



the children's charity

A Review of a Near-Miss

London Borough of Bexley Safeguarding Children Board

Serious Case Review – Y Children

EXECUTIVE SUMMARY

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1. Introduction

1.1 Circumstances leading to a Serious Case Review

This is the Executive Summary of the Serious Case Review report relating to the Y children. The Serious Case Review was convened by the London Borough of Bexley Local Safeguarding Children Board (LSCB) further to an incident on 28 August 2007. In this incident, Ms Y connected a hose from the exhaust pipe of her car to the window of that car in which she and her three children were sitting. The actions of a psychiatric nurse working at the unit which Ms Y had recently visited saved all concerned as he removed the hose. The family had been known to adult mental health services through Oxleas NHS Foundation Trust and LB Bexley's children's social care for the previous 2 weeks with only limited contact prior to that. Ms Y lived for the duration of the period under review in the London Borough of Bexley.

- 1.1.1 This incident fell within the criteria for a Serious Case Review as laid out in Government guidance, "Working Together to Safeguard and Promote the Welfare of Children" (HMSO, 2006). The purpose of a Serious Case Review is to consider the actions of professional agencies and practitioners in a case in order to consider whether there are lessons to learn for dealing with similar cases in future.

1.2 Description of Services

- 1.2.1 The agencies involved and requested to provide individual agency reports in this review were:

- Bexley Care Trust (primary health care and commissioning)
- Greenwich Primary Care Trust
- London Borough of Bexley Children's Social Care Services
- London Borough of Bexley Education Services
- Metropolitan Police Service
- Oxleas NHS Foundation Trust (mental health services)

- 1.2.2 Bexley Care Trust is responsible for oversight of GP services in the London Borough of Bexley and for the provision and commissioning of primary care services within that borough. The second family GP and primary health visiting services were provided from a health centre located in the London Borough of Bexley.

- 1.2.3 The Greenwich Primary Care Trust carries out the same functions within the London Borough of Greenwich which is the neighbour to Bexley. The first family GP and primary care services were provided from a health centre in the London Borough of Greenwich although Ms Y and her family were at this time always residents in the London Borough of Bexley. Although in two different boroughs, the two health centres were within walking distance of one another.

- 1.2.4 The children's social care services and education services are both part of the unified Children's Services Department of Bexley Council.

- 1.2.5 The school that the children attended is not directly part of the local authority but is supported by the authority as are all state schools.
- 1.2.6 The Metropolitan Police Service has a station at Bexleyheath and officers from this station attended when Ms Y called police at the end of June 2007. The Metropolitan Police Service runs borough-based Child Abuse Investigation Teams (CAIT) one of which is located in Bexley. The CAIT is responsible for investigating crime relating to abuse of children within families and family networks. During the period under review, the police service was piloting a joint referral service for eight South London boroughs so that all referrals for all these boroughs went through a common front desk.
- 1.2.7 The Oxleas NHS Trust is responsible for provision of mental health services across the boroughs of Bexley, Bromley and Greenwich. There is an acute mental health admissions facility for each borough. There is frequent use of either resource for residents of either borough depending on where there is most appropriate capacity for new admissions.

1.3 Terms of Reference

- 1.3.1 The terms of reference of this Serious Case Review were to consider the issues suggested in the Government guidance and in addition specifically to seek to answer the following questions:
- (i) Were services offered and information shared appropriately in respect of Ms Y and family following the death of her eldest child in March 2007.
 - (ii) Were agency responses to child care, child protection/safeguarding and mental health issues between March 2007 and end August 2007 adequate in terms of safeguarding the Y children? In answering this question, agencies should pay particular attention to but not restrict themselves to:
 - Response to imminent homelessness at the end of June 2007
 - Police response to call by Ms Y at the end of June 2007
 - Social care follow up to police response end June 2007
 - Assessment of low to medium risk of self harm and mental health state of Ms Y by mental health staff in August 2007
 - Decision to allow children to return to care of Ms Y after hospital discharge – 18/08/07
 - Multi-agency planning and analysis of risk throughout August 2007, including how agencies understood implications of adult mental health assessments
 - Agencies to pay key attention to services offered over the weekend of 24th to 27th of August 2007
 - Response at Woodlands in advising Ms Y to go to A & E on 28/08/07
 - Role of school services
 - (iii) What was the significance of any recording differences in relation to family details in respect of the Y family?
 - (iv) Are there lessons to learn about safeguarding and promoting the welfare of children from Nigerian backgrounds as a result of this case?

- (v) Were links between agencies in planning, sharing information and analysing issues adequate? This should pay particular reference to a focus on adults and children's services.
- (vi) Agencies should pay attention to the guidance on writing IMRs contained in Working Together to Safeguard Children, Chapter 8 (2006) and should additionally ensure that the matters listed in that guidance are covered by reports.

1.3.2 The time span for consideration in this review was agreed to be from the date of FY's death in March 2007 until the conclusion of events of 28 August 2007. Historical information from agencies involved has also been considered by the Serious Case Review

1.4 Parental Involvement

1.4.1 The mother was advised of the Serious case Review and the Overview Writer was able to ascertain her views in writing through her solicitor.

2. Agency Involvement / Background History


2.1 The family can be shown in a genogram as below:

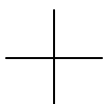
KEY to GENOGRAM:

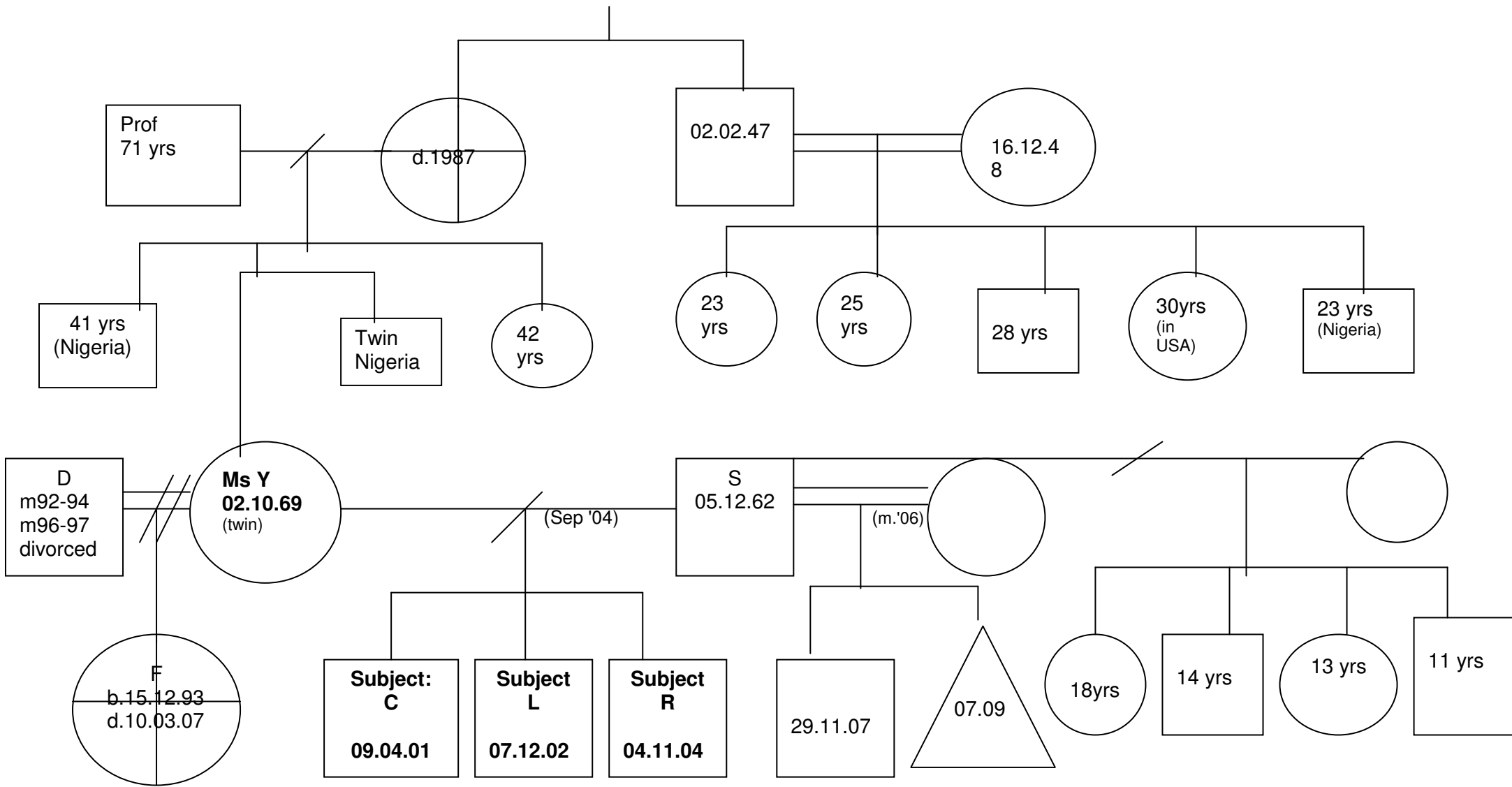
 Male

 Female

 Gender unknown

 Relationship ended

 Deceased



- 2.2 Ms Y was originally from Nigeria but had lived in the UK since 1991. Her children were born in the UK. The family was not known to children's social care services prior to 2007 and the children had never been subject of child protection concerns by any other agency. There was some historical information in respect of past domestic violence with previous partners. Ms Y had been investigated for fraud concerning Housing Benefit payments in 2004.
- 2.3 Ms Y had had three previous mental health episodes involving suicide attempts and the Greenwich GP had referred her to mental health services for counselling in early 2006. This was not known to the majority of agencies involved until after the incident as it was contained in GP notes that were in transit between practices.
- 2.3 FY died of natural causes in March 2007 aged 13 years. Her mother blamed the hospital where she died, and wrote alleging neglect on the part of the hospital in the care of her daughter.
- 2.4 It is believed that Ms Y and her surviving children visited Nigeria for a period of time following FY's death.
- 2.5 Ms Y contacted the local authority's children's social care services for the first time in June 2007 to request assistance in view of impending eviction and homelessness as a result of mortgage arrears. Following close liaison with the Housing Department the family were allocated housing.
- 2.6 Two days later the police were called by Ms Y who stated that she had poisoned her daughter. They were able to ascertain this was not true Police officers assessed the 3 children and referred the case to children's social care services however this notification was initially sent to the wrong London Borough and arrived several days later at Children's Social Care where it was filed.
- 2.7 On 15 August 2007, Ms Y attended a meeting at the Hospital where her daughter died to discuss the death of her daughter. She took with her a suicide note. Ms Y was assessed and admitted to a mental health unit as a voluntary patient and therefore not detained under the Mental Health Act 1983. Ms Y had arranged for the children to stay with a friend and remained adamant that she did not want them cared for by strangers or only cared for by Nigerian foster carers who could preserve the children's diets.
- 2.8 Following assessment of Ms Y in hospital and the children by children's social care Ms Y decided she wished to leave the mental health unit and as there were not the grounds to require detention under the Mental Health Act Ms Y went to stay with her friend and the children but returned home with the children on about 21 August...
- 2.9 MsY received visits from the mental health service's crisis team responsible for supporting people with acute mental health issues in the community. Children's social care services also visited three times in succession during this week. The health visitor also visited once in that same week.
- 2.10 On 24 August 2007, the mental health crisis team worker referred to children's social care services that Ms Y had advised the mental health

worker that she had left the children alone two days earlier to visit her daughter's grave.

- 2.11 At around midnight in the morning of 28 August 2007, Ms Y presented at the Bexley mental Health Unit and spoke to a nurse over the intercom. Ms Y gave a different name for herself from that with which she was known by the unit staff. She was advised to present herself to the next door Accident & Emergency Department. The nurse was concerned and shortly afterwards went outside the unit to see if she was alright. The nurse heard a car engine running in the car park and found Ms Y and her three children in the car with a hose leading from the exhaust pipe. The nurse disconnected the hose and called the police and ambulance services. The children were taken into police protection and placed together in foster care. Ms Y was later placed in mental health care under the terms of a compulsory detention via Section 2 and then Section 3 of the Mental Health Act 1983.
- 2.12 The police service carried out a criminal investigation and in October 2007 referred papers to the Crown Prosecution Service. Ms Y has subsequently been remanded on a charge of attempted murder to a secure forensic mental health facility further to the making of a court order under Section 48 of the Mental Health Act 1983. Ms Y has entered a plea of guilty to the charges and was sentenced to be detained under the Mental Health Act.

3. Views of Ms Y

- 3.1 Ms Y has provided this Serious Case Review with her views about aspects of the services which she received between March and August 2007. They are summarised as follows:
- Ms Y recalled having been offered bereavement services by her second GP but not by other professionals even though records suggest that the health visitor from her first practice had made particular efforts. Ms Y was keen that there should have been an automatic referral of her for such services.
 - Ms Y believed that the council's housing service could have done more and could have been more open to helping her. She believed that this service offered her help only after children's social care services liaised with the housing service.
 - Ms Y thought that she received positive help from the mental health crisis team worker, the children's social care social worker allocated to her family's case and the Head Teacher and other teachers who were all very sympathetic to her.
 - Ms Y stressed that in her view the worries about homelessness and benefits difficulties were at the heart of her stress levels in the summer of 2007. She stated that she called the police in June 2007 as she believed that if she was arrested the children would be provided with a roof over their heads in foster care.
 - Ms Y believed that she should have been allowed entry to the Mental Health Unit building in the early hours of 28 August 2007 and stated that she was distressed, and had consumed toilet cleaner and painkillers.
 - Ms Y believed that the responses she received from some services were wrongly influenced by knowledge that she held a Nigerian passport albeit with indefinite leave to remain in the UK.

- Ms Y continued to hold strong feelings about the nature of the cause of death of F. She had found the coroner's office and the Hospital generally unhelpful and unsympathetic in dealing with her.

4. Analysis of Agency Actions

4.1 It is not possible to be absolutely clear that the incident on 28 August could have been avoided. The mental health deterioration in respect of Ms Y was reasonably rapid development first signalled to professional agencies on 30 June 2007, detected further on 15 August 2007 and subject to intensive planning and work between 16 and 27 August 2007. Agencies in this latter period worked hard to provide services that would help Ms Y and any lessons to learn are for agencies and for multi-agency working and not in relation to individual practitioners, many of whom acted with thorough professionalism in striving to assist and support Ms Y and her family in this limited period.

4.2 There is evidence that workers across agencies were sensitive to the cultural needs of the family however the focus on the children's needs was at times lost because of the focus on Ms Y's mental health needs. The impact of this on the children was not always appreciated.

4.3 It is important to identify aspects of good practice. Examples include:

- The diligence of the children's social care duty social worker in liaising with the Housing Department when Ms Y called children's social care services about her impending intentional homelessness on 29 June 2007.
- The speed with which Bexley's Housing Department made an offer of alternative permanent accommodation on 9 July 2007 having only been notified of the matter at the end of June 2007.
- The commitment and endeavour of Ms Y's GP in finding out about the circumstances of F's death and in offering to be available to Ms Y personally after she registered with the practice.
- The effort made by the allocated social worker in August 2007 to prioritise visits amidst a busy caseload to a case where there were not children in care or subject to formal child protection enquiries at that time.
- The engagement and rapport with Ms Y established by both the mental health crisis worker and the children's social worker; Ms Y herself said in her response to this review that she valued their efforts to assist her.
- The evidence that the GP, mental health workers at the mental health unit and in the crisis team and children's social care staff took steps to ensure as full an understanding as possible of Ms Y's culture and personal life story and their impact on her current problems and difficulties.
- The actions of the mental health nurse in discovering the risk to Ms Y and her children on the night of the incident.. This action is likely to have saved the lives of all the living members of this family.

4.4 There were missed opportunities to take action which might have reduced the likelihood of this incident occurring:

- A limited appreciation of past concerns when records existed on previous health care notes in the process of transfer to Bexley. An appreciation of past concerns in August 2007 could have altered the analysis of agencies involved.
- The absence of an initial assessment of need in June 2007 in response to the police referral following Ms Y's call to the police on 30 June 2007 as a result of the mis-filing of the police referral form.
- No consideration being given to undertaking a CAF assessment in relation to imminent homelessness in June 2007 or in relation to the visit to the GP in early August when possible mental health issues were first considered and the subsequent unsuccessful attempts of GP and health visitor to see Ms Y.
- Insufficient pro-active consideration or recording of the consideration of need for a formal mental health assessment in respect of Ms Y on 16 August 2007.
- The decision to change the level of risk in the mental health assessment carried out at the Mental Health Unit on 16 August 2007 to a low to medium risk level with little notice to children's social care services and the lack of a shared understanding of risk in relation to children..
- The decision to allow Ms Y to resume full time care of her children without some form of more planned phasing or more thorough assessment of likely risks to the children's physical and emotional well-being.
- The absence of a formal robust planning meeting between children's social care and adult mental health services to develop planning prior to or immediately after Ms Y's discharge from hospital on 16 August 2007.
- The acceptance by the mental health crisis team of Ms Y's account of going on holiday leading to a decision not to carry out a planned visit on 27 August 2007 and the failure to liaise with children's social care professionals about this.
- The inability of the Mental Health Unit to admit Ms Y as a former patient for an initial assessment when she presented at the door of the unit in the early hours of 28 August 2007.

4.5 A number of these problems have been highlighted in other Serious Case Reviews elsewhere. It is important that all should appreciate that the decisions facing professionals in August 2007 were decisions of the most complex kind. Questions of liberty of a woman recently bereaved but struggling to cope and questions of keeping families together were evident in almost all the discussions which did take place. Furthermore, all practitioners worked extremely hard and at great speed given the limited time available to undertake work in August 2007 in this case.

4.6 One further additional issue relates to the role of the church which Ms Y attended. Ms Y clearly stated to mental health staff at the point of her admission on 15 August 2007 that she believed that the pastor had told her that she had failed as a wife. It is unclear whether this is what the pastor said or the context in which it might have been said but in view of the need to be sure of this issue for the safeguarding of other children, it will be important that some discussion with the church takes place around this issue and general approaches and procedures towards safeguarding children.

5. RECOMMENDATIONS

5.1 The recommendations arising for consideration and action from this Serious Case Review are:

1. The Bexley and Greenwich Primary Care Trusts should together work to ensure speedier transfer of patient records when required between the two respective practices and should address the question of sharing information between the practices when requests for information are made by one or the other practice.
2. The Bexley LSCB and Children's Trust arrangement should ensure that in implementing the Common Assessment Framework, questions of children's needs arising from homelessness or adult mental health issues, attendance or leaving school without an adult in the case of young children and bereavement issues are prioritised for attention at an appropriate level. The former of those issues will also involve the LSCB needing to consider how it implements the CAF in relation to decisions affecting children about families becoming intentionally homeless as defined in homelessness legislation.
3. Additional multi-agency training should be offered to ensure that there is a shared understanding of risk and the impact on children of parental mental illness between across all agencies responsible for the welfare of children and adult mental health services
4. The Bexley LSCB should persevere with efforts to engage all faith organisations in contact with Bexley residents in developing effective procedures and practice with regard to the safeguarding of children and support of vulnerable families. The Bexley LSCB should ensure that its work in relation to faith organisations and any work in relation to that involved in this case are notified to other LSCBs as appropriate bearing in mind the mobility of faith groups and many people living in London.
5. Mental Health Assessments:
 - (i) The Bexley LSCB should ensure that whenever a mental health patient service user or customer expresses ideas of harming children there should be a meeting held with Children's Social Care services, the local police child abuse investigation team and other involved agencies to review risk to the children and to inform a subsequent assessment by child protection agencies where appropriate.
 - (ii) Work to continue in respect of joint assessment arrangements between adult mental health and children's services to ensure that the work already underway since the original SCR is further progressed.

- (iii) Wherever a psychiatric patient is being discharged from hospital, and there is a recent history of possible concern to children, Bexley Council should ensure that its staff assess the needs of the children for support or protection or both before the discharge happens or on the same working day or next working day if the former is not pragmatically possible.
 - (iv) Wherever there is a future request for a potential or possible mental health assessment concerning possible compulsory detention in hospital, the Oxleas NHS Trust should ensure that a formal and clear record is made of why such an assessment is not carried out whenever this is the clinical decision in cases where the adult patient or service user is in significant contact with children.
 - (v) The Oxleas NHS Trust should ensure that its crisis teams contact the Council's emergency out of hours service for children and families whenever it is working with families where a parent or carer appears under undue pressure when working out of hours.
 - (vi) The Oxleas NHS Trust should ensure that in all forms of mental health assessment, the family GP and previous records are consulted wherever possible.
6. Bexley Council should ensure that all new information about cases is reviewed by a social worker or manager and not filed without such review.
7. The Metropolitan Police Service Detective Inspector in charge of the Child Abuse Investigation team in Bexley should bring to the attention of senior officers in the police service Child Abuse Investigation Command (SCD5) the need to consider the question of ensuring that referral information is sent to the correct local authority when reviewing the current South London Joint Location and Referral pilot project bringing together child abuse policing services across a number of London boroughs.
8. The Oxleas NHS Trust should consider how best to deal with former patients reporting to in-patient units and devise a means of ensuring that any such callers (to in-patient units) arrive safely at the Psychiatric Emergency Assessment Team service at the A and E next door and are not simply told to find their own way there.

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