impact or risks deriving from mental health on Child I

Key recommendations

Guidance on the use of Common Assessment Framework (CAF) should be issued to make it an explicit requirement that professionals working with pregnant women under the age of 18 should discuss with the young woman (and her partner if appropriate) whether a CAF should be undertaken

If the young woman is found to be a child in need she should be referred to the local authority for initial assessment. If there is suspicion of risk of significant harm the unborn baby should be referred under child protection arrangements.

Reinforce the need to consider the use of child protection procedures when a young person (including those age 16 and 17) who has an adult partner is notified or referred as a victim of domestic abuse.

Ensure that managers of child protection work in all member agencies are properly equipped to assess and manage risk in child protection work where domestic abuse is a concern. There should be a multi-faceted approach, which reflects the very high percentage of referrals that have domestic violence as a feature and should include briefing, training, supervision and making available relevant research.

Ensure that the draft Surrey MARAC guidelines are completed and published as quickly as possible.

Ensure that the outcomes of all child in need meetings are properly recorded and that all participants are given a copy of the plan and the actions agreed

Written agreements made in child protection and children in need cases should always involve all professionals involved in the work to safeguard the child and be circulated to them

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surrey safeguarding CHILDREN BOARD

LEARNING FROM A SERIOUS CASE REVIEW

Child I

www.surreycc.gov.uk/safeguarding

The SSCB conducted a serious case review of the services provided to an infant Child I, who died in late 2009 while in the care of the mother.
The SCR also concerns the services provided to Child I's mother whilst she was herself under 18.
The SCR followed the guidance contained in 'Working Together' and covered the work of the agencies in Surrey, two other local authorities and one other Police service.

Synopsis

Child I lived in Surrey during the period under review but for significant periods child I's mother stayed with or visited child I's father in a neighbouring area.
Child I's mother had significant difficulties in her behaviour and learning, including missing education. Her chaotic behaviour led to her putting herself at risk. Child I's mother was hospitalised following two reported overdoses. Neither Children's Services nor CAMHS were effectively able to engage with the family.
Child I's mothers' relationship with child I's father was marked by violence and domestic abuse. After Child I's mother's contact with father ended, she began a relationship with a new partner who also had a confirmed history of domestic abuse.

Key Lessons and Practice Implications

Individually professionals became aware of mothers difficulties, problems with housing, her previous partner's violence and some of her history of mental health problems, based on information provided by Child I's mother. However: there was very

- little communication between the professionals,
- no professional adopted any overall responsibility for coordinating care and
- professionals were only aware of history that was contained in their own agency history or in their own referral papers.

A number of agencies recognised mother's vulnerability as a pregnant teenager but services were poorly coordinated. Child I's mother was not recognised as a child in need in her own right, Periodic CIN review meetings would have ensured that all professionals involved had a shared understanding of mothers needs and that there was a coordinated approach to the problems.

Work with the family was made more difficult because the mother of Child I, her male partners and other members of her family did not readily cooperate with agencies and were difficult to engage.
At times information was withheld from agencies or information was fabricated. This presented a particular challenge to workers and highlights the need for a high level of good quality supervision to ensure that this complicating factor has been considered, that family members are challenged and that the lack of cooperation has not lead to risk to children being underestimated.

At the time when Child I's mother was pregnant there was enough information to indicate that she would need support in becoming an effective parent and that her infant might be at risk of significant harm. There needed to be a thorough pre-birth assessment of need and risk
The SSCB launched two guidance documents during early 2009 at the time when some of the critical decisions were being made on this case. multi-agency guidance for staff on domestic abuse (dated April 2009) and pre-birth assessment (March 2009).If they had been followed the steps taken to manage this case would have been very different.

A principle concern is that the significance of incidents of domestic abuse was not appreciated by staff and managers who were responsible for assessing the nature and level of risk to Child I. Staff faced two particular challenges common to many cases. The first is the difficulty created for staff working with a victim who repeatedly puts herself and her baby at risk, despite clear advice not to. The second is the danger that professionals may be drawn into focusing just on the victimisation of the woman and treat the man as 'the problem'. In doing so they may lose sight of the potentially devastating consequences for the child**.**

Two sets of concerns about the operation of MARACs were identified firstly failures in communication of information about incidents of domestic abuse to staff dealing on a day to day basis with the case; secondly concerns about the operation of MARAC panels when a victim of abuse is moving across geographical boundaries and the difficulty of identifying all of the professionals who need to be involved in discussion about the case

There were numerous points at which a mental health assessment was identified as being needed, but the CMHTs were unable to engage Child I's mother. The mother's GP was treating her for depression however there was no clear understanding of the potential