|  |
| --- |
| **SERIOUS CASE REVIEW**  **Children O and P**  **Lead Reviewer: Fiona Johnson** |
| **Published: July 2022** |

**CONTENTS**

**1 Introduction 3**

1.1 Background to the review 3

1.2 The Terms of Reference 3

1.3 Review process 3

1.4 Parallel processes 4

1.5 Family input to the review 4

**2 Summary of facts 5**

2.1 Family Composition 4

2.2 Background history 4

2.3 Key episode 1: First Contacts (Nov 2017–August 2018) 5

2.4 Key episode 2: Child O is seen with black eyes (Sept 2018) 6

2.5 Key episode 3: Parents separate (Nov 2018) 7

2.6 Key episode 4: Mother talks about suicide (Dec 2018) 7

**3 Views of family and other relevant bodies 9**

3.1 Father’s views 9

3.2 Mother’s views 9

3.3 Relevant information from the criminal process 10

**4 Analysis of practice in this case 10**

4.1 What was life like for the children in this family? 10

4.2 What was the impact of Single-Agency and Multi-Agency working? 11

4.3 How were assessments, including risk assessments, undertaken? 12

4.4 Response to self-referrals by mother to mental health services and

recognition of potential safeguarding issues for children when services are aware

of a parent with mental 12

4.5 Response to children when they experienced injuries; was consideration given to

any referral to Children’s Social Work Services? 14

4.6 Identified good practice 14

**5 Lessons learned from the review**  **15**

5.1 Sharing of information between agencies 15

5.2 ‘Whole Family Working’, risks to children when parents have mental

health problems 16

5.3 Increased reliance on assessments undertaken by phone 17

5.4 Factors to consider when assessing risk in suicidal ideation 17

**6 Conclusions 19**

**7 Recommendations 20**

**1 Introduction**

**1.1 Background to the review**

1.1.1 This review was commissioned by Kent Safeguarding Children Board as a serious case review (SCR) following recommendations to the Board’s Independent Chair that the circumstances met the statutory criteria for an SCR because:

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

(b) (i) the child has died[[1]](#footnote-1)

The children had been found unconscious and not breathing in the family home by the Police. The Police had previously been called to a road traffic collision where Mother had admitted harming the children. Mother was arrested and charged with murder and eventually pleaded guilty to two counts of ‘manslaughter by reason of diminished responsibility’.

The recommendation for a serious case review was agreed by the Chair on 10th January 2019 and was reported to the National Panel on that day, who confirmed their agreement to the decision on the 8th February 2019.

**1.2 The Terms of Reference**

1.2.1 All agencies were asked to report on their work under the following headings: -

* What was life like for the children in this family?
* What was the impact of Single-Agency and Multi-Agency working?
* How were assessments, including risk assessments, undertaken?
* General areas to be explored:
  + Response to self-referrals by mother to mental health services.
  + The recognition of potential safeguarding issues for children when services are aware of a parent with mental health issues.
  + The earlier attendances at different Accident and Emergency Departments when one child had suffered two black eyes and the other had a head injury - was consideration given to any referral to Children’s Social Work Services?

1.2.2 The time frame of the review was for the last year of O and P’s lives. In addition, agencies were asked to provide a brief background of any significant events and safeguarding issues in respect of children O and P’s immediate family that fell outside the timeframe, if agencies considered that it would add value and learning to the serious case review.

**1.3 Review process**

1.3.1 The review was conducted using a systems methodology that: -

* recognises the complex circumstances in which professionals work together to safeguard children.
* seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
* seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
* is transparent about the way data is collected and analysed; and
* makes use of relevant research and case evidence to inform the findings. [[2]](#footnote-2)

1.3.2 Individual agency reports were received from the following sources: -

* Kent Police
* Kent Community Health NHS Foundation Trust, (KCHFT)
* A local Hospital Foundation Trust (LHFT)
* Medway Hospital Foundation Trust (MFT)
* Kent and Medway Partnership Trust (KMPT)
* South East Coast Ambulance Service (SECAmb)
* Insight Health Care[[3]](#footnote-3)
* A local Clinical Commissioning Group (CCG) General Practitioner (GP)

1.3.3 A key part of the methodology was contact with frontline professionals who had been involved with the family. There were two meetings: a workshop where frontline practitioners and their managers examined inter-agency working, and a recall day, where the same professionals discussed the first draft of the report.

1.3.4 The Lead Reviewer was Fiona Johnson, an independent social work consultant who was Head of Children’s Safeguards and Quality Assurance in East Sussex County Council between 2004 and 2010. Fiona qualified as a social worker in 1982 and has been a senior manager in children’s services since 1997, contributing to the development of strategy and operational services with a focus on safeguarding and child protection. She is independent of Kent SCB and its partner agencies, although she previously worked for Kent County Council as the Independent Chair of one of their foster panels.

**1.4 Parallel Processes**

1.4.1 The criminal trial was underway during the review; this was concluded on 16th August 2019 and the outcome was that Mother pleaded guilty to manslaughter on the grounds of diminished responsibility and was sentenced to concurrent sentences of 10 years imprisonment on each count, with a hospital and limitation direction meaning that she would be contained in a psychiatric hospital until she was deemed fit to move to prison. The inquest has yet to be finalised.

**1.5 Family Input to the Review**

The father and mother were informed of the review and the Lead reviewer met with them both separately, see section 3 for their contribution to the review.

**2 Summary of facts**

#### 2.1 Family composition

|  |  |
| --- | --- |
| **Family member** | **Age at the time of the children’s death** |
| Child O | 23 months |
| Child P | 23 months |
| Father | 35 years |
| Mother | 33 years |

This was a white British family who were living in owner-occupier accommodation. Paternal grandparents lived nearby, but after the parents separated, Mother and the two children moved into rented accommodation nearer to maternal grandmother and aunt. Throughout the period of the review, Father was employed in London as a senior manager, whilst Mother did not work outside of the home.

**2.2 Background history**

2.2.1 Very little was known by agencies about this family prior to the review period. The parents met in 2004 and married in 2008 prior to moving to the Middle East where father had work. The children were born abroad in 2017.

2.2.2 Mother had some involvement with the Police prior to 2004 relating to a previous relationship. No agency had any contact with Father. There was no relevant or significant agency involvement with the parents or children prior to 2017.

**2.3 Key episode 1:** **First Contacts (Nov 2017–August 2018)**

2.3.1 The family had bought a property in Kent (as a holiday home) in 2017, and in November 2017, the family registered with a GP using that address. As a result, the health visitor was notified of the children and arranged a ‘movement-in visit’ for the end of the month. This was cancelled because Child P was in hospital, but the visit was re-arranged in December 2017. The health visitor met with both parents and the two children who advised they were spending Christmas in the UK but would return abroad in January 2018. The visit was routine, and the parents were engaging and friendly with a positive home environment. The Health Visitor undertook a standard assessment of Mother’s mental health and no concerns were noted. She also asked about historic mental health concerns and nothing was reported. Domestic abuse was not discussed as the father was present. Based on this assessment, the health visitor decided that the family would be offered the ‘universal health visiting service’.[[4]](#footnote-4)

2.3.2 In early December 2017, Child P was admitted to hospital for two days because of a urinary tract infection and possible febrile convulsions[[5]](#footnote-5), and was treated with antibiotics. The child was seen again on Boxing Day, at another hospital, because of a fever, and was discharged home. Neither presentation was considered unusual and the parents’ actions were considered appropriate.

2.3.3 In February 2018, Father left his job and the family returned to live in the UK. It is now reported that this move was to be nearer the paternal grandparents and that Mother was not in favour of it.

2.3.4 Between February and August 2018, Child P was seen by the GP on four occasions because of recurring chest infections which were treated with anti-biotics. The child was also seen once with an injury to the right index finger which was infected and not responding to treatment, so again was treated with anti-biotics. Child O was seen on one occasion with a temperature and both children were seen with nappy rash. The GP had no worries about the children and considered that the concerns raised by the parents were appropriate and their responses, good. The level of involvement with GP services was normal for children of this age. There was no other contact by any agency with the children during the period.

**2.4 Key episode 2:** **Child O is seen with black eyes (Sept 2018)**

2.4.1 On the 11th September 2018, Child O was taken to Hospital with bruising to both eyes. The Father reported that the child had fallen twice hitting the head; the first fall was five days earlier and the second three days previously. The Father had brought Child O to hospital because, two days after the second fall, the child was developing ‘black eyes’ and had a clear watery discharge from the nose. The Nurse at Triage was concerned as two safeguarding risks when assessing children on admission were ‘black eyes’ and delayed presentation and so completed a safeguarding assessment highlighting these concerns. The Doctors, when they assessed the child, did not consider there were safeguarding concerns, and felt that the bruising to the eyes was a result of a second blow to the head, which could result in delayed bruising becoming apparent. They felt that the explanations given by the father for the injuries, which had been seen by the Mother, were plausible and accidental and that there were no issues of concern.

2.4.2 On the 18th September 2018, the safeguarding form completed by the Triage Nurse was received by the hospital safeguarding team. The duty advisor contacted the health visitor and left a message. The matter was then discussed at the weekly safeguarding meeting held the next day. At the meeting it was decided to ask the consultant to review the case. Feedback was given on the 26th September that it was likely to be a ‘tracking bruise’ and therefore there were no concerns. Following this, further attempts were made to speak to the health visitor, and when they were told that the sole contact was the ‘movement-in visit’ it was agreed that no further action would be taken by the hospital.

2.4.3 Following the contact from the hospital the health visitor attempted to contact Mother to discuss Child O’s attendance at the hospital. An unsuccessful home visit was attempted and eventually, telephone contact was achieved. The health visitor discussed safety arrangements in the home and was satisfied that Mother was aware of the risks of falls by a mobile toddler and was responding appropriately.

2.4.4 In Mid-October 2018, Child P was taken to hospital by ambulance because of a possible febrile convulsion. The child was admitted to hospital and discharged the next day. There were no concerns regarding the parents’ presentation and actions.

**2.5 Key episode 3:** **Parents separate (Nov 2018)**

2.5.1 On 15th November 2018, Mother contacted the GP and said that Father had left her, and she was finding it difficult to sleep. She reported that the children were staying with the paternal grandparents. Mother was given medication for one week and was told to make contact within the week. Two days later Child P was seen at Medway A&E with two cuts to the head, caused when an ornament fell on the child’s head at paternal grandmother’s house, no safeguarding concerns were recorded.

2.5.2 A week later, Mother was seen at the surgery. Initially she arranged a telephone appointment, but the GP requested she attend for a face-to face consultation. She reported that she had been tearful over the previous two weeks after Father had left. She said that she had thoughts of ‘sleeping and not waking up’ but would not do anything to hurt the children. She said that Father was not willing to consider counselling. Mother was given diazepam and propranolol and was asked to call back one week later. A day later Mother telephoned the GP and said she was still not sleeping; she was now staying with maternal grandmother in a different area of Kent. She was given a new prescription for different medication to help with sleeping.

2.5.3 On 27th November 2018, Child P was seen by the practice nurse for wound care. No major concerns were noted but the practice nurse noticed that Mother seemed distracted and less happy. At this point Mother reported her change of address which meant she had driven forty miles to enable the child’s wound to be checked. The same day Mother reported to the pharmacist when she collected her prescription there had been no pills in the box. The pharmacist checked and was confident that the appropriate medication had been issued although on checking the records (as part of the SCR) there did not appear to be an electronic prescription generated or recorded.

2.5.4 On 3rd December 2018, Mother contacted NHS111 because Child P had a fever and breathing difficulties. Following advice, she took the child to A&E where the child responded well to treatment.

**2.6 Key episode 4:** **Mother talks about suicide (Dec 2018)**

2.6.1 On 7th December 2018, Mother rang NHS111 very late at night and told them that she was depressed and thinking of ending her life. She was struggling to look after her children and had relocated four weeks previously to live nearer her mother. The out of hours doctor made contact and an appointment was made for her to be seen by a doctor the next day, which was a Saturday. She was seen by a duty doctor who considered she was not suicidal and thought that the children were a protective factor. Mother was prescribed further anti-depressants and was advised to register with a local doctor. This contact was fully recorded, and a letter sent to Mother’s registered GP, however it appears that this letter was filed without being seen by the GP.

2.6.2 On 14th December 2018, Mother self-referred to Insight[[6]](#footnote-6) saying she was separated from her husband and struggling to cope. She reported to the reception team that she was thinking ‘it would be better if she was not here’, but that she had no plans to ‘take action’. A clinical practitioner attempted to ring Mother back 15 minutes later, but it was not possible to make contact, so a voice mail was left. As the Mother had noted thoughts of harming herself, a letter was sent to the GP advising them of the contact by Mother and a letter was also emailed to the Mother, asking her to get in touch. The GP received the letter from Insight on the 17th and responded by arranging a phone conversation with the Mother. This took place on the 21st December and the GP assessed that Mother appeared on a more even keel, so reviewed her medication and gave her details of local crisis support systems.

2.6.3 On 21st December 2018, Mother called Insight again and reported thinking of suicide daily saying she ‘didn’t have a life anymore’. The Mother was asked if she had made plans to end her life and she reported thinking about taking an overdose. The Mother did not give a clear response as to whether she could keep herself safe, but she mentioned the children as a reason as to why she would not necessarily take her own life. After this contact the Insight practitioner decided to refer Mother to the Single Point of Access (SPoA)[[7]](#footnote-7) team. This referral was made on the 21st and a copy was sent to the GP. The Practitioner attempted to contact the Mother again to inform her that a referral had been made (in accordance with standard practice) however, was unable to reach her and sent her an email and text message with details of helpline numbers including The Samaritans. A few hours later, an email was received from the Mother thanking them for their actions.

2.6.4 The referral was received by SPoA on 21st December and was assessed as urgent, so was allocated for contact within 72 hours. It was noted that the referral clearly identified the risk of suicide and that there were children in the house, however the age of the children was not included, and the address provided was the family home, not her temporary accommodation near her mother. On 23rd December, SPoA made their first contact which went to anonymous answerphone, so no message was left. A further attempt was made on 24th December, which also went to answerphone, so no message was left. It was therefore decided to pass Mother to the local Community Mental Health Team (CMHT)[[8]](#footnote-8) in order that they could review the plan.

2.6.5 The local CMHT received the information from SPoA and telephoned Mother but got no reply so left a message on her answerphone. It is noteworthy that they contacted the GP Surgery to check the telephone number but did not ascertain the ages of the children living with Mother and were not advised that she had moved to live nearer to her mother. The CMHT were using the contact details available to them on the NHS ‘Spine’[[9]](#footnote-9), which were Mother’s permanent address at the family home.

2.6.6 The children spent the Christmas period with their father at the paternal grandparents’ home; however, they were returned to their mother’s care by Father on 26th December 2018. Early in the morning on 27th December 2018, Kent Police received a call from a lorry driver who was reporting that a vehicle had deliberately driven into the back of his lorry and ricocheted off into the verge adjacent to the hard shoulder. Police attended the crash and found Mother who said, “I killed my babies”. Police officers attended Mother’s temporary address and found the children unconscious and not breathing, they were pronounced dead soon after.

**3. Views of family and other relevant bodies**

**3.1 Father’s views**

3.1.1 The Lead Reviewer met with Father at the family home soon after the criminal trial was ended; the timing was at his request. Father was very angry about the decision of the court to accept Mother’s plea of guilty to manslaughter on grounds of diminished responsibility as he considered that she was fully aware of her actions. He described his relationship with Mother as having always included difficulties if ‘she was not getting her own way’; and said that he thought she had a ‘narcissistic personality’[[10]](#footnote-10). Father said that he was clear that once he discussed separation with Mother, she became difficult but that was not unexpected. Father was clear however that while he thought Mother to be selfish and manipulative, he had no concerns about her care of the children and did not think she would harm them.

3.1.2 Father’s perspective about the services that were provided to Mother and the children was that he had no criticism of the care provided to the children but wondered if the GP and mental health services should have intervened earlier to provide mental health services to Mother. He did acknowledge that this may have been difficult if she did not accept that she needed help and agreed that Mother did not present, to him, as someone who was psychotic or capable of harming the children. He also accepted that whilst having lived with Mother for many years, he saw her as having a ‘narcissistic personality’, this would not be immediately apparent; and would probably require quite a skilled professional to undertake a detailed assessment. Father was, however, aware that Mother had attempted suicide earlier, before she lived with him, and wanted to know whether this was taken into account by professionals working with her. This matter has been checked and it is now known that Mother took an overdose of 20 paracetamol when aged 14 years. This information was available, but not obvious in the GP records. It was not known by any other professional working with Mother.

**3.2 Mother’s views**

3.2.1 The Lead Reviewer met with Mother in a secure psychiatric setting; her psychiatrist assessed her as being capable of contributing to the review. Mother described to the Lead Reviewer her move back to the UK with the children, and the break down in her relationship with Father. She was clear that she did not want the relationship to end and was distressed by Father’s intention to seek a divorce. Mother said that she considered that she had been depressed for a long period, (possibly prior to the return to the UK), but that her mental health deteriorated after she separated from Father, and particularly after she moved away from the family home. Mother reported that she was persuaded to move out of the family home by Paternal Grandmother, but that with hindsight, she thought it exacerbated her depression. A problem that she reported was being unable to register with a doctor in the local area because all the GP lists were closed, which was why she continued to access the GP near to the family home.

3.2.2 Mother reported on the contact she had with the GP and Insight when her mental health was deteriorating and denied receiving any positive response from these professionals. Mother said that she initiated all contact with these agencies and denied receiving any emails or telephone calls from them. Mother was clear that she felt she had not received enough support from the mental health services and that if a professional had made contact, she would not have harmed the children. Mother felt that her physical presentation showed that she was very mentally ill and considered that the professionals had missed how poorly she was because most of her contact with agencies in the last weeks was by telephone.

**3.3** **Relevant information from the criminal process**

3.3.1 Mother pleaded guilty to manslaughter on grounds of diminished responsibility and received concurrent sentences of 10 years imprisonment on each count, with the hospital and limitation direction that Mother would be detained in a secure psychiatric unit and would be subject to the special restrictions set out in section 41 of the Mental Health Act 1983[[11]](#footnote-11). In his summing up the judge stated the following: -

*‘It is agreed between the three doctors who have given evidence that your mental state was a result of your personality, and also of the stresses which were caused by the ending of your marriage by your husband. By reason of your nature and history you were very fearful of being abandoned, and less able to cope with that than other people… It is agreed that you developed a depressive illness which became associated with particular features of your personality, which … substantially impaired your ability to form a rational judgment, although there is a dispute about whether it also impaired your ability to exercise self-control. It is agreed that this abnormality played a part in causing you to act as you did. I conclude that despite the depressive illness you were still able to choose what to do’.*

3.3.2 The Lead Reviewer had access to the psychiatric court report which confirmed Father’s suggestion that Mother had narcissistic traits which meant that she had ‘*a sense of entitlement and admiration of herself and her fortunate circumstances…[and that] negative occurrences in her life are attributed by her to factor external to her own sense of self…[and that these] … are essentially self-preservative in nature …’* The report author went on to say that these traits were not of diagnostic severity because historically Mother was able *‘to find people to dynamically compensate these traits’.* The report also clearly stated that, in their review of Mother’s psychiatric records, there was no evidence that mother had disclosed any harmful thoughts towards the children to any of the professionals involved.

**4 Analysis of practice in this case**

**4.1 What was life like for the children in this family?**

4.1.1 One aspect of this review was how little contact any agency had with the family prior to the children’s death in December 2018. It is clear, however, from the contact by the health visitor and GP, that prior to the parents’ separation in November 2018, the children presented as happy and contented and the parents were caring well for them.

4.1.2 After the parents’ separation, it is probable that the children experienced some disruption as they were staying at different houses (with paternal grandparents and at Mother’s new home); however there is no evidence that they were distressed by these changes. It is also evident that Mother was prioritising their care in that she drove forty miles in order to ensure that Child P’s wound was dressed. It is not possible to estimate how affected the children were by their Mother’s distress at the breakdown in her marriage nor whether her deteriorating mental health affected them materially or emotionally.

**4.2 What was the impact of Single-Agency and Multi-Agency working?**

4.2.1 Another unusual feature of the review was the absence of multiagency working. There was no communication between the GP and health visitor, the only professionals to see the children in their home environment. The children were seen in hospital on several occasions and most of these presentations were reported to the GP via discharge summaries by the hospital. The health visitor also was advised by the hospital of some admissions, usually by telephone, however, she was not informed when Child O was seen with possible black eyes. It is unclear why this information was not shared as there are systems in place to send reports to health visitors.

4.2.2 When there were possible safeguarding concerns identified and Child O was seen at the hospital with bruised eyes there was appropriate communication by the hospital with both GP and health visitor, albeit somewhat delayed. This did result in the health visitor contacting Mother to check safety issues within the home, albeit again, this contact was solely by telephone. When Mother initially presented at the GP in distress because of her marriage breakdown, this information was not shared with the health visitor and there was no consideration of whether Mother would benefit from support from the health visitor or Early Help services.

4.2.3 Later, when Mother had moved and was seen by the duty doctor, and her mental health was clearly deteriorating, there was again no consideration of whether she would benefit from additional support and no attempt to refer the family to the health visitor or Early Help. In part, this was because the GP that saw Mother was an out-of-hours GP who would normally only respond to the immediate presenting health concerns, however this issue was also not picked up when the registered practice received the report from the out-of-hours service as this letter was filed without being seen by a medical practitioner.

4.2.4 A significant feature of the service offered by the GP was the absence of a holistic over-view of the whole family. The children and Mother were treated separately, with each presentation looked at in isolation without any consideration of the wider picture. There is no evidence of any contact with Father who was also registered with the GP. The GP is a pivotal figure in that they receive copy letters for all health services provided to families, so they are best able to have an overview of the wider picture, but this does require them to move beyond looking at incidents and concerns in isolation.

4.2.5 The absence of a holistic over-sight became more apparent when Mother’s mental health deteriorated. It is significant that some professionals, (the GP and Insight), who spoke to her about the risk of suicide, did identify that she was caring for children. In fact, for these professionals, the children were seen as a protective factor in preventing her taking her life, but there is little evidence that consideration was given to the impact of Mother’s deteriorating mental health on her capacity to care for the children, or whether this needed to be assessed.

4.2.6 This was particularly relevant when Mother contacted Insight who on their first contact identified that she was caring for toddlers. When Mother contacted Insight for a second time expressing stronger suicidal thoughts, they appropriately referred Mother on to SPoA but did not include detail about the age of the children. SPoA noted that there were children in the household and provided this information to the Community Mental Health Team but did not have full details about their ages. The Community Mental Health Team contacted the GP Surgery to check contact details for Mother, and at this point the age and vulnerability of the children could have been clarified, but this did not happen, possibly because the service was experiencing a high number of urgent referrals and was under-staffed because of sickness and annual leave meaning the professionals focussed on the most urgent issue which was clarifying whether they had the right contact details. It is noteworthy that the Surgery did not inform the Community Mental Health Team of Mother’s recent change of address, which was also not recorded on the NHS spine.

**4.3 How were assessments, including risk assessments, undertaken?**

4.3.1 In the main, assessments, including risk assessments, were undertaken in accordance with local procedures and protocols. All assessments were individual agency assessments and were largely undertaken in the context of the presenting information, with little knowledge or understanding of the wider contextual picture. This is partly because the family had little history with any agency and many of the assessments were undertaken out-of-hours or were initial screening contacts.

4.3.2 The information provided to the health visitor about the assessment of Child P at Medway Accident & Emergency did not include a safeguarding assessment, however it is not thought that this incident which happened in the paternal grandparents’ home was anything other than accidental.

4.3.3 The hospital assessment of Child O when seen with the two black eyes was thorough and there was appropriate follow-up of the Triage Nurse’s concerns around possible safeguarding risks. There was some delay in the Hospital Safeguarding Unit receiving the notification, but the matter was, nevertheless, given appropriate scrutiny and there was good liaison with community services, particularly the health visitor.

4.3.4 The GP assessment of Mother’s emotional well-being and possible mental health concerns was initially centred around her need for sleep, due to acute stress. The GP who first saw Mother documented the presence of small children and ensured a timely review which was good practice. The GP recommended referral to Primary Care Counselling, (Insight), in a timely manner, however, no enquiry was subsequently made to ensure she had contacted the counselling service. Similarly, when Mother was initially assessed the children were thought to be a protective factor and she reported that there was support from family members. There was no detail taken, however, of who was providing the support, and on subsequent contacts, no consideration of whether a referral to Early Help would be useful. There was no routine enquiry around any likely harm that could come to the children due to the Mother's poor mental health. There was also no system in place within the practice for reviewing the children’s attendances at Accident & Emergency.

**4.4 Response to self-referrals by mother to mental health services and recognition of potential safeguarding issues for children when services are aware of a parent with mental health issues.**

4.4.1 Mother self-referred to the Insight Service on 14th December 2018. Initial attempts at contacting her were unsuccessful and the service sent a letter to the GP that identified the risk of suicidal ideation and advised that the client had not responded to telephone calls. Mother contacted the service again on 21st December 2018. She was reviewed that day and Primary Care services were deemed as not suitable for her due to the ‘risk to self’. Insight Healthcare is not an emergency service; it provides regular (usually weekly or fortnightly) therapy sessions for people with mild to moderate depression and some anxiety disorders. Clients whose needs cannot be met by such an approach, including clients with more severe and complex presenting issues and significant risk, are discharged back to their GP and referred to secondary care services via the SPoA service. Mother was referred to Secondary Care services via the SPoA Team and the GP was advised that this had happened.

4.4.2 The decision to refer Mother to SPOA was appropriate however it is unfortunate that they did not include in the referral the age of the children or that Mother had moved address to live near her family. The reason this information was not shared appears to have been an oversight as the information was easily accessible in the records. At this time information was passed to SPoA ‘free-text’ however a new process has now been developed with a pro-forma which includes key information that must be shared including the dates of birth of all children in the household. The absence of this information meant that SPoA and the Community Mental Health Team did not have full information when making their assessments about how to prioritise their work.

4.4.3 The referral was received, by SPoA, at 17.26 on Friday 21st of December 2018; any clarification of any risk or concerns could not be sought as this was out of hours for the Insight Service. The referral had been emailed into SPoA, it had not been marked as urgent, and the referrer had not contacted SPoA to highlight any urgent concerns. The referral was allocated for contact to be made with mother within 72 hours, which appeared to be the correct pathway, based on the information provided in the referral. At this time SPoA prioritised work as: red – triaged within 4 hrs and crisis response same day; amber – urgent, tele-triaged within 72hrs and response same week; green – SPoA routine referrals on to the CMHT for triage and assessment. Given the information provided, amber priority was a correct decision.

4.4.4 Contact was attempted, by phone, on Sunday 23rd December 2018, at 16:55, on telephone numbers that were obtained from the NHS spine, as the referring letter did not contain any contact numbers. Two of the numbers failed, the other two calls were not answered, and no message was left as these were generic answer machines, and it was unclear if any message left for the mother would be confidential. A further attempt to contact was made on Monday 24th December, at 09:04, again SPoA were unable to obtain contact and the referral was closed to SPoA and opened to the local CMHT on the afternoon of 24th December 2018. This is an agreed course of action in cases where, there is an indication of risk and SPoA have been unable to contact the client.

4.4.5 CMHT screened the referral when it was received and made a further attempt to contact the mother on 24th December 2018 at 15.56, and left a discreet generic message on the answerphone, requesting that Mother call back. They had previously contacted Mother’s registered GP to clarify the contact details. They did not ask for further information regarding the children because the referral gave no indication of risk to the children. It was noted that, if CMHT had been aware of the age of the children, it was possible they would have prioritised Mother for a visit that day. At the time of the contact, the service was under considerable pressure, due to staff sickness and annual leave, it was Christmas Eve and there were 12 referrals received after 12 noon. 5 referrals were determined to require an urgent response and were allocated, including Mother. It was noted that the Mother had stated that she had not made plans to end her life, she had agreed to attend A&E and contact other services. Contact was put in the diary for the 27th December if the Mother did not contact the service before then. If she had not made contact by then, the service would have visited her home address, however this would not have been where she was living, as they were using the contact details on the NHS Spine which did not reflect her move to live nearer her mother.

4.4.6 A final factor that was raised at the workshop regarding the services provided to Mother was that she had only been on anti-depressant medication for two weeks, which may have been a risk factor as it is known that the risk of suicide or self-harm is greatest in the first 28 days of starting treatment[[12]](#footnote-12). A possible explanation for this is that there may be a delay in noticeable improvement after starting an antidepressant, mood remains low with prominent feelings of guilt and hopelessness, but energy and motivation can increase and may be related to the increased suicidal thoughts[[13]](#footnote-13). The medication may increase energy levels, but have not yet fully impacted on mood, and, therefore, can give someone the energy to act on their suicidal ideation.

**4.5 Response to children when they experienced injuries; was consideration given to any referral to Children’s Social Work Services?**

4.5.1 There were two occasions when the children sustained injuries: the first was when Child O was taken to hospital because they had blackeyes which had appeared days after they sustained two falls, hitting their head in the same spot. The assessment of the doctors involved was that the injuries were in accordance with the explanations given and that the bruising around the child’s eyes was as a result of “tracking” from the injury on the forehead (a process where blood can track through the layers of tissue, from the site of injury to another location). The paediatrician reported that, instead of being concerned by the delay in presentation and the bruising seen on examination, he was actually reassured, as if the child already had a bruise to the forehead from the initial accident, when the child hit the head in the same place for a second time, this could easily cause the bruising to start tracking down from the forehead and around the eyes. Given this assessment, referral to Children’s Social Work Services was unnecessary, the review of the hospital response to the injury indicated that all staff acted appropriately. One weakness in the system that was identified, (but which was not relevant in this case), was that there was a delay in the safeguarding notification being received by the Safeguarding team. Since then there has been the introduction of a poster sized guide for quick reference by Emergency Department staff, guiding them in what action should be taken for attendances where safeguarding concerns for children are raised which should act as an additional reminder to staff to respond quickly.

4.5.2 The second injury was to Child P who sustained a small cut to the head while in the father’s care at the paternal grandparent’s house. The child was taken immediately to the hospital by Father, the explanation for the injury was considered as plausible and the child’s presentation was good therefore no further action was taken. It is however unclear why a safeguarding assessment was not recorded.

**4.6 Identified good practice**

4.6.1 It was noted that the assessments by the health visitor and the Hospital staff were appropriate and that practice was sound. The response by the hospital Safeguarding Team was delayed but following this, the appropriate checks were undertaken.

4.6.2 The GP was very accessible and made conscious efforts to contact Mother. This was also true of all the mental health services, and there were repeated efforts by staff to engage with Mother and enable her to access services.

**5 Lessons learned about the wider safeguarding system**

**5.1 Sharing of information between agencies**

5.1.1 Information sharing is at the crux of effective safeguarding; however, there are many reasons why information is sometimes not shared, and it is important to understand these reasons if the safeguarding system is to be strengthened. A feature of this case was the absence of information sharing between the GP and the health visitor. GPs are in a prime position to identify vulnerable children, particularly when, as in this case, parents use the GP as the main support system. Treating whole families over long periods of time, GPs can become aware of valuable insights into the difficulties that some children face. However, they rarely see into the homes of young families, with domiciliary visits being largely reserved for frail older people and those with multiple morbidities, they therefore need to draw on the wider healthcare team to obtain as full a picture as possible of a child’s life if they are to recognise those in need.

5.1.2 In this case the GP was the first professional to be aware of the breakdown in the parents’ marriage and the impact this had on Mother’s emotional well-being. There was a responsive and caring service offered to Mother, however, there was less insight into the impact this might have on her children. There was no consideration of whether it would have been helpful to offer Mother a referral to Early Help, or to consider asking the health visitor to check the well-being of the children. The reasons for this are not totally clear but one explanation is that initially Mother’s presentation was not that unusual, and if all such families were referred to the health visitor, the service would be overloaded. Another possible explanation is that, due to the changes in both the location and nature of health visiting, GPs no longer consider sharing information in the same way as they did when there was co-location and closer day-to-day working. Another factor that may impact on information sharing between agencies is the high workload for GPs and the lack of continuity of care for the individual patient, which makes it difficult for a more personalised support to be provided.

5.1.3 In the area where Mother was registered with the GP, there are two Health Visitor/GP Multi-Disciplinary Team meetings a month. One for under-5s and one for over-5s. They are run by a practice administrator who adds names to the meeting agenda from GPs who have any concern about a child. They are well attended. They have been running prior to this case. However, since the deaths of O and P, any child where a parent’s mental health is deteriorating will be added to the agenda as well for discussion.

5.1.4 Another time when information was not shared effectively was when Mother was referred to SPoA and the details of the age of the children and Mother’s change of address were not shared. In part, this was an oversight by an inexperienced professional, however there are now new systems in place that require the use of a pro forma for passing on information with key details, such as ages of children in the household, being included which will make such an error less likely to happen.

5.1.5 An example where there was a clear systematic problem in information sharing was with regards to updating the NHS Spine when people move. Mother had advised the GP of her change of address however this was not reflected on the NHS Spine, meaning that other health professionals were not given her new address, despite the Community Mental Health Team telephoning the GP to clarify contact details. Generally, if a patient or family move address and register with another GP, a request is made for the previous GPs records, and at that point the address is changed and the patient de-registered. If there are any children under 5 within the family, then the Health Visiting team will be notified of the change of address and new GP details. If a patient informs the practice they have changed address *within* the practice catchment area, then the address will be changed, and no further action is required.

5.1.6 In the case of O and P, the mother informally advised the GP she was moving to be nearer her parents. In such circumstances, it would not be routine to change an address to one that was outside the practice area without there being a request for notes from a new GP, especially when the patient was of concern as there is a risk that the patient would then be without a registered GP. In this situation, there would be no informal passing over of the new address to the Health Visiting team.

**5.2 ‘Whole Family Working’, risks to children when parents have mental health problems**

5.2.1 Previous serious case reviews have shown professionals may lack awareness of the extent a mental health problem may impact on parenting capacity, meaning they do not identify potential safeguarding issues. The learning from these reviews highlights that professionals need to recognise the relationship between adult mental health and safeguarding children. Adult and children’s services need to work together when there is a parent with mental health problems. In particular, GPs may need to remember to consider what caring responsibilities people who present with mental health issues may have and the impact on their ability to care. An area for further work identified by the CCG is the provision of safeguarding training for GPs regarding the risks to children from poor parental mental health.

5.2.2 In this case there was insufficient focus on the impact of Mother’s deteriorating mental health on her capacity to care for her children and no attempt made to involve the wider family, (either her mother and sister or the father of the children), in order to assess whether the care was good enough. A ‘Think Family’ approach was needed. Previous research evidence has demonstrated the impact of parental mental health problems on children. A Social Care Institute for Excellence (SCIE) guide to parental mental health and child welfare, highlights key recommendations for practice which include:

* effective screening tools to identify adults with mental health problems who are parents.
* assessment of the whole family.
* effective planning to meet the individual needs of each family member[[14]](#footnote-14).

5.2.3 Reasons for the absence of a holistic inclusive family assessment may include Mother moving addresses and frequently asking for help out-of-hours, meaning there was little continuity of care with professionals often responding to the immediate presenting problem. There was, however, an over-reliance on pharmaceutical solutions which did not address the wider social issues and particularly failed to consider the possible risks to the children. It is probable that this reflects a wider mindset and is not purely a response to resource pressures.

**5.3 Increased reliance on assessments undertaken by phone**

5.3.1Another factor that was identified in this case review was the frequency of professional contact with Mother being by telephone which may have affected the quality of the assessments. It was noteworthy that on 21st December 2018, Mother had a telephone consultation with the GP where he noted that she seemed on a more even keel. Later that same day, Mother contacted Insight and was expressing suicidal ideation, that in their view required her to be referred to SPoA. When contact with a service is over the telephone, there is less likelihood of determining a patient’s true condition as much assessment of a person’s physical and mental health is based on physical appearance and body language.

5.3.2 Discussion with professionals at the workshop identified that services are increasingly being provided, in the initial stages, via telephone or internet. Such services are seen as a good use of resources and also enable the potential service user to determine how and when they contact the service. Clearly there may be benefits to providing services in this way but there may also be limitations and this needs to be factored into any assessment processes. Research into this issue suggests that for open access services such as Insight telephone contact is a positive benefit and enables greater access to services, however, there is some evidence that it is less beneficial for more specialist services such as CMHT.

**5.4 Factors to consider when assessing risk in suicidal ideation**

5.4.1 Homicide–suicide incidents occur mainly in family contexts with a parent killing a child (filicide) followed by suicide being the second most common form of homicide–suicide after intimate partner murder[[15]](#footnote-15). Specific motives for filicide were initially described by Resnick, classified as (1) altruistic, (2) acutely psychotic, (3) accidental filicide (fatal maltreatment), (4) unwanted child, and (5) spouse revenge filicide. In this case the most relevant criteria are (2) and possibly (5)[[16]](#footnote-16). Mother pleaded guilty to manslaughter on grounds of diminished responsibility and there was significant focus in the criminal trial on whether she displayed evidence of psychosis. It is clear, however, that this was not evident to professionals prior to events on 26th December 2018. Contacts with Mother in December 2018 assessed her as being depressed with some indications of suicidal ideation, however, it was also thought that there were protective factors that could prevent this happening. There was a common view that caring for the children was a ‘protective factor’ and this was on occasion discussed with Mother. This term is sometimes used in Mental Health Services to mean that a mentally ill vulnerable adult is less likely to take a child’s or other person’s life if they are securely attached. However, it can be misunderstood, and in cases when a vulnerable adult has started to seriously self-harm or attempt suicide, the child as a protective factor is negated, and the risk may become that filicide-suicide is planned. With hindsight it is in fact now known that as early as 10th December 2018 Mother was undertaking google searches about how to kill both herself and her children.

5.4.2 This issue is a relevant factor to explore further. Analysis of statistics regarding deaths by suicide would support the premise that caring for children is protective against suicide. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness reported that, in the UK in 2005-2015, 938 patients who died by suicide were carers, (i.e. providing care for young children or someone else at home, or living with a mental health patient), this was 5% of all patient suicides, an average of 85 deaths per year. These figures showed that they had fewer risk factors for suicide compared to other patients who died, and it was noted that generally, carers were more likely to be female[[17]](#footnote-17). Such analysis however purely examines the statistical risk of suicide and does not include in the risk assessment the impact or effect on the child. In the UK there were 200 homicide-suicide offences between 2005 and 2015, an average of 18 per year. There were 301 victims in total of whom 33 (17%), were sons/daughters (including stepchildren). It is noteworthy that 14 (7%) homicide-suicides were identified as patients, i.e. the individual had been in contact with mental health services in the 12 months prior to the offence.

5.4.3 An NSPCC briefing based on serious case reviews published since 2013, analysed reviews where the mental health problems of parents were a key factor. It highlighted the learning contained in the reports. In these reviews, children died or were seriously harmed in the following ways:

* killed or seriously injured by a parent suffering from depressive mental illness or a severe psychotic episode.
* neglect as result of parents with mental health issues prioritising their own needs.

This briefing concluded that, as well as leading to a referral to mental health services, disclosure of suicidal feelings should lead to full consideration of child protection issues in relation to a suicidal parent and that children should never be considered a protective factor for parents who feel suicidal. The serious case reviews had identified that, in some cases, professionals inappropriately viewed the child as a protective element who could help to reduce the parent’s risk of self-harm. This belief significantly increased the risk to the child[[18]](#footnote-18).

5.4.4 There has been comparatively little research in the UK about homicide-suicide incidents, however, Moskowitz et al. writing about homicide-suicide events in New Zealand, concluded that they appear broadly similar to such events in other countries and that mental illness plays a significant role in some forms of homicide-suicide. However, there is considerable variation in the prevalence of mental illness in studies, due in part to different definitions for mental illness. A number of authors have identified depression as significant in cases of homicide-suicide, and research in Asia, Australia, Canada, Europe and the USA over the past sixty years (Roma et al, 2012), indicates that mental illness plays an important part in homicide-suicide, and that depression was the most frequently reported disorder[[19]](#footnote-19). Pritchard et al noted that parents kill children substantially more often than strangers, and that in their study 55% of parents were mentally disordered[[20]](#footnote-20), this being twenty-two times the rate of the severely mentally ill in the general population[[21]](#footnote-21). There has also been international research into the significance of discordant adult intimate relationships and their influence on the occurrence of murder-suicide. A recent study identified that of the incidents that they describe, 81% with paternal perpetrators and 59% with maternal perpetrators, were preceded by parental discord[[22]](#footnote-22). Separate research in Australia found that nearly 70% of all murder-suicides occur in the context of disputes relating to termination of a relationship, jealousy or other domestic matter, with the most common relating to disputes over the termination of a relationship[[23]](#footnote-23).

5.4.5 A better understanding of maternal filicide motives may provide a framework for filicide prevention; it is clear that ‘suicidality, psychosis and depression elevate risk, as does a history of child abuse’, however, many mothers who do not attempt filicide experience thoughts of wanting to harm their child. This summarises the significant difficulty in identifying when children are at risk: ‘Prevention is difficult, because many risk factors, such as maternal depression and social disadvantage, are common among non-filicidal mothers’[[24]](#footnote-24). An effective preventive approach would need to include three lines of enquiry: i) the mother's potential to abuse; ii) the vulnerability of the child; and iii) the presence of a crisis which might precipitate the abuse. ‘Positive assessments in all three spheres suggest a high-risk situation where a multi-disciplinary intervention is required. The possibility of homicidal tendencies should never be overlooked in depressed individuals, particularly mothers, and it should be assessed systematically as part of any psychiatric evaluation’[[25]](#footnote-25). In this case, the age of the children clearly made them vulnerable and there was significant evidence in Mother’s presentation that there was a crisis, both in her mental health, but also in the breakdown of her relationship. The factor that was not assessed or immediately apparent was Mother’s potential to abuse. The question that remains unanswered is whether that information could have been identified if there had been a more holistic assessment that included contact with the wider family.

**6 Conclusions**

6.1 This review has confirmed that the children were killed by their Mother, who was experiencing a mental health condition, however it has not identified that any professional, involved with Mother prior to the death of the children, was aware that she posed a risk to her children. It is apparent that there were some limitations in the assessments of Mother’s mental health, however, it is not clear that, even if these had been more robust, Mother’s intention to harm the children would have been evident. Father, who knew Mother very well, did not see her as a risk to the children and there is nothing to suggest that she would have told professionals her intentions.

6.2 This review has however identified areas where information sharing between professionals could be improved. Communication from GPs to Health Visitors needs to be strengthened to enable better sharing of concerns. Furthermore, the processes for updating information on the NHS Spine needs to be clarified and strengthened to ensure that when a family moves (even if temporarily) health professionals are alerted and can then make contact.

6.3 The review has shown that professionals assessing parental mental health did not sufficiently consider the needs of the children and the wider picture when assessing possible risk. In 2009, the NHS and SCIE published a guide for professionals, ‘Think child, think parent, think family: a guide to parental mental health and child welfare’[[26]](#footnote-26) that identified the need for a strategy that promoted co-ordinated thinking and delivery of services to safeguard children, young people, adults and their families/carers. Children, young people and adults do not exist, or operate, in isolation from each other and professionals need to undertake assessments that do not just focus on adults *or* children but are holistic and consider the strengths and needs of the whole family including the father and grandparents. This was not a feature of the assessments undertaken with this family and the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) needs to review whether professionals have sufficient knowledge and understanding of this guidance.

6.4 The review has also identified a possible weakness in assessments due to the increase in the use of the telephone and email to contact service users. The full impact of these changes is not fully understood and may be different depending of the needs of service users. However, it is clear from this review that there may be limitations in the information that professionals can gather when they are not in direct contact with the service user and the effect of this on safeguarding needs to be evaluated.

6.5 The review has also highlighted the need for fuller assessments of depressed parents to enable the possible risks to the children to be considered and the dangers of professionals thinking of them purely as a ‘protective factor’.

**7 Recommendations**

7.1 KSCMP to ask the CCG and Public Health to review the effectiveness of the ‘Health Visitor/GP link meetings’ in relation to parental mental health issues.

7.2 KSCMP to ask the CCG to work with GPs consider how to enable patient’s addresses on local records and the NHS Spine to reflect their current whereabouts when they have moved but have been unable to register with a new GP.

7.3 KSCMP to ask all agencies to evidence how ‘Whole Family Working’ is embedded in their services.

7.4 KSCMP to ask health agencies to review the effectiveness of telephone and email contact and its impact on mental health assessments and practitioners’ capacity to assess risk.

7.5 KSCMP and its partners to ensure all professionals are aware of the risks around parental mental health, including the potential for children being harmed, and that children should not be viewed solely as a protective factor.

Fiona Johnson, 11th December 2019

1. Working Together to Safeguard Children, 2015 4:18 p 76 [↑](#footnote-ref-1)
2. HM Government, (2015) *Working together to safeguard children A guide to inter-agency working to safeguard and promote the welfare of children*. London: Crown copyright 2015. [accessed 15/6/2015] [↑](#footnote-ref-2)
3. Insight Kent is commissioned by the local NHS clinical commissioning group to provide a primary care psychological therapy service as part of the national programme for Improving Access to Psychological Therapies (IAPT). Individuals registered with a General Practice in Kent, aged 17 and above, are able to access the service through self-referral, or referral by a GP or an appropriate health professional and receive short term psychological therapy treatment under the stepped care approach. Insight Healthcare is not an emergency service; it provides regular (usually weekly or fortnightly) therapy sessions for people with mild to moderate depression and some anxiety disorders. Clients whose needs cannot be met by such an approach, including clients with more severe and complex presenting issues and significant risk, are discharged back to their GP and referred to secondary care services via the Single Point of Access service [↑](#footnote-ref-3)
4. Universal Offer: Working in partnership with parents and carers to lead and deliver the full healthy child programme (HCP) from ante-natal care through to school entry. ‘A universal service from health visitors and their teams, providing the full HCP to ensure a healthy start for children and family, support for parents and access to a range of community services/resources.’ <https://www.england.nhs.uk/wp-content/uploads/2014/03/hv-serv-spec.pdf> [↑](#footnote-ref-4)
5. **Febrile seizures (febrile convulsions) are fits that can happen when a child has a fever. They most often happen between the ages of six months and three years.** [**https://www.nhs.uk/conditions/febrile-seizures/**](https://www.nhs.uk/conditions/febrile-seizures/) [↑](#footnote-ref-5)
6. Insight talking therapies is a free and confidential service, commissioned by the NHS offering a range of therapies, including cognitive behaviour therapy (CBT), counselling, Eye Movement Desensitization and Reprocessing (EMDR), self-help, interpersonal therapies (IPT). [↑](#footnote-ref-6)
7. **Kent** and Medway's mental health Single Point of Access (**SPoA**) provides a single route to obtain Urgent advice to all new patients to our **Kent** and Medway mental health services in urgent situations. When calling our **SPoA** you will be speaking to someone who can ensure you are put through to the right person or service. <https://www.kmpt.nhs.uk/information-and-advice/> [↑](#footnote-ref-7)
8. Community Mental Health Teams (CMHTs) support people living in the community who have complex or serious mental health problems. <https://www.rethink.org/advice-and-information/living-with-mental-illness/treatment-and-support/community-mental-health-team-cmht/> [↑](#footnote-ref-8)
9. The '**Spine**' is the digital central point allowing key **NHS** online services and allowing the exchange of information across local and national **NHS** systems. The **Spine** connects pharmacy teams with GP practice staff, patients and others. <https://psnc.org.uk/contract-it/pharmacy-it/spine-nhs-it/> [↑](#footnote-ref-9)
10. Narcissistic personality disorder involves a distorted **self**-image. Emotions can be unstable and intense, and there is excessive concern with vanity, prestige, power, and personal adequacy. There also tends to be a lack of **empathy** and an exaggerated sense of superiority <https://www.medicalnewstoday.com/articles/9741.php> [↑](#footnote-ref-10)
11. Section 41 of the Mental Health Act 1983 means that the Crown Court may also impose restrictions on the patient’s discharge. It means that the patient cannot be discharged from hospital unless the Ministry of Justice or a Tribunal say they can leave, and the discharge may be subject to certain conditions. <https://www.hcsolicitors.co.uk/section-41> [↑](#footnote-ref-11)
12. Antidepressant use and risk of suicide and attempted suicide or self harm in people aged 20 to 64: cohort study using a primary care database <https://www.bmj.com/content/350/bmj.h517> [↑](#footnote-ref-12)
13. Depression in adults (update): full guideline FINAL DRAFT (July 2009) <https://www.nice.org.uk/guidance/cg90/documents/depression-in-adults-update-full-guideline-prepublication2> [↑](#footnote-ref-13)
14. Social Care Institute for Excellence Guide: <https://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp> [↑](#footnote-ref-14)
15. Homicide: Includes murder and manslaughter, manslaughter defined as ‘an unlawful killing that doesn't involve malice aforethought’, for example manslaughter by gross negligence or by diminished responsibility. [↑](#footnote-ref-15)
16. **Filicide-Suicide: Common Factors in Parents Who Kill Their Children and Themselves** Susan Hatters Friedman, MD, Debra R. Hrouda, MSSA, Carol E. Holden, PhD, Stephen G. Noffsinger, MD, and Phillip J. Resnick, MD **J Am Acad Psychiatry Law 33:496–504, 2005** [↑](#footnote-ref-16)
17. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Annual Report: England, Northern Ireland, Scotland and Wales. October 2017. University of Manchester. Louis Appleby, FRCPsych et al. <http://documents.manchester.ac.uk/display.aspx?DocID=37560> [↑](#footnote-ref-17)
18. Parental mental health How to help children living with parents with mental health problems [**https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/**](https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/) [↑](#footnote-ref-18)
19. Roma, P., Pazzelli, Pompili, M., Lester, D., Girardi, P, Ferracuti, S (2012), ‘Mental Illness in Homicide-Suicide: A Review’, J Am Acad Psychiatry Law, 40, 4: 462-468 [↑](#footnote-ref-19)
20. Pritchard C., and Bagley C. (2001) ‘Suicide and murder in child murderers and childsexual abusers’, Journal of Forensic Psychiatry, 12, 2: 269-286 <https://psycnet.apa.org/record/2001-11174-001> [↑](#footnote-ref-20)
21. Jenkins R., Bebbington P., Brugha T.S., Farrell M., Lewis G. and Meltzer H. (1998) ‘British Psychiatric Morbidity Surveys’, British Journal of Psychiatry, 173; 4-7 <https://pdfs.semanticscholar.org/8efe/92850cf4cf9f3669e9a9c3d689f2743a9732.pdf> [↑](#footnote-ref-21)
22. Logan, J E., Walsh, S, Patel, N & Hall, J E (2013) ‘Homicide followed by suicide: incidents involving child victims’, American Journal of Health Behaviour, 37, 4: 531-542 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4699178/> [↑](#footnote-ref-22)
23. Carach C, Grabosky PN. (1998) ‘Murder-suicide in Australia: Trends and issues’, Crime and criminal justice, 82:1-6 <https://aic.gov.au/publications/tandi/tandi082> [↑](#footnote-ref-23)
24. Child murder by mothers: patterns and prevention SUSAN HATTERS FRIEDMAN, PHILLIP J. RESNICK Department of Psychiatry, Case Western Reserve University School of Medicine, Hanna Pavilion, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, OH 44106, USA (World Psychiatry 2007;6:137-141) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2174580/> [↑](#footnote-ref-24)
25. Homicidal Parents DOMINIQUE BOURGET, M.D. 1 AND JOHN M.W. BRADFORD, M.B.2 CANADIAN JOURNAL OF PSYCHIATRY Vol. 35, No.3 [↑](#footnote-ref-25)
26. <https://www.scie.org.uk/publications/guides/guide30/> [↑](#footnote-ref-26)