from the Intensive Team to the Recovery Service. In keeping with the roles of the teams, she was seen less often. Having told the service on 4 June 2015 that she planned to move, Child M's mother was first contacted at her new address on 10 July 2015 and seen on 17 July. This had been planned as a joint visit with the Oxfordshire health visitor. The health visitor did not attend, possibly because two days earlier she had been told by Child M's mother that she was not willing to see the Swindon mental health worker.

4.5.4. At the visit Child M's mother politely refused to allow the Swindon mental health worker access to the home though she spoke with her on her doorstep for some time and she was able to see Child M. His mother said that she had made contact with the GP in her new area and was expecting to hear from the local mental health service. She said that she was grateful for the help she had received in Swindon and made it clear that she would work with the Oxfordshire mental health service.

4.5.5. Arrangements were made for discharge summaries covering the assessments and treatment provided in Swindon to be shared with the mental health service in Oxfordshire, as well as a list of historical hospital admissions. In September 2015 the mental health worker made a phone call confirming that an assessment appointment had gone ahead in Oxfordshire. The Swindon records were closed in October 2015.

Social care

4.5.6. Swindon social care had worked closely with Child M's mother following his return to her care in March 2015. The key role was played by the local

authority family support service, there were regular social work visits and two child in need meetings. The final social work visit took place on 10 June 2015. Originally this had been envisaged as the date of the final child in need meeting but in the end it took place only as a social work visit. The reasons for that are not clear but the allocated social worker told the review that in hindsight it would have been better if the mental health service and the health visitor had attended so that they had a shared understanding of the family's circumstances and could transfer the case to colleagues in a more coordinated way.

4.5.7. At the time the social worker did not have significant concerns about Child M, though he feared that the problem of the mother's isolation would not be solved by the move to a new area. He believed that the mother's mental health had improved; superficially this was correct although the Swindon mental health trust was aware that she had stopped taking some of her medication. He liaised with professionals in Oxfordshire, including the children's centre serving the town where Child M would be living, though once the case was closed the centre's attempts to obtain additional information from Swindon were unsuccessful.

4.5.8. The social worker's initial intention had been to arrange for the transfer of the work with Child M and his mother as an active child in need case. However by the time of the transfer the social worker placed the emphasis of his work on ensuring that the Oxfordshire children's centre knew about the family and had a suitable package of support services in place when the family moved. He believed that this had been done and the package of care provided proved to be effective, even though the centre was not aware of key parts of the family history. Child M's mother had also arranged to register with a new GP who would refer her to the mental health service.

4.5.9. When the social worker contacted social care services in Oxfordshire (via the MASH) there appeared to be no need for a social worker to be allocated to assess the family and make those arrangements. In line with the approach described in Section 4.4 of this report the terms used to describe the events of January 2015 understated their seriousness, focusing again on *'concerns about whether* (the mother) *could keep Child M safe'* rather than whether a relapse into her psychotic illness would place him at risk.

4.5.10. Given the information presented to the Oxfordshire MASH it is easy to understand why the social worker who reviewed the referral and the manager who authorised the decision decided that there was no role for a social worker at that point.

4.5.11. The SCR has been told that if the case had been presented to Oxfordshire as a request for the transfer of a child in need it would have been passed directly to the local assessment team to consider. Faced with the same information it is likely that the decision made would have been the same. The level of risk was much lower than in January 2015 and arrangements were in place which everyone believed would meet the needs identified.

Given the presumption that social care intervention should be proportionate to need and risk identified it is not surprising that the case was not taken on as a child in need case in Oxfordshire. Even if the case had been transferred as an active child in need case, it would probably not have been allocated for any length of time because there were no pressing concerns about the family and what appeared to be good support arrangements had been put in place.

Health visiting

4.5.12. The Swindon health visitor had worked closely with the family and other professionals following the mother's hospital attendance in January 2015. When Child M and his mother moved to Oxfordshire in June 2015, he transferred to the Oxfordshire health visitor's case load. The health visitors discussed the family on the phone so that the health visitor became aware that Child M's mother had moved from London and that she had then '*suffered a psychotic episode that had led to him being taken into foster care'*. The mother was said to have received significant support from the mental health service and the social worker would be arranging a meeting to coordinate further support.

4.5.13. The Oxfordshire health visitor made a transfer in visit within a few days and allocated the family to the 'partnership plus' level of care, meaning that she could continue to visit periodically to assist and advise the mother and monitor Child M. The health visitor had the expectation that there would be a 'child in need' or 'team around the family' meeting to coordinate support, but soon came to feel that this was not necessary. She understood these processes as being a way of securing the involvement of agencies whereas in this case agencies were involved and working with the family.

4.5.14. The health visitor kept in regular touch with the mother and although never formally allocated a lead professional role she initiated a number of contacts with the mental health service and the local authority when the mother seemed under additional stress. She maintained this approach until the point in early 2017 when Child M started school, health visiting involvement would cease and she made arrangements for the school to offer similar support. During this 18 month period the health visitor saw no signs of significant deterioration in Child M's mother, made careful observations of Child M and dealt with the family's situation in a thoughtful and diligent way.

GP

4.5.15. The Swindon GP does not appear to have known that Child M and his mother had moved to Oxfordshire until the mother registered at a new surgery and the GP there made contact with her. The Oxfordshire GP was sufficiently concerned about the complexity of Child M's mother's history to make phone contact with the previous surgery to ensure that records were transferred as quickly as possible. This is an unusual step, but fully merited by the circumstances.

Children's Centres

4.5.16. Child M and his mother were referred to the Oxfordshire children's centre by a centre in Swindon, run by another organisation but with similar objectives and activities. The referral said that the mother would benefit from assistance in managing Child M's behaviour, parenting support and opportunities to integrate with other parents through the activities of the centre. The referral noted that the mother had a diagnosed mental health problem and referred to her anxiety. These had led to Child M being accommodated for seven weeks under Section 20 and subsequently being defined as a child in need with an allocated social worker.

4.5.17. The centre established from the mother that she suffered from bipolar disorder, but staff did not seek any further clarification or confirmation from adult mental health services or the social worker in Swindon. Later mother referred to her medication (Lithium) and behaviours observed over time were ones that are associated with bipolar disorder.

4.5.18. The children's centre had been told to expect that the case would be allocated to a social worker and, following the first home visit, the family support worker made contact by phone with the Swindon social worker to clarify the transfer arrangements. She was told that it would now not be allocated by Oxfordshire as there was no need for further social work input at that time.

4.5.19. Knowing that Child M had been looked after by the local authority and a child in need the children's centre sought additional background information in order to inform its work with the mother but this was not provided until the centre received a copy of a closing summary in August 2016 (a year after it had been written). When it became clear that Child M would not be transferred as a child in need staff the children's centre did not challenge this or ask more senior managers in their organisation to become involved or the local authority to reconsider it.

<u>Factors that influenced practice and service provision</u>

4.5.20. The four agencies working closely with Child M and his mother all recognised the need for services to continue to be provided and the need to avoid a break in contact. Individual professionals focused on different aspects of the family situation and there was no coordinated transfer of the case. Agencies communicated with their counterparts at different times providing slightly different information about previous events and different views about the help that the family needed. The information transferred reflected the information held in each agency and the state of contact that the agency had with the family at the time of transfer.

4.5.21. None of the transfer information fully explained the most serious events in the history. Some information was given about factors that might trigger a deterioration in the mother's mental health, but this information was not

consistent. The lack of a coordinated transfer of the case meant that it was not brought together or evaluated.

National learning and findings

4.5.22. Nationally a number of SCRs have highlighted the vulnerability of children in need when their family moves between local authority areas,[8] or in one case is believed to have moved but cannot be found.[9] One SCR report has noted that there is '*no requirement to do an assessment when a family with a Child in Need plan moves into the area, which increases the possibility that decisions to cease providing social work services have no relation to the risks to the child and needs of the family'*[10]*.* Another notes the lack of an '*agreed national case transfer protocol for non-child protection cases across local authority areas'* and asks the Scottish Government '*to consider the need for the development of national guidance similar to that which exists in child protection'*.[11]

4.5.23. Some local authorities take the view that in cases where there is no current safeguarding concern (i.e. a child is not subject to a child protection investigation or plan) information about children who have been designated as being in need can only be shared with the agreement of a parent. This was not relevant in relation to Child M as his mother agreed that information should be transferred between the two local authorities. However discussion of the wider principles has brought to the surface concern that the introduction of the General Data Protection Regulation (GDPR) may lead individual professionals or agencies to adopt a more cautious approach to such cases, due perhaps to a misunderstanding of changes in the legal framework.

<u>Recommendations</u>

4.5.24. It is not right to try to determine from a single case example whether arrangements for the transfer of children in need should be standardised and whether such a system would be practicable. There are however grounds for the LSCBs to research at a local level to establish how systems to transfer Child in Need cases into and out of the local authority area currently operate and whether other cases have caused concerns.

4.5.25. 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

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[8] Johnson, Fiona and Doherty, Jane (2017) *Report of the serious case review regarding Child J*. Luton: Luton Safeguarding Children Board; McKinnon, Moira and Fife Child Protection Committee (2015) Executive summary from a significant case review: Child MK. Edinburgh: Edinburgh Child Protection Committee

[9] Johnson, Fiona and Trench, Sally (2015) *Serious case review: Sofia: overview report*. London: Local Safeguarding Children Board for Hammersmith and Fulham, Kensington and Chelsea and Westminster

[10] Johnson, Fiona and Doherty, Jane (2017)

[11] McKinnon, Moira and Fife Child Protection Committee (2015)

others that fall below the threshold of child protection (i.e. Section 47 investigation or subject to child protection plan or care proceedings). Boards should satisfy themselves that current approaches are satisfactory.

4.5.26. Swindon LSCB and Oxfordshire LSCB should seek reassurance that the implementation of the GDPR has not limited information sharing about the welfare of children in need, including those who move in and out of the local authority area.

4.6. Involvement of the mother's own family and the father of Child M

Introduction

4.6.1. This section of the report considers how professionals worked with members of Child M's extended family and whether it would have been in Child M's interest to have involved them more.

Information from the narrative

4.6.2. Child M's mother was consistently hostile to agencies having any contact with other family members.

Child M's father

4.6.3. Child M was known by his father's family name. His father is understood to have been named on the birth certificate and therefore to have had parental responsibility for his son. Child M's mother told professionals that she had encouraged his father to move with her to Swindon in 2014 but that he had refused. She also blamed her own mother for the father's lack of involvement. Neither assertion can be verified. Child M's mother accused the father of verbal abuse and cannabis misuse, but the allegations were not specific.

4.6.4. Child M's father had no direct contact with services during the period under review. The grandparents told the SCR that he sometimes visited Child M but often cancelled visits and did not play an active role in his son's life. He was not informed when Child M became looked after by the local authority in Swindon.

Maternal grandparents

4.6.5. Child M's mother reported to professionals that she had a negative relationship with her mother. She stated that all ties and contact with her parents had been cut as a result of this and requested that no information be shared with her parents. When she was living in Swindon she told professionals that she feared her mother was trying to gain custody of Child M.

4.6.6. Child M's mother also told mental health professionals that she had a friend, living some distance away, who she viewed as being her support network. When Child M was in local authority accommodation she suggested that a

member of the extended family network could act as a potential carer. No professional ever spoke to either person so it is not clear if they would have been willing to assist if asked.

4.6.7. Child M's grandparents told the review that during her 20s, when her mental health began to deteriorate they sought help for their daughter with her cooperation. However at other times she was too ill for them to understand what was happening or how best to help.

4.6.8. Mental health professionals working with the family never sought contact with extended family members and appear to have viewed the mother's wishes and feelings in relation to this as being binding.

4.6.9. In January 2015 when Child M's mother was admitted to an inpatient mental health unit she contacted her own mother who in turn contacted the local authority offering to act as a carer for Child M. The social worker tentatively explored this by asking for information to complete police checks, but did not pursue it when it became clear that Child M's mother intended to resume responsibility for his care and that this was a viable option.

4.6.10. During phone conversations with the Swindon social worker Child M's grandmother gave more details about the relationship, saying that there had been monthly contact between her and Child M until late in 2014 when his mother became more difficult. She believed that the mother's mental health had started to deteriorate at that time. The grandparents told the review that they visited Child M and his mother over Christmas 2014 and were concerned by her appearance and some of her behaviour.

4.6.11. During further contacts with the maternal grandmother in April – August 2015 the social worker explained that he could not disclose information about Child M without the mother's consent, but that he would pass on messages to Child M's mother. Child M's mother firmly stated that she did not want her family to know where she had moved to, so it was agreed that the social worker would tell the grandparents that Child M was no longer in care and had moved, but not give further details.

4.6.12. In August 2015 the Swindon social worker received a letter from Child M's maternal grandmother in which she thanked social services for keeping Child M safe and expressed her sadness that Child M's mother wanted no contact with the family. She recognised that the local authority could not provide her with a forwarding address or provide any information.

4.6.13. The letter set out the grandmother's concern that her daughter had a tendency to stop taking her medication without telling professionals and that she would be very worried for Child M's safety if this were to happen again. Noting that Child M had moved three times in three years she asked to be considered as an alternative carer should Child M's mother not be able to care for him.

4.6.14. There was no record of contact between the maternal grandmother and professionals in Oxfordshire during Child M's life. They were not aware of the potentially valuable information contained in the letter.

Evaluation of the approaches taken to practice and service provision

4.6.15. The narrative shows differences in approach depending on professional attitude and circumstances. Mental health services accepted the mother's wishes and did not contact her mother taking into account her right to confidentiality and the fact that she was viewed as having the capacity to make that judgement. Had Child M's mother's mental illness been more severe or had she refused assessment and treatment her parents may have had a legal role but events did not take that course.

4.6.16. No one in the mental health service considered approaching the grandparents to obtain background information about the family from her. It is not clear whether approaching them would in itself breach the patient's confidentiality but to do so would have gone outside the normally accepted approaches. It may have provided additional or alternative information, although it could then be difficult to know which account to accept (as it has with information provided to the SCR). It might also have made Child M's mother less willing to cooperate with clinicians.

4.6.17. It is possible that the mother's repeated reluctance to involve any other family members was evidence of persistent anxiety and possibly paranoia. Isolation from her family heightened risks associated with mental illness. There is a strong case that the mother's attitudes and pattern of behaviour needed to be sensitively challenged. Information about her pattern of behaviour could have been shared and would have informed assessments.

4.6.18. The Swindon social worker was able to be more pragmatic because the maternal grandmother contacted the local authority and offered information. This was accepted, while at the same time the authority respected the Child M's mother request not to provide further details to the grandmother. Had the case taken a different route (for example if a court application had been made or if Child M had remained accommodated for longer and a family placement was needed) the statutory framework within which children's services operates would have required that the grandparents be considered as the first possible alternative carers for Child M.

4.6.19. Not surprisingly the maternal grandparents feel very strongly that professionals should have involved them much more. They point out that they could have provided valuable information about the history of the mother's mental illness, filled gaps and corrected errors in professionals' understanding. They believe that when Child M became looked after by the local authority they should have been informed and considered as carers, even if the plan was for this to be a short term placement. Even if they were not going to be considered as potential carers they should have been contacted as part of the assessment and their views taken into account.

Recommendations

4.6.20. This is an area in which it is difficult to make specific recommendations since there will be circumstances when the interests of a child or vulnerable adult will not be promoted by involving extended family members. However the review shows that agencies should be open to challenging parents who do not want members of the extended family to be involved when they may have information that can usefully inform the assessment or may play a role in safeguarding and promoting the child's interests. In healthcare discussions with patients should be led by individual circumstances – and reflect the fact that a child's needs are affected by decisions - rather than be treated as matters solely of patient confidentiality or data protection.

4.7. The roles of GPs and mental health services in the coordination of mental health treatment, including the management of medication

Introduction

4.7.1. This section of the report deals with the provision made in relation to Child M's mother's mental illness, including the coordination of her care and the management of prescribed medication. The main focus is on the role of GPs and specialist mental health services. Its purpose is to provide an account which is accessible for professionals working in services for children because they need to have a good understanding of the roles and responsibilities of those working in mental health services and of the constraints that they face. This part of the report does not evaluate services or make recommendations for mental health services as this is the role of the Mental Health Homicide Review (MHHR) (see Section 4.8) commissioned by NHS England.

4.7.2. Child M's mother did not have a stable psychiatric diagnosis across the period under review and her medication was changed on several occasions. The SCR has not commented on this issue in detail as it is also the subject of detailed evaluation in the MHHR. Neither the lack of a consistent diagnosis nor the changes in medication mark Child M's mother out as unusual. She is believed to have stopped taking her medication on at least two occasions during the period under review, both leading to a deterioration in her mental health.

Information from the narrative

4.7.3. For the majority of the period under review the lead responsibility for the mental health care of Child M's mother sat with her General Practitioner, though the responsibility for diagnostic decisions and significant changes in medication were made by psychiatrists in mental health services. GPs saw Child M's mother throughout (other than her period as an inpatient in

Swindon). An overview of key periods of involvement is set out in the following table:

Start	End	Lead responsibility and other roles
May 2014	January 2015	Swindon GP
January 2015	June 2015	Avon and Wiltshire Mental Health Partnership Trust including a brief inpatient admission
June 2015	September 2015	Oxfordshire GP
September 2015	February 2016	Oxford Health NHS Foundation Trust assessment, care coordination and outpatient care GP prescribing
February 2016 – March	March 2017	Oxfordshire GP retained responsibility for overall care and prescribing. Referrals were made to 'Talking Space'; referral made, assessment undertaken and treatment offered by Oxford Health NHS Foundation Trust psychology service)

4.7.4. Child M's mother discussed her medication with a Swindon GP in July 2014, telling her doctor that she had been taking Lithium (for bipolar disorder) for 8 months and an antidepressant, prescribed and managed by her GP. The Swindon GP continued this regime and arranged for periodic blood tests to gauge the level of Lithium and review appointments to monitor her progress. No further background records or information were sought.

4.7.5. On 3 December 2014 blood tests showed that the level of Lithium was normal. An appointment to review the mother's mental health on 22 December 2014 appears to have been routine. However in early January 2015 the mother presented at hospital, telling the mental health liaison team that she had stopped taking her medication four weeks previously believing that its content had been altered. This had not been disclosed to the GP at the December consultation.

4.7.6. During her subsequent period of assessment and treatment, it was recorded that the mother's drug regime had been in place for three years, much longer than she had told her GP. Discrepancies in accounts given to different professionals were not identified at the time.

4.7.7. During her hospital admission the mother's diagnosis was changed to one of possible schizophrenia due to her suspicious, delusional thinking and the lack of any evidence of mood disorder. In line with this she was prescribed anti-psychotic medication to which an anti-depressant medication was added

in April 2015. Treatments were modified at the mother's request because she said that one of the medications made her eat more. Prescriptions were reviewed over the following months, though there are no notes of direct discussions with the mother, so there are no statements about what she was taking in practice.

4.7.8. In May 2015 Child M's mother told her social worker that she had reduced her medication with the agreement of her care coordinator, though there is no indication in the mental health records that this had been agreed. Again the discrepancies were not identified.

4.7.9. Child M's mother's medication was next fully reviewed at an outpatient assessment appointment in September 2015. This had been requested in June by the Oxfordshire GP following the case transfer to Oxfordshire. The psychiatrist agreed to continue the current regime of antipsychotic and antidepressant medication but acknowledged the mother's desire to resume taking Lithium. The plan was to establish this before reducing the anti-psychotic, though no timescale was given. The plan was confirmed a month later by the care coordinator, again with no specific timescale recorded.

4.7.10. In late October 2015 Child M's mother initiated the prescription of Lithium by contacting her care coordinator in the mental health service who involved the junior doctor in the team. It was agreed that after initial blood tests Lithium treatment would recommence. The doctor set out a monitoring plan initially with weekly blood tests, becoming less frequent as the effective level of the medication was established. The GP was notified of the plan by a handwritten, faxed message and arrangements were confirmed when Child M's mother saw her GP and her care coordinator at appointments on the same day. The GP noted that she would continue to prescribe Lithium under the shared care protocol and offer regular blood tests, while the community mental health team would '*monitor progress'*.

4.7.11. Monitoring of blood levels began in November 2015, in line with the mental health service recommendations.

4.7.12. Child M's mother was seen again by the consultant psychiatrist in February 2016. His care plan update to the GP stated that she was taking Lithium as well as small doses of antidepressant and antipsychotic medication, presumably based on her self-report. The psychiatrist decided to close the case to the mental health service at that point, noting in his letter that *'we do not seem to have a role in her care at the moment. However, we would be happy to see at any point...she could call us at any point if she thinks we can help'.* His advice was that she might need to take Lithium for up to five years.

4.7.13. However a case summary (which in error had not been updated) accompanying the letter stated that the mental health team would continue to hold care plan reviews. The GP practice noted this part of the

correspondence and believed that the mental health team would maintain some oversight of the mother's progress.

4.7.14. In June 2016 the GP increased the dose of Lithium and asked for a further blood test in response to Child M's mother reporting concerns about her elevated mood and an increase in online shopping. The GP suggested that the mother should refer herself to Talking Space (a community service offering cognitive behavioural therapy and counselling).[12] The referral fell outside the remit of that service because of the patient's existing diagnosis of bipolar disorder and was instead responded to by psychological services which would be better placed to take account of the patient's underlying psychiatric illness. The GP redirected the referral to the psychology service but this referral 'went missing' and was only considered when the GP followed it up.

4.7.15. In August 2016 two psychiatric nurses assessed Child M's mother who reported having a fear of using public transport.

4.7.16. After a delay of four months Child M's mother had one appointment with the psychological service and another scheduled which did not take place because of the death of Child M. Responsibility for the management of the patient's medication and overall mental health care remained with the GP surgery because it was not the brief of the psychological service to take on a coordinating role.

4.7.17. In February 2017 the mother was reviewed by the GP surgery. This was planned to take the form of three contacts beginning with an appointment with the practice nurse for Lithium blood tests and general health advice, followed three days later by a face to face GP appointment. At this the GP discussed the recent psychology appointment and the planned follow up appointment. Child M's mother's mental health was noted to be stable and it was agreed that she would be seen again in four weeks.

4.7.18. Shortly after this the blood tests were returned, showing an abnormally low Lithium level, possibly indicating that Child M's mother had stopped taking her medication. Noting her compliance throughout the 18 months in which they had been in contact, the recent positive face to face appointment, the GP review scheduled for three weeks and the involvement of the psychological service, the GP decided to take no specific action ahead of the planned appointment. The GP believed that the psychologists would be best placed to identify any deterioration in the mother's mental health.

<u>Factors that influenced practice and service provision</u>

[12] Talking Spaces is a partnership providing services to patients with mild to moderate mental health difficulties run by Oxford Health NHS Foundation Trust, Oxford MIND and a GP owned private company

4.7.19. Unless a patient is detained under a legal order, medication is taken as part of a voluntary agreement with the prescribing clinician. Knowledge of compliance relies on honest disclosure by the patient and observation of behaviour.

4.7.20. When Lithium is prescribed blood tests are carried out to avoid harmful side effects. They are not designed primarily to highlight non-compliance with the medication and they are conducted too infrequently to be relied on for that purpose.

4.7.21. Psychotropic drugs are complex, interact with other medications and have a range of side effects. It is therefore not surprising that patients often stop taking them or use them in different quantities or ways to those envisaged by the prescribing clinician. Regular home visits by a care coordinator will allow for more discussion of medication but knowledge of compliance still relies on the patient providing accurate information, unless there are signs of a marked deterioration in the patient's mental health. In this case Child M's mother gave different accounts of her treatment and medication to different professionals but these discrepancies were not identified.

4.7.22. Once established the arrangements for prescribing Lithium under the joint protocol were clear and were followed. The records show that Child M's mother recommenced Lithium before reducing her other medication but it is not clear from the evidence available how the transition to Lithium as the main medication was managed. After the care coordinator visits ceased in early November 2015 Child M's mother would be the only person who could be certain what medication she was taking.

4.7.23. The mental health service decided that it was not necessary to provide a care coordination arrangement from November 2015 onwards, but instead to rely on monitoring of Child M's mother at outpatient appointments. At this point, given the assessment and the absence of any risk indicators, it was not unreasonable that the service perceived Child M's mother to be a low risk patient. This decision appears to have been taken on the basis of the severity of her mental illness and did not specifically take her role as a parent into account. Other professionals were informed that the mental health service involvement had ended after making their own enquiries of the consultant.

4.7.24. The decision not to continue providing a care coordinator (from November 2015 onwards) meant that no reliance could be placed on the mental health trust to monitor any signs that Child M's mother had stopped taking her medication, except when she attended at an outpatient appointment. This was not understood by the GP. The confusion was repeated from late 2016 when the GP assumed that the mental health service would pick up on any deterioration in the mother's general mental health because the psychology service was involved.

4.7.25. The MHHR identifies the delays in assessment and errors in the community mental health service as being in part due to changes in management and pressure on services in the service.

4.8. Collaborative review and learning from serious incidents

Introduction

4.8.1. This section considers the responsibilities placed on agencies by statutory guidance and NHS policy and procedure to learn from serious incidents, in this case the killing of a child by an adult who was a current patient of a mental health trust and had received treatment and care from mental health services for a lengthy period, in a number of localities. A large number of agencies outside the health sector had also been involved.

The responsibilities to review the provision of services when a patient has killed her child

NHS Serious Incident Investigation (SI)

4.8.2. Oxford Health NHS Foundation Trust carried out a review of the services provided under the NHS Serious Incident (SI) procedures.[13] This covered the health services provided by the trust during the period of its involvement (August 2015 – March 2017), though some account was taken of earlier information contained in reports that had been received from other mental health services. The scope of the SI included mental health services and health visiting, because those services are provided by the trust but did not include other health services or other agencies with safeguarding responsibilities.

4.8.3. The intention is that SI investigations should be concluded within 60 days and submitted to the Clinical Commissioning Group (CCG) which is the commissioner of the service caring for the patient.

4.8.4. The SI investigation was conducted by senior and experienced clinicians and accident investigators from the trust who had not been involved in the patient's care. It began soon after the death and reported to the CCG in December 2017.

4.8.5. The findings (which are not published) focus on mental health risk assessment, care coordination, collaboration in the prescription of Lithium and assessment of parenting in adults with mental health problems. The findings have informed the SCR and will inform the mental health homicide review.

4.8.6. Staff members who were interviewed for the SI report were not re-interviewed for the SCR and with their agreement the health trust made the notes of staff interviews conducted for the SI available to the SCR. This

[13] https://improvement.nhs.uk/resources/serious-incident-framework/

avoided unnecessary duplication of work, but also reduced the direct involvement of staff in the review that was focused on the safeguarding of children. There was no involvement of family members in the SI because Child M's mother remained a patient of the trust and refused consent for this to happen. Child M's mother was not interviewed because the SI investigation was completed before the criminal trial.

Mental health homicide review

4.8.7. NHS England determined that the killing of Child M met the criteria for a mental health homicide review under Department of Health guidance.[14] The terms of reference of this review require a detailed and specific account of the provision made by three mental health trusts from 2012 onwards, focusing on mental health risk assessment, care coordination and clinical pathways. The terms of reference include a brief reference to the role of services in relation to Child M.[15]

4.8.8. The review was scheduled to start work in Spring 2018 and is designed to be completed in six months, though such reviews sometimes take much longer. The findings of mental health homicide reviews are normally published.

Serious Case Review

4.8.9. The function and remit of the SCR are set out in Section 1 of this report. The SCR considers the work of all services with safeguarding responsibilities in relation to children, including mental health services, and the interaction between them. The findings will be published in full.

4.8.10. The focus is on the impact of service provision on the child, though inevitably this requires consideration of the effectiveness of work with the adult patient and in particular the extent to which assessment of risk took account of the fact that the patient was responsible for the care of a child. The panel agreed that it would review service provision during the period August 2014 – March 2017 in Swindon and Oxfordshire.

4.8.11. Restricting the period covered (3 years instead of the 6 covered by the mental health homicide review) may mean that less information about the origins of the patient's difficulties is identified, but is designed to allow the review to be proportionate and to focus on current and recent service provision.

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[14] Department of Health (no date) 'Independent investigation of adverse events in mental health services', http://webarchive.nationalarchives.gov.uk/20130124070128/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf

[15] The review should *'determine whether there were any missed opportunities to engage other services and/or agencies to support (the mother) and her child'*.

4.8.12. The review began in June 2017 and will be completed by November 2018. Child M's mother and maternal grandparents have contributed, and no particular weight is given to the views of his mother as to whether or not this should happen. Speaking to Child M's mother and her parents has provided important background information.

4.8.13. It is of interest to note that had an adult household member been killed in this incident the Home Office guidance on domestic homicide reviews would also have been applicable. [16]

Was there a more effective way to learn from this incident?

4.8.14. At each of its meetings the SCR has considered the parallel reviews being undertaken (or planned) and efforts have been made to avoid duplication of effort which would waste time and could have a negative and impact on staff involved and the family.

4.8.15. The view of the SCR independent lead reviewer is that, regardless of the quality of the individual reviews, conducting three parallel enquiries triggered by the same incident will not prove to be either the most effective or the most efficient way of learning.

4.8.16. Attempts to ensure that they do not overlap of duplicate work, or produce inconsistent findings are hampered by the fact that they have started at different times, have different terms of reference and have been conducted at different speeds. Even if each review seeks to understand the multi-agency nature of the services provided, the existence of three separate reviews must make it more likely that findings and recommendations will be focused on the work of a single agency or a discrete set of services or disciplines. In a case with such a large number of agencies working with the family it is not clear how anything other than a review which looks at all services could come to a final determination as to whether the death of Child M was predictable or preventable.

4.8.17. It is recognised that each of the reviews is mandated by different statutory guidance or NHS procedure. It has been argued that this makes it difficult for local managers to avoid following separate, established process. In fact all of the relevant guidance and procedure allows for substantial flexibility. Statutory guidance on SCRs allows considerable flexibility and need not be followed when '*exceptional circumstances arise'.*[17] Although not relevant in this case it is useful to note for the future that agencies must only '*have regard to'* procedures for domestic homicide reviews.[18]

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[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

[17] Working Together to Safeguard Children 2018 (page 7)

[18] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

4.8.18. While recognising the complexity of achieving a single review, there is ample scope within NHS guidance to operate flexibly:

'*there are occasions … where the processes described in this framework will coincide with other procedures. In such circumstances, co-operation and collaborative working between partner agencies is essential for minimising duplication, uncertainty and/or confusion relating to the investigation process. Ideally, only one investigation should be undertaken (by a team comprising representatives of relevant agencies) to meet the needs/requirements of all parties'.* [19]

4.8.19. One version of the mental health homicide review guidance explicitly suggests that *'if other agencies or partnerships will be carrying out investigations into the same event(s), e.g. in the case of a death of a child, then the agencies involved should consider if it is possible to jointly commission a single investigation process. This should help ensure that expertise is most appropriately used, duplication of process is minimised and inter-agency lessons learnt. In cases where joint commissioning occurs, then early agreement on funding arrangements should be made.* [20]

4.8.20. It is a requirement of NHS guidance that such arrangements are agreed locally in anticipation of individual incidents arising.[21]

'The interface between the serious incident process and local safeguarding procedures must … be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible'.

4.8.21. It has also been argued that in line with the NHS framework it was necessary to conduct an initial screening and serious incident investigation into the role of the mental health service in order to determine the need for a mental health homicide review and to provide a focus for its terms of reference. There is a counter argument that the need for a mental health

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[19] https://improvement.nhs.uk/documents/920/serious-incidnt-framwork.pdf

[20] http://webarchive.nationalarchives.gov.uk/20130124070128/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4113574.pdf

[21] '*The interface between the serious incident process and local safeguarding procedures must … be articulated in the local multi-agency safeguarding policies and protocols. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible'.* Footnote 17 at page 19)

homicide review in relation to Child M's death was self-evident from the beginning and that its terms of reference (or the terms of reference of any jointly conducted review) could have been drawn up quickly after an initial rapid desktop review of the case history as part of a wider exercise.

4.8.22. There is thus a strong case that in the weeks after the death of Child M local managers could have decided to streamline or combine the three review processes and that government guidance at the very least allows this and in some respects provides substantial report for it to happen.

4.8.23. This would have required an early discussion at the strategic or executive level between the local authority, health commissioners (including both the clinical commissioning group and NHS England), the police service and the LSCB to determine whether it would be possible to combine review processes while still fulfilling separate statutory and regulatory responsibilities.

Recommendations

4.8.24. Oxfordshire Safeguarding Children Board, its member agencies (including the local authority, 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 also take account of other statutory reviewing processes such as Domestic Homicide Reviews.

5. Recommendations

Introduction

5.1.1. 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.

5.1.2. These recommendations are designed to complement those made by individual agencies in internal reviews of their involvement with Child M and his family. The LSCB has published a response to the review and an action plan showing how it will implement the recommendations.

Recommendation 1

5.1.3. 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.

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

Recommendation 2

5.1.5. 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

5.1.6. 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

5.1.7. 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

5.1.8. 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

5.1.9. 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

5.1.10. 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.

Appendices

Appendix 1	Views of family members
Appendix 2	Principles from statutory guidance informing the Serious Case Review method, Terms of Reference and lines of enquiry. How the review was undertaken
Appendix 3	SCR panel members
Appendix 4	References

Appendix I

VIEWS OF CHILD M's MOTHER AND OTHER FAMILY MEMBERS

Introduction

1. Child M's mother and his maternal grandparents were interviewed in order to obtain their views about the services that the family had received. Family members also provided additional information about the family history from their individual perspective.

2. The information set out below includes all of the comments that are relevant to the SCR terms of reference, including all of the information that is critical of agencies. Some sensitive health and other personal and health information has been removed. Information is presented as reported by family members. It has not been checked against other sources.

Child M's mother

3. Child M's mother made the following comments about professionals and agencies who had been involved:

   - Her second Swindon social worker was very good and had encouraged her to take Child M out and arranged trips to do this
   - The Oxfordshire health visitor was 'brilliant'.
   - The school home link worker was hard to reach. She and the school 'brushed off her concerns about bullying' and did not do anything.
   - She had got a good welcome and a lot of support at the children's centre in Oxfordshire. They did trips out which Child M liked
   - The GP had been very organised and got all the information from Swindon and involved the Oxfordshire mental health service

4. She had not been sure if there would be a social worker in Oxfordshire. She had phoned her Swindon social worker and asked him what happened now. He said that Oxfordshire would need to decide if there should be an assessment. She was phoned by Oxfordshire (MASH) who said that they believed that she had a strong support network, and there was no need for social services to be involved. Everyone seemed to agree with that and she did. She was happy with the services she received in Oxfordshire.

5. Child M's mother said that the mental health service in Swindon had not been good. Child M's mother had asked the worker not to keep in touch but she had insisted on visiting her in Oxfordshire which was why she didn't want to let her into the house.

6. Child M's mother gave considerable information about her mental health and family history, including the following.

7. On one occasion (in 2009) she had been detained by the police under Section 136 of the Mental Health Act. She had also taken an overdose

8. During her pregnancy she had first received a diagnosis of bi-polar disorder from a female psychiatrist in the perinatal services at SLAM. This involvement was helpful and enabled her to look after Child M successfully for three years.

9. She felt that she had a good life in South London but wanted to move because of her mother interfering, for example attending appointments with her. She did not work after Child M was born and they spent all of their time together.

10. She had felt unhappy and isolated in Swindon, wanted to take Child M on lots of outings but was scared of using public transport (this had started in London). Where she lived was a notoriously 'bad' part of Swindon, but she had not realised that until she moved there. She had ended up hating living in Swindon. She did not get much additional support and changed Child M's nursery because he came home swearing one day.

11. During the time at Swindon Child M's mother said that she got it into her head that her mother wanted to take Child M off her. There was a letter written to social care, which she did not want to see. She thought this said that her mother wanted to take Child M off her. In response to the question as to whether there was any evidence of that, or if perhaps it meant that 'I will look after him if his mother can't' she agreed that it could mean a lot of things but she did not know.

12. Child M's mother felt that the build-up of her suspicions of people wanting to remove Child M from her began when he was in foster care. There was silence on the phone when she was supposed to be able to talk to him, when he was usually very chatty. She felt he wasn't allowed to talk to her and she was anxious that Child M was bullied by the foster carer's granddaughter. She then became more generally worried that other people would want to take him away.

13. Child M's mother was asked whether it wasn't understandable that Child M had found it hard to talk to her on the phone. He was very young and had not been separated from her before. Child M's mother replied that more could have been done to reassure her that Child M was OK, given that she had mental health problems and was anxious.

14. Describing the period towards the end of Child M's life his mother said that she had been discharged by the mental health service but then tried to get a service because of her travel phobia which had started in London. Says she did not know why 'Talking Space' did not offer her a service, she received a letter but did not know why this was.

15. Then she went to a psychology appointment after she phoned the mental health service. She said that the appointment was not much use and underestimated the impact that not being able to go on public

transport was having on Child M and herself. Psychologist just said that she would 'talk to her team about it'.

16. Child M's mother did not think that anyone could have noticed that she was deteriorating in the days before Child M was killed.

17. Her concern about Child M and with the school was due to another boy with behaviour problems who was bullying Child M (i.e. pushed him and pulled his coat). Questioned as to whether this constituted bullying, Child M's mother agreed that these were behaviour problems but also bullying and the school should have done something about it. She knew another child who had been bullied (pinched) by this boy

18. She sent a letter to school about the bullying but as far as she knew the school did not reply. She had read the witness statements for the criminal investigation and said that one mother said that she had seemed 'edgy and talkative' which was unusual the week before Child M died. That was all. She did not know how she had deteriorated.

19. In a second discussion (over the phone) Child M's mother told the independent reviewer that she wanted to underline that she believed that she had had a poor relationship with her mother over a long period. It was agreed that she had made comments on this to the forensic psychiatrists who had written reports for the criminal court and that the independent reviewer would familiarise himself with them.

Child M's maternal grandparents

20. Child M's maternal grandparents provided background information about their daughter's mental health, which they said had begun to show signs of deterioration from the age of 21. They reported that Child M's mother was in a relationship with a man who smoked a lot of dope and was very controlling. Prior to that she had been a very normal child and teenager, outgoing, she had part time jobs and friends and was apparently able to cope with setbacks.

21. From this point Child M's mother had been ill for long periods and had a pattern of having relationships with a number of men who seemed to have mental health problems. The family sought help from a number of doctors and psychiatrists, but she often presented very well to professionals, who said they could not help her. She had contact with a number of mental health units

22. Child M's mother made suicide attempts or gestures and self- harmed several times. In between periods when she was more ill she held down jobs, though sometimes they did not last long and she was often suspicious of work colleagues. She had not been violent as far as they knew.

23. They now believed that Child M's mother had been misdiagnosed and that she had been psychotic and had schizophrenia, and that she had

never had major swings in her mood. This meant that she had been taking the wrong medication.

24. The parents were on good terms with Child M's mother when she moved to Swindon though they were nervous about her moving to what they felt was a bad area of the town. They visited regularly and things seemed OK until December 2014 when her behaviour was strange and it appeared (because of her weight loss) that Child M's mother was not taking her medication. They were reticent to challenge her over this because they feared she would get upset and break off contact.

25. At the time of her breakdown in January 2015 Child M's mother phoned her mother and unusually went through her work switchboard to be able to talk to her. She said that Child M was in care, but did not want her mother to interfere. However they visited a few times during this period. Once Child M returned to his mother's care she did not want them to be involved and made excuses as to why they should not visit or speak to Child M on the phone, e.g. he was asleep, they needed to 'bond' because he was different after coming back from care.

26. The grandmother sought information from social care and eventually was able to speak to the allocated social workers. The social worker offered to accept a letter in which the grandmother expressed her concerns, but would only say that Child M and his mother had moved to another district.

27. After March 2015 the maternal grandparents had no contact or any information about Child M's whereabouts or wellbeing.

28. Their main criticisms of services were as follows:

- When Child M was in care no one explored the possibility that they could care for him in the short term
- The diagnosis was questionable – Child M's mother did not suffer from high and low moods. Her medication was therefore questionable
- Grandparents ought to have more rights and an automatic right to be involved when a child was in care, even if it was voluntary care
- They should have been included in the assessment as they could provide a more accurate history. They do not believe that a proper assessment could have been carried out if the history was not known

Child M's father

29. Child M's father agreed to meet the independent reviewer but then did not confirm the appointment and did not respond to further messages left for him

Appendix II

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

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

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

Terms of Reference / details of areas to be considered by the review

1 Overall purpose and terms of reference

The purpose of the review 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'*.[22]

The specific objectives of the review are

1. To establish what happened
2. To establish why professionals acted as they did
3. To identify and understand the significance of a range of contributory factors that shaped the practice of professionals, including wider organisational factors.
4. To identify any episodes and background factors that may have a direct bearing on the death of Child M and therefore may be relevant to a consideration of whether or not the death could have been prevented.
5. In addition the review will seek to understand what the case history tells us about the strengths and weaknesses of local safeguarding arrangements (sometimes referred to as using the individual case as a 'window on the system').[23]

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[22] HM Government (2015) *Working Together to Safeguard Children*

[23] Charles Vincent (2010) Patient Safety second edition

How the review was undertaken

1. The LSCB asked member agencies to compile a chronology of key events based on the written and electronic agency records. Agencies also compiled brief initial reviews of the possible learning for their own agency
2. The LSCB established a review panel to oversee the conduct of the review consisting of the independent lead reviewer and senior staff from participating agencies and commissioners who had not been involved in the work with the family. The review panel was chaired by the Independent Lead Reviewer
3. Members of the review team held individual interviews with members of staff and managers, supported by review of records where this assisted
4. The lead reviewer obtained and considered a range of original documents and records
5. The lead reviewer drafted findings which were discussed with the review team
6. Further drafts of the report were prepared and circulated to panel members taking into account feedback from the agencies and professionals involved
7. The Oxfordshire LSCB CRAG discussed a draft report
8. Further reports were discussed at a review panel meeting
9. A learning and reflection session was held with staff and managers involved
10. The final report was presented to the LSCB

Appendix III

SCR REVIEW TEAM MEMBERSHIP

Independent and LSCB representatives	
Keith Ibbetson	Independent Lead Reviewer
Business Manager	Oxfordshire Safeguarding Children Board
Review Team Representatives	
Agency	**Designation**
Thames Valley Police Service	Detective Sergeant PVP - CAIU
Oxford Health NHS Foundation Trust	Service Manager
	Trust Lead Nurse Safeguarding
Action for Children	Improvement and Consultancy Manager
Avon and Wiltshire Mental Health Partnership Trust	Service Manager Recovery Services
Oxfordshire Clinical Commissioning Group	Designated Nurse & Safeguarding Lead
	Named GP for Safeguarding
Oxfordshire County Council	Area Social Care Manager
	Local Authority Designated Officer
NHS England	Head of Investigations (Mental Health Homicides)

Appendix IV

References

Statutory and NHS guidance

HM Government, *Working Together to Safeguard Children* (2015),

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Sidebotham, Brandon et al, *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 - Final report* (May 2016).

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Johnson, Fiona and Doherty, Jane (2017) *Report of the serious case review regarding Child J*. Luton: Luton Safeguarding Children Board;

McKinnon, Moira and Fife Child Protection Committee (2015) *Executive summary from a significant case review: Child MK*. Edinburgh: Edinburgh Child Protection Committee

Johnson, Fiona and Trench, Sally (2015) *Serious case review: Sofia: overview report*. London: Local Safeguarding Children Board for Hammersmith and Fulham, Kensington and Chelsea and Westminster

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Other references

Charles Vincent (2010) *Patient Safety* second edition