Child Safeguarding Practice Review for SN20

1. Executive summary.

1.1. This review concerns Jean who was 19 months old when she died in 2020. Her mother was subsequently charged and convicted of her murder and received a life sentence. Jean and her mother were involved with a range of children's social care and health services and Jean's mother with adult community and mental health service. The focus of concern was Jean's mother's vulnerability due to mental health and substance misuse problems and the impact these might have on Jean's care. At no stage were there concerns about the development or standard of care of Jean. The review concluded that Jean's death could not have been anticipated or predicted.

1.2. The review has highlighted issues in how children and adult health and social services work together. There is a need for better joint working to improve access to the expertise held within each service and to improve the quality of assessments of adults with parental responsibilities. Improved assessment will help the implications of adult issues to be fully considered in relation to an adult's parental responsibilities and appropriate help provided. The review also highlighted the negative impact of long waiting lists for service in adult mental health service.

2. Reason CSPR undertaken

2.1. As Jean was a child who died and the cause of death was abuse or neglect Nottinghamshire Safeguarding Children Partnership undertook a 'rapid review' of the case immediately following Jean's death as required by Working Together to Safeguard Children (2018). The 'rapid review' concluded that this case met the criteria for a serious safeguarding case; a child had died, and her mother had been charged with criminal offences relating to the death. The rapid review had highlighted issues regarding the way children and adult

services had worked together and considered that additional learning would be gained by undertaking a more detailed review. The decision of the rapid review was that a local child safeguarding practice review was required and this decision was endorsed by the strategic leadership group of Nottinghamshire Safeguarding Children Partnership.

3. Jean – pen portrait.

3.1. Jean was described by her Family as a child who was always happy, funny and mischievous. She was into everything and would leave nothing alone. She was able to wrap members of her family round her finger and cried if she did not get what she wanted. She was affectionate and sociable and liked to mix with other children but was wary of men. She enjoyed her food. She was generally healthy and well but small for her age.

4. Family Composition

4.1. Sarah Mother Mid-twenties
Jean Child

Maternal Grandparents (MGPs). Jean and Sarah lived with MGPs for part of the review period until they secured their own accommodation close to MGPs home.

Younger siblings of Sarah living with MGPs.

Adult sister of Sarah. Lived nearby and active in support of Sarah.

5. Chronology of multi-agency work with Sarah and Jean.

5.1. The period covered by the review is 1st January 2018 (early in Sarah's pregnancy with Jean) to Jean's death in 2020. There are several important events outside the review period. These are:

- Sarah was sexually abused aged 7 yrs. This was not perpetrated by a member of the family household. The abuse was disclosed during Sarah's mid-teens and investigated by the Police but the abuser was not prosecuted or convicted. Sarah was supported by her parents.
- Sarah reported historical domestic abuse with a previous partner.
- Sarah had taken an overdose in 2016 and was seen by the rapid response mental health team and directed to the Improving Access to Psychological

Therapies (IAPT) service and her GP for further help. Sarah wanted help with anger and mood problems. Sarah was reported as having had mental health problems including depression and anxiety from adolescence.

5.2. Sarah's pregnancy was medically uneventful but Sarah reported it as emotionally difficult. Jean was born at full term and in good health. Sarah did not disclose who Jean's father was and this person played no part in Jean's life. Sarah was living with her female partner and her partner's children when Jean was born. Sarah brought Jean for immunisations and made regular use of her GP for her own and Jean's health needs. The universal services they were in contact with expressed no concerns about Jean's care and development up to March 2019 when Jean was nine months old.

5.3. In March 2019 Sarah took an overdose of paracetamol and over the counter sleeping tablets. She informed her partner who called an ambulance. The relationship with Sarah's partner broke down while Sarah was in hospital following the overdose. Sarah and Jean moved to live with Sarah's parents and siblings.

5.4. The overdose led to the first of three referrals to the Multi-agency Safeguarding Hub (MASH) over a three-week period. The MASH made enquires including with the family about how Jean's safety was ensured and where she was at the time of the overdose. After these enquiries it was decided by MASH that no further action was needed on this first referral given the support for Jean and her mother from their family. The trigger for the overdose was not clear. There seemed to be several factors including Sarah's drug use and her relationship with her ex-partner.

5.5. The second referral was from maternal grandmother (MGM) concerned about Sarah taking cocaine, the extent of this drug taking and its impact on Jean. Sarah said she had a diagnosis of anxiety and depression and that she had been referred to the local provider of substance misuse services. At the time of the referral MGM was doing most of the parenting of Jean, and both Sarah

and Jean were living with MGPs and being supported by them. MGM made a further contact with MASH a few days later reiterating her concerns about Sarah taking cocaine and that Sarah had not attended her appointment with the substance misuse service. Following this referral and considering the evolving picture given by all three referrals, a social worker was allocated to undertake a Child and Family Assessment. The MASH assessed that the Tier 4 threshold was met given the concerns about drug use and whether Sarah could safely parent Jean. The thresholds document is available at pathwaytoprovisionhandbook.pdf (nottinghamshire.gov.uk)

5.6. The assessment involved two visits to the family home where MGM and Sarah were spoken to and Jean was observed. The assessment concluded that Jean had a supportive and loving family within which she was thriving. However, there were concerns about Sarah and that she had not parented on her own before. Sarah said she would accept support. The assessment was clear that if Sarah did not engage and continued to use cocaine then social care would need to be involved.

5.7. The recommendation from the assessment was for support to be provided to Sarah and Jean from the Family Service, an early help service, when Sarah and Jean moved to their own accommodation close to Sarah's parents' home. The case was to remain open to a social worker until the handover to the Family Service. This approach recognised that Sarah needed support in relation to guidance and boundaries, general parenting and budgeting and the continued concerns about her drug taking. It recognised the strength and level of support and care Sarah and Jean received from their family including their concern about Sarah's drug taking. The Family Service case manager worked with Sarah and encouraged her to attend the substance misuse programme to help her cease cocaine use. With this encouragement Sarah did attend the substance misuse service.

5.8. The Family Service case worker organised a Team Around the Family (TAF) meeting in August 2019. The records show there was active liaison between

Sarah, the Family Service case worker, substance misuse worker and community health services. Sarah and Jean moved to their own home in July 2019 which was close to the MGPs. In July 2019 Jean had her 8 to12 month developmental review where it was assessed she was developing appropriately and was described as a happy social child with positive interactions. The next developmental review would be when Jean was 2 to 2½ yrs.

5.9. In July 2019 Sarah said she was having thoughts of harming someone. In the Family Service visit that followed the practitioners were reassured as to Jean's safety and Sarah agreed to refer herself to mental health services. On 5th August Sarah contacted by telephone the IAPT, which is part of the Primary Care Psychological Therapies Service, and said she felt she was now getting psychotic and while she did not want to hurt anyone, she got very angry and paranoid. Sarah said she occasionally went out armed with a knife. She said she was looking for someone to stab. The reason she said this had not happened was because she went out at night and could not find anyone. In response to this the IAPT service contacted the Police who attended. This was following the IAPT service's usual protocol for someone reporting risk to others. The service also called the crisis team for mental health intervention for an urgent psychiatric assessment.

5.10. The Mental Health Crisis Team would not visit because of the perceived risk i.e. that Sarah was armed with a knife. Three Police officers attended with Tasers. The Police found Sarah not armed. She had told the Police she was experiencing thoughts of harming someone and felt that she needed help. The Police did not assess Sarah as a threat to herself or others. Jean was at her MGPs home during these events. The Police sought help from the Street Triage Team but they could not help as Sarah was in her home. No mental health service was provided to Sarah on the day of this crisis. Following this crisis, the GP referred Sarah to the local mental health team who discussed this referral on 12th August and agreed Sarah should be accepted for assessment. This assessment took place in November 2019, a wait of three months.

5.11. This episode led to a further referral to MASH from the Family Service worker. After review, it was agreed with the Family Service that they should continue to work with Sarah and Jean. The social worker discussed the concerns with the Family Service worker and decided that the criteria for Level 4 was not met as other services were meeting the Family's needs. The criteria for level 3 and 4 are in brief:

- Level 3 Targeted Early Help– Children and young people where there are significant concerns over an extended period or where concerns recur frequently.
- Level 4 Specialist – Children and young people who are very vulnerable and where interventions from Children's Social Care are required.

5.12 The Family Service were concerned about the safeguarding issues and agreed that they had a plan in place to address these. Following these events Sarah engaged with the Family Service and the service felt progress was being made. The information those working with Sarah had was that her drug use was reducing and that the work with substance misuse service had been helpful. This was based on Sarah's self-reporting of her drug use. After the TAF meeting in October 2019 Jean was stepped down to the universal level of Health Visiting service which meant no active role for the healthy family team until the next developmental review.

5.13. In November 2019 Sarah and Jean transferred from the Family Service to the Children's Centre Service. They continued to have an allocated key worker who was from the children's centre. Sarah and Jean were already attending stay and play at the children's centre. This was a familiar local service for Sarah and Jean.

5.14. In November 2019 two CPNs saw Sarah for assessment. This was the assessment arising from the GP referral and crisis in August 2019. The outcome of the assessment was that Sarah was placed on a waiting list for Distress Tolerance and Stabilisation Therapy (DTST) and was provided with

the contact details of the mental health crisis team. The likely wait for the DTST service was twelve months. The CPNs assessed that they did not think there was a risk to Jean or that Sarah would act on her thoughts of harming someone. One of the CPNs who had seen Sarah made a referral to MASH. The CPN wanted to share information and this was seen as a contact in the MASH. The information from the CPN was not seen as new by the MASH. The concerns shared had been previously considered and there was an existing plan in place to address the concerns. Following enquires by MASH the case was closed to MASH with the key worker from the Children's Centre Service continuing as lead professional. The continued allocation to a lead professional recognised there were concerns and that the family were seen as "level 3" meaning they needed intervention and coordination of a multi-agency plan.

5.15. The children's centre worker worked with and saw Sarah and Jean regularly over the following weeks. This was both at their home and at the children's centre. The children's centre worker made positive observations of interaction between Sarah and Jean and of Sarah's handling of Jean. Sarah was said to be receptive to suggestions made by the children's centre worker about her care of Jean.

5.16. In December Sarah talked to the children's centre worker and the substance misuse service worker about dark intrusive thoughts and that cocaine was an escape from her negative thoughts. Sarah said she was using cannabis but not using cocaine. The children's centre worker believed this and saw no indications of cocaine use. Sarah's family did not observe or see any evidence of cocaine use. Sarah said Jean was a protective factor for her by which she meant the consequences for Jean of Sarah doing something to harm someone acted as a restraint on her behaviour.

5.17. Jean was seen at least once a week by professionals outside the family, usually at the children's centre. The substance misuse service and children's centre workers' concerns were about Sarah's mental health and not the care of Jean. Just before Christmas the children's centre worker contacted the

community mental health team who agreed to contact Sarah but they were not able to contact her. The children's centre worker also made an appointment for Sarah with her GP. In late December Sarah saw the Advanced Nurse Practitioner at her GP surgery who was concerned about Sarah's mental health. Sarah's GP wrote to the community mental health team saying that Sarah felt her mental health was deteriorating. The community mental health team considered the GP letter and advised that the crisis team could support if urgent intervention was required. Sarah did not want to go to the crisis team as they called the Police the last time she contacted the mental health services.

5.18. Sarah's own concerns about her mental health and the concerns about her mental health of the children's centre and substance misuse workers increased in late December 2019 and January 2020. Sarah told her former substance misuse worker in early January about her thoughts of killing someone and that her intrusive thoughts were more frequent. She also said she felt she could not be totally honest with agencies because she said they would have worries about her parenting of Jean. The substance misuse worker discussed the information with the community mental health team who advised Sarah had been referred for DTST and that if Sarah needed support, she should go to the crisis team. The CMHT did not see the information from the substance misuse and children's centre workers as new information but reflections of the issues covered in the November 2019 assessment by the CMHT.

5.19. The last contact by the Family Support worker was in late February 2020 which was at Sarah and Jean's home. This visit did not indicate any concerns about Jean's care. Jean died in early March.

6. Information known to only one or two agencies.

6.1. There was significant information known to the Police service about Sarah which was not known to other agencies and which suggests important aspects of Sarah's life which were not visible to those trying to support and help her.

This information included allegations of deception, theft (£40), Sarah giving someone where she worked cocaine and obtaining £11/12K from an older man. None of this information led to charges against Sarah. None reached the threshold where Police would submit information to CSC as none were seen to raise safeguarding concerns about Jean.

6.2. Information within NHS and Family Support.

- Referral of Sarah for repair of septum damaged by cocaine use. This damage was not visible without examination. The children's centre worker saw this as historical and not reflecting current cocaine use.
- Broken nose from an altercation in December 2019.

7. Information only available after Jean died that was found as part of the Police enquiry.

7.1. In the month before Jean died Sarah had 20 or more contacts about obtaining controlled drugs in particular cannabis and cocaine. Immediately before Jean died the contacts suggest purchase of cocaine and Xanax tablets. Sarah said she was helping others obtain drugs as she had contacts for supply and these were not for her use.

7.2. When the Family home was visited after Jean's death there was a broken cot and clutter. It looked like there were no cleaning routines. Sarah's family do not agree that the home was in a poor state based on their subsequent clearance of the home. They did agree it was untidy.

8. Family contribution to this review.

8.1. MGPs, Sarah's adult sister and Sarah were interviewed. All family members have been seriously affected by Jean's death. Jean was a much-loved grandchild and niece.

8.2. Sarah's Family were aware of her emotional and psychological vulnerability and consistently provided her with practical and emotional support. They saw Sarah as vulnerable in other ways for example poor awareness of risk e.g.

presence of a hot object or drink near Jean not being recognised as a risk and poor management of money. The Family accepted Sarah was gay and this was not an issue for them or in their view for any of the services who worked with Sarah. Sarah agreed her sexuality was not an issue for her family or led to any discriminatory practice from the services who worked with her.

8.3. The Family saw Jean nearly every day and said she spent a lot of time in her MGPs house but did not sleep there. The Family link Sarah's mental health problems to the abuse she suffered as a child which Sarah disclosed at 15yrs. The Family saw Sarah's cocaine use as self-medication and were concerned about money going on drugs and not on Jean's care. The Family were aware of Sarah's previous drug use as she told them or they found drug paraphernalia not because they identified her as under the influence of drugs. The Family said Sarah was emotionally very up and down and that her relationships reflected this as she was either "all in" or the relationship was failing.

8.4. The Family view is that Sarah was not listened to about her mental health problems. They saw the substance misuse and children's centre workers as trying to help Sarah and that both had helpful relationships with Sarah. The Family view was that Sarah would not act on her intrusive thoughts and the thoughts of harm were linked to the person who abused her not to Jean or her Family or others. In early 2020 Sarah's sister thought she was dealing with money better and her drug use was better.

8.5. Sarah said she was pleased to be pregnant with Jean. Sarah gave a history of two overdoses before the one on March 2019 at ages 16/17yrs and 21 yrs. She confirmed the significant impact of the abuse she suffered aged 7yrs and that when she disclosed the abuse when 15yrs there was no prosecution. Sarah was supported by her immediate family. Sarah regularly felt very low and on bad days Jean went to MGPs. This could be up to 2 or 3 times a week.

8.6. Sarah's view of her contacts with mental health services reflected that she did not get the help she sought. In March 2019 following her overdose she wanted to be sectioned but as Sarah recognised that she needed help it was not

appropriate to section her. In August 2019 the intrusive thoughts were constantly in her head but the response was the Police came and not a mental health service. The November 2019 assessment Sarah described as alright but was followed by knowledge that she would be waiting a year for the service she was assessed as needing. Sarah said that later in 2019 the thoughts about stabbing someone became more intrusive and she was again seeking help. Sarah wanted to talk to someone who would help her understand why she was thinking as she was and that would help change her mindset. She wanted to understand what was going on in her head. Advice to contact the crisis team she did not find useful as her previous experience was, they would not come to her and the Police were called. Sarah wanted someone to talk to about her thoughts not an emergency response. Sarah said that in November 2019 to January 2020 she was otherwise feeling better with a good working relationship with her children's centre worker and with her mother.

9. Relevant research, policy and other reviews.

9.1. Relevant areas of policy and research

- The importance of an identified key worker/lead professional for effective early help/early intervention services is well established. There is a growing body of evidence from the Early Intervention Foundation, Local Government Association and ISOS study of enablers for an effective partnership based early help offer, the evaluation of the troubled families programme and other evaluations of the importance of an effective key worker in delivering early help to children and families.[1]
- A trauma informed approach across all services may enable earlier identification and intervention for adult survivors of childhood abuse. There are strong links between experience of childhood trauma and

[1] Realising the Potential of Early Intervention. The Early Intervention Foundation October 2018. The key enablers of developing an effective partnership based early help offer: final research report. Natalie Parish & Ben Bryant ISOS Partnership. Commissioned by the Local Government Association March 2019 and National evaluation of the Troubled Families Programme 2015-2020: Findings Evaluation overview policy report Ministry of Housing Communities and Local Government March 2019.

adverse childhood experiences for example as described in Young Minds publication on Adversity and Trauma Informed practice. [2]

- The long-term negative impact on adult mental health and wellbeing of childhood sexual and other abuse is well understood as one of the most harmful of adverse childhood experiences (ACEs). The impact of ACEs is described in the EIF publication Realising the Potential of Early Intervention and their report on ACEs.[3]

9.2. The evidence on the impact of adverse childhood experiences including sexual abuse on adult mental health is strong but of itself it does not help practitioners know how to address these issues in practice when working with a child and their family. The Triennial Reviews of Serious Case Reviews, Child Safeguarding Practice Review Panel report for 2020 and the chapter on assessing parents by Murphy and Rogers in The Child's World ed. Horwath and Platt provide valuable advice and guidance on how practice with a parent with Sarah's difficulties could be improved.

9.3. Key points from the Triennial Reviews Serious Case Reviews are:

- The importance of the child's voice which for very young children like Jean means practitioners reflecting on and imagining what life was like for her. This goes beyond what was done which was to consider her development and health and physical care all of which appeared good.
- Maternal mental health, which was a common feature of the cases reviewed by the Child Safeguarding Practice Review Panel, was sometimes not recognised or factored into the overall assessment. The

[2] Adversity and Trauma-Informed Practice A short guide for professionals working on the frontline by Rebecca Brennan, Dr Marc Bush and David Trickey, with Charlotte Levene and Joanna Watson. June 2019 Young Minds, Anna Freud National Centre for Children and Families and Body & Soul transforming trauma with love adversity-and-trauma-informed-practice-guide-for-professionals.pdf https://youngminds.org.uk/media/3091/adversity-and-trauma-informed-practice-guide-for-professionals.pdf

[3] Adverse childhood experiences What we know, what we don't know, and what should happen next EIF February 2020 Dr Kirsten Asmussen, Dr Freyja Fischer, Elaine Drayton & Tom McBride https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Triennial Analysis of SCRs for 2014-2017 found 47% of the cases notified the mother had mental health problems.

- Avoiding using generic phrases such as 'children doing well'. Inaccurate or imprecise language does not support critical thinking and can give false assurances when viewed by other practitioners.
- The role of suicide attempts as indicators of risk.
- The importance of recognising the interaction of mental health and other risk factors e.g. drug use, childhood abuse, criminal behaviour.

9.4 The chapter on assessing parenting and working with adult orientated issues in The Child's World[4] raises questions about how well Sarah's needs were understood and the impact of her mental health and emotional difficulties on her care of Jean. These issues include:

- Sarah's availability physically and emotionally, her understanding and ability to act in response to Jean's needs.
- The impact of Sarah's mental health on her predictability and behaviour in relation to her response to Jean
- When Sarah was not well Jean went to MGPs. Whether this entirely understandable response of MGPs masked the degree of difficulty Sarah was experiencing in parenting Jean?
- 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.

10. Single agency learning and conclusions.

10.1. Youth, Families and Social Work (YFSW)

The YFSW agency report reflects that the service responded with care and proportionately to the information presented. The consideration of the information provided to the MASH was proportionate and the decisions made were carefully considered. There was good liaison with partners and management oversight of decisions on when assessments should be

[4] 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.

undertaken and what service should be provided to Sarah and Jean. The Family Service and then the children's centre worker offered Sarah and Jean a key worker service which was essential to ensuring good communication with partners, with the family and ensuring there was coordination of the work with the family. The transfers between social work team, Family Service and then children's centre worker were all well-handled. When the CPN contacted MASH in November 2019 the opportunity for a direct discussion between the CPN and the children's centre worker was not taken. Such a conversation might have been used to explore further the CPN's assessment of Sarah and the impact on Jean of living with Sarah having thoughts of harming others.

10.2. The YFSW files were described as in good order with updated chronologies and detailed observations of Jean. Learning was identified in relation to the use of language and the need to be precise, for example that the case was stepped down to Level 3 because there were no safeguarding concerns when it would have been more accurate to state that there were no immediate safeguarding concerns. The use of the term 'effectively working' described engagement rather than necessarily positive or sustained change.

10.3. The YFSW agency report notes that with hindsight it is clear that Sarah was selective with information she gave and was not providing information in areas she was most worried about or aspects of her behaviour e.g. her contacts with the Police described in 6.1. The continued involvement of the children's centre worker reflected concern about the impact on Jean of Sarah's mental health difficulties and vulnerability. This case was worked with Sarah's consent. This is usually the most effective way to engage parents and help them change and develop. The observations of Sarah's parenting of Jean were positive which gave no basis for intrusive challenge. Sarah was well supported by her family which was correctly seen as a strength and protective for Jean.

10.4. With hindsight more probing could have been done about Sarah's fluctuating mood and her intrusive thoughts of harming others and the impact these might have on Jean. There was not a detailed reflection on what it was

like for Jean to be with her mother when she was experiencing intrusive thoughts or in one of her regular periods of feeling down or of what Jean may have experienced when her mother took an overdose and was separated from her or was otherwise unavailable to Jean.

10.5. The practitioners in the Family Service and the children's centre workers are not Social Work qualified and work in services where the clear remit is to work alongside and with the grain of parents' areas of need and focus. Family support and children's centre workers are dealing with a lot of parents who are experiencing poor mental health and who have had difficult histories. However, they would not routinely work with parents who are experiencing intrusive thoughts or complex mental health issues. They would not have had the training or confidence to discuss potentially complex mental health issues with Sarah or her experience as a survivor of sexual abuse. The children's centre worker had a Level 3 Child Care Diploma Qualification. Their grade was 7b of the Notts. County Council competency framework which is one tier up from entry level staff. The children's centre worker did raise and had a full discussion about their concerns in supervision and with mental health services.

10.6. In this case the critical challenge was how to work with parents with mental ill-health and access support for their distress and substance misuse. These were not staff with expertise in mental health and they relied on the experts in the CMHT for guidance. There was a gap between the CMHT and the children's workers. The CMHT were not part of the TAF meetings because Sarah had no allocated worker in the CMHT who could have been invited and while the mental health assessment of November 2019 had been shared with Sarah's GP, Sarah's consent would have been needed for it to be shared with any other professionals. Consent for sharing with the children's centre worker or other professionals was not sought from Sarah. There was no opportunity for a full discussion and reflection on all the information CSC, CGL and community health services had about Sarah and Jean with the CMHT.

10.7. The YFSW report did not make any recommendations. The report identified the need for practitioners to use more precise language in their

recording when describing children and parents' needs, how these are met and the work undertaken with them.

10.8. Police

The Police report sets out the contacts with Sarah. It makes no recommendations. Except for the contact in August 2019, when the Police were contacted after Sarah had said to the IAPT service that she felt like stabbing someone, all the contacts were with Sarah in relation to possible offences of dishonesty or related to drugs or disputes between Sarah and other adults. The incident in August 2019 was described by Sarah's family as well handled by the officers who attended.

10.9. The issue from these contacts except for the August 2019 contact which led to a referral to MASH is whether a referral should have been made or information should have been shared in relation to the occasions Sarah came to Police attention for a variety of possible offences. These were all adult related matters. They did not appear to significantly impinge on Sarah's role as a parent. It would not have been normal practice for the Police to refer or share information from such contacts. Had Jean been subject to a child protection enquiry or on a child protection plan then this information would have been shared. The Police view was that the current guidance on information sharing gets the balance right between protecting privacy and sharing information to safeguard children and adults. The review panel endorsed this view.

10.10. Substance misuse service

The substance misuse service is the local service of a specialist national provider. Its services were commissioned by Nottinghamshire Public Health Service. The substance misuse service works with its clients by consent. They provided Sarah with one of their programmes designed to help people reduce and end their substance misuse. The substance misuse practitioner worked with the Family Service worker and then the children's centre worker and were part of the TAF. The service depends on self-report for assessing their client's level of substance misuse except where drug screens are needed for clinical

purposes or they are specifically requested which was not the case for Sarah. The substance misuse service worked well with partners and there were no recommendations for action.

10.11. Local Hospitals

The agency report shows good standards of care to Sarah and Jean in their contacts with this service and no recommendations for action.

10.12. GP Services

The GP report highlighted the volume and differing formats of information recorded within primary care records. This is the benefit of a single electronic record but it does make identifying key information or understanding trends inherently more difficult for those using the records. The report gives the example of Sarah's emergency department attendance in December 2019 which resulted in four discharge letters to the GP. Sarah and Jean made regular use of their GP and the GP practice was proactive and responsive in ensuring Sarah and Jean had timely medical services. The practice did not initiate a multi-disciplinary safeguarding practice meeting for Sarah and Jean. There was no trigger for such a meeting to be initiated. The GP report identified the need to record safeguarding practice meetings on individual patient records rather than as separate minutes. The Practice has heightened awareness across their staff group of the significance of the impact of mental health and substance misuse on parenting capacity.

Nottinghamshire Healthcare NHS Foundation Trust

10.13. The Health Care Trust provided services to Sarah and Jean from the Healthy Family Team and CMHT.

10.14. The Health Family Team services to Sarah and Jean were provided on the universal level of need reflecting that Jean was a healthy child who appeared to be developing well. The report reflects on whether Jean should have been on the Universal Partnership Plus level of service when Jean was referred to CSC. However, it is hard to see this made any difference as the children's health team liaised with CSC and took part in TAF meetings. The

report reflects on the limited curiosity about Sarah's mental health and its impact on Jean. The report recommended that the service should standardise the process with regards to thresholds for decision making when placing children on Universal Services. This action has been completed.

10.15. The report on the CMHT service to Sarah is detailed and focuses on the assessment of Sarah's needs, Sarah being placed on the waiting list for DTST, management of patients on the waiting list, how far consideration was given to Sarah's role as a parent and the liaison with practitioners in partner agencies. The most significant issues were:

- Reference to Jean as a protective factor within risk assessments and running records. The risk formulation did not explore how a baby could be a protective factor or ascertain the context of Sarah's anger in relation to her care of Jean. The risk assessment focused on Sarah's perspective. There was no picture of how Sarah's rapid mood changes and her periods of anger might have impacted on Jean. There was overall a lack of curiosity about the day-to-day functioning of Sarah as a parent to Jean and the impact of her mental health difficulties on Jean.
- There were weaknesses in members of the mental health team's understanding of how the MASH referral process worked and there was no record of the referral made to the MASH in November 2019 in the mental health team electronic record.
- The contacts between mental health services and practitioners working with Sarah and Jean in December 2019 and early 2020 are described. The report noted the reliance on the Crisis Team or reference to A & E or MIND or Samaritans as the places where Sarah should seek help while on the waiting list. The lack of direct contact with Sarah by the CMHT and limited discussion with those who were working with Sarah were barriers to any reassessment of the level of risk she might have been at or risk she posed to others or the level of her need. From Sarah's perspective none of this was useful as she wanted someone to talk to about her troubling thoughts and what was happening in her head. There was no reflective discussion

with the practitioners who were in contact with Sarah but a referring up and down which led nowhere.

- The report identified weakness in the documentation of Sarah's needs and how her mental health needs might impact her parenting of Jean. The documentation stated that there were no risks as Sarah said she would not harm her child. It was not recorded where Jean was when Sarah was experiencing the periods of anger for which she was seeking help.
- The escalating concerns of others in December 2019 and January 2020 were not further considered within the mental health multi-disciplinary team. There was not a fuller exploration of Sarah's mental health needs including detailed discussion with those calling to express concerns.

10.16. The Mental Health Service has taken the following actions:

- Reviewed the existing waiting list to assess need and prioritise.
- Undertaken work to implement a waiting well strategy across local mental health teams with minimum standards for contacting people on the list.
- Improved training for the mental health services duty workers
- Commenced an Internal Complex Review (Adult Mental Health Services) due to be completed by the end of July 2021.
- A nationally led transformation programme for community mental health services is being implemented in Nottinghamshire; it is accompanied by a significant investment to increase service capacity, reduce waiting times and improve services. The programme will deliver many improvements including a named worker for every individual on a waiting list.

10.17. The report makes the following recommendations:

- Review the correspondence (letters) sent out to patients when they are offered an intervention specifically in relation to waiting well whilst on the list.
- Review the clinical risk formulation training to ensure that the term 'protective factors' is clearly defined in relation to what should and should not be considered a protective factor. Also enhance/change to the risk

training to further reinforce the importance of think family and child safeguarding as part of risk formulation.

- Issued guidance to Mental Health Duty Workers with regards to escalation within the service.

11. Partnership conclusions.

11.1. The services to Sarah and Jean were delivered within accepted practice in nearly all services. Much of what was delivered would be considered good e.g. community health services including GP, substance misuse services, YFSW assessment and services and the Police response to mental health crisis. There was positive and regular communication, including TAF meetings, when needed between YFSW including MASH, Family Services, substance misuse services, Children's Centre and GP. There was communication by all of these services with the CMHT but the CMHT was not part of the team around the family and communication was related to specific events or points of assessment or efforts to escalate for further mental health service intervention.

11.2. There was communication and engagement with Sarah and Jean's wider family who were supportive of Sarah and Jean and actively involved in their lives. Sarah was rarely seen alone and in retrospect agencies reflected that this may have made it more difficult for both practitioners and Sarah to discuss her mental health or other more intimate parts of her life. This was not an obvious issue at the time as practitioners saw the involvement of Sarah's family in her and Jean's life as positive and an indication of the active support Sarah had for her care of Jean.

11.3. There were important aspects of Sarah's life which were not known to those working with her or to her Family. This information held by the Police would not be disclosed to YFSW or health practitioners under current information sharing guidance. The partnership after careful reflection agreed that the current guidance does not need to change. Widening what can be shared without consent risks creating unmanageable quantities of shared

information which could obscure rather than illuminate where safeguarding effort needs to be placed.

11.4. There were weaknesses in the response of community mental health services. However, they worked within their usual norms for managing demand and providing a response to those assessed as not acutely ill. Sarah was not assessed as mentally ill and requiring the level of service where the Care Programme Approach would have been applied. The service relied on Sarah to use the pathways available. These did not address her needs and the level of distress she was experiencing.

11.5. The information suggests that Sarah was a vulnerable woman who had experienced mental health difficulties for some years. The abuse she suffered as a child was probably an important part of the mental distress she was suffering as an adult. Sarah told others about her feelings of anger and how she felt like harming someone and how she might do this, with a knife. Sarah expressed a general wish to harm an unspecified someone but it was not explicitly considered whether this might include her child. Sarah was seen as a loving parent who expressed the view that having a child was a restraint on her acting on her angry impulses. This was the accepted view of those working with Sarah and of her family. Based on information available the assumption was made that Sarah would never physically harm her child – those working with her would have found this unthinkable.

11.6. Sarah saying she would not harm her child was relied on without a consideration of the wider context for her distress and how this might impact her care of Jean. There were indications she was more distressed in late 2019 and early 2020. She did tell people about her distress and what might help her deal with this distress but this was not identified by CMHT as more serious than when she had been assessed in November 2019. She remained on a waiting list and without a helping response to her distress. She was advised to access services which gave an emergency response and which she had no confidence would address her needs. This was the approach of the mental health service to managing more demand than they could meet.

11.7. There were no indications to anyone that Sarah would kill her child.

12. Partnership Learning

12.1. The following are suggested as areas of partnership learning:

- The importance of holistic assessment of the adult and child which considers predisposing vulnerabilities, risks for the adult and child and the potential impact on and experience of the child in relation to those vulnerabilities and risk.
- The availability to children's workers of access to expertise in adult factors such as mental health and substance misuse which may affect their care of a child.
- The gap in understanding between children's services practitioners and adult mental health services.
- The need for attention to adults' parenting role when in contact with adult mental health services.
- The importance of recording which is accurate and precise in the use of language, avoids formulaic language and better supports understanding of risk, areas of concern and impact on the child.
- Children should not be described by professionals as protective factors for their parents – they cannot protect their parents. If parents say their child is a protective factor because their parental role places restraint on their behaviour that needs to be recorded clearly as the parent's statement and evaluated as part of the assessment of the parent and child's needs and level of risk each may be subject to.
- The importance of good case transfers involving personal contact between practitioners and practitioners and clients/patients.
- The importance of identified key workers in all services including early help services.
- The need for empathetic curiosity and doubt about what parents say on topics which are inherently very sensitive and where many will struggle to be honest, not least due to fear they may lose their children, e.g. substance misuse, financial circumstances, mental health.

- Whether there can be an over reliance on wider family when they are positively engaged. This can lead to families feeling they are being left to get on with caring without sufficient support. Assessments need to consider what it is reasonable for families to be able to provide including what other demands there are on the caring capacity of the family.

13. Recommendations

13.1. The safeguarding children partnership should explore models of integration or ways to develop closer working between adult and children's health and social care services so that the services can 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. The services need to enable each service to have access to each other's expertise.

14. Learning already implemented.

14.1. The Nottinghamshire Healthcare NHS Foundation Trust has implemented the following actions:

- Standardised the process with regards to thresholds for decision making when placing children on the Universal Services part of the Healthy Family Team caseload.
- Reviewed existing waiting list to assess need and prioritise.
- Undertaken work to implement a waiting well strategy across local mental health teams with minimum standards for contacting people on the list.
- Commenced an Internal Complex Review (Adult Mental Health Services) due to be completed by the end of July 2021.
- The transformation agenda has given significant investment in services as part of a national programme. The ambition is that this translates into a named worker for every individual on a waiting list.

14.2. The GP services have:

- Changes have been made to ensure that safeguarding practice meetings about a patient are recorded on individual patient records.

- The practice has heightened awareness of the significance of the impact of mental health and substance misuse on parenting capacity.
- The GP National Contract has been implemented and post-natal checks now include a requirement to ask open questions around maternal mental wellbeing.

15. Action timeline for implementation of learning and development.

15.1. The Child Safeguarding Practice Review will be shared with the Learning and Workforce Development group of NSCP for dissemination via the existing NSCP learning and improvement framework. This will include

- Summary provided in 'Safeguarding Children Today' seminars.
- The content of core safeguarding training will be updated with the learning from this review.
- Learning will be disseminated through the multi-agency training pool.
- A briefing at the NSCP Forum.
- Specific briefings to Strategic Leadership Group, Safeguarding Assurance and Improvement Group, Child Safeguarding Practice Review group, Child Protection Chairs, Local Authority senior management meetings, elected members, CCG lead health learning events.
- Briefing in relevant publications.

Work on progressing the dissemination of the learning will commence immediately and be an ongoing process over the next 12 months. The requirement for further work will be reviewed at the end of this period.

15.2. It is recognised that the recommendation (see 13.1) requires an in depth consideration of system options. This work will be taken forward through a working group of senior managers from across the Partnership and include representatives from Children's Social Care and Adult Mental Health. Initial work will commence immediately, and a more detailed plan will be drawn up once options have been assessed.

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Independent Review Author

2nd July 2021.