Serious Case Review on W Family
1. Introduction.

Ms W, the mother of AW and BW, is thought to have killed her two children prior to taking her own life. At the time of this tragic incident the children were aged nine and three. Ms W had left a number of notes indicating her intention to take her own life. The family were experiencing housing issues and were living in temporary accommodation provided by the Royal Borough of Greenwich through their Housing Options Support Service (HOSS). Five days before the tragic event, Ms W had been notified that the Independent Review was likely to uphold the decision made by Greenwich that she was Intentionally Homeless. The family had moved five times in a period of three months (June – August 2016). There were also questions about whether Ms W had debts, which she was worried about.

The Greenwich Safeguarding Children Board (GSCB) in consultation with the relevant agencies recommended that the case met the criteria to carry out a Serious Case Review (SCR) as set out in Chapter Four of Working Together to Safeguard Children. The Independent Chair of GSCB endorsed this decision. The purpose of a SCR is to seek to understand what happened and why it happened in the context of local safeguarding systems, rather than solely the actions of individuals relating to a single case. The case under review is an example of local working arrangements at the time that the work was undertaken. It was agreed that the timeline for this review would be from April 2015 – January 2017. The Terms of Reference and scope of the review were agreed and are set out in Appendix 1.

The case is subject to a Coroner’s inquest, the Coroner set out a number of lines of enquiry that the inquest would pursue; these are included in Appendix 2. The Coroner also instructed that the suicide notes should be made available to the Serious Case Review Panel.

Much of the background information concerning the family was obtained from Police statements prepared for the Coroner’s Inquest by family members and friends and would not have been known by professionals working with the family at the time. The professionals working with the family were: staff at the school and nursery, housing and health. Information that was not known at the time has been put in italic for ease of understanding. Other sources used to inform the report were provided from a chronology of agency contacts with Ms W and her family or between agencies by the key practitioners involved. This was used to create the Timeline for analysis. Stakeholder agencies provided Independent Management Reviews (IMRs) describing and analysing their agency involvement and work in a systemic way.

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1 Intentionally homeless means that you could have avoided becoming homeless.
2 Working Together to Safeguard Children, 2015: Published by the Department for Education for HM Government.
A Serious Case Review Panel with two Independent Reviewers and representatives from the key agencies who are independent of the service delivery or direct management of the case analysed the material. Where necessary, the Panel sought clarification about information or actions.

A Serious Case Review should avoid hindsight and seek to learn from what information was available and known, or what practitioners could have known at the time that they made their assessments and plans. It should also be proportionate. Its purpose is primarily to learn about how local safeguarding systems were and are operating and if any changes may be required as a result of the wider lessons from the case.

2. Executive Summary and Key Lessons

Case History: Ms W reported that she had an unhappy childhood as a result of problems that her parents had had. An assessment was undertaken when she was a child and it concluded that the threshold for child protection had not been met.

Ms W had been in a relationship with the father of both children from the age of 14 years until October 2015 when at the age of 25 she asked him to leave the family home. There had been some volatility, which had been referred in 2010 to both the Police and Children’s Services. Professionals involved formed the view at the time that Ms W tended to minimise the marital difficulties, and did not want to take matters further.

Ms W also claimed that she had felt depressed from the age of 14 and had suffered from postnatal depression after the birth of both children. However, Ms W turned down any additional support offered to her including Early Help and appeared to be coping with the circumstances that she found herself in.

In the months leading up to this tragic event Ms W had been experiencing housing problems and was living in temporary accommodation provided by the Royal Borough of Greenwich through their Housing Options Support Service. HOSS is set up to prevent homelessness wherever possible. HOSS deal with about 10 ‘homeless families’ a day and have a caseload of 500 families. The family had moved between privately rented accommodation and Local Authority (LA) housing in the Royal Borough of Greenwich and the London Borough of Bexley. The family moved five times in under three months from June – August 2016.

Five days before the fatal incident Ms W had been informed that the Independent Review carried out by the London Borough of Southwark, at her request, was likely to uphold the decision of Intentional Homelessness and outlined the reasons for this. This was not the final decision and Ms W was invited to make further representation about her circumstances. However, it is not clear whether Ms W was aware of what help could be offered to her by services regarding her housing needs. It was also thought that Ms W was in debt although this had not been substantiated, nor the possible cause of the
debt identified. Ms W was known to have a car and reference is made to parking fines that were not paid immediately and the amount owed spiralled very quickly. Family members also assisted financially when they could.

Ms W was reportedly in a recent relationship with the ex-partner of a friend. She became pregnant; understood to be as a result of the relationship. Ms W experienced a miscarriage in January 2017. On two occasions, in the 15 months up to the deaths, Ms W had expressed ‘feeling suicidal’. The first was over the phone to the Department of Works and Pensions (DWP) in October 2015 when she was querying why her benefits had been stopped and she said that ‘she owes so much money there was no point in going on for her or her children.’ This was appropriately referred by the Department of Works and Pensions to the Police, who followed it up with a welfare check\(^3\). Ms W explained to the police that she was frustrated with DWP after her benefits were cut but had no intention of harming herself or the children.

The second time was when she had a phone consultation with her GP in August 2016. The GP made an urgent referral for a Mental Health Assessment (MHA) for low mood and thoughts of suicide. The Mental Health Assessment concluded that there was no suicidal ideation and the plan was for Ms W to see her GP for follow up and that the GP could prescribe antidepressants. Ms W again contacted the GP by phone requesting a prescription for antidepressants; an appointment was made for a face-to-face consultation in order to reassess her mood prior to commencing the antidepressants, which Ms W did not keep. A letter was sent by the GP practice asking Ms W to contact them, this was during the period when the family had moved five times in three months. It is now known that the letter was sent to an address that the family was no longer living at, as Ms W had not notified the practice of her new addresses.

The children were described by the school and nursery as being well cared for and having no problems. They appeared to be happy and talked about family life, revealing no concerns. AW had attended the same school from Reception class, there were no concerns identified by the school and AW was making good progress. BW commenced nursery in April 2016 (the nursery was not attached to the school) and attended term time only for two half days (1-4pm) and all day on a Friday (9-4) BW was funded for his term time place under the two-year-old funding scheme which was awarded for economic reasons. There were no concerns in relation to BW. Neither the school nor the nursery staff saw anything to suggest that Ms W might be struggling to cope with the children or any signs of depression. There were no concerns about their care and Ms W came across as a competent parent, there were no visible signs of neglect or of harm to the children. AW was occasionally late for school; her mother drove her to school and sometimes got caught up in traffic.

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\(^3\) The term ‘welfare check’ has become established as common parlance across all UK police forces, applied when an external agency requests that police visit someone who is believed to be vulnerable, or at risk for a wide variety of reasons. In the majority of cases the responsibility for these checks, or the management of the specific risk or vulnerability should not fall to the police. (Briefing note Metropolitan Police 2015)
Ms W and her two children were found dead by the police in their temporary house, empty packets of over the counter sleeping tablets and painkillers were found alongside a two-thirds empty bottle of methadone. A series of messages were written on the wall with reference to betrayal and loss and personal letters to family members explaining her actions were found within the property.

The toxicology reports state: Ms W: Methadone detected in the blood at concentration that lies within range encountered in fatalities. A significant amount of alcohol was also detected. AW: Methadone detected in blood at concentration that would have yielded toxic effects, if not a fatal outcome. Diphenhydramine was detected in higher quantities than a therapeutic dose. BW: Methadone detected in the blood at concentration that lies within range encountered in infant fatalities. Diphenhydramine was detected in higher quantities than a therapeutic dose.

Ms W was not prescribed methadone.

**Key lessons: Headlines.**

*Understanding the Impact of a Parent’s Mental Health on the Children and how professionals should ‘Think Family’ in order to better understand the possible wider impact and risk within the family.*

*When children do not attend or there are repeated cancellations and rescheduling of appointments professionals should be curious about why and move away from the term ‘did not attend’ to ‘was not brought’.*

These key lessons will be discussed more fully in the report.

**3. Family details**
4. Ms W’s, AW and BW profile.

4.1. Ms W
Ms W was a white British woman and had lived in southeast London all her life; she had attended local schools and went on to attend college. Ms W appeared to come from a close-knit family who were supportive to one another. Ms W’s parents continued to have health and social needs in adulthood. Ms W was not a drug user but expressed worry about possibly becoming dependent upon drugs and was wary about drinking alcohol although she did drink occasionally. Ms W had a number of stress factors that she was dealing with in the months leading up to the incident: a relationship with a friend’s ex-partner that resulted in a pregnancy and subsequent miscarriage, homelessness, possible debt and the loss of the friendship with her ‘best’ friend who had previously provided a lot of support to Ms W. These were combined with an underlying ‘depression’ which seems to have continued following the birth of the second child; she reported having post-natal depression with both children to family, but not to professionals.

The few practitioners who had met Ms W described her as polite but she did not share her world with professionals. It is unclear as to whether she was protecting her privacy or was wary about sharing information with professionals for other reasons. When Ms W did divulge information or reported domestic problems she tended to minimise these. She did not tell the school, nursery or GP about the frequent changes of address or any stress or debt problems, or risk of homelessness.

On both occasions when she was reported to be ‘suicidal’ she quickly refuted that she meant it and maintained that she had said it more for effect. While the children were at school / nursery Ms W spent a great deal of her day times with a friend from childhood; this friendship ended shortly before the incident occurred. Ms W appeared to have a good relationship with her ex partner’s sister (paternal aunt) who she stayed with shortly before the fatal incident. She also had regular contact with her own family, who saw no signs of her being suicidal.

4.2. AW.

AW was a nine year old girl of mixed heritage. AW had attended the same faith school from September 2012 when she joined Reception class. During her time at the school she was described as popular with her peers, a smiley child and was talented at art. AW went on ‘sleepovers’ with her friends. AW talked at school about her grandparents and about her father and brother BW, and about days out with the family. She was performing at expected academic levels for her age, was well behaved and her attendance record was good.

When Ms W told the school that she had separated from AW’s father, the school arranged four 1:1 therapeutic play sessions for AW; and there was nothing about her in these sessions, which would suggest that she was unhappy. The staff had no concerns for AW’s wellbeing.
4.3. BW.

BW was a three year old boy of mixed heritage. BW started at the nursery school in April 2016, at the time he was described as unconfident and a solitary child. During his time at the nursery he had grown into a confident and chatty child who enjoyed imaginative role-play and making things. He was described as a ‘smiley boy’ because he was always smiling. BW was a happy, healthy three year old, who was reported to have had a strong bond with his mother and sibling; he didn’t talk about other family members. BW was always well presented and was never angry. BW was slightly behind in his language skills and social interactions for his age but the Nursery staff had no concerns for BW’s wellbeing, or his care.

5. Timeline and Key Events

Prior to the timeframe for this SCR, Royal Greenwich Children’s Services received a copy of a notice of eviction letter for Ms W from Housing Options Support Service on the 29/01/15. A contact and referral episode was created and a letter sent to Ms W reminding her of her responsibility towards AW and BW and inviting her to contact Children’s Services if she needed assistance. This episode was closed on the same day. Ms W then made a self-referral on the 20/02/15, as the family was homeless. A Child and Family Assessment was to be completed however this assessment was closed six days later without completion as Ms W stated that she was receiving support from her friends and family to access private rental accommodation. The case was closed on the 02/03/15.

The timeframe of public agency involvement with the Family being reviewed has been divided into four phases:

Phase 1 April 2015- December 2015

In April 2015 the family moved from Thamesmead to Abbey Wood. At the point at which the family moved into the area covered by the East Greenwich Health Visiting Team the Health Visiting records reveal that Ms W had a past history of vulnerabilities which included growing up with parents with health and social problems, brief involvement of Social Care in another local authority in her childhood. Later she experienced some difficulties around her mental health, including post-natal depression following the birth of both her children. It was also recorded that the family had financial and housing problems.

The family had been in receipt of the Universal Health Visiting Service following the birth of BW. At the time, this decision was made the Health Visitors

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4 Advice, information and signposting to help and support for the child and family: Protocol for assessment and threshold guidance-Royal Greenwich Children’s Services, 2015.

5 “The universal level of service is offered to all children, young people and families. This includes offering the Healthy Child Programme, signposting and referring, and monitoring referrals to other professional groups”.

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considered that there was no information that was made available to them during their contacts with the family to put them onto a Universal Plus\textsuperscript{6} caseload. They made this decision based on no concerns being identified and Ms W “presenting normally”. However, if they had asked more questions, especially about previous vulnerabilities and followed up post-natal mental health systematically further information could have been collated to potentially inform this decision.

There was an opportunity at the point of moving in to the area to review the offer of a Universal service but because the family moved within the Greenwich borough, the Health Visiting Standards at the time were, that contact was made by phone rather than a home visit (this is still the case). During a telephone conversation with Ms W she informed the Nursery Nurse (NN) that BW was under the dietetic service for possible cow’s milk protein allergy and was currently on antibiotics for a urinary infection. Information was sent to Ms W about Child Health Clinics in the local area. BW was discharged from the dietetic service in August 2015 as he ‘failed to attend’ (was not brought). The Did Not Attend (DNA) policy states that a letter is sent and if there is no response then there is no further follow up.

At the end of October 2015, a member of the Department of Work and Pensions (DWP) staff called the Police to report concerns for Ms W after she had told the worker on the phone, in a conversation about her benefits being stopped, that “she owed so much money there was no point going on for her or her children”. Police Officers attended the family home and completed a welfare check. Ms W explained that she had become frustrated with the DWP after they had cut her benefits. She stated that she had no intention of harming herself or her children but was pleased that it provoked a reaction from DWP to respond to her. She reported that her benefits were going to be re-instated in a couple of days and she had secured a loan from a friend in the interim. The Police Officers were satisfied that there were no immediate concerns. A Merlin report\textsuperscript{7} was created and shared with Royal Greenwich Children’s Services on the same day.

Royal Greenwich Children’s Services undertook agency checks and reviewed the information and made a referral to the Early Help Service to assess what support Ms W may require.

In November the Early Help Service sent a referral to the Health Visiting Team and advised the Health Visitor (HV) to follow up with the family. This was another opportunity for the Health Visiting team to undertake a home visit to assess the needs of Ms W and her children and review the need for support. However, the Health Visiting Team contacted Ms W by phone and accepted her assurances that she was all right. Following this discussion, the Health Visiting

\textsuperscript{6} Universal plus service is offered to all children, young people and families who have been identified with additional needs and/or risk factors, who may require short-term interventions or longer follow up.

\textsuperscript{7} Merlin is the name given to the police system used to record and notify the local children’s services of incidents to which the police have been called where a child was present. The notification is sent irrespective of whether the incident related to the child. The child’s presence is sufficient to trigger a notification.
plan was for the Nursery Nurse to contact Ms W in December 2015 to arrange BW’s 2-year developmental review; this seemed appropriate.

Ms W had a termination of pregnancy in November 2015 following the failure of the morning after pill.

Ms W did not bring BW to his review on three different occasions. On the third appointment Ms W arrived late and the review was unable to be completed due to the fact that the Nursery Nurse needed to be at another appointment; Ms W was offered an appointment for three days later which she subsequently cancelled and requested another appointment. There appeared to be no professional curiosity as to why the appointments were not kept by Ms W and there has been no evidence found whilst conducting this review that professionals considered the significance of these missed appointments, or that this may have been disguised compliance.  

In the middle of November the Police completed a second Merlin (five weeks after the first one) when Ms W reported that the father of the children was outside the property and was angry as they had separated (but had remained living together in the property) and she had finally asked him to move out the previous day. The Merlin was received by Royal Greenwich Children’s Services but was not uploaded on to the electronic file.

The Early Help Practitioner had difficulty making contact with Ms W. When contact was made Ms W declined an Early Help Assessment. However, Ms W was offered further advice on accessing the Together for 2’s nursery provision and the case for Early Help was closed at the end of January 2016.

**Phase 2 January 2016- May 2016**

In January 2016 BW attended Queen Elizabeth Hospital Emergency Department, following an accident on a climbing frame and the Health Visiting Team were notified. This prompted the Nursery Nurse to contact Ms W by telephone, a message was left asking Ms W to rearrange the overdue developmental review for BW and contact the Health Visiting Team; this did not happen and was not followed up by the Health Visiting Team. BW started Nursery in April 2016.

In April, the mother attended the Housing Options and Support Service and completed a Client Housing Information Form (HOSS1) detailing her housing situation; her landlord, who had applied for a Possession Order due to rent arrears, had served her with a Section 21 Notice (Notice to Quit). Ms W had acquired the privately rented property by making a false declaration about her income but it was now unaffordable. Ms W had been looking for alternative private rented accommodation but had been unsuccessful. Ms W cancelled the follow on appointment with Housing Options and Support Service and did not attend a further four appointments. In early May the caseworker sent the mother a ‘Minded to’ letter (This is a letter HOSS use when they have completed  

8.involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention
enquiries and before issuing a decision that the applicant has made themselves ‘intentionally homeless’). This is the second time that the mother engaged with a service seeking support and then did not follow through with the scheduled appointments.

The Housing Options and Support Service officer made the appropriate level of contact and carried out enquiries as per legal and good practice requirements. An “intentionally homeless” decision would mean the Council does not have a duty to secure permanent accommodation but would have limited duties to provide temporary accommodation for a reasonable period. When the Housing Options and Support Service are due to make a negative decision, which states that a family is “intentionally homeless’ a ‘Minded to’ letter is sent giving the applicant the chance to make further representation. This gives the applicant the opportunity to provide any extra information, which may change the decision and gives them the chance to offer mitigating information and factors defending their actions.

The Housing Options and Support Service officer recognised the risk that the family would be homeless and on that basis referred to Royal Greenwich Children’s Services Multiagency Safeguarding Hub, as there were dependent children in the family. There is a Joint Working Procedure with MASH for Intentionally Homeless cases which is currently being updated.9

Phase 3 June 2016- September 2016

By the middle of August the investigation into homelessness was concluded and the finding was that Ms W was Intentionally Homeless; a letter was sent outlining the decision. The Housing Options and Support Service moved the family on the same day to a three-bed roomed property in Woolwich for an interim emergency period. Royal Greenwich Children’s Service was notified and a Contact and Referral episode was opened and a letter was sent to the family offering support and then closed the same day, as was the standard response to eviction by Royal Greenwich Children’s Services, at that time.

Ms W submitted a request for an Independent Review of the Intentional Homelessness decision to be carried out and cited delays with payment of her housing benefit and the arrangements she had tried to make to clear her rent arrears in mitigation of her circumstances.

9 FAMILIES WITH CHILDREN UNDER 18
11.29. It is important that social services are alerted as quickly as possible to cases where the applicant has children under 18 and the housing authority considers the applicant may be homeless, or threatened with homelessness, intentionally. Section 213A(2) therefore requires housing authorities to have arrangements in place to ensure that all such applicants are invited to agree to the housing authority notifying the social services authority of the essential facts of their case. The arrangements must also provide that, where consent is given, the social services authority are made aware of the essential facts and, in due course, of the subsequent decision on the homelessness case.
In the middle of August Ms W had a telephone consultation with a GP. She told the GP that she was depressed and felt suicidal. The GP was unaware of the previous occasion when she expressed suicidal thoughts to the Department of Works and Pensions worker over the phone. The GP made an urgent referral for Ms W to have a Mental Health Assessment (MHA) as Ms W was expressing low mood and had thoughts of suicide. Ms W collected the referral letter, which included that she was the sole carer of her two children from the GP surgery later that day (it is unclear as to whether she was seen by a GP at this time or collected the referral letter from the reception area in the practice).

Ms W presented herself at Queen Elizabeth Hospital Emergency Department (QEH ED) BW was with her, a Mental Health Liaison Psychiatric Nurse carried out a Mental Health Assessment and recorded:
- Previous history of depression from 14 years of age
- The circumstances that she has experienced over past six months have made her feel low.
- Made homeless by her landlord; housed in temporary accommodation
- Feels stressed and under pressure and what will happen to her and her children in 20 days time
- Separated from her partner in 2015
- Ms W sometimes felt like drinking alcohol to cope with stress but considered this as not a good option and did not want to become drug or alcohol dependent (*she had seen the impact of this in others*)
- Things are out of her control- started crying when she would not normally do so
- States her children are her protective factor
- No report of psychotic symptoms or delusions, denied any regular use of alcohol
- No suicidal ideation

The plan was for Ms W to see her GP for follow up and that the GP could prescribe antidepressants, if necessary. The Adult Mental Health Liaison Administrator sent the Care Plan and discharge summary to the GP electronically.

The assessment completed by the psychiatric nurse was comprehensive and the risk assessment took in to consideration the fact that the Ms W was stating that the children were her protective factor. The psychiatric nurse could have explored Ms W’s family background including the level of support that they provided as well as any other support networks that were available to Ms W and her children. (*Children should never be considered a protective factor for parents who feel suicidal*)

Ms W again had a telephone consultation with the GP the next day, and requested anti-depressants, the GP asked Ms W to come in for a face-to-face appointment, which was appropriate. This appointment was not kept and although the GP practice sent a routine Chase Up Letter to Ms W at her home address asking her to contact the GP practice there was no response. It is now known that Ms W had not given the practice her latest address. The practice did not to follow this up further and this was a missed opportunity to get a better understanding of Ms W’s mental wellbeing and to consider
safeguarding in relation to the children. Whilst recognising that there is no national framework in place that outlines the GP responsibility to consider dependents of patients, the National Society of Prevention of Child Cruelty (NSPCC), identified from learning gained from a number of serious case reviews that GP’s must:

‘Always ask patients with mental health difficulties, learning difficulties or drug and alcohol misuse whether they have significant care responsibilities. Consider their capacity to care for children safely. Record this information in medical records and emphasise it in referrals and correspondence about patients’

It is worth noting that over the course of the timeline Ms W had 27 consultations with her GP, only four were face-to-face consultations. This included four requests for Emergency Contraception when she was prescribed the morning after pill. This method of contraception failed on one occasion, which resulted in a termination of pregnancy. AW was not seen by the GP during the timeframe of the review and BW was not registered with the practice.

As a result of the mental health consultation, the Sister in charge at the Emergency Department (ED) at Queen Elizabeth Hospital sent a modified Common Assessment Framework (CAF) for Emergency Department referrals to Royal Greenwich Children’s service Multi Agency Safeguarding Hub. The form indicated that this form had also been shared with the Health Visiting and School Nursing Services (but there was no evidence found during this review that it was shared). Although at the time there was a Liaison Health Visitor in post the review has been unable to determine whether this case was discussed with the post holder. The information that was shared on this form was limited and did not include the details of the Mental Health Assessment, set out above; meaning that vital information was not shared with Multi Agency Safeguarding Hub. When the referral was received the Administrator within the Multi Agency Safeguarding Hub Team sent an email to the Social Care Practice Manager (PM) who outlined in an email, the need for a Contact and Referral episode to be created and allocated to a social worker for further follow up in gathering information, completing a risk analysis with the view of making a recommendation on whether a Child & Family Assessment was required. Mistakenly this information was not viewed as a new referral, the Team Administrator added it to the Contact and Referral episode opened and closed on the 15.08.16. (Two days earlier); hence the case was not re-opened and the proposed action was not followed up. This was a missed opportunity to make contact with the family.

Changes have already been implemented within the Multi Agency Safeguarding Hub in that all managerial decisions are now recorded on Framework-I (the electronic case record system) and not in separate emails; which will reduce the chance of human error.

The psychiatric nurse was aware that the referral had been made to the Multi Agency Safeguarding Hub by the Sister in the Emergency Department but did not record this information on the health RiO system (electronic health records). The Mental Health Assessment was recorded on Ms W’s RiO health records but the Health Visiting Team were unaware of this assessment as the psychiatric nurse did not send a form alerting the team to this assessment and the Health Visiting Team remained unaware of the Mental Health Assessment and that Ms W was feeling depressed.

At the end of August, the Health Visitors were identifying missed developmental assessments on their current caseload, the Nursery Nurse identified that BW was overdue his two year developmental assessment and was still not registered with a GP, a message was written in the Health Visitor communication book that a home visit was required. The message was not acted on. Systems are now in place to ensure the messages are actioned and signed off when completed. This was another missed opportunity to make contact with the family.


In October 2016 Ms W informed AW’s class teacher at a parent’s evening that she had separated from her partner, in fact they had been separated for over a year. AW was given four therapeutic 1:1 play sessions, during this time AW talked of a normal family life and no concerns were raised.

Ms W informed the nursery on the 16.01.17 that she was taking the children on holiday due to personal reasons for one week. About this time staff in the nursery had been made aware from another mother whose child also attended the nursery that Ms W was allegedly in a relationship with that mother’s ex-partner. The two mothers had been good friends and used to spend most of the day together at either the friend’s house or the friend’s mother’s house.

Ms W also informed AW’s school that the family were staying with her sister-in-law whilst dealing with housing issues and AW would be absent from school for one week.

It is now known (after the deaths) that the family went to stay with the paternal aunt, outside London, for one week as Ms W felt threatened following the disclosure of her relationship with a friend’s ex-partner. Ms W had talked with the paternal aunt about moving AW to a school nearer to where the aunt lived as she was finding it difficult to get her to her current school due to the traffic. Ms W also thought about moving away from Greenwich and making a fresh start. Ms W also disclosed to the paternal aunt that she was pregnant, later in that week she reportedly had a miscarriage.

On the 25/01/17, the London Borough of Southwark Reviews Team sent a ‘Minded to’ letter to Ms W (the Reviews Team had been commissioned to undertake the independent review of Greenwich’s previous decision of Intentional Homelessness). It stated that they were likely to uphold the decision of Intentional Homelessness and gave the reasons for this. Ms W was asked to
make any further submission within seven days, and that this timeframe was negotiable.

Royal Greenwich Children’s Services Multi Agency Safeguarding Hub was notified and sent out the standard response letter for pending evictions, which reminds the parents about the responsibility to provide accommodation for their children, and inviting Ms W to contact Royal Greenwich Children’s Services. Changes have been made to this process, in that staff working in the Multi Agency Safeguarding Hub now attempt to speak to the family directly following receipt of the notification from Housing Options and Support Service. The sharing information protocol between Housing and Royal Greenwich Children’s Services is being updated.

AW returned to school on the 26.01.17 and was present on the Wednesday, Thursday and Friday of that week. The staff had no concerns about AW on her return to school. BW returned to the nursery on the Friday, he was dropped off late and collected early, which was unusual. A staff member asked Ms W if she needed to talk to anyone, this was not because Ms W presented as depressed, sad or anxious on the day but because she had taken BW on holiday for ‘personal reasons’ and nursery staff knew that she was no longer friends with the mother who had told staff that Ms W was allegedly in a relationship with her ex-partner.

Ms W and her two children spent the Friday evening with the maternal grandmother and enjoyed a Chinese Takeaway meal together. Ms W told the grandmother that they were going to ‘chill’ over the weekend.

Ms W and her two children were found dead in their home on the Monday.

6. Family Views and Perspectives.

The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Letters were sent to key members of the family, including the children’s father, inviting them to contribute. Following a telephone conversation with one of the Independent Reviewers the family decided that they did not wish to be any further involved as it was too distressing and they wanted to respect Ms W’s privacy. In that conversation Ms W was described by her family as a strong person but a very private individual, who had been affected by depression since the birth of B. She also had housing problems. She was a good mother to her children. The family were close and had not picked up any signs of suicide.

In a brief conversation with one of the Reviewers the father said he would consider sharing his views. However, he did not respond to further attempts to involve him.

7. Practitioners’ and Managers’ Perspectives.
A half-day Practice Learning Event (PLE) was held on the 4.07.17 and was attended by 11 practitioners from the relevant agencies; the school and nursery were the only practitioners at the event who had met and knew the family. The Practitioners were given a summary of the timeline and a summary of the emerging lessons identified by the Serious Case Review Panel. The purpose of the Learning Event was to obtain the Practitioners’ experience of the case and understand the operation of local systems at the time the case was being managed to assist with understanding what happened and why.

**Debt:** The practitioners’ group had no awareness of any issues relating to debt, there were no visible signs of debt, Ms W ran a car, and the children were well dressed and looked well cared for. Ms W was always up to date with payments for BW’s lunch at the nursery.

**Geography:** it was noted the school and nursery were in different areas and different boroughs to the family home - lateness at school was not caused by Ms W taking BW to nursery as he went in the afternoons on Monday and Wednesday and all day on Friday.

**Mother’s network:** little was known about what Ms W did during the day, the school was aware that she did have a couple of friends and would chat with them in the playground. The nursery commented that she was ‘isolated’ although had a strong friendship with another mother who also had a child at the nursery. Little was known about the father of the children. The school was aware of the paternal grandmother’s link to the parish in Thamesmead.

Feedback from the Practitioner Learning Event was positive and for most of the attendees this was the first time that they had a full understanding of the events that led up to the tragic incident.

A comment was made by one of the practitioners at the Learning Event that ‘it is hard to imagine temporary accommodation being described as home.’

**8. Lessons learnt:**

8.1. **Understanding the Impact of a Mother’s Mental Health on the Children and how Professionals should ‘Think Family,’ in order to better understand risk within the family.**

*Published case reviews tell us that professionals sometimes lack awareness of the extent a mental health problem may impact on parenting capacity. This may result in a failure to identify potential safeguarding issues. The learning from these reviews highlights that professionals must recognise the relationship between adult mental health and child protection. Adult and children’s services need to work together to safeguard children when there is a parent with mental health problems. (NSPCC 2015)*

There were limited opportunities for a full assessment in this case and Ms W kept agencies at arm’s length, providing reassurance that she was managing
the situation. When the Department of Works and Pensions contacted the Police following Ms W stating that 'she owed so much money there was no point going on for her or her children' the police carried out a welfare check and were reassured that after speaking to Ms W that there was no immediate risk of significant harm and made the appropriate referral to Children's Services via a Merlin. It is always a difficult call for police officers when asked by other agencies to carry out a welfare check as they can only make a judgement based on the presentation of the situation at the time, and whether the children are at risk of immediate significant harm.

The Mental Health Assessment was thorough and the outcome of the assessment was that Ms W may benefit from commencing anti-depressants and should discuss this further with her GP. The psychiatric nurse who carried out the mental health assessment was unaware of the previous threat of suicide that Ms W had made to the worker at the Department of Works and Pensions. It might have been helpful if the nurse had explored what support networks Ms W had.

Some information was available to practitioners about her past mental health including: depression, post-natal depression and two episodes of ‘feeling suicidal’ although not all of the practitioners involved with her care had the complete picture. The first time that Ms W had threatened suicide the police completed a Merlin and shared it with the Multi Agency Safeguarding Hub. This resulted in a referral to Early Help, which Ms W declined. There is always a challenge to practitioners about accepting the self reported assurance, in this case by Ms W that all was well and that she had no intention of ‘taking her life’ Professionals should remain curious.

There was a missed opportunity to address Ms W’s depression when she did not attend the follow up face-to-face appointment arranged by the GP, following her telephone request to commence anti-depressants. While an adult may make such a choice not to attend a medical appointment the GP should have considered a referral to health visiting or other child based services in order to consider whether there was any impact on Ms W’s ability to care for her two children.

Services in health and social care are still predominantly commissioned for adult or children rather than for families, the consequence of this is that there is a danger that the impact of risk within the family is not fully understood which potentially leaves adults and children vulnerable. The challenge for the safeguarding system is how to break down professional barriers to achieve change in culture, so that all practitioners see their clients in the context of their family, including where a person with mental health difficulties has responsibility for the care of children or vulnerable adults. Services must ‘Think Family’ and be willing to work with other service providers. In this case there were risk factors present but they were viewed in isolation and as ‘one-offs’ and were mitigated by acceptance of the self-reporting by Ms W that all was well.

Information sharing did occur between some agencies when there were concerns about suicidal ideation. As already stated the two occasions when Ms W expressed feeling suicidal were not known by all of the professionals. In part
this was due to the fact that the circumstances did not meet the safeguarding threshold. The full understanding of the stresses surrounding the family were not known.

8.2. When children do not attend or there are repeated cancellations and rescheduling of appointments by parents professionals should be curious about why and move away from the response ‘did not attend’ to ‘was not brought’.

Recent research into health agency ‘Did not attend’ policies has shown inconsistency and that they can, at times, be a systemic defensive response by agencies to help manage large workloads.\textsuperscript{11} Non-compliance with appointments may be a parent’s choice but it may not be in the child’s best interest. Repeated cancellations and re-scheduling of appointments for children should be treated with curiosity. A shift away from using the term did not attend (DNA) to was not brought (WNB) would help ‘maintain a focus on the child’s ongoing vulnerability and dependence, and the carer’s responsibilities to prioritise the child’s needs. In some cases it may be considered a sign of neglect, although in this case there was no evidence of neglect.

In this case Ms W did not follow through on appointments for B on a number of occasions for the two year developmental assessment. Nor did she follow up the consultation with the GP for the possible prescribing of anti-depressants for herself. This raises questions about how busy services assess whether to terminate a service for either children or possible vulnerable adults after a failed appointment, or series of failed appointments.

8.3. Areas of Good Practice

The school provided 1:1 therapeutic play sessions for AW following the disclosure that the parents were no longer together. They clearly knew AW well and provided a comprehensive observation of progress and development during her time at the school. The family was very complimentary about the school.

Lisa Arai, Terence Stephenson & Helen Roberts; The unseen child and safeguarding: ‘Did not attend’ guidelines in the NHS; Archives of Disease in Childhood, March 2015; http://adc.bmj.com/content/early/2015/03/16/archdischild-2014-307294
The nursery provided detailed observation reports on BW and developmental milestones; and sought to reach out to Ms W in January 2016 to enquire if she needed assistance and wished to talk, as they were aware of stresses in the breakdown of her relationship with her longstanding friend.

The Police carried out two welfare checks on the family five weeks apart, one at the request of another agency and the second following a call from Ms W. The Police made an assessment of the situation at the time and made the appropriate referrals following completion of the visits. However, it must be remembered that a welfare check is only an interim, cursory and emergency measure, the Police are making a judgement as to whether the children are at risk of immediate significant harm on information before them – they do not have information on history held by other agencies.

The Mental Health Assessment was good; the problem was that it was not followed through.

The Housing Options and Support Service followed the National Code of Guidance for Intentional Homelessness and made appropriate referrals to Children’s Services, given that the family would be vulnerable if found to be intentionally homeless.

8.4. Care and Service Delivery Points.

The use of an internal email rather than recording directly on to the Royal Greenwich Children’s Services client database system led to an Admin / human error in Children’s Service which resulted in the second referral following the Mental Health Assessment, two days after the notification from Housing Options and Support Service, not being re-opened; despite there being actions to be under-taken. Royal Greenwich Children’s Services has now rectified this issue and all communication and management instruction is put directly on to the client database system.

The standard letter sent by Royal Greenwich Children’s Services when informed of a possible eviction of a family may not have been sufficiently encouraging to a parent to seek advice and support or how Children’s Services may be able to assist them. This approach has been amended and a revised Royal Greenwich Children’s Service – Housing Protocol is being brought into place. Children’s Services now seeks to make direct contact to speak with the parent in possible homelessness cases rather than relying on a letter.

Staff working for Oxleas NHS Foundation Trust followed the ‘Did not attend policy’ where-by one letter is sent to the parent and if no response there is no further follow up. This review has questioned whether this is an appropriate response when dealing with children (or vulnerable adults) and whether the Trust or Clinical Commissioning Group should consider a ‘was not brought’ policy for children and vulnerable adults.
The use of technology to aid communication and the better use of time such as, telephone consultations and Skype between patient and GPs is on the increase and therefore safeguards need to be built in to ensure that any early warning signs are managed safely and effectively.

GPs need to remember to consider what caring responsibilities people who present with mental health issues may have and the impact on their ability to care. There was insufficient curiosity about the possible impact on AW and BW – a ‘Think Family’ approach is needed – See the Social Care Institute for Excellence Guide: https://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp

GP practices must have a system to follow-up patients who fail to respond or do not present at booked appointments to review their mental health wellbeing; especially where that patient has responsibility for children or vulnerable adults. A Did Not Attend Policy of a simple letter giving one more chance to respond may be insufficient as a global solution.

An information sharing process is in place between community mental health and health visitors; the alert was not sent in this case and therefore the Health Visitor was unaware of Ms W’s depression.

Nurseries and schools should ensure that they have contact details for use in emergencies, and that addresses are checked, at least annually.

9. Conclusion.

The view of close family members was that in the final weeks after New Year Ms W was finding things tough but that she was coping and was looking forward to how life might be better.

Although there are a number of areas from this review where we have learned that practice to support parents with mental health and/or homelessness issues could be improved, the panel have found nothing to suggest that this tragic tragedy could have been predicted. Ms W was seen as a good mother who appeared to be coping with the circumstances that she found herself in. The children were well cared for and neither the school nor nursery staff had any concerns about AW and BW.

The family was assessed by the Health Visitors following the birth of B as meeting the Universal Health Visiting Service. Although there were some clear risks identified the decision was made to offer the Universal Service. It could be argued that some short term interventions with the family at this point under the Universal Plus service may have been beneficial, however this work would have been time limited.

Ms W was offered services or appointments on a number of occasions but chose not to accept them or follow them up. She was seen as competent in
managing her affairs, and professionals accepted her assurances that all was well and that she did not need any further help or support. The professionals who were in contact with her in the months leading up to this tragic event were not aware of all of the stresses that she was under, particularly around housing, the number of moves, an unexpected pregnancy that ended in a miscarriage, and the loss of a friendship that had provided a great deal of support to her over a number of years.

To those professionals who met her, who were few, she appeared to be a good mother, to be coping and to have (mental) capacity. Her care of AW and BW was good and they were happy children, developing well. There were no concerns about their care and wellbeing and their voices were appropriately heard through the school and nursery.

On the two occasions practitioners saw Ms W where suicidal ideation was a possibility she either retracted and/or was found not to be at risk of suicide. Although offered a follow up assessment for treatment for depression, possibly through medication, she did not follow this up.

Agencies did try to reach out to Ms W but although she sometimes agreed this on the phone she did not follow through these offers. There were no grounds, given her apparent capacity and the children’s good care to compel her to use services, under either children's or mental health legislation. The family met the threshold criteria for early help services, which were offered but declined, as Ms W said that she was receiving help from her family.

She has been described by family and friends who knew her well as a private person who, despite her depression, was resourceful and managed her life and parenting despite the increasing stresses.

There was no complete picture held by any agency of the stresses she was under or how they were affecting her mental health.

Her family's view was that her strong love for the children led her to take them with her when she could no longer face things and planned to take her own life.

10. Recommendations

Lesson:
Understanding the Impact of a Parent's Mental Health on the Children and how professionals should ‘Think Family’ in order to better understand the possible wider impact and risk within the family.

Recommendations:
1. The Greenwich Safeguarding Children Board had agreed work to implement a multi-agency ‘Think Family’ approach prior to the conclusion of this review. It is recommended therefore that the Board should complete introduction of that work by March 2018 and agree to review its impact by March 2019.

2. The Greenwich Safeguarding Children Board should ask the relevant Health Commissioners to review arrangements in GP Practices to ensure that the welfare of children is considered when assessing the mental health of parents and carers.

Lesson:
When children do not attend or there are repeated cancellations and rescheduling of appointments by parents professionals should be curious about why and move away from the response ‘did not attend’ to ‘was not brought’.

Recommendation:

3. The Greenwich Safeguarding Children Board should ask all agencies to review their policies for when children and vulnerable adults ‘do not attend’ scheduled appointments to ensure that in making a decision to terminate a service for non-attendance proper attention is given to the vulnerability of the patient or service user. For children an approach of ‘was not brought’ should be considered and a service should not be terminated without considering any risks of doing so.

Ann Duncan, Lead Independent Reviewer

November 2017
Appendix 1:  
Scope of the review

Agency Chronologies and Agency Individual Management Reports (IMRs) will cover from 1st April 2015 and conclude at the date of incident (30th January 2017). If agencies hold records on the parents and of the children prior to this period, the background information and a note of any significant involvement should be summarised in the IMR.

Methodology

A hybrid systemic model of analysing agencies’ IMRs and agency chronologies from a multi-agency perspective has been agreed. Practitioners who worked with the child or family in the period under review, and their first line managers, will be expected to contribute to the review, as set out below. This methodology is reflective of the principles set out in Working Together, as well as meeting the needs of Greenwich LSCB. In evaluating the work undertaken, judgement should not be based on hindsight but on the rationale for the actions taken at the time with the, then, known or knowable information. Hindsight may add to the lessons but not the judgements.

Any Actions identified from IMRs for each agency should be undertaken immediately.

The final SCR Report will be fully anonymised.

The SCR Panel will make recommendations to the GSCB about any actions, which are required, arising from the lessons learned.

The anticipated completion of the SCR will be September 2017 depending on progress of the reports and notwithstanding consideration of parallel processes, which may cause delay. Publication of the final report will be mindful of the timescale of the inquest.

Family involvement

Relevant family members will be informed of the SCR and will be invited to contribute to the process. Other family members or members of the family’s network will be invited to contribute as appropriate.

Staff involvement

Practitioners and their line managers, who were directly involved with the family, will be involved in the review through individual meetings with the IMR Authors within their own agency. There will also be a multi-agency Practitioners’ Learning Event, led by the Independent Reviewers. This will promote effective learning, and enable the collation of the practitioners’ perspective. The GSCB expects Agencies to release and support practitioners in contributing. The Practitioner Learning Event took place on the 5th July.
Membership of SCR Panel  Need to put full names in

Chair of Panel - Malcolm Ward, Independent Consultant

Author of SCR/Lead Reviewer – Ann Duncan, Independent Consultant

Greenwich Clinical Commissioning Group CCG- Anita Erhabor, Designated Nurse for Safeguarding

Greenwich Children’s Services – Henrietta Quartano Head of Quality Improvement

Oxleas NHS Foundation Trust – Jane Downing Head of Safeguarding Children, Lead Named Nurse

Greenwich Community Services, Carol Sewell Housing Access and Allocations Manager,

Metropolitan Police – Ben Voss Detective Sergeant, Specialist Crime Review Group

Pre-School Alliance- Lisa Graham

Education Commission Catholic Diocese of Southwark- Yvonne Epale, Education Officer

Greenwich Adult Safeguarding Service – Peter Davis Service Manager

GSCB Dan Timariu (left August 2017) Business Manager

GSCB – Zakk Cartlidge, Business Support Officer (minute taker)

Agencies to complete IMRs

Greenwich Children’s Services;

Greenwich Housing,

Oxleas NHS Foundation Trust

Primary Health Care/GP for children and parents

School

Nursery

Metropolitan Police Service

Greenwich Adult and Older People Services
Analysis of involvement

The individual management reviews need to consider the events that occurred, the decisions made, and the actions taken, which indicate that practice or management could be improved. Particular strengths of practice should also be acknowledged, where applicable. Consideration should be given to not only what happened but also why something did or did not happen. Consider the following areas:

Events in the case

What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family?

Professional awareness – was this sufficient to effectively respond to:

The needs and the lived experiences of the children?

The needs of both parents?

Cultural, identity and other diversity issues within the family?

Potential indicators of abuse, e.g. the impact of the toxic trio: (mental health, drugs and alcohol, domestic abuse)?

History - Were historical facts known or sufficiently taken into account:

The parents’ history

Any other previous involvement of either parent with adult or children’s services, the police or probation etc.

Policies and procedures – were these effective:

Did practice accord to Working Together 2015 and/or the London Child Protection Procedures?

Any local multi agency policies or procedures

Any individual agency policies or procedures

Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquires made, in light of assessments?

Were records systematically reviewed to evaluate and assess risk?

Quality of the work – was this good enough?

Voice of the children
Information sharing
Thresholds for intervention
Assessments
Decision making
Record keeping
First line managerial oversight, including supervision
Appropriate involvement of senior managers and their accountability

Were there any deficiencies due to organisational capacity – resources, staffing problems, or other underlying systemic issues, which impacted on the work etc.?

Were there any professional disagreements?

Outcomes:

Was the application of threshold appropriate given the available information?

Nicky Pace
Independent Chair
Greenwich Safeguarding Children Board
April 2017

Appendix 2:

- Whether mother was mentally ill or had post natal depression
- What were the stress factors in her life leading up to her death
- Whether she intended to take her life and that of her children when she knew what she was doing. Did intoxication affect her decision-making?
- Whether the children were at risk of abuse or recognised to be?
- Whether mother was at risk of suicide and whether it was recognised
- Whether she should have been allocated a universal plus health visiting service.
- Whether the deaths were preventable – were there any care or protection service failings, in particular the recognition of risk or vulnerability and communication problems between Mental health and Health Visiting services