Bolton Safeguarding Children Partnership

SERIOUS CASE REVIEW

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A Serious Case Review Commissioned by Bolton Safeguarding Children Board under Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations 2006

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Lead Reviewer & Report Author
Karen Perry

CONTENTS

1. INTRODUCTION AND PROCESS OF THE SERIOUS CASE REVIEW

1.1. This Serious Case Review (SCR) is in respect of Child 1 and Child 2 who died aged three and one year old respectively. [1] At the time of undertaking the review it was suspected that they died as a result of being given poisonous substances by their mother, who then took her own life. The inquest which will determine their cause of death has been held in 2022. It concluded that mother died as a result of suicide, while both children were unlawfully killed.

1.2. The learning from this review relates to six themes: domestic abuse, harassment and exploitation; mental health; engaging suspicious and avoidant parents; care experienced parents; the right support at the right time; filicide-suicide. All learning points are listed in section 4, at the end of each theme. What follows below is a summary of the most significant learning from this review.

1.3. Domestic abuse is consistently under-reported. Research findings show that the most common reasons parents are reluctant to report is because they have no-where else to go, they fear repercussions and they have had experience of no action being taken by the authorities to protect them, or of action being taken that makes them feel re-victimised. This review process could not establish the precise reason(s) that Mother did not report domestic abuse although there was evidence from a number of sources that she feared the removal of her children.

1.4. A person's parenting style is created by the experience, context and style of parenting they have received. The mother of child 1 and 2, had experienced damaged attachments, neglectful and inconsistent parenting from her own mother (Maternal Grandmother). This is a similar experience shared by many children who go into care and whilst the mother of 1 and 2's time in care gave her a period of stability, the nature of the relationship she had with her own mother (Maternal Grandmother) impacted on her parenting capacity.

1.5. We cannot measure the impact of these cumulative experiences on this mother. However, there is research and serious case reviews which evidence the difficulty that parents who have had such experiences demonstrate in providing adequate care, safety and stability for their own children, partly due to their own lack of resilience to be a parent over the long term. It seems that the weight of these experiences may not have been part of the multi-agency consideration in delivering services and interventions.

1.6. It is important that practitioners look beyond a child's normal development, especially when it is suspected there may be parental mental health issues, to build a coherent narrative of the child's lived experience in the moment and over time. Practitioners in Bolton feel they would benefit from more training about mental health (illnesses and conditions, the impact on the person and their parenting) easier access to advice and consultation from specialist practitioners about how best to consider need and risk, as well guidance on techniques/approaches to engage the adult parent.

[1] Working Together 2018 states a Child Practice Review should be held for every case where abuse or neglect is known or suspected and either a child dies or is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child. On 6th February 2019 Bolton Safeguarding Children Board (BSCB) conducted a Rapid Review of this case and concluded that the criteria for a Serious Case Review were met. On 5th March 2019 the 'National Review Panel' confirmed it agreed with this recommendation.

1.7. GPs being made aware of the existence of a Child in Need plan, and housing officers being involved more consistently in meetings about children, would strengthen protection and support for vulnerable families. It is challenging for social workers in particular to balance authoritative practice with working in a caring and empathetic way. Practice models that enable parents to understand what they need to do to improve the care of their children, but also demonstrate to them that their strengths have been recognised can help with this. Practitioners acorss the multi-agency system co-ordinating home visits offers opportunities to share workloads and identify patterns of engagement, as well as avoiding unnecessary antagonism.

1.8. Features which are correlated with filicide have low predictive value as they are fairly commonly occurring risk factors for something which is very rare; it is hard therefore to predict which parents will kill their children. Although very unusual, there are cases of mothers killing children due to fearing they will be taken into care; it does not necessarily matter how realistic that fear is.

1.9. This report will be published on the Bolton Safeguarding Children Board (BSCB), or its successor's website. The BSCB, or its successor will also ensure that learning is widely disseminated locally. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning.

1.10. The SCR takes into account multi-agency involvement from January 2016 (when it was decided that Child 1 no longer needed a child protection plan) until January 2019 when the children and Mother were found deceased.

1.11. The BSCB agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time. Family members were also offered the opportunity to speak to the lead reviewer.[2] Only Child 1's Father, Paternal Grandmother and Maternal Grandmother agreed to speak to the author. Their comments are included at the relevant places in the report. It has been possible to include some information about Mother's views regarding the service she received by taking into account a private "electronic diary" she kept in the weeks before the deaths of the children[3] and the views she expressed to an independent complaint's investigator in 2017/18.

2. DETAILS OF THE FAMILY AND CONTEXT

2.1. The family are referred to as Mother, Child 1 and Child 2. Other family members will be referred to by their family relationship to the children or Mother e.g. Child 1's Father, Maternal Grandmother, Ex-Partner.

2.2. The children had no other siblings. Child 1 was described as a bright, chatty and confident child; a "girlie girl" who liked make-up and dressing up especially in "clippy cloppy" shoes.

[2] Attempts were also made to contact the foster carer that cared for Mother when she was a teenager. These were not successful as their current details could not be located

[3] This appears to have been intended to explain her actions. No-one knew about the diary until the police found it after her death

Child 2 was described as a placid baby, of dainty build. Both children presented as being loved and developing normally.

2.3. Mother was a full-time mother and reliant on benefits. She had high aspirations for her children. The family lived in one of the more deprived parts of a local community which had a good range of amenities. The family was quite isolated; Mother had few friends and unstable relationships with her own extended family.

3. KEY EPISODES

3.1. Some previous history prior to 2016 is relevant. Mother went into care aged nine because of neglect; Maternal Grandmother had a serious long-term mental illness. Mother lived with the same foster carers for over 4 years (between the ages of 11 years to 15 years). Offending behaviour involving theft and violence resulted in a period in a secure unit before she returned home aged 17 years to live with Maternal Grandmother. Mother viewed the period with the foster carers very positively. She was reluctant to move back with Maternal Grandmother.

3.2. In 2012, in light of the family history of mental illness, and following an overdose after some concerns about depression, Mother was referred to mental health services, where an adult psychiatrist diagnosed her with Emotionally Unstable Personality Disorder (EUPD).[4] Mother disclosed previous thoughts about killing herself and some attempts, which were not serious enough to come to the attention of agencies. In Autumn 2015, at Mother's request, the GP referred her twice to the mental health service to rule out bi-polar disorder. Mother did not respond to efforts by the service to encourage her to opt-in.

3.3. Mother was not a teenage parent; she was well into her 20's when Child 1 was born. At birth, Child 1 was made subject to a child protection plan under the category of neglect. There were concerns about potential risks due to: Mothers poor emotional health; a lack of suitable accommodation; and the potential impact of her own childhood experiences on her parenting**.** Mother and Child 1 were provided with supported housing for almost a year after Child 1's birth, where Mother was provided with advice on parenting skills, as well as preparation to manage her own tenancy.

Key Episode 1: February 2016–December 2016 (from the cessation of the child protection plan to the discovery of the 2nd pregnancy)

3.4. At the beginning of February 2016, in preparation for the review child protection conference, social worker 1 requested that Mother's GP refer her via the Single Point of Access (SPOA), for a mental health assessment. It would appear that the GP did not mention that Child 1 was subject to a child protection plan, the reason for this is not known. As was the case for

[4] Emotionally Unstable Personality Disorder (EUPD) is sometimes referred to as Borderline Personality disorder. EUPD/BPD involves feelings of intense negative emotions, and severe mood swings which can change quickly and unpredictably from despair to euphoria. It can involve hallucinations. Impulsive behaviour including self-harm and involvement in reckless activities e.g. binge drinking, drug use. Unprotected sex with strangers is common especially in teenage years. Personal relationships tend to be unstable either because of fear of abandonment or fear and anger at being smothered or controlled. The usual cause of EUPD is neglect and abuse in childhood including the impact of living with someone who has a severe mental health problem or abuses alcohol and/or drugs. Treatment involves a range of psychological therapies https://www.nhs.uk/conditions/borderline-personality-disorder/

all three referrals for support with her mental health during the whole period under review, Mother did not receive treatment because she did not follow the opt-in procedures.[5] The GP was sent a discharge letter with a view to re-referring if appropriate; this letter does not seem to have been received, nor was it copied to anyone else. Practitioners told this review that, had SPOA staff known about the child protection plan, they would have sent a copy to the children's social worker.

3.5. In mid-February 2016, practitioners at a review child protection conference agreed that Mother had achieved all that had been asked of her and agencies were satisfied there was no longer any risk of significant harm to Child 1. Nonetheless they felt a Child in Need plan[6] would be beneficial as Mother still appeared to be vulnerable.

3.6. The practitioners most consistently involved during this key episode were the social worker, the health visitor, and various housing officers.[7] Their attempts to contact Mother by phone and home visits were only intermittently successful; comment is therefore, limited to the most significant instances.

3.7. The first Child Action Meeting (CAM),[8] was held promptly at the end of March 2016. These meetings occurred approximately six-weekly for the 18 months duration of the Child in Need Plan.

3.8. At the beginning of April 2016, as a result of Mother's request at the CAM, the health visitor contacted the GP surgery to find out progress regarding the mental health referral made in January 2016. The surgery promptly contacted the SPOA and established that Mother had not opted in. Three weeks later the SPOA sent a letter to the GP stating that, following a review of the information available to the service, they had signposted the referral to the psychological therapy service. No other agency was copied in.

3.9. At the beginning of May 2016, Mother and Child 1 had moved into a 12-month starter tenancy[9] with a local social housing provider. Mother had a good reference from staff at the supported accommodation; the only concerns related to her ability to manage money.

3.10. Towards the end of August 2016, the police shared intelligence with the social worker about a man in his 70's, visiting Mother and Child 1.[10] This was discussed at a CAM meeting co-incidentally held on the same day. Mother did not make herself available for that meeting but

[5] SPOA would send letter asking patient to telephone for an appointment. Even if Mother telephoned to obtain an appointment, she then did not attend it

[6] A multi-agency plan co-ordinated by a social worker which describes the services to be provided under Section 17 Children Act 1989 services to support children to achieve or maintain a reasonable standard of health or development or to prevent significant or further harm to health or development

[7] Since October 2018 the housing provider has changed its delivery model to ensure contact is more likely to be with the same officer during the duration of the tenancy

[8] Child Action Meetings (CAMs) are multi-agency meetings for children subject to CIN plan to agree and review with parents the services to be delivered.

[9] These last for 12 months during which time tenants can be given 2 months' notice for antisocial behaviour and be evicted without a court order.

[10] The referral implied Older Male was the vulnerable one, while practitioners considered it was more likely to be the other way around, as he had a history of using sex workers. By November 2016, the care home in which he lived was asking him to leave due to the number of visits by young adults who the staff suspected were drug dealers.

did accept a joint home visit from the social worker and health visitor the next day to discuss the advisability of allowing males she did not know to visit the home, no matter how sorry she might feel for them.

3.11. During that visit in August 2016, Mother reported a recent four day "blow out" which included taking cocaine with men she did not know. This was the only time that practitioners were aware of Mother taking cocaine. Mother reported a new boyfriend, who was to become Child 2's father. She was not willing to disclose his name. The social worker arranged to visit the next day because Mother refused to allow her to see the bedrooms; this visit was unsuccessful.

3.12. The health visitor visited again just over a week later to follow up the declining mood Mother had mentioned during the previous visit; Mother reported feeling well and that support from the mental health service was not necessary. Mother described the relationship with the new boyfriend as positive but again declined to provide details when asked.

3.13. At the beginning of October 2016, after a number of failed visits to discuss rent arrears, the social housing provider contacted the social worker to make a joint visit. Until now neither the social worker nor the health visitor had been aware that Mother was in rent arrears. The joint visit was not successful, but two days later Mother did attend a CAM at which a housing officer was present as well as the health visitor and social worker. Practitioners were worried that Mother might lose the tenancy. Mother accepted a first visit from the specialist housing support team,[11] but did not engage with the support officer again despite a number of attempts made to contact her during the remainder of 2016.

3.14. To begin to develop a relationship with Mother and help address the housing arrears, Social Worker 2 made three home visits between the middle of October and the beginning of November 2016. Only one of these was successful; Mother had initially refused access, but then agreed when told that the police would be called.

3.15. At the beginning of November 2016 Social Worker 2 also made a home visit to introduce herself to Child 1's father when Child 1 was there. This was the only time that Social Worker 2 met Father. Although there was some subsequent phone contact until he changed his number, he did not respond to a letter suggesting a further meeting.

3.16. In early November 2016, Child 1's Father was allowed by Mother to have Child 1 for overnight contact. During this contact Mother phoned the police from a call box stating that she had been assaulted by a male whom she had refused entry to her home "for a drink" and she was now locked out of her house. The police were very busy that night and delayed by other priority calls; by the time they attended the address 30 minutes later Mother was not there. As Mother did not respond to attempts, including a letter, to contact her, the incident was closed. Information about this incident was not shared with any other agency. It did not include any record of a child living in the household as Mother had not been seen and there was no flag on the address because Child 1 was no longer subject to a child protection plan.

[11] The Floating Support team offers 2 hours a week one to one support to prevent homelessness

3.17. At a CAM meeting in early November 2016, which Mother did not attend, practitioners shared a number of concerns: that Mother might be pregnant; that the health visitor believed Mother might be bi-polar and that she would not go to the GP to get a mental health assessment; that she was reluctant to attend mother and baby groups to give Child 1 opportunities to interact with other children; and that court proceedings had commenced regarding the arrears, which now amounted to over £2,000. Practitioners were aware that the proceedings could result in eviction if Mother did not make, and keep, a satisfactory arrangement to pay off the arrears; she was seldom responding to the housing officer's attempts to contact her.

3.18. Practitioners were keen to encourage mother to accept practical help and advice from a Family Support Worker. They thought this source of help might be more acceptable to Mother than the social worker. Social Worker 2 was intending to visit Mother again that day, the housing officer and health visitor decided to accompany her; all were keen to try and encourage Mother to accept help, especially for the rent arrears. Mother would not answer the door.

Key Episode 2: From November 2016-June 2017 (from the discovery of the 2nd pregnancy to the birth of Child 2)

3.19. Two days after the CAM meeting at the beginning of November 2016 the social worker made a successful visit to Mother and Child 1. Mother agreed to family support worker involvement to help with: money management and the arrears; play tips for stimulation of Child 1 at home; routines and home conditions.

3.20. Family support worker involvement commenced in mid-December 2016. This required a joint visit with the social worker as Mother had refused access on the family support worker's first visit. Unusually, Mother was present at the CAM just before Christmas 2016.

3.21. The family support worker made three further unsuccessful visits in December 2016 and January 2017. Around the New Year the social worker made three visits, primarily to discuss how to address a notification from Environmental Health about the rubbish in the back yard.

3.22. Mother eventually participated in three planned sessions with the family support worker over 6 weeks in February and early March 2017. The Family Support service is set up to be a short-term focused intervention. Accordingly, as the agreed work had been completed, including providing a skip to clear the back yard, this involvement ceased.

3.23. By mid-January 2017, Mother had visited her GP to request a referral for antenatal care. She also requested a referral to the mental health services and the GP gave her a first and only prescription for antidepressants, which Mother reluctantly accepted. Mother was advised to make a follow-up appointment in 3-4 weeks. She did not do so.

3.24. At the end of January 2017, at Mother's first attendance at antenatal clinic, she told the midwife that she had a social worker and that she was "under the care of a psychologist" The midwife left a message for the social worker seeking information and made a referral to

the midwifery outreach service.[12] During the remainder of her pregnancy Mother almost always attended antenatal clinic appointments and was at home when the midwife visited.

3.25. In February and June 2017 respectively, the health visitor made successful home visits to conduct Child 1's 18- and 24-month development reviews. Child 1's development was within normal ranges, although the health visitor felt she would benefit from attending nursery to help the development of her fine motor and social skills; in May 2017 funding was agreed by Children's Social Care to support this.

3.26. At a CAM at the end of March 2017, there was discussion about Maternal Grandmother being homeless and staying with the family. The social worker told this review that Mother had felt sorry for Maternal Grandmother, but although she recognised the risks, she "needed a push" to ask her to leave.

3.27. In early April 2017, Mother told the midwife that she was still taking the anti-depressants and that she still wanted a referral for a psychological assessment. Mother's presentation at a subsequent appointment about a week later was described as 'odd' in that she demanded to be seen immediately, stating that she would usually sleep during her child's nap. She also said that she was about to come into some money which she would use for a three-month holiday. Mother's request, coupled with these comments, encouraged the midwife to ensure that the obstetrician made a referral to the SPOA.

3.28. In early May 2017, the midwife made a home visit. Mother told her she had received an opt-in letter from the psychological service. As is usual practice the midwife requested to use a bed to palpate the Mother's abdomen. Mother seems to have viewed this as a ploy to see the bedroom and subsequently asked for a different midwife.

3.29. In early May 2017 Mother made contact with the psychology therapy service as requested to book an appointment. Mother failed to attend the appointment offered.

3.30. Unusually, Mother attended the CAM in early May 2017. Practitioners told this review that she was fed up that the social worker remained involved and challenged views about a lack of daily routines, and the midwife's account of the recent home visit. Rather than refusing access to the bedroom she said she had wanted to tidy up and the midwife had arrived earlier than expected. Mother informed practitioners that she was taking medication to ensure her mental health did not affect her parenting capacity. She refused to say when her psychology appointment was because she had so many appointments currently, she did not want this input until after the baby was born.

3.31. Within a couple of days of the CAM meeting, having established with the psychology service that Mother had missed her appointment, the outreach midwife sought advice from the SPOA; practitioners were still concerned about Mother's mental health. Three attempts by the Bolton Assessment Team (BAT) to make contact with Mother by phone and letter were unsuccessful. After a discussion in the Multi-disciplinary Meeting, a standard discharge letter was sent to the GP with advice to re-refer if necessary.

[12] This service provides additional support for vulnerable mothers

Key Episode 3: From June 2017 to November 2017 (from the birth of Child 2 to the formal decision to cease the Child in Need plan)

3.32. Child 2 was born at the end of June 2017 and Mother and baby were promptly discharged home as there were no concerns about either of them. During July 2017 the health visitor successfully completed a new birth visit. There were no concerns, although Mother indicated that Child 2's Father was shortly due to leave prison. The health visitor advised her to contact the police if he came to the house. In mid-August 2017, Mother attended the GP for a postnatal check; there is no record of any discussion about her mental health.

3.33. In early July 2017, Child 1 was scalded on the foot by boiling water from a kettle being used to make up bottles for the baby, that had been knocked over. Mother tried to treat the burn herself then took Child 1 to A&E the following day. As the burn had become infected, Child 1 was referred to the Burn's Unit. Some follow-up home visits by community nursing staff to change the dressings were not successful. The hospital recommended that Child 1 be admitted. Mother did not want this, so staff arranged daily attendance at the hospital for treatment which Mother attended with both children.

3.34. A&E staff had promptly contacted Children's Social Care because of the delayed presentation. In the absence of Social Worker 2, a duty social worker made a home visit after attempting an unsuccessful joint visit with the health visitor. Burns Unit staff contacted the health visitor about the missed community nursing appointments. No consideration was given to calling a strategy meeting.[13] In mid-August 2017, hospital staff informed the health visitor and Social Worker 2 that all treatment had been satisfactorily completed.

3.35. In mid-August 2017, after two recent unsuccessful visits, a discussion in supervision resulted in a plan for social work involvement to cease after one more visit if the CAM to be held that day, was satisfactory. This proposal was due to a view that the care of the children was considered to be "good enough".

3.36. At the CAM in mid-August 2017, the health visitor reported that the 6-week check had been done for Child 2; and there were no concerns about either child. Mother was present and she was vociferous about not needing social work involvement any longer. The only outstanding part of the CIN plan was support for Mother's mental health, but practitioners felt there was no tangible evidence that this was impacting on the care and development of the children. Mother told practitioners that Child 1 was to start at nursery in September 2017 and the health visitor would continue to be involved on a "universal plus" basis, which meant contacts every 3 to 4 months, including standard developmental checks.

3.37. In early September 2017 and mid-October 2017, Social Worker 2 made unsuccessful attempts to complete a final "closure" visit to Mother, as previously agreed in supervision. As she considered social worker involvement had finished, Mother told Social Worker 2 by text, that she did not see any need for such a visit.

[13] The absence of a strategy meeting is discussed in section 4 of this report

3.38. In November 2017, the social worker liaised with the health visitor who had seen the children recently and had no concerns about either child. The team manager agreed case closure.[14]

3.39. At the beginning of October 2017, Mother made a formal complaint to Children's Social Care about Child 1 being made subject to a child protection plan in 2015. Practitioners had always been aware that Mother had disagreed with this decision and (as confirmed by her electronic diary) that she felt she had not been protected soon enough in her own childhood. However, it is not known what prompted the timing of this complaint. Perhaps she felt safe to raise issues now social workers were no longer involved. Mother was not satisfied with the initial response to her complaint and in early November 2017 she requested that it progress to stage 2.[15]

Key Episode 4: From January 2018 –January 2019 (from domestic abuse incident until the deaths of the children)

3.40. In mid-January 2018 the police received two phone calls just after midnight from Mother and Maternal Grandmother respectively, stating that an Ex-Partner had assaulted Mother.[16] By the time police officers arrived the Ex-Partner had left. Mother was reluctant initially to let the police officers in, she told them that the Ex-Partner had hit her and kicked her in the head; she had no visible injuries and did not wish to provide a statement. Police officers thought she seemed reluctant to give details of the Ex-Partner and her children. The Police had a number of concerns: the state of the house, which smelt of urine; the sleeping arrangements (mattresses on the living room floor); and the number of bin bags in the back yard, some of which animals had ripped open. Mother was reluctant to involve Children's Services. She stated the family were sleeping downstairs while in the process of tidying upstairs. The police identified a risk rating of medium on a DASH[17] assessment which resulted in an automatic referral to Children's Services. This was passed to Social Worker 2 because the case had not been closed due to lack of capacity to prioritise updating the record.[18]

3.41. In the three days following receipt of the referral, social workers made three unsuccessful home visits. The original decision that a strategy meeting was required seems to have been changed due to difficulties arranging this with the police. Social Worker 2 contacted the health visitor who was not aware of any additional concerns, although she had not seen the children recently. Social Worker 2 also identified and contacted the nursery where Mother had enrolled Child 1. The nursery had no immediate concerns about Child 1's care or

[14] Any closure of CIN cases requires team manager agreement https://boltonchildcare.proceduresonline.com/chapters/p_cin_plans_rev.html

[15] Children and their families have a statutory right to make complaints about services they receive from the local authority. The first stage is dealt with internally; if the complainant is not satisfied the second stage involves an Independent Investigator. Because of Mother cancelling two meetings with the independent Investigator it took 2 months to agree the statement of complaint.

[16] Information in Mother's electronic diary suggests she got involved with Ex-Partner about 12 months before she died. Although Mother told the police she had been assaulted by Ex-partner she later told the social worker it was in fact Child 2's Father

[17] Domestic Abuse Stalking & Harassment (DASH gradings: STANDARD - Current evidence does not indicate likelihood of causing serious harm. MEDIUM - There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse. HIGH - There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious.

[18] Since the period covered by this review the policy has changed so that all new referrals are dealt with by the Multi-Agency Screening and Safeguarding Service MASSS irrespective of how recently they were closed

attendance; occasionally Child 1 was a bit smelly and had a sore bottom due to nappies not being changed frequently enough; Mother addressed these issues when the nursery staff raised them with her.[19]

3.42. Social Worker 2 spoke with Mother on the phone but was not able to achieve a successful visit until early February 2018, three weeks after the referral. Police bodycam footage shows the conditions were concerning but not sufficiently that the children were unsafe enough to be removed. By the time of the social worker's visit the home conditions had improved, and there had been no further reports of incidents of domestic abuse. Mother told the social worker that the perpetrator was Child 2's father; she had given the wrong name to the police because she was concerned social workers would get involved again. The social worker kept an open mind about who the perpetrator was and had a conversation with Mother about protecting herself and the impact on children of domestic abuse. Taking into account the feedback about the children from the health visitor and the nursery, it was agreed in supervision by the team manager that there was no need for further involvement.

3.43. The Health Visitor made three unsuccessful visits between mid-April 2018 and May 2018 for Child 2's nine-month review.

3.44. In mid-April 2018, Child 1 stopped attending nursery; Mother told the nursery this was because she was intending to move; two months previously she had enquired with the housing provider about making a lump sum to clear her arrears to enable a move.

3.45. In May 2018, Mother made an unscheduled visit to Children's Services offices to get a letter of support to confirm Child 2 had always lived with her, for benefits purposes.

3.46. In early June 2018, Refuge records in another town show that Mother made contact due to harassment from Mother's Brother. Maternal Grandmother told this review that she assisted Mother to make phone contact with a Refuge worker as Mother was "getting grief" from both Ex-Partner and Mother's Brother. Mother did not mention any concerns about anyone else in response to questions in the risk assessment, which scored her circumstances below the threshold for MARAC.[20] As another family was higher priority for the vacancy at the Refuge[21] a national search for an alternative vacancy was done over the next few days. Maternal Grandmother informed this review that Mother had told her the Refuge would not give her a place because she had not reported incidents to the police. If this is what Mother believed, she was mistaken as there is no such requirement; staff understand the reasons why many women are reluctant to call the police. As no Refuge place was available, records show that Mother was advised to make a report to the police should Mother's Brother approach her again, and to ask Bolton Housing for housing advice and assistance.

[19] The nursery does not have a record of the dates the social worker made contact as these were then recorded in a diary rather than on the child's record and the diary was given to mother when Child 1 left. The nursery has since changed ownership

[20] A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed, and protection plans agreed

[21] It is not unusual to have three or more families applying for a single vacancy as demand for refuge far outstrips the availability of safe spaces.

3.47. In June 2018, Mother had contacted the housing provider to report concerns about Mother's Brother's anti-social behaviour. The housing officer contacted Children's Services by phone. Social Worker 2 was on leave[22] so a message was left and followed up with two further messages. Unfortunately, Social Worker 2 did not receive any messages. Messages should have been added to a case-note or sent to the social worker by email. It is not known why neither was done, although practitioners told this review that sometimes messages got overlooked if the taker was distracted by another activity. The housing provider told this review that in their experience it was not unusual for social workers not to return phone calls. As housing staff had followed advice given by the duty social worker, to advise Mother to contact the police, and there were no further reports of similar concerns, the incident was closed once reported.[23]

3.48. Towards the end of July 2018, the police received a phone call in the afternoon from Mother stating that Ex-Partner, who she named, had turned up and had been shouting at her children. She also said that the previous day he had caused damage to her door. As no-one was at immediate risk, the police did not attend straightaway.

3.49. When police records were finalised at the end of September 2018 for the July 2018 incident, they referred to the damage Mother's Brother (rather than Ex-Partner) had caused. This may have been due to the influence of an officer who attended another incident involving Mother's Brother at the end of August 2018. Mother had not co-operated with attempts to complete the DASH risk assessment in person. Mother did not want any further action taken, and as there had been no physical violence and the damage to property was minor, the risk on the DASH assessment was categorised as "standard". Accordingly, no information was shared with partner agencies. Had the risk level required the information to be shared with Children's Social Care, enquiries would have been made into Mother's Brother's current circumstances, which would have identified the original report could not have involved him as he was in prison.

3.50. In August 2018, the health visitor made a successful visit to conduct a development review for Child 2. Both children were seen and appeared well and happy. Mother reported variable mood, but not at a level that she felt required medication or additional support. The home conditions were satisfactory, although Child 1 was wearing "grubby" clothing. Mother also said she was expecting compensation from the local authority due to the management of her needs in her own childhood. It is not known to what she was referring as the only complaint on record is the one relating to Child 1 being subject to a child protection plan; although elements of this complaint were upheld, these were not so serious as to warrant the payment of any compensation.

3.51. At the end of August 2018, the police receive a call from Maternal Grandmother in the early evening due to having received a text from Mother that Mother's Brother was outside banging on the door. Maternal Grandmother reported that Mother's Brother was a crack user and that there were children in the house. On attending the house Mother told police officers that he had been staying with her since being released from prison a few days earlier. Mother said she had felt sorry for him but did not want him to stay any longer as his coming

[22] Again, the record had not yet been finalised to close her previous period of involvement

[23] The housing service intends to ensure that a forthcoming internal review of their service considers the learning from this

and going was disturbing the family and her neighbours. Police records show that whilst there was food and bedding for the children, the house was described as generally untidy and very dirty with flies buzzing around old food, and the yard was full of bin bags; these did not look like recent problems. Mother was advised not to allow him re-entry and to contact the police if further help was required.

3.52. As the risk category of the DASH assessment was "medium" the incident was discussed in the Multi-Agency Screening and Safeguarding Service (MASSS) and it was agreed that a social worker would make a visit.[24] Because the case had been closed less than 3 months earlier this was allocated to Social Worker 2. Usually such requests for a visit would be communicated in person to the social worker or her team manager but as they were both out an alert was sent to the social worker's electronic "in-tray".[25] Unfortunately, the social worker was in court for a 5-day hearing so did not have access to her electronic in-tray. Therefore, a home visit was not attempted until two weeks later in mid-September 2018; this was unsuccessful as Mother refused access and asked the social worker to make an appointment.

3.53. A few days later, having got to stage 2 of the statutory complaints process, Mother put her complaint on hold. On being offered further opportunities to continue to pursue some new issues she had raised (which were essentially about Social Worker 2 remaining involved after the discontinuation of the child protection plan and after the birth of Child 2), Mother emailed the Independent Investigator to inform her that she had been unwell and would be in touch once she had recovered.

3.54. Because Social Worker 2 was about to change jobs, involvement was allocated to another social worker in the same team. During October 2018, Social Worker 3 achieved two out of three planned visits. On the first successful visit, Mother's mood was "excitable", and she expressed a fear that social workers were planning to remove her children. Checks with the health visitor raised no concerns. It became apparent that Mother had withdrawn Child 1 from the nursery; she told the social worker that she had stopped Child 1 going because she worried that every time, she took her social workers would put her in care. Social Worker 3 did a child and family assessment, which concluded that social work involvement seemed to be exacerbating Mother's mental health issues rather than being supportive. Social Worker 3 decided against holding a CAM as originally intended; she told this review this was because Mother would not have attended, and the only practitioner involved was the health visitor with whom she had already spoken.

3.55. Maternal Grandmother told this review that in October or November 2018, she had received a call from Mother who was in a shopping centre in another town, asking what to do as Ex-Partner was following her and the children. Maternal Grandmother told this review that Mother followed her advice to find a security guard who could call the police. The police escorted Mother and children safely to the station. Without a precise date it has not been possible to find any records to confirm this incident or obtain further details.

[24] The duty health visitor had also received a copy of the notification at the beginning of September 2018 and knew that the social worker would be visiting.

[25] This was addressed with the relevant worker at the time and as a result of this review Children Social Care have reinforced that staff sharing messages about safeguarding matters should only do so in ways where they know that the message has been received

3.56. In December 2018, Mother and a friend Female 1, met in a local town with the explicit aim of killing themselves. Mother brought the children with her, apparently planning to include them; the friend backed out and the plan did not go ahead. No-one else knew about this incident until after Mother and children's deaths. Maternal Grandmother told this review that Mother had asked her for the refuge number again just before Christmas to get away from Mother's Brother and Ex-Partner. The refuge has no record of any contact from Mother at this time.

3.57. On 10th January 2019, Child 1's father contacted the MASSS stating that Mother was not allowing him contact. Child 1's Father told this review, that Mother had sent him a private message on social media threatening to kill herself and the children. There is a record of Child 1's Father mentioning contact by text from Mother, but no details of any content. The record does not indicate any concerns about the children and the practitioner taking the call does not recall any being mentioned. He was advised to contact a solicitor as this was a private law matter; this is in line with usual practice as it is not appropriate for agencies to intervene in matters relating to contact unless there are concerns about a child's safety.

3.58. During January 2019, Mother did not want to answer Ex-Partner's calls; analysis of Mother's phone records after her death, show approximately 3000 texts/calls in January. Mostly, these were short, pleading for Mother to contact him; Maternal Grandmother told this review that they also included pictures of him crying. None of this contact was shared with practitioners working with Mother and the children at the time.

3.59. On 21st January 2019, the police were contacted after Mother's Brother and Ex-Partner had broken into the house as they were concerned that they had not been able to contact Mother. On entering the home police found the Mother and children's bodies. The current hypothesis is that approximately a week earlier Mother had killed the children and then herself.

3.60. Child 1's Father and Paternal Grandmother told this review they were not present at the children's funerals. The children's fathers were not identified on the birth certificates, so they did not have parental responsibility and therefore no right to be involved in planning the funerals. Child 1's Father and Paternal Grandmother were appreciative of the support they have received from police personnel since Child 1's death, however they were very upset when he was referred to as "only an interested party" by one of the forensic team, as they thought this was insensitive language.

4. THEMATIC ANALYSIS

4.1. The learning from this review was identified from information and opinions provided in the agency reports and at the learning events. The themes are:

- Domestic abuse, harassment and exploitation
- Mental health
- Engaging suspicious and avoidant parents
- Care experienced parents
- The right support at the right time
- Filicide-suicide

Theme: Domestic Abuse, Harassment and Exploitation

4.2 The Home Office definition of domestic violence and abuse[26] includes emotional and psychological abuse, and physical violence by family members as well as partners. During the period covered by this review, reports were received about assaults of Mother, or threatening behaviour towards her, by Child 2's Father, Ex-Partner and Mother's Brother. These were minor in the sense that no injuries were observed. It is not known how aware the children were of the incidents, but research suggests[27] that the impact of the stress, fear and anxiety associated with domestic abuse can be significant for even very young children. An entry in Mother's electronic log certainly suggests she felt they were affected by her "shouting every time my door was kicked".

4.3 It was usual for this Mother not to cooperate with enquiries and/or change her account about who was the alleged perpetrator of any particular incident. Whilst this is not uncommon in relationships involving domestic abuse, it makes it more difficult for police to take any action to prevent further incidents, unless there is corroborative evidence. Victims can withdraw allegations because reporting them has ensured their immediate safety but following through would then increase the risk to themselves or their children. The signs of fear, and the reasons for it, may not always be obvious, and women may act in ways that appear inconsistent and harmful to their best interests.[28] It is not known whether this applied in Mother's case, but what is clear is that Mother feared that being known to be in relationship with violent males might result in her children being removed from her care. This could have made her reluctant to report incidents.

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[26] The cross-government definition of domestic violence and abuse is: any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality. The abuse can encompass, but is not limited to: psychological; physical; sexual; financial; and emotional abuse. https://www.gov.uk/guidance/domestic-violence-and-abuse

[27] National Scientific Council on the Developing Child. (2005/2014). *Excessive Stress Disrupts the Architecture of the Developing Brain: Working Paper 3*. Updated Edition http://www.developingchild.harvard.edu National Scientific Council on the Developing Child (2010). *Persistent Fear and Anxiety Can Affect Young Children's Learning and Development: Working Paper No. 9*. http://www.developingchild.net

[28] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education para 4.2.5 passim

4.4 Domestic abuse is known to be under-reported.[29] It is reasonable therefore to assume there were more than the relatively few incidents reported. Since Mother and children's deaths, one additional specific incident involving Ex-Partner has been suggested. There is also evidence that Mother was considering entering a refuge in June 2018, due to harassment from Mother's Brother (and from Ex-Partner according to Maternal Grandmother). Maternal Grandmother also suggested Mother was considering contacting the refuge again before Christmas 2018.

4.5 Unfortunately, probably because she was keen to get/keep social workers out of her life, Mother did not feel able to contact and confide in the practitioners that she knew. Maternal Grandmother told this review that Ex-Partner got Mother involved in taking cocaine in 2018 and then threatened to report her to Children's Social Care when she tried to finish the relationship. Mother's comments in her electronic diary confirm this. The accounts of Ex-Partner's behaviour that have come to light since the deaths of Mother and children, including the numerous texts/phone calls in January 2019. These alone, show considerably more concerning behaviour than was known to agencies at the time, particularly when Mother was trying to "distance herself" from Ex-Partner, as she put it in her electronic diary. Checks done by Social Worker 2 in January 2018 only revealed two previous incidents: one relating to Mother and one relating to a previous partner.

4.6 Mother was also vulnerable due to her tendency to feel sorry for people and get (over) involved against her and the children's best interests, whether this was with extended family members or strangers. Contact with Mother's Brother was inevitable, according to Maternal Grandmother, as he went to Mother's for clean clothes and to collect his benefit, which were paid into Mother's bank account. It is not known why this was the case, such an arrangement offered lots of scope to increase conflict between Mother's Brother and Mother. Prior to leaving prison, Mother's Brother had declined to attend the appointment at the Job Centre that his offender manager offered to arrange. He stated that he was aware how to make a benefit's claim and had "no issues" with a bank account.

4.7 Something brought apparent strangers to her door in November 2016; both practitioners and Maternal Grandmother told us of Mother's habit of buying food for homeless people and giving them bedding obtained free via Facebook, which could have made her potentially vulnerable. Children's practitioners were not aware of the incident with this unknown male, (if indeed Mother did not know him) but they did know about her befriending of Older Male. His involvement in her and Child 1's life, must have been more significant than she was willing to acknowledge given the number of times he was observed by different practitioners to be with Mother and/or present at the house, over a period of nearly 6 months. Whilst Mother agreed to Social Worker 2's suggestion that he should not have unsupervised contact with the children or stay overnight, there is no evidence of consideration being given to a written agreement which would have provided clear expectations. There are no clear management oversight discussions or decisions regarding Older Male. It seems that contact with Older Male stopped soon after Mother became pregnant, but this was not as a result of actions by practitioners. In fact, Mother told the social worker that Older Male had "tried to groom her", but she had not allowed this.

[29] The most recent report indicating this is Women's Aid (2018) Survival and Beyond; the Domestic Abuse Report 2017 Bristol: Women's Aid

Summary of Learning: Domestic Abuse and Violence

- Domestic abuse is consistently under-reported, practitioners should always assume it is likely to be more frequent than reported
- One of the reasons victims may be reluctant to report Domestic Abuse and Violence or be truthful about the alleged perpetrator is because they are worried about the consequences for themselves or their children; where practitioners are aware of this they should proactively explore and discuss this
- Kindness by vulnerable people is potentially open to exploitation by adults whose behaviour may pose a range of risks to children.

Theme: Mental health

4.8 Being a child in family where a parent has a mental health problem[30], does not inevitably mean negative consequences. Many mentally ill parents can care successfully for their children, especially if they have received treatment and support. However, some potential features of mental illness: erratic behaviour; mood swings; lack of emotional availability; difficulties establishing routines and boundaries; neglect of personal and household hygiene; can result in emotional abuse or neglect. Children with mentally ill parents are also more vulnerable to stressful life events like divorce and separation, homelessness, unemployment, discrimination, and lack of social support. Risks to children are compounded if mental illness co-exists alongside domestic abuse and abuse of drugs or alcohol; the so called "toxic trio". A recent survey of local authorities indicated 65-90% of children in need cases involved all three of these factors.[31]

4.9 Attempts to obtain support for Mother's mental health were not sufficiently proactive. An assessment of her mental health had not been achieved during the time that Child 1 was on a child protection plan. The only treatment Mother received for her mental health during the period under review was one prescription for anti-depressants, with no review by a GP of its impact because Mother did not make a follow-up appointment. The GP assumed that the referrals in January 2016 and 2017 respectively, were being followed up because no communication was received to indicate otherwise. Mental Health practitioners told this review that when SPOA staff know children are subject to child protection plans, they send a copy of correspondence to the social worker; however it appears they were not aware that Child 1 was subject to a child protection plan and this was no longer the case after February 2016. The referrals in January 2016 and 2017 respectively were followed up but not until some months later at Mother's request, by the health visitor and midwife respectively. There is no evidence of the GP reviewing Mother's mental health at the post natal check after the birth of Child 2. No further mental health referrals were made; practitioners enquired about

[30] For example, diagnosable conditions like depression, schizophrenia, or anxiety, bi-polar or personality disorders

[31] ADCS (2016) Safeguarding pressures phase 5: research report. Manchester: ADCS cited in https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

Mother's mental health with her but she either said she felt well or did not want a referral, and no-one had sufficient concerns about Mother's mental health to pursue this any further.

4.10 The GP told this review that the surgery held monthly Multi-Disciplinary Team (MDT) meetings but there were no criteria for which children would be discussed[32] and no representative from the health visiting team attended. The health visitor called in to the surgery to liaise with the GP every 3 months about current issues. These arrangements were not sufficiently robust to ensure effective information sharing about Mother's mental health. The GP told this review that it would have been helpful to have known that a social worker was involved/the children were subject to a CIN plan; this could then have been mentioned in referrals made to the SPOA and would also serve as an alert if any other contact was made about the children. Unless there were safeguarding concerns, such an arrangement would need the consent of the parent. Health visitors told this review that an audit in 2018 had discovered a perception by health visitors that the focus of MDT meetings was primarily on older patients or those with medical needs, and that the 3 monthly liaison visits with surgeries might involve only meeting with practice managers as where they were the safeguarding lead. Whilst it is a joint responsibility to ensure that communication between GPs and health visitors is effective, it is also important to be clear which of the practitioners involved in CAM arrangements is going to contact the GP, when, and about what.

4.11 As well as being the referral point for access to the mental health service, the mental health practitioners at the SPOA also offer advice and consultation. With the exception of Children's Social Care staff, all the agencies who had contact with Mother were aware of this. Some had sought advice about Mother by phone, however no-one considered convening a meeting specifically to consider Mother's presentation and what it could mean, both for engaging Mother and the potential impact on the children.

4.12 Practitioners who were not specialists in mental health, told this review that they did not feel confident about dealing with adult mental health. They felt that they needed more understanding of the various illnesses and conditions, the impact they had on the person and on their parenting, as well as tools to help them screen and assess, especially where drug use and domestic abuse were also present.

4.13 Social work practitioners told this review about the benefits they were getting from CAMHS staff holding 'surgeries' that they could attend for advice about children in care they were worried about. This enabled them to reflect and plan for which children they might need to discuss, and ensure they prioritised accessing the 'surgery'. Practitioners told this review that they thought this kind of support from the adult mental health service would be potentially feasible and worth trying. Involving specialist mental health practitioners in multi-agency training would also strengthen relationships and information sharing between the adult mental health service and other practitioners.

4.14 Until information came to light during this review, none of the children's practitioners involved with Mother were aware that she had had a diagnosis of EUPD. The GP would have been aware of this but there were no GP reports provided to child protection conferences; despite

[32] This is being addressed as part of a review of 0-19 local health policy guidance

some improvement in the proportion of child protection conferences in Bolton that receive reports from GPs the rate remains under 50% at the time of writing. There is no evidence of a systematic attempt by a social worker to find out what information might be held in Mother's patient records, and a lack of sufficiently precise and specific recording; there is a mention of Mother having a "personality disorder" in the minutes of the final review child protection conference but no detail about what that might mean. Practitioners were aware of her mood swings and had considered that she might be bi-polar; this was Mother's strong belief about herself. Mental health specialists present at the practitioner meetings confirmed that Mother's behaviour was more typical of someone experiencing EUPD; practitioners told this review that more information about how EUPD can affect people's moods, presentation and behaviour would have assisted them.

4.15 Practitioners were aware of Mother's history of suicide attempts in adolescence. However, no-one had ever heard her mention suicide during their involvement, although family members told this review that she mentioned this frequently over the years and then would appear to be in a better frame of mind. No-one was aware of the suicide plan made with a female friend in late 2018, until after Mother and the children's deaths. Maternal Grandmother told this review that Mother was very good at putting on a "brave face" when low in mood and that it was very difficult for anyone to know, unless she chose to tell them.

4.16 Mother's use of cocaine will have exacerbated her tendency to mood swings as the euphoric effects are short lived and the after-effects often include increased paranoia, low mood and anxiety. Maternal Grandmother told this review that at one-point, Mother talked about sewing a "spyware" camera into Child 1's clothes so she could monitor what was being said by nursery staff.

4.17 Practitioners could see the many positives in Mother's parenting; the children were well clothed and fed, they had toys and books, Mother treated them with affection, they had had all their immunisations and they were developing normally. At the same time the house was always dark and stuffy at best, smelly at worst and sometimes dirty. The front of the house faced onto the street; practitioners told this review that Mother kept the curtains drawn for privacy, especially as she was ashamed of her home. The back faced onto the yard, which was often full of rubbish, Mother did not manage to put the bins out regularly as collections were fortnightly the rubbish quickly mounted up. The children got up and went to bed late and sometimes they were a bit grubby.

4.18 Whilst practitioners were aware of these issues, they did not translate them into a coherent understanding of the children's lived experience to weigh against the positives in Mother's parenting, including the children's normal development. Patterns of care in vulnerable families are often variable; intervention by non-universal services, for example, family support or Children's Social Care is often short-term due to demands on services, as well as a wish to promote independence, but even those parents who engage well are not always able to sustain change. The long periods when Mother and children were not being seen whether due to lack of engagement or lack of agency involvement, meant that it was difficult to be clear how variable the care of the children or Mother's mental health was. This was particularly the case in 2018, when it would appear that Mother was finding incidents involving Mother's Brother and Ex-Partner very stressful, if she was considering entering a

refuge is correct. Certainly, it was very unusual for her to seek help from housing of the kind she did, regarding Mother's Brother in June 2018.

4.19 During 2018, the children were rarely being seen and the impact of emotional harm, needs to be chronic and severe to be easily identifiable in young children. Practitioners were aware that Mother would "rant" when she was not happy with them. Maternal Grandmother told this review that volatility was part of Mother's personality; she could "go from 0-10" in a split second and "keep going" for a long time. This, and the awareness of aggressive visitors/partners will potentially have been frightening for the children. Practitioners also experienced this volatility directed at themselves, their need to cope with it did not translate into considering the impact on the children. Persistent fear and anxiety impair children's ability to learn, solve problems and relate to others.[33] The impact of the deficits in physical care and routines would also have become increasingly apparent once the children began attending school.

Summary of Learning: Mental Health

- The potential benefits for vulnerable children if GPs are made aware of, or they make enquires to find out, if there is a Child in Need plan
- The importance of children's practitioners liaising directly with the GP about diagnosis and any treatment being given, both proactively and also to check parent's accounts
- The benefits of sharing/identifying which agencies are involved at the point of referral to Single Point of Access for mental health services
- The importance of timely sharing of information about non-engagement with mental health services with key practitioners and reflecting on the significance of non-attendance where an adult is a parent
- The benefits for practitioners of the advice function of the SPOA, which should be more widely promoted and include capacity for face-to-face input into professionals' meetings
- The importance of looking beyond a child's normal development to build a coherent narrative of the child's lived experience in the moment and over time
- That non- specialist practitioners would benefit from: -
    - More training about mental health: illnesses and conditions; what impact they have on the person as well as on their parenting
    - Tools which assist in screening and assessment especially where domestic abuse and substance abuse also feature

See Recommendation A

[33] Shonkoff J et al (2010) Learning Paper 9 Persistent Fear and Anxiety Can Affect Young Children's Learning and Development National Scientific Council on the Developing Child, Centre on the Developing Child at Harvard University

Theme: Engaging Suspicious and Avoidant Parents

4.20 Practitioners knew Mother well, they empathised with her and she prompted a desire in others to help her, despite her variable presentation. This involved mood swings, and "rants" in person or by text when she was unhappy about something, as well as reflective and insightful conversations, and mostly being open about her childhood experiences and feelings about her extended family and relationships with them. She was much more guarded about her relationships with men.

4.21 The quality of relationships practitioners had with Mother were often affected by their role or the circumstances at the time. Social Worker 2 commenced involvement when the rent arrears were becoming serious. Other future contacts with social workers were likely to be difficult. This is because establishing a regular visiting pattern was difficult and tended to mean that visits were disproportionately likely due to concerns having been raised. In addition, the check Social Worker 2 did with the nursery was in line with expected practice but would likely have been seen as surveillance by Mother. Maternal Grandmother told this review that Mother took Child 1 out of nursery because she thought the staff were talking about her to one another and wanting to take the children away.

4.22 Mother generally related well to the health visitor and the midwives (as universal services) and eventually, with the family support worker whose involvement had been partly introduced by the social worker as "please try the family support worker instead of me". It is not unusual for parents to resist involvement of social workers. They tend to be seen as the "big stick," alongside a widely held but mistaken belief, which is especially prevalent amongst vulnerable families, that they frequently take children into care rather than support families to stay together.[34]

4.23 Mother was always highly motivated to have social work involvement end and responded well to clear structured plans; she knew what she needed to do to finish the child protection plan. Social Worker 2 used a structured strengths, concerns and actions approach to engage Mother and develop a clear plan for the family support worker. The social worker told this review that although Mother engaged well with this approach, there was only one opportunity to use it formally in this case. The use of the approach had come from a discussion in supervision and represents the social worker's persistence in trying to find an approach that might engage Mother.

4.24 Practitioners knew Mother preferred pre-arranged appointments. They did not see that as necessarily an attempt to hide anything but described Mother as seeing visits as a "necessary evil" about which she wanted some control including how she presented herself. She did not like to be seen without make-up. Practitioners put thought into how best to arrange appointments, apart from letters, the health visitor and social worker in particular, used phone and text reminders. However, in common with many other service users, Mother could be difficult to contact by phone as she constantly changed her sim card/number. Practitioners had not considered informal venues other than home or the children's centre to meet with Mother, perhaps places she would recognise as also being fun for the children, for

[34] Burgess C et al (2013) Action on Neglect- a resource pack University of Stirling http://stir.ac.uk/9b and Weston JL (2013) "Care Leavers experience of becoming parents" University of Hertfordshire

example, the park. Having said this, whilst such suggestions might be helpful in building relationships with parents and less resistance to social work involvement, mental health practitioners told this review that this type of strategy would not have worked for someone with EUPD.

4.25 When Mother was not at home for pre-arranged appointments which was experienced by all practitioners,[35] practitioners then made unannounced visits. This was especially the case if there was a specific concern to discuss, for example the seriousness of the rent arrears or referrals from the police.

4.26 Whilst practitioners sometimes arranged joint visits, and liaised if they were not getting in, there was no formal co-ordination of visiting arrangements. Sometimes this meant several visits from different practitioners within a few days, occasionally on the same day. This may have had the inadvertent effect of making Mother feel more resentful and resistant, certainly the content of her complaint described embarrassment about what neighbours might make of the attempted visits. Practitioners confirmed there were a number of occasions when Mother was at home but not willing to let anyone in.

4.27 Whilst the attempted joint visit by health visitor, social worker and housing officer after the CAM in November 2016 was well intentioned and, reflected the level of concern about the rent arrears, it is not surprising this was not successful given Mother had already declined to attend the CAM. When the children were subject to a CIN plan, social workers attempted to see the children every 4 weeks. This was irrespective of whether there was a specific concern and appears to have been an application of expectations for children subject to a child protection plan. This may also have inadvertently impacted negatively on Mother, especially when sometimes she was told that, if she did not allow the children to be seen, then the police would be asked to do a welfare visit. Sometimes this might be a necessary tactic, but which needs to be directly related to occasion where there is a specific serious concern.

4.28 Co-ordination of visits might have made it more likely that a higher proportion were successful, which would have given a better insight into how variable Mother's mood and the home conditions were. Co-ordination of visits would also have highlighted some periods of several weeks when no-one was getting in. It might also have become apparent that there were a high proportion of unannounced visits, despite practitioners trying to avoid these as they were rarely successful, and therefore unhelpful.

4.29 Practitioners made attempts to encourage Mother to attend CAMs; these were pre-arranged nearby at the children's centre, and someone would call in to collect her. Mother saw these meetings as unnecessary and did not usually attend unless she was concerned about something. For example, once when her rent arrears were so serious that she was potentially facing eviction and twice when she wanted to challenge practitioners about their concerns or the need for social work involvement. Whilst Mother had agreed where CAMs would be held, in practice she did not like coming to the children's centre. She associated

[35] (Records show during the period of the review only about two thirds of approximately 30 per-arranged social work visits and four out of 7 pre-arranged health visitor visits were successful.

the centre with use by vulnerable people who had been in supported accommodation with her, and from whom she wanted to distance herself.

4.30 Mother was very socially isolated. She was in periodic contact with her mother and brother, but practitioners felt they were more likely to be reliant on her and cause her difficulties, by either reminding her of her childhood or antisocial behaviour respectively. She appeared to have no friends; Maternal Grandmother told this review the only friends she knew of in the last 12 months or so of Mother's life were Ex-Partner and Female 1. Mother did not mention any friends to practitioners. A lack of friends and positive extended family relationships meant Mother had no informal support with the children; her sister was the only person she would occasionally allow to look after the children, when she felt her sister was well enough.

4.31 Mother had not allowed Child 1's Father to have contact since Child 1 was about 18 months old. Child 1's Father told this review that on the one hand she would phone him frequently during contact to ask him how Child 1 was, but on the other hand once asked at very short notice, (when they did not have time to get the necessary equipment), whether he and Paternal Grandmother could keep Child 1 overnight, as she wanted to go out. Child 1's Father told this review he was very unhappy about contact being stopped but could not afford legal advice to challenge it; he felt that social workers should have given him more help and advice to get parental responsibility so that his hand was strengthened in trying to persuade Mother to allow him (and Paternal Grandmother), to play a role in Child 1's life. Paternal Grandmother pointed out the protective role of extended family in keeping an eye out for children especially as they get old enough to talk. Records show that social workers did try to involve Child 1's father whilst Child 1 was subject to a child protection plan; he was invited to all the child protection conferences and a parenting assessment was completed on him when the parents were no longer a couple. This concluded there was no reason for him not to have contact. Mother told practitioners that she had stopped contact due to her feeling suspicious that Father was smoking cannabis during contact[36]. Practitioners saw this as a protective act, and whilst Social Worker 2 tried to encourage Mother to see the benefits of Child 1 having contact, if this could be arranged safely, Mother was not willing to explore this further.

[36] Attempts to contact father to seek his response are in progress; his response will be included once known

Summary of learning: Engaging Suspicious and Avoidant Parents

- The importance of reflecting on why parents might be suspicious or avoidant and taking advice about how best to engage them if a mental health problem is known or suspected
- The difficulties of balancing authoritative practice with working in a caring and empathetic way for example using models of restorative practice
- The potential benefits of practice models that enable parents to understand what they need to do to improve the care of their children but also demonstrate to them that their strengths have been recognised by practitioners
- The benefits of co-ordinating visits in terms of identifying patterns of engagement and sharing the workload as well as avoiding unnecessary antagonism
- The importance of identifying people who are significant to parents and children and who could provide support, including paternal family

See Recommendation E

Theme: Care Experienced Parents[37]

4.32 Research shows that, as a group, care leavers are consistently more likely to have poor outcomes in adulthood. They are disproportionately likely to be unemployed, have mental health problems, abuse alcohol or drugs, experience homelessness or spend time in prison. These factors undermine a parent's ability to care well for their children. However, outcomes for individual care experienced people will still vary considerably depending on such factors as the child's age of entry, their reasons for entering care, their experiences within the care system and their experiences prior to entering care. Whilst studies show that the figures for care experienced parents having children removed from their care are similar to intergenerational abuse i.e. from 10%-40% this means 60%-90% of care –experienced parents don't repeat the cycle.[38]

4.33 It is not possible to predict which parents will abuse their children based on their care experienced status alone. However, considering the impact of a parent's care status on how they see themselves as a parent and their hopes, fears, vulnerabilities and any protective factors for example supportive people that were significant in their lives is very relevant to assessing risk and providing help.

4.34 In her review of the literature on care-experienced parents Weston[39] describes how some mothers felt motherhood provided a sense of loving and being loved, promoting a sense of maturity and sense of purpose and changing priorities which brought some stability to chaotic lives. Motherhood was valued for providing a sense of personal achievement and

[37] Parents who have spent part of their childhood in the care of the local authority whether made subject to a care order or accommodated at the request of their parents.
[38] Weston JL (2013) "Care Leavers experience of becoming parents" University of Hertfordshire
[39] Weston JL (2013) ibid

adult identity which included a sense of control that many had felt was lacking when they were in care. Whilst many had an ambition to offer better parenting than that which they had received, this was often focused on what not to do, without necessarily having the role models and the support to do things differently. They also felt they were stigmatised and under more scrutiny from professionals than other parents, who they feared might remove their children. Most lacked consistent support from family and friends, exacerbated by feelings of needing to be and being seen to be independent. Weston identifies that the limited research devoted to protective and supportive factors tends to focus on the absence or opposite of risk factors. Financial, emotional and practical support in general was considered to be important, and professionals who made them feel listened to and who provided advice with options and alternatives were appreciated. Friends were an important source of support especially those who were pregnant or who themselves had young children; some recommended the use of other young mothers as mentors as they thought this source of advice and support was more likely to be accepted.

4.35 Practitioners told this review that Mother talked about being determined to be a better Mother than Maternal Grandmother had been and gave examples which illustrate this. Mother was concerned about making a poor choice of partner; initially she had been ambivalent about her pregnancy with Child 2 as she did not think the putative father would be a good father. When social worker 2 visited in February 2018, Mother told her she was well aware of the impact of domestic abuse on children, having lived with much more serious domestic abuse in her own childhood than the incident in January 2018 and that she would not allow her children to experience that. In August 2018 Mother told the health visitor she was avoiding contact with Maternal Grandmother and Maternal Aunt due to concerns about the impact of their mental health on herself and the children.

4.36 Being determined to avoid mistakes made by one's parents is not enough in itself to avoid making them especially in times of stress. However, Mother would engage with those services she perceived as being directly relevant to the children's welfare. Once booked in she mostly attended her antenatal appointments for Child 2, any resistance to the outreach midwife service tended to be due to the fact that she did not see the need for additional support as she felt she had already proved herself with Child 1. Both children were fully immunised, she took them to the GP or A&E for minor childhood ailments and usually ensured they received their developmental checks; the health visitor told this review that Mother appeared to really enjoy talking about how the children were developing.

4.37 Practitioners told this review that Mother did feel she was treated differently because she had been in care. She was very resentful of Child 1 being subject to a child protection plan – this formed the main part of the statutory complaint she made. Practitioners also described examples of Mother needing to be in control. Both practitioners and Maternal Grandmother told this review that Mother resented feeling she did not have a choice about where she should live. At the time practitioners knew that Mother did not want to be in the supported housing but thought she recognised the benefits; Mother's electronic diary described herself as having been forced to live there. When Mother moved into her own tenancy Maternal Grandmother told this review that she had wanted a privately rented property in a particular area. Practitioners encouraged her to take social housing as this would give her greater security of tenure, and support for any settling in problems. After being told in May 2017 that funding to support Child 1's attendance at nursery had been approved, although Mother

stated she felt attendance was not necessary, without telling practitioners, she went the same day to view the nursery and put Child 1's name on the waiting list. This need to be in control could be a feature of her EUPD or perhaps a result of not feeling she had much to say about what happened to her when she was in care.

4.38 Like many care experienced parents Mother was very socially isolated. She had no consistent friends and, at best, ambivalent relationships with members of her extended family. There is evidence that she sometimes sought or received help from Maternal Grandmother, for example, advice when she was being followed in the shopping centre, obtaining the phone number for the refuge worker, and Maternal Grandmother reporting incidents to the police on her behalf. However, when Maternal Grandmother was unwell Mother felt a need to distance herself and this was reinforced by social workers. Practitioners told this review that she did talk fondly of her ex-foster carers, but no consideration was given as to whether or how, that relationship could be a source of support to her and the children.

4.39 Parents who participated in a recent study of neglect talked about needing places to go, especially for practical help, before there was a crisis and preferably without involving Children's Social Care.[40] It is unfortunate that Mother associated the local children's centre with people-with-problems that she wanted to avoid, as this was precisely the kind of place that could have provided low level, less formal support, including in the home. No consideration was ever given to alternatives, for example involving Home Start[41] which is a service offering practical help and moral support delivered by trained volunteers who have experience of caring for young children (mostly as parents), i.e. people Mother might have seen as positive peer mentors. This was partly due to the scheme being commissioned in a way that input is not provided when there is a social worker involved. Mother did not meet the criteria for higher level Family Support Worker involvement, a service which in any case is only set up for short-term support. The success of the Home Start scheme is based on the recognition that many parents need a friendly helping hand occasionally. If there was any chance that Mother would have accepted a referral, the moment might have been when she had a new baby. This is the point at which step down from the CIN plan was being considered.

4.40 Mother's fear of her children being removed from her care had two elements; losing them and not wanting them to have the experience of care she had had particularly the unstable placements in her later teenage years. Practitioners were aware that Mother was fearful about the children being removed from her care; periodic reassurance was offered by Social Worker 2. However, this fear was not something that was ever explicitly explored with her in depth. Such discussions, however frequent and detailed, would have been unlikely to have reassured her, even when the likelihood of the children being removed was very low, and even less so when she knew she was not being honest about circumstances (for example the drug misuse) which would have been perceived as increasing the risks for the children. However, such discussions are always worth having with any parent who fears that their children might be removed, whether these fears are realistic or not. In this case they might have enabled an understanding about how these fears impacted on the children and

[40] Burgess C et al (2013) Action on Neglect- a resource pack University of Stirling http://stir.ac.uk/9b
[41] http://homestartbolton.org.uk/

identified any extreme beliefs which could have indicated that her mental health was more fragile than initially realised. For example, disclosing worries about taking Child 1 to nursery for fear of social workers taking her was rather extreme, considering use of spyware to overhear the staff who she feared were talking about her (which she did not disclose to practitioners) was potentially symptomatic of paranoia.

4.41 The care experienced parents in Weston's study[42] perceived social workers and Children's Social Care as all powerful that could remove their children from their care on a whim. Maternal Grandmother reminded this review that Mother grew up within a family and community where having your children taken into care was a frequent experience, which continued to be the case in the circles in which Mother mixed as an adult. Maternal Grandmother told this review that "poor people worry about this in a way that rich people don't have to" and that a feeling of lack of control was common; "social workers tell you what to do and they have the power" and that "when you do tell them things, they use it against you and twist it". These last two comments are very similar to those expressed by parents in a recent study of neglect.[43] Maternal Grandmother also told this review that these views and feelings were reinforced by the social media and internet sites Mother spent a lot of time on.

4.42 Evidence from Mother's electronic blog suggests that she was fearful of what would happen to the children if she could not care for them. She knew there was no-one suitable in her own immediate extended family to care for them. Practitioners would know that consideration would be given to the children's fathers' extended family, if this thought had occurred to mother, it would not have reassured her as she would have seen them just as much strangers as unrelated foster carers. She had stopped contact between Child 1 and her father because she did not perceive it as safe.

Summary of Learning: Care Experienced Parents

- The importance of practitioners knowing/enquiring about parents' past Adverse Childhood Experiences (ACEs)[44] and assessing the impact of these experiences on the individual and their parenting capacity
- The importance of understanding the potential negative impact on parents of their own or family members' experiences of services, for example, for Mother being in care or relatives' experiences of mental health services
- The benefits of attempting frank and detailed conversations about parents hopes, fears, vulnerabilities and any protective factors for example people that were significant in their lives that might be supportive again
- The potential value of low-level practical help and emotional support which is accessible without social work involvement.
- The value of having explicit and detailed discussions with parents who practitioners suspect or know have fears about their children being removed from their care, irrespective of how likely that is

See recommendations F and B

[42] Weston (2013)
[43] Burgess C et al (2013) Action on Neglect- a resource pack University of Stirling http://stir.ac.uk/9b
[44] ACEs range from experiences that directly harm a child, such as physical, verbal or sexual abuse, and physical or emotional neglect, to those that affect the environments in which children grow up, such as parental separation, domestic violence, mental illness, alcohol abuse, drug use or imprisonment.

Theme: The Right Support at the Right Time

4.43 Prior to moving into her own tenancy Mother had been receiving Housing Benefit which was paid directly to her landlord. National policy objectives for the implementation of Universal Credit (UC) are intended to encourage claimants to budget to pay their rent themselves. Due to having no savings, first payments of UC always being 5 weeks in arrears. This Mother was not used to receiving large lump sums of money and not being very well organised, it was predictable that she would get into rent arrears. In addition, her claim for UC was also delayed because she did not provide the benefits agency with the necessary information about the housing element. Housing officers are dependent on what information the tenant discloses about any difficulties regarding benefits**.** There was some confusion about whether staff from the supported accommodation were helping to ensure these were in place. The housing officer's initial focus was on supporting mother to make a successful claim for UC and make regular payments rather than requesting an Alternative Payment Arrangement (APA) for rent to be paid directly to the housing provider. It took three attempts to get the APA set up. By then (November 2016), Mother was in 7 month's rent arrears and court proceedings, which increase tenants' costs, had been commenced.

4.44 When Mother moved into the starter tenancy in 2016 insufficient consideration was given by children's practitioners to the likelihood of her paying her rent, and what support she might need. The health visitor and social worker accepted Mother's assurances about "financial issues being ok" at face value; they saw that the children were always adequately fed and clothed, so they did not consider the possibility of financial problems and never enquired specifically about the rent. They felt practitioners would benefit from a better understanding of the benefits system and some reflection on how best to assess financial vulnerability.

4.45 The housing manager told this review that housing officers are not routinely included in child protection or CAM meetings; in this case they were not involved in a CAM meeting until the arrears position was so serious that it was a threat to the continuation of the tenancy. Child 2's birth was not registered for a few weeks, this meant late access to child benefit and additional UC. This was also something that children's practitioners had not enquired proactively about.

4.46 There were a number of barriers which undermined Mother's access to mental health treatment, both service and circumstance specific. Successful treatment of EUPD requires long term psychological therapy. Normal staff turnover and general pressures of work and workload do not make it easy for the development of the kind of trusting and long–term therapeutic relationship Mother required. Patients need to positively opt in for treatment (otherwise they do not engage and benefit fully), but Mother's readiness to do so was intermittent. In general, Mother was ambivalent about accessing support for her mental health. Practitioners told this review that while she was periodically self-aware enough to know that she might need it, barriers to accessing it included stigma, fear of "being judged" by Children's Social Care and Mother's view that her sister had not been treated well. Mother's resilience also varied; she recognised that the kind of help she needed would be long term and suspected it would be emotionally challenging given her adverse childhood experiences. The opt in arrangements required getting organised to make a phone call followed by attending an appointment sometime later; the kind of life Mother led, which

lacked routines, plus the other barriers mentioned, undermined her ability to successfully opt in.

4.47 Specialist mental health practitioners told this review that since the end of 2018 mental health practitioners have been located in GPs surgeries for a number of hours/days per week according to the size of the surgery. This has the benefits of enabling timelier access to face-to-face support than making a referral via SPOA and support being delivered at a local non-stigmatising venue that patients are familiar with. Practitioners thought there would have been a higher chance of Mother accessing this kind of provision, which is available each week at the same time. Two attempts Mother made to engage with mental health services were thwarted by an error in an agreed appointment time and her use of the wrong phone number. On the surface these are small barriers, but the importance of being able to seize the moment, when people with mental health conditions are ready to engage, should not be under-estimated.

4.48 An audit of children subject to child protection plans conducted in spring 2019 identified that when social care intervention ended arrangements were not consistently made for involvement to be stepped down effectively to a named lead professional who is clear about the plan of support for the child and their family. Although this was not the case when the child protection plan was discontinued for Child 1, the contents of the CIN plan (a parenting assessment of Child 1's Father, assessment of Mother's mental health, and promoting a successful move into her own tenancy) were mostly outstanding tasks from the child protection plan. The mental health assessment at the very least, should have been completed earlier to inform the decision that a plan was no longer necessary. As a result of the audit report about child protection plans, Bolton SCB accepted a recommendation that the current step-down process should be reviewed. Moreover, all agencies should ensure their practitioners know and use the current process consistently and offer challenge when it is not followed. In the meantime, social care managers are making arrangements to ensure step-down arrangements are consistently effective across all social work teams.

4.49 For about half of the period under review the children were receiving services as "Children in Need". Initially this was due to recognition of continued vulnerability after discontinuation of the child protection plan[45] and then the discovery of the pregnancy; 20% of women have mental health problems in pregnancy or shortly afterwards; and risks are increased for women with a history of mental health problems.[46] It is this context that social work involvement continued.

4.50 During the period of CIN involvement, the burns incident in July 2017 should have prompted formal consideration via a strategy meeting about whether child protection enquires were necessary; this did not happen. Information from practitioners suggests this appears to be due to a combination of factors; recognition that Mother had tried to treat the burn; the focus of early activity being to ensure Child 1 got treatment; that Mother did take Child 1 daily for hospital treatment; other concerns (about Child 1's hygiene) being minor; and a view expressed by social care practitioners that where there was no clear potential offence, the

[45] Practitioners told this review that it is common custom and practice for children who have been subject to a child protection plan to be stepped down to a CIN plan in the first instance
[46] https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/mental-health-in-pregnancy

outcome of any strategy meetings would be a single agency response.[47] Mother not presenting Child 1 to the hospital on the same day could have been due to a genuine belief she was able to treat the injury herself or, perhaps, embarrassment and fear that the accident had happened at all. However, not accepting follow up treatment in the community (something she would normally recognise as being directly relevant to Child 1's needs) was unusual. Mother not accepting medical advice for Child 1 to be admitted to hospital was also unusual behaviour for any parent, especially given the inconvenience of the alternative, which was taking both children quite long distances daily on public transport. A strategy discussion would have considered these issues.

4.51 The first period of CIN involvement was not formally ceased until November 2017 due to Mother's lack of co-operation with a closing visit. Whilst it is understandable that Social Worker 2 thought such a visit would have been good practice, especially as it had been originally agreed in supervision, it is also understandable that Mother was mystified why it was necessary, having been present at the CAM where she had told practitioners that Child 1 would be starting nursery shortly, future involvement of the health visitor was discussed and closure was agreed. The team manager agreed to case closure only after seeking a discussion in supervision with the Head of Service to reflect on the appropriateness of the decision. Whilst current risks were considered to be low, lower than the threshold of risk of significant harm, she nonetheless recognised that the history was complex, the children were young and, the overall circumstances such that there was potential for re-referrals in the future.

4.52 A health visitor was present at the last CAM but there was no representative from housing. Had a housing representative been invited, Mother's call for help with the behaviour of Mother's Brother and thoughts about moving might have come to light. Step down to universal plus services meant that the health visitor visited in October 2017. However, she did not see the children again until August 2018, mainly because Mother did not make herself available for three home visits in April and May 2018 to do Child 2's nine-month development check. A formal workplace risk assessment was in place between May and November 2018 for the health visiting team due to sick leave and vacancies. Nonetheless, had there been any concerns raised about child with the health visitor she would have made another attempt to visit before August 2018.

4.53 In February 2018, there was essentially a one-off social worker visit to address concerns about domestic abuse and household conditions. A formal (multi-agency) strategy meeting at the time of the referral might have explored the implications of the household conditions described in detail by the police more thoroughly and prompted a visit from the health visitor. By the time a successful visit was achieved the conditions had improved and Child 1 was still attending nursery.

4.54 Similar concerns about the state of the house were referred again by the police in August 2018. This prompted a child and family assessment which concluded at the end of October 2018 that the risks were low, and that social work involvement exacerbated Mother's (unfounded) fears that her children would be removed. Whilst this assessment sought information from the health visitor, there does not appear to have been any explicit

[47] This will be addressed as part of the Children's Social Care learning from this review.

consideration of what the ongoing support for Mother and children would be and whilst the health visitor reported no concerns, she had not seen the children since August 2018.

4.55 Had a CAM been held this would have enabled more detailed exploration of Mother's presentation and perhaps led to consideration of contacting the GP or SPOA for advice. This might also have prompted a visit from the health visitor who otherwise was not due to visit again until January 2019. The health visitor knew Mother well and would have been well placed to observe the nature of any deterioration in Mother's mental health or the children's care or presentation**.** Mother might have accepted some help; practitioners told this review that sometimes she had the insight to know when she needed help, for example when she finally sent Child 1 to nursery this was partly prompted by the challenge of having a new baby. If involvement had continued over the next few weeks/months Mother might have disclosed the domestic abuse that she was experiencing.

Summary of Learning: The Right Support at the Right Time

- The benefits of considering of transition arrangements when people move from supported accommodation into starter tenancies
- The importance of practitioners assessing the financial resources available to a family and how the availability and spending of these resources may impact on children
- Practitioners having a better understanding of state benefits a family may be entitled to and knowing where families can access help to ensure they receive all the financial support they are entitled to
- The potential benefits of a joint working/information sharing protocol setting out the processes and principles for multi-agency information sharing, involving housing officers, including attendance at CAMs to facilitate better joint working
- The importance of ceasing contact and closing cases promptly where risks are low, and parents have been told that there is no need for further social work involvement
- The benefits of raising practitioners' awareness of the weekly Mental Health Practitioners sessions at GP surgeries for screening and low-level support, and encouraging parents to access them
- The importance of holding timely, multi-agency Section 47 Strategy Meetings where there is on-going social work involvement; other agencies need to feel confident to request these when needed
- The value of holding Child Action Meetings to inform assessments and consider future support whether or not social work involvement is to continue

See Recommendation C

Theme; Filicide- Suicide[48]

4.56 The body of research on filicide is small and frequently hard to interpret due to methodological issues.[49] In 1969 Resnick[50] developed a typology which is still broadly accepted today. His five categories were altruistic (sic), to protect the child in some way or relieve their suffering; as a result of an acute psychopathic episode; the child being unwanted; accidental killing; and spousal revenge.

4.57 O'Hagan's review of the literature[51] indicates that those - filicides which are not associated with a chronic history of abuse and neglect, often involve the parent attempting or committing suicide at the same time or shortly afterwards; 'contact' provides the opportunity for non-custodial parents to kill, especially in the many cases that are premeditated; a significant minority of cases involve mental health problems (known or undiagnosed) and a proportion involve domestic abuse where a risk factor is separation, or the discovery of a new relationship, either of which can prompt both men and women, but especially men, to kill their children and/or partner in revenge.[52]

4.58 All features described above are correlated with filicide rather than being causal; they are commonly occurring risk factors for something which is very rare, i.e. having low predictive value. This often means that they are usually only evident with the benefit of hindsight.

4.59 The latest triennial review of Serious Case Reviews 2011-14[53] found a theme of a desire to exert control or exact revenge in filicide perpetrated by males. The motive for women was more likely to be "altruism" and a desire to prevent their children from (perceived) suffering.[54] Filicide-suicide due to a fear of children being removed into care is very unusual but does happen. O'Hagan[55] refers to two cases between 1994 and 2012. The triennial review describes one case of a mother whose children had previously been in care where a recent child protection investigation prompted fears children would be taken back into care if she did not do what was expected of her.

4.60 Mother's electronic diary makes it clear that she had two reasons for killing herself. The most prominent was a desire to escape from Ex-Partner, the second was a fear of her children being removed from her care, which it seems Ex-Partner was trying to exploit. There was no imminent danger of the children being taken into care due to agency involvement at the time. However, Mother will have been aware that social workers could have become involved again had her drug use come to light, and she knew many examples of children in her network being removed due to domestic abuse. Regarding killing the children, Mother refers to her belief that there was no-one else in the family who could look after her children, and her own history of being in care influencing fears about what their experience of care would be like. Killing the children appeared to give Mother control over what happened to them;

[48] Filicide is defined as the killing of one's own birth child over the age of 12 months. Filicide-suicide is where the parent takes their own life at the same time or very soon afterwards

[49] Small numbers, inclusion of a variety of parental relationships (birth, adoptive and stepparent) inclusion of neonaticide (within 24 hours of birth) and infanticide (within 12 months of age) both of which tend to have some very different characteristics to Filicide, a greater focus on female perpetrators many of whom are locked up in psychiatric institutions, lack of access to parents who committed suicide

[50] Resnick PJ (1969) Child Murder by parents; a psychiatric review of filicide American journal of psychiatry 126:1414-20

[51] O'Hagan K (2014) Filicide-suicide; the killing of children in the context of separation, divorce and custody disputes Palgrave Macmillan

[52] Judged to be revenge by the context or remarks of the perpetrator, conclusions drawn by judges, psychiatrists and relatives.

[53] Sidebotham P et al (2016) Pathways to protection a triennial analysis of Serious Case Review 2011-14 Department for Education

[54] Bourget, Grace et al, 2007 cited by Sidebotham page 57

[55] O'Hagan K (2014) Filicide-suicide; the killing of children in the context of separation, divorce and custody disputes Palgrave Macmillan

practitioners described how Mother needed to have some control about their interactions: whether she let them in the house; sending Child 1 to nursery when she thought the time was right; not letting Child 1 stay overnight in hospital. A feature of EUPD can be fear of being controlled.

4.61 No agency was aware of the level of domestic abuse/stalking in the weeks before Mother and the children died. Practitioners were aware of Mother's fears of the children being removed from her care, however the depth of this fear and the lengths she was prepared to go to prevent it were not apparent.

Summary of Learning: Filicide Suicide

- Filicide-suicide is extremely rare, and it is not possible to predict from parental histories or parental presentations their propensity to kill their chid and themselves
- Where a parent may talk about depression and taking their own life it is important for practitioners to directly ask about the future of their children in the event of them taking their own life
- Practitioners should also take opportunities to reflect on whether any child is considered by a parent as an extended part of the self or the focus of paranoid delusions

See Recommendation B

5. GOOD PRACTICE

When undertaking a review, it is important to also consider any good practice. Good practice is defined as that which has had a positive impact and which agencies would like to see consistently undertaken. Examples include:

- Continuity of practitioner involvement; from the same health visitor throughout and Social Worker 2 through most of the period
- Key information about Mother's history had been migrated to electronic records; Social Worker 2 familiarised herself with this and reviewed the records to check information provided by Mother
- Regular liaison and joint working between the health visitor and the social workers
- Attempts made to find out about the men in the children's lives: reports of an older male living in the household were promptly followed up; the social worker made a visit to see Child 1 in the care of her father; social worker and health visitor asked Mother who her new boyfriend was; they and the midwife asked Mother who the father of Child 2 was; practitioners sought and shared information between themselves about males identities, and health staff asked Mother whether she was vulnerable to domestic abuse at key points during antenatal and postnatal care
- Swift response to late booking by the midwifery service
- The midwife promptly and tenaciously followed up a referral for mental health support
- Detailed recording by police officers describing the home conditions
- Social Worker 3 was ingenious in overcoming Mother's reluctance to allow her to inspect the bedrooms by suggesting she take a photograph
- Use by the health visiting service of formal risk assessment process to identify and support teams under pressure

- Housing staff asked for specialist advice from the MASSS when they were unsure about how to respond to Mother's concerns about Mother's Brother's anti-social behaviour
- Hospital staff flexibility to meet Mother's preference in providing follow up appointments to treat Child 2's burns at the hospital and reporting that the treatment had been adhered to
- All those involved in the investigation of the complaint made by Mother were flexible and persistent to ensure it was fully considered

6. SUMMARY AND CONCLUSION

Mother was not known by agencies to have displayed any suicidal thoughts or actions for a period of years and not since having her children and those that had occurred in the past were not serious enough to have come to any agency's attention at the time. No agencies were in contact with her for almost 3 months before her death, and whilst practitioners were aware of her fears of her children being removed, there was nothing known previously to indicate a level of desperation that would lead her to kill herself and her children.

7. RECOMMENDATIONS

To address the multi-agency learning, this Serious Case Review identified the following recommendations for Bolton Safeguarding Children Board (Bolton SCB):

A. That Bolton SCB considers how best to ensure that all practitioners, especially those who are not specialists in mental health, feel confident and supported in identifying, assessing, referring, and supporting parents who have or may have a mental health problem, whether or not the parent recognise this, and whether or not they engage with mental health services

B. The Bolton SCB considers through a 'restorative practice' approach how best to ensure that practitioners have open discussions with parents about any fears or concerns they have about service involvement and the interventions being offered to improve their children's outcomes

C. That Bolton SCB considers developing information sharing arrangements that facilitate all services relevant to families who have children subject to CIN plans, knowing that a social worker is involved.

D. That Bolton SCB assures itself, that the revised Early Help offer includes opportunities for parents to directly access low level support in local communities without being referred by any practitioner, in ways that ensure barriers to doing so have been considered and addressed

E. That Bolton SCB ensures that the current work being done to implement a strengths-based model of practice incorporates the learning from this review.

F. That Bolton SCB considers how best to ensure that agencies are effective "corporate parents" including providing support to care leavers and older care experienced parents to prepare for parenthood

G. That Bolton SCB considers how best to ensure practitioners systematically bring together, analyse and challenge all available information to fully understand the child's lived experience at a moment in time and over a period of time and projecting into the likely future

H. Seek assurance from agencies involved in this review that learning points have been identified and action taken to address them within their organisation

Glossary of Key Terms

Glossary of Terms.docx