Serious Case Review

T Family - 2008

EXECUTIVE SUMMARY

February 2008

Amended following the Inquest 2 August 2011

Introduction

1.1 This Executive Summary reflects the findings from a recent Serious Case Review which was undertaken in relation to the tragic circumstances of the deaths of two young children and their mother in Peterborough in March 2007. The mother "took her own life when her balance of mind was disturbed after she had unlawfully killed her children" 2 sons aged 5 and 2 ½ years at the time (Coroners verdict.The bodies were discovered by the father upon his return from work.

1.2 As part of the Peterborough Safeguarding Children Board's (PSCB) commitment to learn and develop inter agency child protection practice, this Serious Case Review was undertaken in order to establish the facts of the handling of the case and to analyse the professional involvement with this family. The purpose of the Review was to identify and recommend any relevant changes to professional practice, and about the ways in which the different agencies in the Peterborough area work together to safeguard children and young people.

Case Review Process

2.1 Each agency that had some direct involvement with the family was required to undertake an Individual Management Review, to look openly and critically at individual and organisational practice as it related to their involvement with this family. In undertaking this, each agency was required to produce a chronology of its contact with the family. Those managers conducting the Individual Management Reviews were not directly concerned with the services provided for the children or family, or the immediate line manager of the practitioners involved.

2.2 Selected representatives of the PSCB and of key agencies within Peterborough were brought together to form a Serious Case Review Panel to collate the information provided from the Individual Management Reviews and then to analyse the professional practice and inter agency working as it related to this family. Members of this Serious Case Review Panel included senior experienced professionals from the relevant Strategic Health Authority and Primary Care Trust, Peterborough City Council Children's Services Department, the NSPCC, the Children and Family Court Advisory and Support Service, and from Cambridgeshire Constabulary. The Review Panel was chaired by the Independent Chair of the PSCB and the Panel also included two independent consultants, one with extensive experience in safeguarding children, who was the author of the Overview Report, and another with relevant health experience.

Case Details

3.1 In the Spring of 2005, this mother attempted to strangle herself and threatened to kill her two children, because she wrongly believed them to be seriously unwell, for which she blamed herself. An emergency admission to the local Psychiatric Unit immediately followed, and the mother remained there for a period of a month for treatment, before being discharged. At the time of her discharge back to the

GP and her return to her family, neither Children's Services nor the family's health visitor were informed of this mental health episode by either the GP or the Mental Health Service, and of the threats that had been made to the children.

3.2 The care of the children then appeared to resume to normal and no further concerns emerged. However, there was evidence that the mother's earlier anxieties about her children's health may be returning and these were being responded to by the GP and the health visitor at the time. No referrals were made to the Mental Health Services in respect of these. Tragically it was just a matter of days between these anxieties becoming extreme and the mother then taking her own life, and (it is presumed), that of her children.

Key Findings

4.1 Safeguarding concerns regarding the care of the children only occurred in relationship to occasions when their mother was mentally ill. At no other time were the two children anything other than well cared for by their parents, and the children's growth and development was never a cause for concern by any professional.

4.2 A multi agency Core Assessment should have been undertaken at the time of the mother's admission to the Psychiatric Unit in Spring 2005, which would have given a more holistic view of the family, its background, strengths and weaknesses as well as the particular needs of the children at this time and in the near future. This assessment should have been triggered by either a referral from the Mental Health Services to Children's Services, as per the local protocol, or by the GP.

4.3 Without this assessment, there was a lack of a planned focus and coordination of services to this family in the community once the mother had been discharged, and key information about the mother's threats to harm the children, was not passed to the appropriate agencies and professionals to enable them to respond effectively. There was a need for more child-focussed interventions.

4.4 It was clear that there were similarities between the first mental health admission, and when the deaths occurred almost two years later, in respect of the level of anxieties which the mother expressed about her children being ill. Whilst the first mental health episode was effectively dealt with by the mental health services, the diagnosis of a "moderate depressive episode" did not appear to reflect the seriousness of the mother's anxieties and threats at the time. Had a differential diagnosis of a more serious mental health episode been made, then greater attention would likely have been given to support, monitoring and relapse identification within the community.

4.5 The complexities of working with parents with mental illness cannot be minimised. Alongside the need to offer appropriate treatment to the mother in this case, was the need to consider the needs of the children, including their safety, and to identify the capacity of the parents to meet the needs of the children.

4.6 The lack of information sharing between the GP and the health visitor was a factor which compromised their work with the family, and meant that they were not able to fully support them, and in turn to address the children's needs and any potential risk that may exist. It also meant that they did not jointly consider the appropriateness of making a mental health referral when the mother's anxieties appeared to be re-emerging.

4.7 The mother's mental illness in April/May '05 appeared to be seen by the mental health professionals as an acute episode, which responded well to effective treatment at the time, although some of the evidence of the mother's background and of family functioning, if generated by an assessment, may however have challenged this view and considered that this could have been part of a chronic and more serious condition.

SUMMARY OF RECOMMENDATIONS

5.1 There must be an urgent review of the Inter agency protocol in respect of the delivery of services to families where there are children with mentally ill parents, and a new protocol produced and effectively disseminated.

5.2 Inter Agency training and staff development programmes need to be instigated for relevant staff which focuses on the roles and responsibilities of the different professionals who are involved in a family where there is a parent or parents with mental health issues.

5.3 There should be a review of the Health Visiting service in relation to its ability to deliver the appropriate balance of its core and targeted services, taking into account the population and demography of its geographical service area.

5.4 A Named GP for Safeguarding Children needs to be appointed.

5.5 Actions must be taken to implement efficient systems within GP Practices and with other community health professionals to ensure that information sharing in respect of issues relating to the protection of children, consistently and appropriately occur.

5.6 There should be an audit of practice against relevant guidance provided by the National Institute for Health and Clinical Excellence (NICE "Guidance 45") in respect of ante natal and post natal health.

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