Local Child Safeguarding Practice Review

Commissioned by Greenwich Safeguarding Children Partnership (SCP).

1. Introduction

1.1. This overview report was commissioned by Greenwich SCP following the death of Child B on 27th December 2020. A rapid review of the circumstances of Child B's death was held on 7th January 2021. The rapid review agreed that the criteria for a local child safeguarding practice review were met as the abuse or neglect of Child B was known or suspected, he had died and that a review might highlight improvements needed to safeguard and promote the welfare of children.

1.2. Child B's mother has been arrested and charged with his murder. No date has been set for her trial. An inquest into Child B's death has been opened and adjourned.

1.3. There were no indications in the period prior to Child B's death that his Mother's mental health was deteriorating or that she would harm Child B.

2. Principles underpinning the review

- To remember at all times that the main purpose for undertaking a Local Safeguarding Partnership Review is to learn and improve.
- Recognition that safeguarding children is complex and errors are made.
- It is important to understand not only who did what, but why they did what they did, the underlying reasons that led individuals and organisations to act as they did are equally important in obtaining a full understanding of what happened
- The review will seek to understand practice from the viewpoint of the individuals and organisations and form a view based on what was known and what was knowable at the time rather than using hindsight.

- Relevant research and case evidence will inform findings and recommendations.
- To take a child-centred approach.

3. **Key questions agreed for the review are:**

- Was information shared appropriately across agencies as well as internally?
- How much of an impact did Covid-19 have on this case?
- How effective was management supervision and oversight in this case?
- What support was there for mother's mental health, including around the time of Child B's autism diagnosis?
- What was the impact of mother's mental health on her parenting capacity?
- Was the family history understood by all agencies especially in relation to Child B's Supervision Order and support following the end of the supervision order?
- What impact did the culture and ethnicity of the family have?
- As a result of the learning identified, what will your agency do differently?
- Sharing of Child B's diagnosis with mother and availability of support to mother.
- Community support for Mother and Child B

4. **Review Period**

The review period was agreed as 1st January 2018 to 27th December 2020.

5. **Methodology**

The methodology used by the review was a hybrid model. Building on the information shared by the Rapid Review process each agency was asked to undertake an Individual Management review (IMR) and provide a chronology of their involvement. This allowed them to analyse their own agency practice and identify learning to contribute to the overall findings. The review panel discussed the IMRs and the draft overview report to reflect on the information provided and agree learning and recommendations. The

family were given the opportunity to contribute to the review but at this stage have not felt able to do so.

6. Description of Child B

Child B was 4yrs and 8mths old when he died. Child B was described as a well-cared for child. He was always neat and clean in his dress. His school described him as fun, loving and sometimes mischievous. He would sometimes grab adults to give them a big hug. His relationship with his mother was described as warm.

7. Child B's Family

Child B	Subject	DoB 30/04/2016
Mother	37 yrs	
Father	age Unknown – lives in Lagos	
Brother	13 yrs – lives with Father in Lagos	

Maternal Aunt Lives in London

Child B was of black African heritage. Both of his parents were from Nigeria. His Father lives in Lagos. Child B had an older brother who is 13 years and lives with their Father. Child B's mother came to the UK in 2008 on a student visa after the birth of her older son. She has a sister living in London.

8. Significant history prior to the review period

8.1. Child B's Mother suffered her first serious mental health breakdown in 2011/12. She was treated from 18th July 2012 by Greenwich Early Intervention in Psychosis Team. She was transferred to the Greenwich East Intensive Case Management Team – Psychosis (ICMP) on 12th April 2016. This was just before Child B's birth. Child B's Mother was diagnosed as

suffering from an enduring mental illness, Paranoid Schizophrenia, and this needed follow up treatment in the community to support Child B's Mother in managing her treatment and symptoms. This care and support were provided under the Care Programme Approach framework.

8.2. When Child B's Mother became pregnant with Child B, she stopped taking her medication however her mental health deteriorated and her medication was restarted during her pregnancy. This evidenced that when Child B's Mother was not medicated her mental health was likely to deteriorate significantly. In January 2016 Child B's Mother was referred to Greenwich Children's Social Care (CSC) by the Best Beginning Midwifery Service. The referral gave Child B's Mother's diagnosis and mental health history with other relevant background information. This led to a child and family assessment. The assessment concluded just before Child B's birth that a robust Child in Need (CIN) plan was needed. This led to a CIN meeting in March 2016 which included Child B's Mother, CSC, Adult Mental health Services, Best Beginning Midwifery, Specialist Health Visitor (Mental Health) and Early Help. The CIN meeting agreed a detailed package of support. The Social Worker (SW) completed a detailed risk assessment that was shared with the professionals involved and Child B's Mother. The way services responded to Child B's Mother's pregnancy and her needs as a prospective parent with a serious mental illness and to Child B when he was born was good practice.

8.3. In February 2017 following a risk assessment the CIN plan ended as Child B's Mother was accepting support and engaged well with the professionals in her network. The family were stepped down to Early Help and targeted and universal health services. No lead professional was identified in the stepdown process.

8.4. In April 2017 there were indications, which the HV identified, that Child B's Mother's mental health was deteriorating and Child B's Mother and Child B were referred to CSC. There were also referrals from the Police indicating a decline in Child B's Mother's mental health. A Child and Family assessment

was started in April. Concerns escalated further in May when a family member intervened concerned about Child B's Mother's mental health and the impact on Child B. Child B's Mother was hospitalised under section 2 of the MH Act 1989 and Child B placed with his maternal aunt. Child B's Mother at assessment, before admission on in May 2017, informed the assessing psychiatrist that she had not been taking her medication for a few months. This sequence of events and intervention showed good joint working between agencies and the Family.

8.5. Child B's Mother subsequently disclosed to a doctor and social worker at the time of her assessment under the Mental Health Act she had held Child B under water whilst he was in the bath. The context given by Child B's Mother was delusions about people watching her while she was in her home. This information was shared with the Police and there was a strategy meeting with CSC. The Police investigation was opened but did not proceed as there was no evidence to corroborate what B's Mother had said. This report led to Greenwich CSC initiating care proceedings to safeguard Child B. Child B was made subject to an Interim Care Order (ICO) in August 2017. His Aunt was travelling abroad and Child B was placed with foster carers in August 2017. He remained with foster carers until January 2018. Child B's Mother was acutely mentally ill in August 2017. She was discharged from hospital in

October 2017 to her home. Child B's Mother was asking to be reunited with Child B following her discharge from hospital.

9. **Review Period**

9.1. In January 2018 Child B's Mother and Child B entered a mother and baby foster placement. Child B remained on an ICO. In March 2018 Child B and his Mother returned to live at their home. This plan was agreed with the Family Court. The Family Proceedings ended in late March 2018 with a

Supervision Order made to Greenwich CSC for one year. The Court and the Children's Guardian, appointed in the proceedings, advised a robust plan should be progressed reflecting Child B's Mother's frail mental health and Child B's vulnerability. This was put in place and included funding for a childminder/nursery 3 days a week and twice weekly attendance at a Greenwich CSC children's centre. In July 2018 Child B and his Mother attended a drop in Speech and Language Therapy session where it was identified that Children B was presenting with social communication difficulties. This is the first reference to Child B having developmental difficulties. His Mother engaged well with subsequent workshops and other appointments offered to explore Child B's needs and to provide him with support to improve and address his communication difficulties. The supervision Order was for a year and ended in March 2019.

9.2. In March 2019 the HV contacted the SW with concern and requested Child B remain on a CIN plan until changes were seen in Child B's development. The HV was concerned about the level of stimulation of Child B and that Child B's Mother was not fully engaging with childminder/nursery and health care needs. The Early Years Team at the Children's Centre highlighted concerns about Children B's communication delays and Children Child B's Mother's lack of supervision at stay and play sessions. The Family were referred to Home-Start Family Support Worker (FSW) who identified Children B's additional needs. The FSW worked with Child B's Mother, the SW and HV as part of the CIN plan. The FSW referred to CSC but seems not to have been aware Child B and his Mother were already open to CSC as a CIN case.

9.3. After the supervision order ended CSC worked with Child B and his Mother as CIN. It was becoming clearer that Child B had additional needs. His childminder/nursery wanted him to have additional support which was provided. There was regular and good communication between all the professionals involved with Child B and his Mother.

9.4. The FSW encouraged Mother's attendance at Parenting GYM which she attended, helped Child B be placed with a local childminder/nursery and

supported an application one to one support for Child B when at childminder/nursery to help his communication skills. The Family were closed to the FSW and Home-Start in November 2019.

9.5. The concerns of the HV about Child B's Mother not fully engaging with nursery and health care services do not seem reflected in Child B's Mother's engagement with services more broadly. The HV was aware of when the CIN plan ended and expressed concern about Child B being stepped down from CIN. The HV had concerns about Mother's ability to meet Child B's needs. These concerns were about mother's capacity to meet her child's needs and the lack of insight into how well she was able to stimulate Child B. In supervision it was suggested the HV ask if a cognitive assessment may be required for mother as mother had acknowledged to the Paediatrician that she struggles with reading. The HV stepped down Child B to Universal Plus pathway as there was no longer a multi-agency plan in place. This meant Child B had minimal HV contact from this point onwards.

9.6. In June 2019 the final CIN meeting was held. The HV who had concerns was not able to attend the meeting and nor was a colleague able to cover the meeting. The adult mental health care coordinator did not attend but reported that Child B's Mother's mental state was stable and she was complying with all medication. Child B's Mother was reported to be insightful and capable of self-medicating. Child B's Mother had requested to change from receiving her medication by injection to oral medication. She received additional support from mental health services during this change of medication. The final CIN meeting was at the same time as Child B's Mother's support with the change to oral medication ceased. The meeting was attended by the SW, Home Start Family Support Worker and Child B's Mother. Child B and his

Mother stepped down to early help with the SEN service, Community Health Services, Health Visiting and Adult Mental Health services continuing to be involved. No practitioner or organisation was named as the lead and there was no early help plan. This was a significant gap as there was no

person identified as a key worker for coordination of communication and information sharing or to bring the professional network and B's Mother together to discuss her and Child B's needs and how they could be met.

9.7. In October 2019 Child B was identified by the Community Paediatrician as having global developmental delay and social communication needs. Continuing support from Speech and Language Therapy (SALT) was recommended with an assessment for Autistic Spectrum Disorder (ASD) to be progressed. Child B's Mother was noted in Autumn 2019 to show increased insight into Child B's social communication difficulties and asked for additional time to help her set goals for therapy. In December 2019 Child B's Mother contacted the Early Years Inclusion Team upset about the support Child B was receiving at childminder/nursery. Child B's Mother wanted another placement. There were no other placements available and Child B's Mother agreed to keep Child B at the childminder/nursery. There were further issues raised by Child B's Mother in January 2020 which led to a meeting with the Early Years' Service, the childminder/nursery and Child B's Mother. When lockdown came the Early Years Special Educational Needs Coordinator (SENCO) had regular contact with Child B's Mother. The SENCO tried to contact Child B's Mother weekly. There was discussion about supporting B's transition to school but the school had already met Child B's Mother and Child B and did not feel a transition meeting was needed.

9.8. Following Child B's Mother's discharge from hospital in October 2018 and the end of her detention under section 3 of the MH Act her mental health service was under the Care Programme Approach (CPA) framework and she was entitled to statutory after care under section 117 of the Mental Health Act. OB's care coordinator participated in the Supervision Order and CIN meetings. In the period 1st January 2018 to 27th December 2020 there were 13 CPA review meetings of which Child B's Mother missed two, in July 2018 and October 2019. The contact with Child B's Mother's care coordinator was a combination of home visits, meetings at the Community Mental Health Team (CMHT) base and telephone contacts. The records indicate that

parenting was explored regularly and no safeguarding concerns were identified. The risk assessment was last updated by the care coordinator in October 2020. The Covid 19 lockdown period led to a reduction in face-to face contact and more reliance on telephone or internet video communication. Decisions on face-to-face contact were risk assessed by practitioners within their organisation's guidelines.

9.9. Child B's Mother's medication was by monthly injection up to April 2019. Child B's Mother requested a review of her medication and following review it was changed to daily tablets with additional support and supervision of her medication which ended in July 2019. The reason Child B's Mother requested a change to the way she received her medication was because of scarring on the site where she received her injections. It does not appear that Child B's Mother's mental health worker had any indications that her mental health may have been deteriorating in Autumn 2020 or that the risk Child B's Mother might pose to her child had changed. The CMHT were not part of discussions about Child B's developmental needs nor how his additional needs might impact on his mother's mental health. The last face to face contact by the CMHT was on 28th August 2020 which was at Child B's Mother's home. Child B was present. The last contact with Child B's Mother was on 27th November 2020 by telephone. This was with a Care Coordinator she knew but not her allocated worker who had left the service in November 2020. The summary of this contact said that Child B's Mother was reported to be doing well. She was not experiencing any abnormal symptoms or negative thoughts to harm her son or others. She was complying with medication. The crisis plan was discussed. Child B's Mother was waiting for allocation of a new care coordinator. There was no evidence in that telephone contact of relapse at that point or signs of concern

9.10. In August 2020 Child B's Mother was involved in an incident with another parent. Child B's Mother is alleged to have spat on a bench, the ground and at a child when asked by the parent of the child to keep a metre distant from her. The complainant did not wish to make a statement to the Police

and the matter was not pursued by the Police. Greenwich CSC were informed of the incident but as there was no concern expressed about Child B no action was taken. In retrospect this incident might be seen as an indicator of Child B's Mother's mental health deteriorating.

9.11. In July 2020 Child B had an initial appointment to assess whether he may have ASD. Child B's Mother attended a telephone interview with SLT in August 2020 and disclosed her own concerns about whether she had a learning difficulty or ASD. She was advised to discuss these issues with her GP. There were further appointments for Child B and his Mother with SLT and Occupational Therapy and for the concluding part of Child B's ASD assessment in October and November 2020. These appointments were online including the ASD assessment which was by video communication. Child B's Mother kept these appointments and was clearly concerned about her son and keen to ensure he got the help he needed. Child B's Mother was given Child B's diagnosis of ASD by the SLT during the video appointment on 30/11/20. The SLT said Child B's Mother had mixed feelings. Child B's Mother was upset but got over her initial reaction and asked appropriate questions. Child B's Mother asked for support. A letter was sent by post on 3rd December 2020 confirming the diagnosis. Child B's Mother would have been provided with an information pack and outreach information. Child B's Mother went to the school to discuss the diagnosis the following week.

9.12. Child B started school in a reception class in September 2020. There was a handover from his nursery setting to the school which was good practice. His attendance was excellent at 97% and he was always well presented in school. Child B's Mother was visible at drop off and pick up and she engaged well with Child B's school. She attended meetings when requested, engaged well during these meetings and seemed appropriately concerned about Child B's development and the difficulties he had. Child B's Mother discussed Child B's diagnosis with the SENCO and Child B's class teacher in early December 2020. Child B's Mother's response to the diagnosis was

described as appropriate and she asked questions reflecting her concerns about her child. She was keen to work with the school on strategies to support Child B at school and at home. This was the last meeting Child B's Mother had with professionals and there was nothing to indicate that her mental health was deteriorating.

9.13. Child B's last day in school was 14th December. The school allowed parents to decide about attendance in the last week of term. Child B's Mother decided not to send Child B to school. 14th December appears to be the last contact Child B's Mother and Child B had with any service.

9.14. Child B's Mother and Child B had regular contact with Child B's father by video call. This contact was mostly every day. They had a call on Christmas day where Child B's Father said Child B appeared happy and showed his father his Christmas toys. Child B's Father called again on 26th December several times and did speak to Child B's Mother. Child B's Father said Child B's Mother sounded dull and tired. When he called later there was no reply but Child B's Mother did reply to a text message saying she and Child B were fine. This was their last contact. In a telephone interview Child B's father confirmed he had no indication Child B's Mother's mental health was deteriorating or that she might harm Child B.

9.15. Child B was found dead in his home after Police were called by his Mother to say she had killed Child B. He drowned in the bath. The family home was well kept and tidy. The Police attending found a quantity of B's Mother's prescribed medication. The medication was collected in December 2020. This suggests Child B' Mother had stopped taking her antipsychotic medication some time before Child B's death.

10. **Responses to the key questions in the terms of reference**

10.1. Was information shared appropriately across agencies as well as internally. There was consistently good information sharing within and between agencies in their work with Child B and his Mother up to the end of the CIN

plan. Those working with the Family were aware of who else was involved and shared information and contacted partners when necessary. There were occasions when a professional was hard to contact or there was a delay in returning a request for contact but these were not frequent or significant. What was significant was the ending of formal key working with multi-agency meetings with Child B's Mother when the CIN plan ended in June 2019. Up to this point throughout Child B's life, apart from a short period in 2017 prior to his Mother's breakdown in that year, the Family had been either CIN or Child B was on a supervision order. The decision to end CIN in June 2019 is understandable given the progress made, the apparent lack of concerns and the number of other agencies who would continue to be involved. However, no other agency then picked up a key worker role or initiated team around the family meetings. There was no organised step down from the CIN plan which would have clarified roles in the professional network supporting Child B and his Mother. This lead professional role would also have helped carry forward key knowledge about Child B and his Mother into future planning with them including when Child B started school so that his school would have been aware that he had been subject to care proceedings and a supervision order. There was no formal reassessment of Child B and his Mother's needs together and review of their individual and joint vulnerability which reflected on the entirety of their history when the CIN plan ended and the case was closed to CSC.

The Health Visiting service was concerned about aspects of Child B's Mother's parenting and wanted the CIN plan to continue and made this point to the SW. However, when the CIN plan ended the Health Visiting input was also reduced as Child B was moved from Universal Partnership Plus to Universal Plus level of service. This together with staff shortages within the HV service meant there would be no continuing HV involvement with B.

From Summer 2019 Child B and his Mother continued to have a high level of contact with professionals from community children's health services in relation to the assessment and provision of therapeutic advice for his special needs, from his Mother's care coordinator for her mental health, from Early Years education services, the childminder/nursery, Home Start, the local children's centre and from September 2020 Child B's school. There was no one amongst these professionals who took on a lead professional role to bring together Child B's Mother and all those working with her and Child B. This absence of key working role and leadership to the multi-professional network meant no one had a full picture of the Family's needs from Autumn 2019. There was continuing contact with the mental health service but they did not have details of Child B's autism diagnosis and were working in parallel to other services.

10.2. How much impact did Covid-19 have on this case?

From March 2020 most of the professional contacts with Child B's Mother and Child B, other than Child B being with his childminder/nursery and from September 2020 at school, were by telephone or video call. This included contact with Child B's Mother's care coordinator. There was a lot of contact. Given that a feature of Child B's Mother's deteriorating mental health was withdrawal from contact with others the absence of face-to-face contact made it much more difficult to know whether Child B's Mother's mental health was deteriorating. Covid-19 also reduced Child B's Mother's contacts in the community which also might have been a source of alert to deteriorating mental health. It was a combination of community and professional concerns that alerted services to the serious deterioration in Child B's Mother's mental health in April 2017. By 2020 her relationship with her sister had broken down and we do not think she was in contact with her sister.

Covid-19 may well have increased Child B's Mother's isolation and made it much more difficult for professionals and community contacts to identify if her mental health was deteriorating. The Christmas period with Covid- 19 restrictions will have further reduced the likelihood of contact with others.

10.3. How effective was management supervision and oversight of this case?
There was evidence that the needs of Child B's Mother and Child B were reviewed within each agency in line with their normal arrangements for case oversight. The staff involved were managed and supervised and the IMRs did not identify any significant gaps in oversight of the case. The HV did raise her concerns about the ending of the CIN plan in safeguarding supervision. However, it is not evident that the management and supervision of practitioners at a single agency level ever took a sufficiently broad view of Child B's Mother and Child B's needs that would have considered their needs together and the impact on each of their vulnerabilities.

10.4. What support was there for Child B's Mother's mental health, including around the time of Child B's autism diagnosis?
Child B's Mother continued to have regular contact with her care coordinator throughout Autumn 2020. This was by telephone. Child B's Mother's care coordinator left the service in November 2020 and the contact with Child B's
Mother in November was by another care coordinator who knew Child B's Mother pending reallocation. The last contact was on 27th November 2020. The chronology for this contact says "CPA review and telephone call. Child B's Mother reported to be doing well. Not experiencing any abnormal symptoms or negative thoughts to harm her son or others. Complies with medication. Crisis plan discussed." This was based on self-report by Child B's Mother. There was no independent check of what she was saying and without a visit there were no observations of Child B's Mother, B and how

she was with Child B or of the condition of their home. The diagnosis for Child B of ASD was given to his Mother on 30th November. The chronology says that "Diagnosis provided in session. Mother was very upset in the appointment but advised she was relieved at hearing the diagnosis."

Given the discussion with Child B's Mother over a number of sessions about Child B's needs and the further discussion at school on 4th December it is hard to see in Child B's Mother's response that there was evidence that the diagnosis or how it was given to Child B's Mother was affecting her mental health. None of the professionals in contact with her who were all aware Child B's Mother had significant mental health needs suggested this. Child B's Mother's care coordinator was not informed of the ASD diagnosis for Child B and there was therefore no opportunity to discuss with the care coordinator any implications of this for Child B's Mother's mental health.

There is much stronger evidence for the significance for Child B's Mother's mental health that she almost certainly stopped taking her medication sometime in Autumn 2020. The Oxleas NHS Foundation Trust mental health service chronology sets out the history of OB's medication and her strong desire from early 2019 to move from monthly injections to oral medication and how this was dealt with. The change in medication was made in April 2019 and supported with additional service until July 2019. The effects of ceasing Child B's Mother's medication delivered by injection would take 6 to 9 months to show and of ceasing oral medication 3 to 6 months. Child B's Mother's history showed that her stopping medication could lead to a rapid deterioration in her mental health. This happened when she stopped taking medication during her pregnancy with Child B and when she stopped taking her medication in the early part of 2017. From July 2019 the Care coordinator was reliant on Child B's Mother's self-report that she was complying with her medication and any observation by the care coordinator or others of Child B's Mother's behaviour which might indicate she had stopped taking her medication.

10.5. What was the impact of Child B's Mother's mental health on her parenting capacity?

When in an acute episode of mental illness Child B's Mother was unable to parent Child B and was a danger to him. She had a diagnosis of a severe and enduring mental illness which required her to take medication to maintain her mental health and ability to care for Child B and herself. Child B must have been affected by his Mother's mental health. He was separated from her when she became acutely ill in 2017 and spent May 2017 to January 2018 in the care first of his Aunt and then a foster carer. The comments of professionals who saw Child B and his Mother together were mostly positive but there were observations suggesting Child B's Mother was not sufficiently stimulating him or always supervising him adequately. There are comments in the mental health records suggesting Child B's Mother was struggling with Child B's behaviour. Most comments in the chronologies are positive about Child B's Mother's care of Child B. The Family home was observed to be clean and cared for. Child B's Mother was described as appreciative of support including practical support with food and clothing as she was financially struggling. It was more difficult for those observing Child B and his Mother to judge how far any issues such as Child B's fussy eating were a care issue or related to Child B's development or the complex interaction between the two.

Child B's Mother kept most appointments concerned with assessing and trying to address Child B's needs. There were occasions when she pushed back against advice from professionals but such behaviour is not unusual amongst parents being faced with the news that their child may have significant developmental problems. Professionals also reflected on how far such examples of push back reflected cultural views and beliefs that Child B's Mother might have. The chronologies do not show that cultural views were explicitly explored.

When seriously ill Child B's Mother could not parent Child B and being with her at such times was probably a confusing and frightening experience for him.

10.6. Was the family history understood by all agencies especially in relation to Child B's supervision order and support following the end of the supervision order?

While Child B was on a supervision order there was good communication between the agencies working with Child B and his Mother. Agencies sufficiently understood the history even if they may not have had a full understanding of the exact implications of a supervision order. When the supervision order ended there was a CIN plan which also had good engagement from the agencies working with Child B and his Mother. When the CIN plan ended in June 2019 there was no longer a lead professional for Child B and his Mother or any meetings to coordinate work between all professionals. Those working with Child B and his Mother for the first time from Autumn 2019 were aware of some of the history, most knew Child B had had a CIN plan but they did not know the full history and without the coordination and leadership of a lead professional there was no ready mechanism for them to know the full history.

10.7. What impact did the culture and ethnicity of the family have? This is very hard to evaluate. There is wider evidence of higher rates of mental health problems in some ethnic minority groups for example rates of detention under the mental health act in 2012/13 were 2.2 times higher for black Africans than the average for all adults[1]. However, this area is not well researched and a recent systematic review[1] of mental health disorders among adults from minority ethnic groups found there was littler recent

[1] Rees R, Stokes G, Stansfield C, Oliver E, Kneale D, Thomas J (2016) Prevalence of mental health disorders in adult minority ethnic populations in England: a systematic review. London: EPPICentre, Social Science Research Unit, UCL Institute of Education, University College London.
ISBN: ISBN: 978-1-907345-84-5

information on rates of mental health disorders by ethnic groups. This suggests caution in making any judgements based on ethnicity in this case. The chronologies and IMRs show that those working with the family were aware of the possible impact of issues of ethnicity and culture but there is no evidence of this in explicit discussion with Child B's Mother. There is evidence of reflection in the NHS Oxleas CYP IMR of whether Child B's Mother's understanding of spoken English was sufficient to help her fully understand what she was being advised about Child B's needs and how far she understood Child B's diagnosis. Thought was given to whether an interpreter should be used.

There has not been an opportunity to speak to Child B's Mother about her experience or her sister which might help gain a better understanding of these issues and whether concern about how Child B's diagnosis might be seen in her community might have played any part in how she responded to Child B and to her seeking help for herself and B.

10.8. Sharing of Child B's diagnosis with his Mother and availability of support for his Mother.

Child B's diagnosis came after a series of assessments with the Integrated Neurodevelopmental (IND) team and with SLT and OTs, together with observations of Child B in childminder/ nursery, information from Child B's Mother and observations of her and Child B. Child B's Mother knew Child B was being assessed for ASD. She understood he had social and communication difficulties and wanted help for Child B. In 2020 there are examples of Child B's

[1] Ethnic Inequalities in Mental Health: Promoting Lasting Positive Change Report of findings to LankellyChase
Foundation, Mind, The Afiya Trust and Centre for Mental Health February 2014

Mother contacting professionals for advice and help sometimes following up meetings where she had shown some push back to what was being said about Child B or what she was being advised to do. Child B's Mother was given the diagnosis in a telephone meeting. This was then confirmed by letter and was followed up quickly with a meeting at school. Child B's Mother knew further support for her and Child B was planned. It would have been much better to have had the diagnosis meeting face to face but that was not possible due to COVID-19. Child B's Mother was upset by the diagnosis as reflected in the chronology entry but her upset was seen by those working with her as appropriate for a parent receiving such information. In the circumstances informing Child B's Mother of Child B's diagnosis was dealt with appropriately and should not be seen as a possible pre-cursor to Child B's death.

10.9. Community support for Child B and his Mother.

Child B's Mother did have some community links and was reported as being part of a Church. The nature and extent of these links is not evident from the IMRs and the chronologies. This issue needs to be explored with Child B's Mother and her sister if and when this is possible.

11. Learning relevant from Triennial Reviews of Serious Case Review 2011- 2014 and 2014 -2017[3], the Child Safeguarding Practice Review Panel Annual report for 2020[4] and from assessing adult orientated issues in parents.

11.1 Key points from the Triennial Reviews of Serious Case Reviews 2011-2014 and 2014-2017 and the Child Safeguarding Practice Review Annual report for 2020:

- The importance of the child's voice which for young children like Child B means practitioners reflecting on and imagining what life was like for him. This goes beyond considering his development, responding to the concerns about this and his health and physical care which appeared good.

- Poor maternal mental health was a common feature of the cases considered by the Triennial Reviews. The Triennial Analysis of SCRs for 2014-2017 found that in 47% of the cases notified the mother had mental health problems. Reflecting on this case:
- How far was Child B's Mother's mental health considered in the assessments of her and Child B's needs?
- How well did non-specialist mental health practitioners understand the risks of relapse for Child B's Mother and the high risk to Child B when his Mother relapsed?
- Did any of those working with Child B and his Mother know that Child B's Mother not taking her medication could lead to relapse and her presenting a serious risk to Child B?
- Did the mental health specialists fully appreciate the risks of relapse? Once there was no key worker role and no regular multi-agency meetings there was nowhere for all the agencies working with Child B and his Mother to consider these issues. Professionals other than those from Child Safeguarding Practice Review Panel Annual report 2020 Annual Report 2020 Patterns in practice, key messages and 2021 work programme DfE May 2021 children's social care can call multi-agency meetings but it is rare for them to do so.

[3] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report May 2016 Peter Sidebotham, Marian Brandon, Sue Bailey, Pippa Belderson, Jane Dodsworth, Jo
Garstang, Elizabeth Harrison, Ameeta Retzer and Penny Sorensen and
Complexity and challenge: a triennial analysis of SCRs 2014-2017 Final report March 2020 Marian Brandon, Peter Sidebotham, Pippa Belderson, Hedy Cleaver, Jonathan Dickens, Joanna Garstang, Julie Harris, Penny
Sorensen and Russell Wate

- Children in need and children who no longer require a child protection plan to keep them safe should nevertheless be recognised by agencies as having potentially long-lasting vulnerabilities and or risks of harm. This was true for Child B and his Mother. Should the multi-agency system consider how it provides long term support to families who are vulnerable such as Child B and his Mother?
- Avoiding using generic phrases such as 'children doing well'. Use of stock phrases is easy for hard pressed workers. Inaccurate or imprecise language does not support critical thinking and can give false assurances when viewed by other practitioners. How precise were practitioners about their observations of Child B with his Mother? While most observations were positive there were concerns expressed by the HV.
- Were the signs of Child B's Mother relapsing ever discussed with the multi-agency staff working with Child B and his Mother?
- The importance of recognising the interaction of mental health and other risk factors e.g. childhood abuse and other adverse childhood experiences which Child B's Mother had suffered. Who could have explored these issues of vulnerability and risk with Child B's Mother?

  How could this have been done in a way that did not alienate her?
- The importance of responding to changing risk and need. The Child Safeguarding Practice Review panel identified that there were weaknesses in risk assessment and not revisiting initial assessments when circumstances change or taking sufficient account of potential risks arising from known information. In this case it was known that Child B's Mother could relapse with serious consequences for Child B and for her own mental health but this possibility does not seem to have been sufficiently considered as Child B and his Mother appeared to be managing satisfactorily and the focus was on Child B's developmental problems.

11.2 The chapter on assessing parenting and working with adult orientated

issues in The Child's World[2] raises questions about how well Child B's Mother's needs were understood and the impact of her mental health and emotional difficulties on her care of Child B. How far, once the care proceedings were completed, did the assessment of Child B and his Mother by adult and children's health and social care services consider:

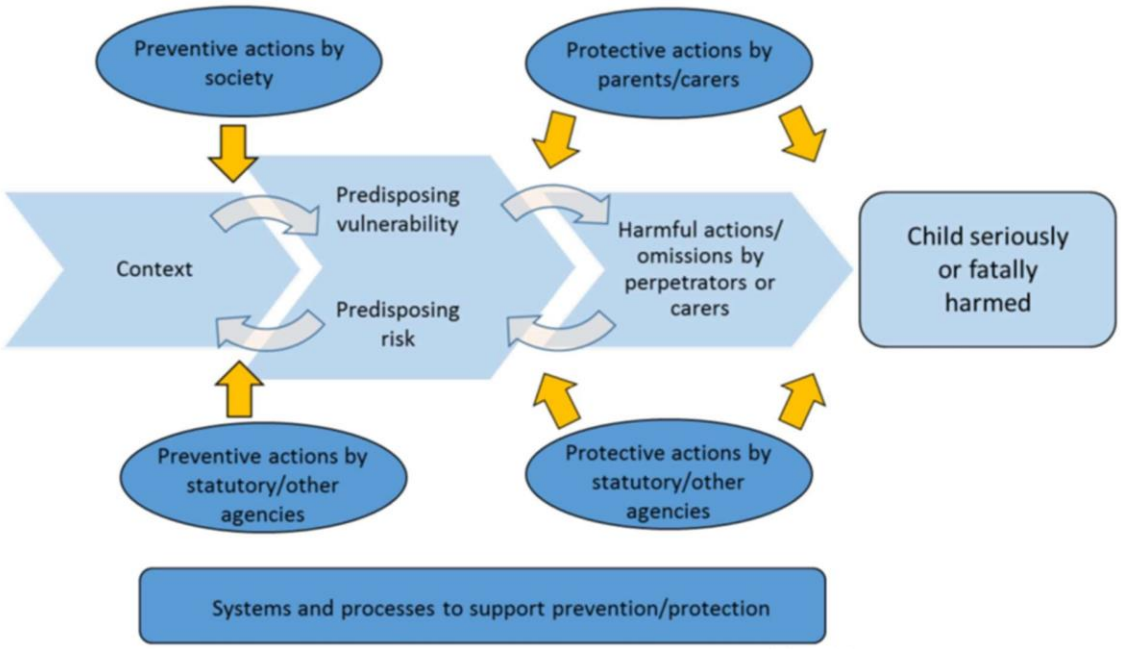
- Child B's Mother's availability physically and emotionally to act in response to B's needs?
- What the impact of Child B's Mother's mental health was on her predictability and behaviour in relation to her response to Child B?
- Recognising that for Child B his mother's' symptoms were more important for their subsequent impact on her parenting than a diagnostic label.
- How could the assessment of Child B and his Mother have been able to understand the overlap between her mental health and her history of adverse experiences?
- The importance of assessments that combine adult and child frameworks so that the adult orientated issues are assessed in their own right and for their impact on the child. Did the organisational and service arrangements make it impossible to achieve an integrated assessment of Child B and his Mother's needs?

12. **Analysis using the Pathways to Harm Framework for analysis**

12.1. There is potential value for this CSPR of using the framework set out in the 2011-2014 Triennial Review of Pathways to Harm for case analysis. The Pathway is described in Figure 1.

Figure 2.

[2] Basarab-Horwath, J. A., & Platt, D. (Eds.). (2019). The child's world : the essential guide to assessing vulnerable children, young people and their families (Third). Jessica Kingsley.



12.2. The context is of Child B's Mother being a single parent with limited family and social support. She was a female migrant with secure immigration status. She was black African and a member of one of the larger ethnic minority communities in London. We can expect she would have experienced some level of discrimination and felt a degree of suspicion and concern about how she might be treated formally and informally by authority figures she had contact with.

12.3. Child B's Mother was a vulnerable adult. She had suffered adverse childhood experiences and there is some information to suggest she had suffered domestic abuse as an adult – not from Child B's Father. She was in a continuing relationship with Child B's father who was supportive but lived in Nigeria. They had almost daily contact. The degree of her support from other family and friends is not clear but she reported in January 2020 having no hobbies or friends. Child B's Mother had a severe and enduring mental illness which required continuing treatment which greatly increased her vulnerability. Failure to take her medication moved her illness from a vulnerability to her being a risk to herself and her child.

12.4. Child B was a vulnerable child by virtue of his age, his history of being in care and separated from his mother as an infant and his developmental difficulties and diagnosis as a child with an autistic spectrum disorder.

12.5. These vulnerabilities for Child B and his Mother led to both preventive and following Child B's Mother becoming seriously ill and disclosing she had tried to drown Child B protective actions by statutory agencies. These protective actions ended when the CIN plan ended. Preventive actions continued but without a lead professional and without coordination across all services including adult and children services. While the predisposing vulnerabilities of Child B and his Mother were recognised the predisposing risk Child B's Mother might present when she ceased her medication was not adequately considered within the network of agencies who were working with her.

12.6. When Child B's Mother's mental health deteriorated there appeared to be no family members or community members in contact with her to identify her changed mental state as there had been in 2017. The loss of social contact due to Covid social restrictions may well have played a part in this though there is little clear evidence on this issue. The capacity for preventive action by society including family and friends was reduced just as the parent's capacity to protect was also reduced. The level of professional contact was reduced by COVID and there was no longer a coordinated network working with Child B and his Mother. The network was focused on B's diagnosis and response to this and the work with Child B's Mother about her mental health was quite separate. The risk of Child B's Mother relapsing and the danger to Child B from relapse had been lost sight of. In terms of the pathway to harm key preventive and protective areas within society, the family and the professional networks were all weakened.

12.7. Child B's Mother's change of medication from injection to oral made it much harder to monitor Child B's Mother's medication. Those treating her had to rely on self-report. Child B's Mother had a history of relapse when she ceased taking medication. This was an important risk factor for Child B. It is likely Child B's Mother had stopped taking or reduced her medication in the period before Child B's death and no one was aware of this. The change of medication in itself was well handled. It is clear the treating psychiatrist was not keen to change from depot injection and when Child B's Mother firmly chose oral medication support

was provided. The recommendation in paragraph 14.3 for a lead professional is to address the need for full

discussion of the risks of medication change and how such changes are monitored by the multi-agency group working with an adult with an enduring mental illness or other needs that need to be monitored. In this case the overall team around the family was not effective and part of that was the lack of a shared understanding of the risks of relapse and of the implications of the change of medication. A lead professional can help keep such risks actively managed within care plans for both parent and child.

13. **Recommendations from agency reviews**

13.1. Agencies identified learning and action following their reviews of work with Child B and his Mother. These recommendations included:

- Revised guidance for assessments and reviews within the Community Mental Health Service
- Reinforcement of the Think Family approach to safeguarding and promoting joint working across adult and children services within the health trust. This work included review of the CPA policy to integrate the principles of the Think Family approach into CPA.
- When imparting complex medical information to a parent for whom English is a second language professionals should consider the benefits of using an interpreter and whether additional and alternative forms of communication e.g. visuals should be used.
- Where a child is given a diagnosis and a parent is known to adult mental health services every opportunity to share this information should be sought.
- Staff to remain curious in regard to culture and family composition and to include an understanding of the cultural impact of diagnosis of children with additional needs in their consideration of service responses.

14. **Recommendations for the partnership**

14.1. The partnership needs to plan to work with families where because of adult needs, including those arising from enduring mental health needs or learning disability, and the vulnerability of a child due to age or other additional needs the family needs support extending throughout childhood.

14.2. All agencies need to reflect on the impact of Covid 19 on face-to-face contact and give weight within their risk assessments to the vulnerability of young children whose parent has an enduring long-term mental illness.

14.3. RBG and Partners have an established process for stepdown from a Child in Need Plan to Early Help Plan. The Partnership needs to ensure that all staff are aware of and understand the importance of this process and how it should be implemented in practice, including the identification of a lead professional and the routes to use to resolve disagreements about the decision to stepdown or about the Early Help Plan.

14.4. When services make referrals to early years services or schools, they should include important historical information so that this information can be carried forward when the child transitions to school or between schools. This requires referrers to recognise what information people need for the future that is key to understanding the child and family's needs. Examples of such information will include care proceedings and the orders made at the end of proceedings, a child being looked after or a child having a child protection plan.

14.5. The partnership should develop the cultural competence of all staff so that they have the confidence and skills to ask children and families about their culture and how this may inform their experience and view of the services they are offered.

15. **Next steps**

15.1. Development of action plan

15.2. Contact with Child B's Mother and her sister when possible and further contact with Child B's father.

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