

Serious Case Review of F

Executive Summary

Cambridgeshire Local Safeguarding Children Board

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**(Revised by Helen Chrystal, LSCB Board Manager
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1. Introduction

1.1. The Serious Case Review (SCR) of F was established under paragraphs 8.2, 8.3 and 8.6 of Working Together to Safeguard Children 2006 in order to identify any lessons to be learned about the ways the agencies involved worked together to safeguard and protect the welfare of F. It was intended to identify clearly what those lessons were, how they would be acted on and what changes those actions were intended to achieve.

1.2. This Executive Summary describes the key facts and findings from the SCR. Nine agencies contributed to the SCR, each providing an Independent Management Review (IMR) on the basis of case records and interviews with staff who had been involved with the family from each agency. The agencies who contributed to the SCR are listed below:

- Cambridgeshire Children and Young People's Service
- Cambridgeshire Constabulary
- Cambridgeshire Community Services
- Cambridge County Council Legal Department
- Cambridgeshire and Peterborough NHS Foundation Trust
- Cambridge University Hospitals NHS Foundation Trust
- East of England Ambulance NHS Trust
- GP Practice (Health)
- Hertfordshire Partnership NHS Foundation Trust

1.3. The scope and terms of reference for the SCR were established by the Serious Case Review Panel (SCR Panel), independently chaired and comprising of senior officers from the key agencies who provide services to children in Cambridgeshire. The SCR Panel provided managerial oversight of the IMR and SCR reports which were approved by the Cambridgeshire Safeguarding Children Board on 8th December 2009.

1.4. The Overview author is an independent consultant who was specifically selected to undertake this SCR. She has no connection with Cambridgeshire County Council other than to provide consultancy on a project basis. She had no prior knowledge of the family who are the subject of the SCR, nor of the staff involved in provision of the family.

2. Brief description of family circumstances and events leading up to F's death

2.1. F lived with her parents and her sister, who was three years old. The ethnicity of F was classified as White UK. Both her parents had a history of significant mental health problems. F's mother was being monitored by

mental health services following a serious psychotic episode in November 2006.

- 2.2. F's elder sister had been on the Child Protection Register from November 2006 to July 2007, and multi-agency and family support services were provided to monitor her welfare and provide support to the family. At this time the family became stable, with support from extended family, to the extent that services were gradually withdrawn in a planned and co-ordinated way.
- 2.3. The family came to the notice of children's agencies again in late 2008 when a relative telephoned to express concern about the isolation of the family, and the impact of the fundamental Christian beliefs held by the parents. The family were not part of a recognised church, but held religious beliefs which led to them being quite isolated. These beliefs were also very influential in the family's resistance to take up of healthcare services.
- 2.4. During F's mother's pregnancy a number of risk indicators were identified, including: the isolation of the family; concerns about the high risk of mental health relapse during the period of childbirth; and the impact of their extreme religious beliefs which prevented them from taking advantage of the healthcare and other social support services.
- 2.5. In March 2009, F (still unborn) and her sister were made subject to a child protection plan (the same as being on the Child Protection Register in new legislation). Following F's birth in early May, multi-agency services were intensely involved in monitoring and supporting the family.
- 2.6. F was a healthy baby and was physically well during her short six weeks of life. She was described as feeding well and both parents showed affection and attachment to the baby. Concerns continued about the parents' resistance to healthcare services, the social isolation of F's sister, and risk of relapse of mental health illness for F's mother.
- 2.7. On the afternoon of 17th June 09, F was taken by her father to the GP surgery close to the family home. She was described by the GP as 'not breathing'. An ambulance was called and despite attempts to resuscitate her by the GP, ambulance staff and doctors at the hospital, her death was confirmed later that afternoon.
- 2.8. Both parents have been charged and are being detained in secure settings. F's sister is in foster care and subject to a Care Order.

3. Lessons Learned

3.1. The evidence provided to the Serious Case Review was critically analysed with the aim of understanding why the agencies involved, and the practitioners within them, made the decisions they made, took the actions they took and omitted to act on other occasions.

3.2. Despite the tragic outcome for F, the IMR reports document evidence of good communication between agencies and of assessments which outlined the risk to the children in a family where there were concerns about both mental health of the parents, and the impact of their religious beliefs.

3.3. The SCR identified key themes where lessons were learned about how the services worked together. The four main lessons learned across the multi-agency network are:

- **There is a need to improve the specific understanding of the nature of psychotic episodes and to ensure that this understanding is shared and utilised in child protection processes**

The high risk of relapse of a psychotic episode for F's mother was known, but the potential dangerousness of her behaviour during such an episode was underestimated. Childbirth is known to be a high risk period for mothers with psychotic illness. Agencies must ensure that for parents who have a diagnosis of bi-polar affective disorder, a clear identification of how this might manifest itself is shared across the child protection network.

- **Maintaining key information about family history is an essential factor in assessment of risk**

The concern about the risk of physical harm was diluted over time and neglect and emotional abuse became the prominent features for discussion between the practitioners and within the formal child protection processes. The tendency for neglect to take prominence, and for physical abuse to be minimised is a recognised pattern in child protection processes and the challenge for agencies is to ensure that this is understood and acted upon by professional staff within their organisations.

- **The link between the religious beliefs of the parents and their mental health was only partially understood**

The interplay between the parents' religious beliefs and their mental health was complex. Practitioners worked hard to understand the impact of the parent's religious beliefs and assessed the safeguarding elements within this context. They also understood the mental health elements in relation to the safeguarding of the children. It was the link between the two which was not sufficiently articulated. In relation to the learning, the particular characteristics of this case are uncommon. The learning is that in such unusual circumstances, particular attention

should be made to fully understand the interplay of each of the risk factors.

- **Monitoring plans between agencies must be clear about expectations on practitioners and followed**

This last point is straightforward and encourages agencies to be absolutely clear about who is visiting when, and the specific responsibilities in monitoring risk factors for each of the practitioners involved.

4. Recommendations

Each of the themes in the lessons learned is outlined in the recommendations below:

Outcome	Recommendations
<p>There is a need to improve the specific understanding of the nature of psychotic episodes and ensure that this understanding is shared and utilised in child protection processes</p>	<ul style="list-style-type: none"> ● In cases where parental psychosis is identified, the mental health agencies should outline clearly the specific behaviours that might be evident during a period of ill health. ● Child protection plans in cases of parental mental health should be categorised into two sections: plans for when the parent is well, and plans for periods of ill health. ● For children who are subject to a child protection plan because of parents' mental health needs, the triggers for deterioration of mental health should be clearly outlined and shared with all agencies.
<p>Maintaining key information about family history is an essential factor in assessment of risk</p>	<ul style="list-style-type: none"> ● All agencies should be reminded of the need to read case files and ensure they are fully informed about the social history of families. ● At all child protection conferences, including review conferences, the chair of the conference should begin by providing all participants with a short history of the family and invite them to add anything which has not been covered.
<p>The link between the religious</p>	<ul style="list-style-type: none"> ● In instances where there are unusual factors, such as

<p>beliefs of the parents and their mental health was only partially understood</p>	<p>individualised religious beliefs, which might impact on the safety of the children, agencies should ensure through supervision and other mechanisms, that there is full understanding of how these complex factors interact with each other.</p> <ul style="list-style-type: none"> • Seminars and workshops outlining the detail of this case should be used to highlight the difficulty of working with families with fundamental religious beliefs which impact on the safeguarding of the children.
<p>Monitoring plans between agencies must be clear about expectations on practitioners and followed</p>	<ul style="list-style-type: none"> • If detailed monitoring /visiting plans are agreed between agencies, they should be written down and circulated, with a clear managerial lead from one agency, about who is responsible for ensuring the plans are followed. This might happen within the child protection framework but also applies to children in need who are not subject to child protection plans.

In addition, each of the IMR reports raised practice and organisational issues for agencies to consider and, in total, there were a significant number of recommendations which are reflected in their single agency action plans. The LSCB will robustly monitor progress against the actions identified to ensure lessons are learnt and practice improves the outcomes for children and young people. All the recommendations were considered and accepted by the Cambridgeshire LSCB.

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