

3. Where local protocols exist they must be followed. There is a responsibility on agencies to ensure their staff know about arrangements. This is the basis for good interagency planning which would have offered support, monitoring and relapse identification within the community.

What are the practice implications for me?

Professionals should read and understand the social care and mental health joint working protocol

4. Efficient systems of communication both between agencies and within agencies are fundamental to developing as full a picture as is possible

What are the practice implications for me?

Professionals should ensure that good and efficient systems of communication are established between agencies

A professionals summary of the Serious Case Review is available from:

Judy Jones
PSCB Policy Officer
Email: judy.jones@peterborough.gov.uk
Telephone: 01733 863745

PSCB/SCR01
(2008)



HIGHLIGHTING LESSONS FROM T FAMILY SERIOUS CASE REVIEW

SYNOPSIS

On 1 March 2007 a mother was believed to have committed suicide after she had apparently smothered her two sons aged 5 and 2½ years.

Mother had a history of depression. She regularly visited doctors however her concerns for her health were not usually verified by medical diagnosis and not significant enough to warrant hospitalisation. Once she became a mother her concerns about health became related to her children. In 2005 she attempted to strangle herself and threatened to kill the children because she believed them to be seriously unwell. This led to an emergency admission to a psychiatric unit where she remained for a month during April and May 2005.

She was discharged as she was considered no longer to be a threat to herself and her children and by November 2005 mental health services ceased. The health visiting services were not informed of the admission or involved at the time of discharge at the time of discharge from hospital and Children's Social Care were not informed at anytime of the circumstances of Mother's mental health problems or of her threats to harm the children

The GP and health visitors maintained a basic level of involvement with the family, although once the mental health episode had passed, no child care or other child protection concerns arose. There was some evidence in early 2007 that Mother's anxiety about the children's health was returning, however this was not seen as being severe enough to warrant a further referral to the mental health services. Her husband had recognised she was becoming unwell and they had agreed she should contact the relevant health professionals which she did. However, no links were made back to the previous episode and her current presentation was seen in isolation. These contacts were just 9 days before she took her life.

THE SCR CONCLUDED

"A more co-ordinated approach, which included child focussed interventions, could have effectively addressed the overall family's needs, and more specifically, those of the children"

LESSONS LEARNED

These lessons apply to ALL agencies

1. Where there is a lack of planned focus and co-ordination of services coupled with the lack of any assessment and failure to pass on key information the delivery of services will inevitably be compromised.

What are the practice implications for me?

Professionals must ensure that key information is shared with agencies and that assessments are undertaken

2. The complexities of working with parents with mental illness cannot be minimised and it is important that there is a routine consideration of the needs of children, including their safety and the capacity of their parents to meet those needs.

What are the practice implications for me?

Professionals must ensure that they understand the complexities and issues of working with parents with mental illness. As a matter of routine, the needs of the child should be considered.