Addendum to Child Safeguarding Practice Review for SN20

A Local Child Safeguarding Practice Review (LCSPR) was commissioned by the safeguarding partners following the death of 'Jean', who died aged 19 months on 6th March 2020.

A subsequent criminal trial led to the conviction of Jean's mother for an offence of murder.

The LCSPR (referred to as SN20) was completed in July 2021 and signed off by the Safeguarding Assurance and Improvement Group (SAIG), subject to minor amendments, on 15th July 2021. The LCSPR included a summary of single agency recommendations made by Nottinghamshire Healthcare NHST Trust (Healthy Families Team and Community Mental Health Team) – no other organisations involved in the review made any single agency recommendations. Learning for the Partnership was identified and, in addition to the usual dissemination of that learning, a recommendation was made for the Partnership to explore models of integration or ways to develop closer working between adult and children's health and social care services. This was with the aim of enabling services to undertake joint assessments of adults with parental responsibilities who have adult issues such as mental health problems, substance misuse, victim or perpetrator of domestic abuse.

A copy of the CSPR report was provided to HM Coroner to help inform the Inquest into the death of Jean.

The NSCP was identified as an interested person in relation to the Inquest, along with a number of partner organisations and Jean's family.

The Coroner concluded the inquest by way of a short form conclusion of unlawful killing with no narrative attached. The Coroner presented a detailed Finding of Fact, Conclusions and Prevention of Future Deaths.

The Inquest took place over three weeks and involved 32 witnesses providing evidence. The NSCP Strategic Leadership Group agreed it would be appropriate to carefully consider the findings from the Inquest to ensure that any additional areas of learning are addressed.

A summary of the key additional areas of practice identified through the Inquest include: -

- The assessment undertaken in April/May 2019 (in response to a referral made by Jean's grandmother to the MASH) included information from the drugs service but failed to obtain information from other agencies involved (mental health services and the police).

- Concerns expressed by the family that Jean's mother was threatening to go to a hotel with Jean were not followed up by the social worker. It only emerged during the Inquest that Jean had actually been taken to the hotel and stayed there for two days and the safety of this arrangement was not assessed.
- In August 2019, Jean's mother disclosed to a therapist that she was having intrusive thoughts to kill others. Whilst the therapist provided details of the disclosure to mental health services the Coroner concluded that the mental health service did not record it fully. The detail of that disclosure was also not shared with the family support worker or children's social care. All three agencies involved that day (Insight, Nottinghamshire Healthcare NHS Foundation Trust (NHCT) and the police) failed to make a safeguarding referral regarding Jean. A 'watered down' version became known to the family support worker (through Jean's mother) and the family support worker made a referral to children's social care. The social worker who received the information did not make contact with the three agencies involved and stated that if they had been aware of the full detail of the disclosure their decision making would have altered significantly.
- A total of five referrals had been made raising issues concerning the safety of Jean between March 2019 and Jean's death a year later. More referrals should have been made. Not one of the referrals which were made resulted in an in-depth assessment.
- The risk that Jean's mother might go on to kill someone was never the subject of an assessment by social care. The agency the Coroner felt best able to assess this risk was the Healthcare Trust and they did not assess the risk between 5 August 2019 and 11 November 2019.
- A further disclosure made by Jean's mother to the drugs engagement worker on 8th January 2020 included a concerning level of detail. The drugs engagement worker notified the family support worker and the mental health worker. The risk was not reassessed, treatment was not brought forward, and a referral was not made to the MASH.

The Coroner concludes '*Various agencies were involved in supporting and assessing Jean's care in the year leading up to her death. Opportunities to intervene were missed and risk assessments were either not done or were misleading. This followed poor information sharing, poor record keeping and a lack of recognition of the complexity of [Jean's mother] presentation'* and continues *'It is not my finding, however, that had these things been done to a high standard Jean would not have died. Her death was the result of a deliberate act'.*

As part of the Inquest the Coroner requested witnesses from key agencies provide evidence in relation to the prevention of future deaths. This provided some assurances to the Coroner regarding the response to issues identified in the CSPR process and Inquest hearing, additional assurances through an informal approach are being sought from NHCT and Nottinghamshire County Council.

The Coroner intended to set out his concerns in correspondence to NHCT with an agreement to be updated within eight weeks. In relation to Nottinghamshire County Council, the Coroner does not agree with the prevention of future deaths evidence

that there are no areas requiring to be addressed and specifically refers to information gathering and the extent to which referrals to the MASH are dealt with at face value, as being issues that he would want to explore in correspondence with the Local Authority on an informal basis. Despite contact with the Coroner's office to request this note regarding his concerns, it is yet to be received. A decision has therefore been made to publish the LCSPR without this additional correspondence to avoid further delay.

In respect of Insight Healthcare and CGL, missed opportunities around relatively narrow issues had not been identified clearly prior to the hearing. Both organisations committed to taking targeted action and offered to update the Coroner regarding implementation.

The Coroner concluded his findings as follows*: - Lastly, I was greatly assisted by the evidence of the author of the Child Safeguarding Practice Review. The significant outcome of that piece of work was the commencement of an ambitious project to take the concept of multi-agency working into a more significant level of integration than has previously been the case. This work will be complex and is at a very early stage and so I do not seek any update at the conclusion of a period of eight weeks, as with the other agencies, as there is unlikely to be any particular progress in that period of time.*

Rosa Waddingham

Chair Nottinghamshire Safeguarding Children Partnership Strategic Leadership Group