Oxfordshire Safeguarding Children Board

Learning from the Serious Case Review for Child M

Summary of the case reviewed:

Oxfordshire Safeguarding Children Board carried out a Serious Case Review (SCR) following the death of Child M, aged 5, in early 2017. Child M's mother pleaded guilty to his manslaughter on the grounds of diminished responsibility and was found to have been suffering from a serious mental disorder when she killed her son.

Child M's mother had suffered from episodes of mental ill health as a young adult and during pregnancy. She had been given a number of diagnoses including psychotic disorder, depression, schizophrenia and bi-polar disorder. There were long periods in which she showed no symptoms of mental illness and for the first three years of his life she cared for Child M without any apparent difficulty.

In early 2015 (while living in another local authority area) Child M's mother became mentally ill, telling professionals that she had thoughts about harming Child M which were understood to be part of her psychotic thinking. Child M spent a period in foster care and his mother accepted hospital treatment.

The family moved to Oxfordshire in mid-2015, Child M's mother's mental health remained good, she was in contact with mental health services and her GP and she worked closely with her health visitor, children's centre, pre-school and primary school. There were no serious concerns about Child M who was in good health, reached all of his expected developmental milestones and was always observed to be calm and happy, interacting very positively with his mother.

Findings:

The SCR found no indication that Oxfordshire practitioners missed signs of deterioration in the mother's mental health, 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.

In parallel with the SCR, NHS England commissioned an independent Mental Health Homicide Review. It concluded that the death of Child M could not have been predicted or prevented by the services that worked with his mother.

The SCR identified a number of learning points and areas for improvement in practice.

Key findings:

- When the family moved from Swindon to Oxfordshire, case transfer and closure summaries did not contain the full details of the incidents that had placed Child M at most risk. Important information from Swindon was added to the electronic record as a document with a file name that did not indicate its significance

- There was no coordinated transfer with agreed objectives and plan, each agency made its own transfer arrangement resulting in a lack of shared understanding of the history or possible risks

- Practitioners working with the family in Oxfordshire had limited or no knowledge of the mother's mental health history and were not aware of the episode where she had thoughts of causing him harm

- Extended family members had important background information that could have added to the assessments undertaken

Strengths in practice:

- Child M was closely observed by a range of professionals and a high level of child focused support was provided to Child M and his mother (including health visitors, social workers, children's centre, nursery, pre-school and school staff). The consistent picture 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

- A number of agencies in Oxfordshire recognised the lack of background information during the case transfer and actively sought to obtain background information

Themes in common with other Oxfordshire case reviews:

- **Parental mental ill health – the impact of the parent's mental health on the safety and wellbeing of the child**
- **Loss of continuity of service (and significance of past history) when families move across boundaries**
- **Professional curiosity – the need for curiosity about the family's past history, relationships and current circumstances that moves beyond reliance on self-reported information**
- **'Think Family' – the importance of thinking about the role of extended family members in the family system**

Learning points for practitioners:

- **Assessment** A detailed assessment should be undertaken that includes parent and family history, strengths/protective factors and potential risks

- **Use of language regarding Mental Health** practitioners should be clear in stating mental health diagnosis and presentation and possible impact on parental capacity, behaviour and ability to keep their child/ren safe

- **Information sharing** remember GDPR are not barriers to sharing information about the welfare of children in need, including those who move in and out of the local authority area

Learning points for the safeguarding system:

- **Joint assessment** To achieve a better shared understanding of parental mental ill health on children and mutual appreciation of roles and responsibilities, practitioners from adult mental health, children's social care and others working with children should consider undertaking joint assessments

- **Case history** member agencies should set their staff clear expectations for obtaining and reading case histories and giving them due weight in assessment

Take the time to reflect…

Analyse and assess the risks that arise when a vulnerable family moves across the boundaries and all professionals change: risks include loss of knowledge and understanding of the family, loss of professional relationships with the parent/s and child/ren, and among the professional network, the risk of 'start again' syndrome.

Did you know? The following links offer useful further information and guidance:

NSPCC: Parental Mental Health- How to help children living with parents with mental health problems

OSCB Seven Golden Rules for Information Sharing

Multi-Agency safeguarding procedures

If you do one thing…..

Take the time to stop and consider whether you are basing your assessment and understanding of what is happening solely on self-reported information.

Do not presume you know what is happening in the family home, ask questions and seek clarity if you are not certain. Be open to the unexpected and incorporate information that does not support your initial assumptions into your assessment of what life is like for the child or adult in the family.