Salford
Safeguarding
Children Partnership

Local Child Safeguarding Practice Review

Child Yvonne

Contents

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Date May 2025

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1 Introduction and summary of learning

1.1 Salford Safeguarding Children Partnership[2] commissioned this Local Child Safeguarding Practice Review (LCSPR) to consider systems and practice within and between partner agencies regarding the multi-agency responses following the death of an eight-year-old girl and her mother at home. Child Yvonne will be used to protect the child's identity. The circumstances of the deaths are identified as murder and suicide. The term maternal filicide[3] and suicide will be used as it describes the killing of a child by the mother. The killing of a child is a tragic and traumatic event for families, communities and professionals involved to understand and process. This review will explore Yvonne's lived experiences and the services and systems that supported her and her family in order to help the Partnership reflect and learn about what helped and what could be improved when working with children and families in similar circumstances.

1.2 Yvonne lived with her mother and had been the subject of a Child Protection Plan for nine months at the time of the incident. Yvonne was 8 years old and an only child; she had no contact with her father but saw her maternal grandmother (MGM). Yvonne's mother was Polish and identified as Polish Italian, and her father is British. Yvonne had global physical, sensory, care and learning needs due to a rare genetic condition.[4] This meant that Yvonne was identified as having a disability[5] because she had a physical and mental impairment that had a substantial and long-term effect on her day-to-day activities. She relied totally on her caregiver to meet her day-to-day needs, and there was a comprehensive care package in place to support this. Yvonne's primary caregiver was her mother, who was passionate about ensuring she had the care and services she needed to thrive; she received regular respite care from foster carers (FC). She attended a special school and had an EHC Plan [6] in place.

1.3 There are no parallel proceedings that could impede the review; the Coronial process is continuing.

1.4 Summary Learning

- Ecological system theory can strengthen the assessment of children and families, ensuring an appreciation of the wider family, social, and community networks and how they intersect.
- Parent carer assessments require collaboration across children and adult services and must attend to the carers' psychosocial and well-being needs to strengthen resilience and identify support.
- Parent carers who provide care for children with complex needs, disability and needing long-term care should be recognised as a group that may be at increased risk of mental health challenges, including suicidal ideation.
- Improved understanding of information sharing to enable practitioners and managers in adult and children's services to fully appreciate what is happening in the lives of children and families. Adhering to the principles of whole family working and statutory guidance[7] [8]

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[2] The term Partnership will be used to denote Salford Safeguarding Children Partnership

[3] Maternal filicide is defined as child murder by the mother.

[4] A note about language The review uses the term complex needs to describe the range of physical, sensory, care and learning needs that Yvonne experienced.

[5] Definition of disability under the Equality Act 2010 - GOV.UK

[6] EHCP Education Health and Care plan is for children and young people aged up to 25 who need more support, and the plan identifies the educational, health and social support required to meet the child's needs.

[7] Working together to safeguard children - GOV.UK

[8] Information sharing advice for safeguarding practitioners - GOV.UK

- There must be greater critical thinking and challenge about the services involved with the parents/carer(s) and children, and the information they both hold. Services and professionals involved with the adults should actively contribute to multi-agency child protection assessments, planning meetings and reviews.
- Where adult issues impact children's well-being and safety, the principles and guidance in Salford's Think Child, Think Adult, Think Family must be applied across services and in direct practice.
- Strengthened knowledge across adult and children's facing services about the impact of mental health difficulties on the care of children and family functioning.
- Improved confidence in critical reflection and challenge across the partnership through existing strength-based processes such as reflective supervision and interprofessional challenge. [9]
- Where mental health services have assessed a parent /carer, best practice is to link the Child Protection plan and adult mental health plan, detailing what actions are needed to minimise the impact of parental mental health on the child and the role of adult mental health services in this.

2 Yvonne overview

Yvonne was described as a smiley, playful little girl with a sense of humour. She was seen at home and in her respite foster placement and responded well to those who cared for her. The school described her as a sociable and affectionate girl who thrived in the company of staff and classmates. She found joy in intensive interaction with familiar adults, often smiling when she noticed them mirroring her actions, whether blowing raspberries, scratching, or drumming with her hands on her tray.

Her expressive communication skills shined when she engaged with adults in the room.

2.1 Yvonne was known to services for all of her life; her health and developmental difficulties were not known until after she was born. In the first year of her life, she was supported by a range of health professionals and the Starting Life Well team[10] to identify her needs and support her mother. Yvonne was identified as having a genetic condition which featured severe epilepsy. She was severely visually impaired, had limited mobility and used a wheelchair; she was supported to use equipment and aids to help her mobility. She had a PEG feed[11] to ensure she received appropriate nutrition. More recently, with guidance and mother's support, she was developing a safe swallow and able to have some pureed food. Yvonne communicated through sounds and gestures, and the adults around her could anticipate her needs based on different sounds. Yvonne was known well by the professionals who were directly involved with her, and there were examples of strong practice and a wide range of services and activities provided to meet Yvonne and her mother's needs, and clear child-focussed descriptions of what staff observed.

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[9] . professional-challenge-and-escalation-procedure.pdf

[10] Speak Up Salford | Starting Life Well

[11] A percutaneous endoscopic gastrostomy (PEG) feeding tube

2.2 Yvonne's complex health, developmental, and care needs were supported by several multi-agency professionals, many of whom had known her for all or much of her life. This meant there were some enduring relationships and good knowledge of her changing needs. In 2019, she was open for a period to the Children with Disabilities team for a short break assessment.[12]

2.3 Yvonne had an EHCP and attended a special school full-time. She received universal and SEND support and had a personal budget. Her mother was the sole carer for Yvonne; information held about her father was that he was not involved. Her maternal Grandmother lived nearby and provided support to the family.

2.4 The family heritage was known to be Polish, and the mother identified as Polish Italian after spending much of her childhood in Italy. Mother was bilingual but understood and communicated in English. Mother was passionate and proactive in ensuring her daughter got the best care and developmental opportunities; she was described as direct and challenging on occasions about her daughter's care and described by some professionals in the learning event as a fierce advocate for Yvonne.

2.5 There were no concerns about the physical care of Yvonne by her mother; however, Yvonne became open to the Children with Disabilities (CWD) as a child in need in late 2023 with emerging worries about her mother's emotional well-being. Escalating concerns from several professionals were raised about mother's mental health and how this could impact her care of Yvonne. There were observations about her emotional responses to Yvonne. A Strategy Meeting was held, and this led to a Section 47 enquiry given Yvonne's vulnerability and her mother's mental health needs. Legal advice was also sought to ensure safety for Yvonne. However, the threshold for care proceedings was not met.

2.6 This forms the scoping period for this review, and a high-level timeline has been completed to show key events over this eleven-month period for Yvonne and her mother and highlights three periods of changing and emerging needs for mother and its impact on Yvonne.

See below.

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[12] Short break care•Salford City Council

Time-line: Yvonne and her mother

Salford
Safeguarding Children Partnership

November to December

Yvonne open as CIN to the Children with Disability team. Escalating concerns about mother's mental health and its impact on Yvonne.

23rd November	Strategy Meeting about mother's low mood and impact on Yvonne. Outcome Section 47 enquiry [1] and increased support package for Yvonne.
24th November	Legal advice sought. Threshold not met for legal intervention.
29th November	Urgent referral for a mental health assessment to CMHT[2]. Outcome mother's needs to be met by the Living Well Service.[3]
30th November	Mother shares her conflicted feelings about caring for Yvonne as a single parent and the restrictions it places on her.
1st December	Increased respite care and support provided for Yvonne . Mother actively seeking help from the Primary Care Care-Coordinator (PCCC). Mother did not always respect professional boundaries.
2nd December	Family friend contacts EDT[4] with concerns about mother's mental health.
4th December	Mother shares she is feeling depressed and lonely. Referral to the Adult Health and Social Care Contact team. Outcome criteria were not met for Section 42 [5], safeguarding enquiry.
5th December	The Children's Community Nursing Team shares concerns about mother's physical and emotional presentation, feelings of isolation and wanting her life to be different.
6th December	Information sharing with PCCC from social worker, mother talking about harming herself and worries about lack of emotional warmth towards Yvonne.
7th December	Outcome of Section 47 enquiry to progress to Initial Child Protection Conference (ICPC) • GP requested an ambulance to facilitate emergency A&E assessment by psychiatric liaison, concerns about suicidal ideation. • Second call to ambulance service from a friend of mother with worries about her mental well-being. • Ambulance attended mother refused to attend hospital.
8th December	GP telephone consultation with the mother. Referral made to CMHT, initially declined as a referral with Living Well service in progress. Following a challenge by the GP, the referral was reconsidered. Yvonne had an extended period of respite foster care.
11th December	Further adult safeguarding referral was made. Outcome criteria not met advice re carers assessment. Initial assessment completed by Living Well social worker and support plan agreed with mother to include loss counselling.
19th December	ICPC – Threshold not met, outcome to manage a child in need.
20th December	Professional challenge made regarding the threshold for child protection.
21st December	Face-to-face consultation and review with mother's GP.

January to April

Successful threshold challenge for Yvonne: increased support package for the family.

4th January	Assessment session with mother with Living Well service.
15th January	ICPC, Yvonne was made subject to a protection plan category of emotional harm, and a multi-agency protection plan was formulated.
17th January	Disability Resource Panel agreed to an increased package of support for Yvonne.
22nd January	Yvonne is seen by GP with her mother. She has been unwell for the past week.

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[1] Child Protection Enquiries (Section 47)
[2] Community Mental Health Team
[3] A community mental health service with a multidisciplinary team
[4] Out of hours Emergency Duty Team
[5] Making Enquiries

30th January	Mother introduced to peer support worker via Living Well.
6/7th February	Mother agreed on a plan of the groups she would attend.
8th March	Positive home visit. Yvonne is seen as happy, relaxed, and well-cared for. Mother shared that she is attending weekly sessions with Living Well community connectors. Seeing a psychotherapist and weekly sessions with a psychiatrist via the GP. She reflected on some improvements but no change to her social network/relationships.
2nd April	Review Child Protection Conference (RCPC) plan to remain in place. There was some evidence of improvements in the mother's mental health. Mother remains frustrated by the process, believing it did not meet her needs.

May to September

Growing differences in mothers' desired outcomes and services and support, leading to disengagement with therapeutic and support services.

10th May	Yvonne's carers raise concerns that mother's mood seemed low and continually asking for help to find her a relationship. Children's Services contact PCCC to request a follow-up regarding mother's low mood.
15th May	GP telephone consultation with mother in response to professional concerns.
13th June	Review of mother's goals and plan by Living Well Service. Mother seen as hostile and refusing to engage with the mental health nurse. Outcome: The service could not meet mother's expectations and was closed. Mother referred back to GP for mental health support and to a community connector to support social activities.
25th June	The family discussed at the monthly GP safeguarding meeting.
28th June	Think family assessment tool undertaken by Think Child Assessment to help mother appreciate how her mental health may be impacting on Yvonne.
5th July	Re-referral for social prescribing services (Living Well) made, closed, and social connector recommended.
10th July	Yvonne and her mother were seen at home visit Yvonne seen as well and happy. Mother became upset and struggled to manage her conflicting emotions for the care of Yvonne, her own needs and what the future holds.
19th July	Mother shared with PCCC and GP that she was struggling to sleep; no other changes.
26th July	Information sharing from dentistry. Attempts to engage mother with the examination was limited. Mother was withdrawn and shared she was lonely and unable to make relationships. Signposted to her GP.
2nd August	Home visit by the social worker, mother was low in mood and feeling isolated. Yvonne was well presented, the carer was present and respite care was scheduled.
19th September	Core group preceding RCPC Mother did not attend; Professionals felt overall progress was being made, Yvonne's physical needs were being well met, and mother was reported to be happier and more engaging. The discussion considered whether Yvonne should be stepped down to CIN.
23rd September	RCPC was held , the social work analysis and manager recommended Yvonne remain on a Child Protection Plan. However mother did not attend and the conference was stood down. This was unusual and attempts were made to contact mother that day. It became known Yvonne was not in School. **Later that day, Yvonne and her mother were found deceased at their home.**

3 Family views

3.1 The reviewer met separately with Yvonne’s grandmother and father and appreciated their willingness to meet and share their views at a difficult time.

3.2 **Father** said he had not seen his daughter since the first few months of her birth; he was aware that she started to have seizures in the first two to three weeks of her life and, as a result, was undergoing lots of tests, which he accompanied Mother to when he was able. He shared that his relationship with Yvonne's mother was relatively short, and he worked away then. The pregnancy was not planned, and he already had a son from a previous relationship. The couple never lived together. He had his accommodation, and Yvonne's mother lived with Yvonne’s grandmother. He reflected that the relationship was not easy, and he described her as being very black and white, saying she was ‘very Italian’ and proud of her heritage. She could quickly become frustrated if he did not understand something. Cooking was an important part of her culture. He shared that she was working as a translator when they were together.

3.3 Father talked about two events he believed contributed to not seeing his daughter. Firstly, he had not shared his recent relationship and daughter with Yvonne’s mother, who subsequently found out following Yvonne’s birth, leading to a loss of trust. Secondly, when driving Yvonne, he was involved in a minor bump. Yvonne was checked over, but the father believes he was then blamed afterwards for her difficulties. Father did not appear to know the extent of his daughter's genetic disabilities, and he was offered the opportunity to understand this.

3.4 He did not see his daughter after this time, and his involvement in her life is limited; mother’s views have been consistent in not wanting contact. He was not aware that Yvonne was subject to a protection plan and shared he continued to pay child maintenance throughout her life. He reflected on whether he should have sought advice and tried to see his daughter. However, he did not pursue this. He reflected that he had an established relationship with a new family and contact with his son from another relationship. He shared he was wary of complicating the family's lives and believed it would be a legal dispute. He felt strongly that he would have offered support if needed and if he had been contacted. There is a gap here: his extended family, including Yvonne's grandparents, may have wanted to be involved. When asked to share what may help other separated families, he wanted it to be known and understood that just because ‘*Dad’s not there did not mean they don’t care.’*

3.5 Talking about her daughter and granddaughter was difficult for **maternal grandmother,** but she wanted the opportunity to speak**.** She was understandably emotional and grieving for her loss; she also shared that she had recently lost her son**,** and this was in the weeks before the tragedy with Yvonne and her daughter. She discussed family life and how she maintained contact with her adult children and family living in different countries. Grandmother also spoke several languages and had taught herself English when she settled here. Her Polish identity and culture remain strong for her.

3.6 Grandmother spoke about the family's experience caring for Yvonne and its impact on their daily lives. Grandmother helped as much as she could but shared the care package, and Yvonne’s care needs were understandably focused on the family’s home base and around fixed times for carers. Grandmother believed this restricted time to visit her or do things as a family. Grandmother felt that this obligated her daughter to stay at home. Grandmother felt strongly that this was not matched by the consistency of carers for her granddaughter;

she believed this was not good for Yvonne, and they sometimes did not know who the carer was. She said she did not feel confident in some of the carer's abilities and saw her daughter as being 'the teacher' in what they needed to do. Therefore, from her perspective, she did not see the carer's input as always helpful, and it further restricted her daughter's opportunities for a break.

3.7 Grandmother recognised that her daughter experienced difficulties with her mental health; it worried her, but she hoped and believed she was getting better. She saw this as relating directly to the stress and worries about care for Yvonne 24/7 and 7 days a week. She shared that some of the community/support groups her daughter was introduced to were not a good fit for her; this was not about culture, but she was looking for different social connections.

3.8 There were three areas she felt should be changed. Firstly, she felt someone should have called her and told her how unwell her daughter was with regard to her mental health. Secondly, whilst she shared that she had some experience of mental health difficulties, she believed it would have been helpful to provide her with some information about depression and what this may look like so she could help her daughter. Finally, she wanted consistency in the care package from the carers who were part of Yvonne's care package at home. She recognised and was appreciative of the foster carers who provided respite care, but overall, she felt her daughter had not been helped enough; she felt very strongly about this.

4 Review Methodology

4.1 The Rapid Review was comprehensive and identified initial learning and key lines of enquiry. Initial single-agency learning and actions have been developed. A thematic approach to areas of learning, including feedback from the national panel, was to focus on

- How professionals and organisations work together to safeguard and support children with complex needs.
- How professionals and organisations work together to safeguard and support children and their families in the context of parental mental health concerns.
- Identify areas of strength in safeguarding practice in Salford and any areas for improvement, including the effectiveness of support, risk assessment, supervision, and escalation processes.

Cross-cutting themes

- Equity, Equality and Diversity and inclusion considerations, spotlighting intersectionality (family background, dynamics, role of the father and demographics)
- System-level record keeping and applying a THINK family approach across children's and adult services, including the extent to which previous learning from local reviews has been embedded across the system.

4.2 The review process was reflective and proportionate, involving practitioners, strategic managers, and discussion with family members. The scoping period for the review covers eleven months and reflects escalating concerns about the mother's mental health, the multi-agency response to this and the likely impact on Yvonne. These themes formed a framework to appraise multi-agency systems and practice. Key lines of enquiry developed areas of learning that were used to analyse the findings and what they meant in these circumstances for Yvonne and her mother. They supported reflective discussions at two learning events and considered; *what was helpful.*

What got in the way? and specifically highlighted Yvonne's voice and the family's experience. This has directly informed this report and supported wider learning and improvements. The reviewer appreciates the discussions at these reflective sessions, recognising that the circumstances of these deaths can be hugely emotional for everyone involved.

5 Thematic analysis and key learning

Single agency learning has been clearly identified at the rapid review and will not be repeated but will be considered in relation to how the different practice systems responded to Yvonne's needs, vulnerabilities, and risk. The report will start with Yvonne and how agencies worked together to meet her needs. The second section will consider the multi-agency safeguarding response, and the third section will explore this in the context of parental mental health concerns.

5.1 How did we understand Yvonne's voice and her lived experience?

5.2 There is clear evidence of strong practice from professionals who were involved in the lives of Yvonne and her mother. Children with complex needs and disabilities are children first. Yvonne's needs and disabilities were clearly understood, and records were strengths-based and highlighted what she could do. Services involved with mother worked hard to try and engage her in a range of interventions that could meet her needs and support her in caring for Yvonne. Most of the narrative and records accessed in the scoping period focussed on mothers difficulties and the possible impact on Yvonne emotionally. The rapid review reflected the challenges professionals faced in communicating with Yvonne in trying to capture her voice, and that, therefore, much of her true lived experience was unknown to the professionals in her life. The reviewer is mindful, therefore, that Yvonne's voice and lived experience in this review process have some limitations.

5.3 This section explores the understanding of what life was like for Yvonne and how her voice and lived experience informed practice. Capturing and understanding the voice of the child is a feature in learning from reviews, and the views of children with disabilities or complex communication needs were often overlooked. This was sometimes due to professionals' lack of confidence and knowledge on how to effectively communicate with children who had limited verbal abilities or used non-verbal methods of communication.[13] In this case, there was expertise and knowledge about communicating with children with complex communication difficulties, and there is a good child-focused narrative.

> *"…when I came to see you at home, you were lying on the floor, stretching out and playing . …I knelt on the floor and tickled your arm, so you knew where I was. This made you laugh, and you grabbed one of my fingers. When it was time for tea, Mum supported you from the floor back to your chair. She guided you and talked you through this gently. (Yvonne)You ate your tea well. you were responsive to (your mum's) voice and instruction and leant over so she could give you a kiss while she sat with you" (CWD home visit)*

5.4 Of relevance here is how Yvonne's mother's lived experience was understood, her individuality, and the impact of caregiving on her psychologically and specifically on her care of Yvonne and her relationship with her.

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[13] NSPCC (2024) evidence-snapshot-childs-voice.pdf

5.5 It is clear from the records and discussion at the learning event that Yvonne's lived experiences were positive; she was a much-loved little girl and was supported to make progress across all aspects of her development. Key to this was the care she received from her mother, and professionals acknowledged how well she had provided care and managed her needs. This posed a dilemma for the professionals involved. They saw Mother's strengths and the level of care she afforded to Yvonne, while on the other hand, they could see the possible risks to her emotional well-being due to Mother's escalating psychosocial needs. Whilst it is fully acknowledged that professionals directly involved saw the risk of emotional harm, there is a risk that Halo bias[14] was being applied here, which could have prevented some more challenging questions and reflection about the contrary behaviours mother was displaying and what this could mean for Yvonne, their relationship, and her care. (see sec 5.21 thinking the unthinkable) The review will explore the professional response to this. Professionals in the learning event reflected on the pressures for mother and the perception for her of being ‘holy’ or ‘perfect’ at all times in caring for a child with complex needs.

5.6 Evidence on how being a parent of a child with complex needs can affect the family is important to help understand the high level and intensity of caregiving required above what is expected, as a parent for children with complex needs, such as Yvonne. The impact of this depends on the individual and their own psychosocial experiences. It is important that any assessment includes a parent carer assessment[15] to support the carer's physical and emotional well-being as an understanding of the carer's responsibilities. Whilst mother was referred for a carers assessment from adult services it was unclear who had seen and had access to this. This meant that it was not fully integrated with the family work.

5.7 Professionals and records show a strong understanding of Yvonne’s complex needs; many professionals had been involved in her life for many years (i.e., community nursing and paediatric services, education, universal and targeted services), and there was a clear sense of her personality and care from them. Because of this, there were timely responses to changes in her needs and the care she was receiving. Despite the challenges in gathering her voice, written records, and direct feedback show that this was creative and observational, demonstrating an understanding of her needs and feelings. Social care records were written from her perspective and narrative, which gave a real sense of the child. There are some examples of excellent practice, warmth, and care from professionals directly involved in ensuring that her health, development, and care needs were attended to.

5.8 Communication about Yvonne's needs was effective between the children’s services involved in her health, educational and care needs, from the wide range of appropriate professionals supporting her care. This can be evidenced through shared information (written logs and verbal updates) about her day-to-day care and when worries arose through regular reviews of her needs through CIN, EHCP and child protection processes. The review will explore differences in how this was managed between child and adult-facing services in the next sections and how the whole family's needs were attended to.

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[14] Halo bias or the halo effect is where one specific trait or quality can influence our overall assessment or judgement without necessarily being able to support this or having contrary information.

[15] https://salfordcs.trixonline.co.uk/chapter/children-and-young-people-aged-0-25-with-special-educational-needs-and-disabilities#parent-carers

5.9 The step-up of the case to CIN and subsequent child protection processes appropriately reflect the concerns and threshold within the family; this was related to the impact on Yvonne of her mother's mental health needs. It is clear that parents with mental health difficulties can parent satisfactorily and *'are able to give their children safe and loving care'* [16] Many parents experiencing difficulties may need the support of family, friends, and /or professionals to help them. This proved to be a barrier for professionals in supporting Yvonne and her mother.

5.10 Appropriately for Yvonne's mother, friends, and professionals identified that she needed help and support (see timeline). However, there was no exploration of how strengthening the family community network could support Yvonne and her mother given mother's reluctance to engage. While it was positive that the professional network came together to increase services and support, the same energy was not as evident in exploring the family and community network. Indeed, the social prescribing interventions recommended for mother through social connectors looked to create this, but without looking to strengthen her existing network. An understanding of ecological systems theory[17] (Bronfenbrenner 1977) would have enabled a holistic approach to connecting all the systems Yvonne and her mother were involved with and considering their influence, strengths, barriers, and opportunities. It is not possible to know if this would have made a difference for Yvonne and her mother, but it would have enabled more critical reflection and challenged how support for the family was understood and delivered. Professionals reflected on some of the challenges posed by mother not wanting her mother involved with the Child Protection processes or agreeing to a Family Group Conference[18]. Whilst efforts were made to engage mother in this voluntary process it prevented the identification and development of a family network and support plan in response to the concerns. This meant that Yvonne and her mother relied on the professional support network and meant any mapping of a wider family support network was underdeveloped, this is important given the evidence base around this and increased risks.

5.11 The responsibilities of care for Yvonne's mother were more acute as she was a single parent. It is not clear what support (practical and emotional) was explored or considered with Yvonne's grandmother and if there were any cultural or family expectations of care for Yvonne or her mother's mental health needs, despite being referenced in the notes. There was information that the grandmother received some carer's allowance for a short period to support Yvonne's needs. Exploring the family's heritage and identity was missing, however, in the learning event, practitioners reflected about the cultural influences for mother from grandmother, for example, indications that Yvonne received respite foster care because she was not able to provide good care for her daughter. This thinking will have contributed to feelings of shame and stigma (see point 5.12). When speaking to grandmother, she shared that her cultural heritage was important to her life and beliefs. We know little about how this may have shaped mothers' beliefs and behaviour.

5.12 Mother shared the difficulties she faced in developing relationships. The wish to have a relationship became an overriding factor for mother. The nature and responsibilities of her caring role are highly likely to have impacted her capacity to develop adult relationships, making this loss more acute and relatable. The review process enabled deeper reflection on this through the lens of ecological systems, which supported an

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[16] Parental mental health problems | NSPCC Learning

[17] Brofenbrenner, 1979 Ecological systems theory

[18] FGC is a family led meeting that brings together a network of family and friends together to make a plan to support and best protect vulnerable children.

exploration of the gaps in understanding mothers' experiences in forming adult relationships and the challenges and barriers that got in the way of her achieving her desire for a relationship.

5.13 Professionals involved with the family were attentive to the responsibilities and level of care that Yvonne needed. She was open to the children with disabilities team, which had appropriate knowledge and expertise. Yvonne had a comprehensive support package that increased when there were indications that her mother was struggling with her mental health (see timeline). Following a core group meeting in July, where mother had shared her feelings about feeling lonely and conflicted about her role as a carer, family expectations and worries that nothing would change for her, the social worker sought consultation with a therapeutic social worker about how to frame her responses to the mother. Mother was seeking advice almost daily. This was excellent practice and linked mothers' distress and mental health to her care role and Yvonne's condition, and how this made her feel about herself and Yvonne. However, it was limited as it recommended a referral for further psychological therapy, which mother had stated she had not benefited from, and to implement boundaries in mother's contact. There needed to be a wider discussion and understanding about ***why*** mother was not seeing this as helpful, and an appreciation of her wish for a partner, and what this meant for her. There may not have been a solution, and professionals can be seen to have managed these overtures professionally, but mother clearly needed to explore these feelings, and nothing had changed for her. There was reflection in the learning events that posed the question about where all these emotions, the anger and frustration, can go. This was a good question and could help professionals consider the mother's response in the context of theoretical frameworks and evidence to support intervention.

5.14 Mother's responses could be seen in terms of 'unrecognised trauma' "Parent carers may experience both major 'Big T' trauma events, and cumulative 'small t' traumas. If we focus solely on 'Big T' trauma, the case for trauma-informed support for parent carers may be missed."[19] particularly when this may be cumulative and intersect with other factors, such as relationship changes. This is unconsidered from the mother's perspective.

5.15 A helpful theoretical perspective that is relevant here to think about why, is the Compass of Shame (Nathanson, D., 1992) and Shame Containment Theory[20]. This explains how people react when they feel shame, such as withdrawal, attacking others, avoidance, or attacking themselves. For Yvonne's mother, her evident love for her daughter, the care she provided and her passion to do and give her the best were compounded by her individual, family, cultural and life experiences about how she understood her life, relationships and family and the options she saw for herself.

5.16 A comprehensive package of support was put in place in response to concerns about mother's mental health. Professionals struggled to understand some of the mother's responses to this, such as her repeated attendance and calls/visits to the foster carer's home, especially at bedtime. It was identified as much-needed respite for mother and safety for Yvonne; on the other hand, it was seen as a mother not respecting boundaries or making the most of the support. For mother, her whole life focused on caring for Yvonne, and letting some of this go may have caused feelings of guilt and shame that she was conflicted over. The unintended consequences of the additional support may have been to increase her feelings of shame.

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[19] Trauma and parent carers | BPS Unrecognised trauma 13th May 2024

[20] Etherson, L. (2023) Shame Containment Theory- a new approach to shame.

5.17 Professionals were faced with the intensity of these emotions, her sadness and loss and the challenge of them, and they worked hard to regulate and put in place boundaries around professional relationships and direct her towards mental health support.

5.18 Research into the parental experiences of caring for children with complex needs highlights the psychosocial impact on families with disabled children. [21]

- 72% experience mental ill health such as anxiety, depression, or breakdown due to isolation
- Almost half (49%) have felt so unwell that they asked their GP for medication or have seen a counsellor
- 65% of families with disabled children reported feeling isolated frequently or all of the time

5.19 There is emerging evidence of suicidal risk for family carers, and a recent study has highlighted the specific suicide risk for parent carers of children with a range of illnesses and disability. [22] It identified a lack of knowledge on risk and protective factors for parent carers and a higher level of risk for this specific group of carers. It highlights that suicide risk is not considered in parent carer assessment or dedicated support for parent carers experiencing suicidal thoughts. This research reflects learning in this review, where a holistic approach is needed and is relevant to understanding the services' responses to helping mothers.

> ***"Depression, entrapment, and dysfunctional coping are also amenable to intervention. It is important, however, that interventions take a holistic approach. While individual approaches, such as anti-depressants or psychological therapies, can offer relief from symptoms or model healthier coping strategies (Han et al., 2021; Mikkola et al., 2021), they do not address the wider social, economic, and political circumstances that contribute to carers' feelings of depression and entrapment or force them to rely on dysfunctional coping strategies (Brimblecombe et al., 2018; Larkin & Milne, 2013)***

5.20 The mother's lived experience over the years reflected wider experiences of parents caring for children with complex needs at home. For mother, as the understanding of Yvonne's care needs evolved, her role and responsibilities grew and became a "full-time job caring and arranging appointments" (Forgotten Families)[23]. While challenges are identified for many parents, some saw that overcoming the challenges and managing the care responsibilities had made them strong and helped develop resilience. Professionals described mother as a '***warrior mum***' and a passionate advocate for ensuring Yvonne's needs were understood and met by those involved in her care. It's a complex interaction for parents in trying to make sense and cope with their situation over the child's lifespan.

5.21 Whilst parents understand their caring role for a child, parental care for a child with disability and complex needs far exceeds what would be seen as 'typical parenting'. Yvonne's mother assumed complex care tasks and became skilled at this; the author reflects on the grandmother's perception that Yvonne's mother became the 'teacher'. This was also linked directly to grandmother's views about the consistency and quality of care for her

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[21] forgotten_isolation_report.pdf

[22] Suicidal Thoughts and Behaviors in Parents Caring for Children with Disabilities and Long-Term Illnesses - University of Birmingham

[23] forgotten_isolation_report.pdf

granddaughter. Practitioners reflected that there was an appropriate level of expertise and care by care staff of significance here is that mother liked the carers to do things as she wanted for Yvonne, underpinning her "*identity as a carer and her struggle to allow others to support with the care of Yvonne*". The evidence shows that *"Increased caregiving demands are a serious risk for adverse psychosocial effects which calls for a better understanding of the consequences of caring for a child with complex care needs in today's modern family."* [24] There was a good understanding from professionals about what is sometimes called the 'burden' of care, and when mother showed acute stress, hopelessness, and suicidal ideation, they responded with support and services in a timely way, recognising the impact on Yvonne. We have previously discussed perceptions of mother as a fierce advocate for Yvonne, combined with her dedication and ability to offer Yvonne good care. When faced with mother's emotional distress, professionals appropriately recognised emotional harm for Yvonne in terms of her mother's unavailability and preoccupations and sought to help her. Whilst there is no indication that the death of Yvonne could have been prevented or predicted, this tragedy asks that we ***think the unthinkable*** in the context of known increased risk factors such as suicidal ideation for parents of children with disability and complex needs. This is complex and challenging thinking that can be supported by reflective supervision.

5.22 The complexity, intensity and fluctuations of these feelings were highlighted from an organisation that provides a voice for the lived experience of parent carers with children in Salford with a range of SEND needs[25]. Positively, mother accessed this group at different times. It can be seen that individual circumstances, capacity, and resilience factors can support our understanding and significantly consider, from an individual's perspective, the "*difference between being supported and feeling supported* "and how these feelings may have contributed to this mother's feelings of shame, consequent isolation, and internal challenges

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Some families cope well with the most distressing problem……. The differences are to be found in the personalities and life experiences of the child and their parents, the functioning and strength of the family unit and the effectiveness of their network of support among relatives, friends, and professional services. (Hall and Hill, 1996)

Why does it matter?

Professionals involved in supporting Yvonne shared a good understanding of Yvonne's needs and the family's situation. A comprehensive package of care was put in place to support her and to provide support for mother as the primary carer. A greater appreciation of the lived experiences of Yvonne was made more complicated by Yvonne's limited ability to communicate. She had started to use aids at school, but these were not easily accessible to wider professionals. Records written from the child's perspective, including direct observations of the child in her care and education settings, built a shared picture of her voice. The children with disability team, her respite foster carer, her school, and health professionals overseeing her medical needs provided direct observations of her responses and interactions with her mother.

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[24] https://rdcu.be/ea3uO Intense parenting: a qualitative study detailing the experiences of parenting children with complex needs.

[25] Consultation with the lead from Salford Parent Carer Forum Salford Parent Carer Forum

Caring for a disabled child can be a rollercoaster of emotions, both rewarding and valuable, and at the same time physically and emotionally exhausting and stressful. Yvonne was dependent on the care she received from her mother and the professional network. Both provided good levels of care and were focused on her needs and development. The assessment of Yvonne's individual needs was clear, but the assessment of the family and environmental factors was not fully considered, specifically Yvonne's experiences of her world and how they intersected. Adopting an ecological model would have attended to the interrelationship between the broader family and community systems and considered both the stresses and supports in the family environment. *Whether parents can perform effectively in child-rearing roles within the family depends on the role demands, stresses, and supports emanating from other settings.*[26]

Whilst mother's mental health needs were identified and responded to, a greater exploration of her experiences and the feelings that underlined these should have been considered when undertaking assessments, particularly as mother did not want her family involved. It should form a core part of a parent carer assessment.

Capturing the voice and lived experience of children The review has highlighted the importance of clearly articulating the lived experiences and voice of children with communication and sensory difficulties and how this was positively demonstrated here. These can reflect the child's lived experience; strengths must be balanced against any worries and risks associated with the parental lived experience and the child's care and health needs. This requires perspectives, observations, and understanding of her abilities, to inform professional analysis of what life was like for a child and her unique circumstances. The children's professionals identified the risks of emotional harm and possible neglect to Yvonne.

Parent carer assessments should include an evaluation of psychosocial needs in response to the caregiving role and reviewed regularly. The complexity and intensity of the parent-child relationship need understanding from the caregiver's perspective: *"My needs are often forgotten; this makes me feel isolated."* Caregiver's Voice Forgotten Families 2011. One of the most pressing needs for Yvonne's mother became her loss of identity, sense of isolation and ability to develop a partner relationship. Professionals heard mother and tried to find solutions, but expectations were very different. Mother consistently shared her feelings of loneliness, which mirrors the emotions experienced by many parent carers[27] An exploration of this and consideration of her existing friendship network was underdeveloped, and the use of the family conferencing model could have strengthened Salford's Family Partnership Model. Whilst the use of Family Group Conferencing[28] forms a key strand of the Social Care Reforms, it provides no guidance (as in this instance) to support staff when families do not consent to this approach.

Learning from case reviews highlights the importance of understanding the impact of a parent's mental health concerns through the means of a carer's assessment. [29] Furthermore, practical support is essential for parent carers' physical and emotional well-being, an assessment of the parent carer should also explore protective factors in developing resilience, which include an appreciation of [30]

- A good/loving relationship between the child and the caregiver

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[26] Bronfenbrenner 1979 The ecology of the family as a context for human development

[27] Consultation with Salford's Parent Carers Forum lead Salford Parent Carer Forum

[28] The_families_first_partnership_programme_guide.pdf page 39)

[29] learning-from-case-reviews_parents-with-a-mental-health-problem.pdf

[30]

- A broad support network
- Positive personality traits

Supporting Parent Carers: responding to mental health risk A growing body of research recognises that this group is at increased risk of mental health challenges and this includes suicidal ideation Learning from this review has highlighted the need for professionals across adult and children's services also to consider the implications of suicide from the parent carer's perception in the context of the parental relationship; if this were to happen, what might we hypothesise about the child's future? However improbable or challenging it may be when assessing risk for the child and carer, all professionals working with the family must consider the possible impact on children regarding critical harm and ***think the unthinkable***.

	What needs to happen - Learning points
1	Assessments of children should be strengthened to ensure understanding of the child within an ecological systems framework, with attention given to the wider family, social and community networks and how they can be developed and intersect. This will support Salford's Family Partnership Model in understanding why some families may decline wider family involvement and /or family group conferencing.
2	Parent carer assessments and reviews must include: • An evaluation of the carers' psychosocial needs and well-being in response to their caregiving role. • Ensure parent carers are asked about suicidal thoughts and behaviours • Consider collaboration with adult mental health services that can provide relevant expertise. • Exploration of protective factors for developing resilience and identifying support.
3	Parent carers of children with special educational needs and disabilities (SEND) should be recognised as a group that may be at increased risk for mental health challenges, including suicidal ideation, due to the complex and demanding nature of their caregiving responsibilities.

5.2 How effective was the multi-agency support across adult and children's services

5.2.1 This section will consider multi-agency practice and how it provided Yvonne with help, support, and protection. There was evidence of good information sharing between health, education, GP, and children's services involved with Yvonne at an early help, child in need and child protection threshold. The rapid review highlighted that adult services supporting mothers' mental health were not consistently engaged. This section will seek to explore why information sharing and seeking between adult mental health services and the rest of the safeguarding system was inconsistent. It will also explore professional challenge and escalation in the context of understanding roles, responsibilities, and service responses to parental mental health.

5.2.2 Following the concerns raised about mother's emotional presentation and its likely impact on Yvonne, there was a prompt and appropriate child protection response that recognised Yvonne's particular vulnerabilities in the care of her mother. A Strategy Meeting was held with key professionals involved in the direct care and support of Yvonne and the police; a multi-agency plan was agreed that focused on the safety and well-being of Yvonne. The threshold was agreed for a Section 47[19] investigation. (see timeline)

5.2.3 There was a plan to seek support and assessment for mothers mental health via her GP. A referral was made to the Community Mental Health Team CMHT [31]. In the weeks following the Strategy Meeting mother's mental health could be seen to be deteriorating. She shared negative thoughts about Yvonne and suicidal ideation (see timeline). There were two separate calls from mother's network to emergency services. The Children's Community Nursing team shared concerns about mother's presentation and low mood. The GP made an Adult Safeguarding referral, and requested mother attend the hospital for assessment by liaison psychiatry. [32] A second call to the ambulance service was made to facilitate this. Mother declined to attend. The family support worker shared that the mother reported feeling depressed, lonely, and upset about personal relationships. The GP made a second referral to the CMHT, and a second adult safeguarding referral was made.

5.2.4 There was a high level of concern about the mother's mental health deterioration and risks to Yvonne associated with this, which impacted her emotional wellbeing, appropriately identified. Overall, mother continued to be seen as meeting Yvonne's physical and care needs. Increased safety was provided for Yvonne, including extended respite foster care, and supporting mother to attend community groups.

5.2.5 The Initial Child Protection Conference decision was that the threshold for child protection was not met. There are two points of significance here. Firstly, there was no reported attendance or invitation to adult-facing services such as the GP, Primary Care Coordinator, or adult mental health services at the conference, despite the referral to adult mental health services. However, the GP provided a report detailing their involvement as expected practice. There was effective information sharing between the GP practice and the social worker, but this did not include firsthand information from the services involved with mother. The mother's primary care and care coordinator became the intermediary for information, and this may have led to the assumption that there was direct collaboration across adult and children's services. The role of the primary care coordinator is to provide a consistent source of support to the patient, particularly when there is complexity, and a number of professionals are involved. This is helpful from the patient's perspective, but it should not replace direct professional interaction. The rapid review highlighted that this role was not fully understood across the multi-agency system, and actions have been implemented to share this. The GP had a crucial role with the family and actively supported maternal wellbeing: "*They have an overview of issues affecting individual family members of a family which in combination may impact on the welfare of a child.*" [33] In the time period, the GP had 13 consultations with mother, the majority of which related to her mental health and covered reviews of her medication and assessment of mood, including active suicidal or self-harm ideation. The GPs' understanding and knowledge of the mother was significant, and mental health assessment and intervention were proactively actioned, including professional challenge of referrals to the CMHT and outcomes for the service.

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[31] Ramsgate House Community Mental Health Team - NHS

[32] The service provides specialist mental health assessment and treatment in acute hospital settings

[33] GPs and primary healthcare teams: learning from case reviews | NSPCC Learning

5.2.6 Discussion in the review process highlighted capacity issues if GP’s were asked to attend all child protection conferences and processes, meaningful learning here is about direct conversations and information sharing with the GP through requests to attend conferences such as the ICPC to contribute to the Protection plan, collaborative updates, and the review of core group minutes. Good practice shared was monthly meetings with the GPs and colleagues in the 0-19 Universal Partnership Plus Team to provide health-related updates; however, this must be aligned with the existing statutory processes in CIN and core groups so that processes are not duplicated.

5.2.7 Given the nature of the concerns and risks regarding mother, the non-attendance of adult-facing services was a significant omission. These agencies did not attend the reconvened Initial Child Protection Conference (ICPC) Review Conference (RCPC) or any monthly Core group meetings. It is a concern that this occurred; there was no curiosity about this, and it was not challenged. This meant that information and discussion in the multi-agency space was mainly self-reported by the mother or third-hand from professionals.

5.2.8 Secondly, the decision from the first ICPC was that the threshold was not met and that there was not sufficient evidence of impact on Yvonne. Given Yvonne's vulnerability and her mother's deteriorating mental health and its likely impact, the decision was effectively challenged, and Yvonne was made the subject of a child protection plan. The second conference provided more concrete examples of harm for the threshold to be met. Whilst there have been some immediate changes to conference decision-making, multi-agency learning has been about how the multi-agency risk assessment was based on a scoring (scaling) system. This highlighted the difference in professional views about thresholds for a disabled child, such as Yvonne, and how scaling was evaluated in critical decision making. The Partnership no longer uses a scoring system in its child Protection decision-making. Effective risk assessment must consider all aspects of the child and the family's life and must consider the systems and processes that support professionals in making good decisions about risk.

> *“In order for professionals to make good decisions about children in need of protection, they have to have a full picture of what is happening in a child’s life. Part of this is about having access to all the information known about the child. But just as important is seeking out missing information, considering disparate pieces of information in the round, and asking what bigger picture is being painted about a child’s experience.*
>
> *Child Protection in England National Review Arthur and Star 2022*

5.2.9 The Salford Safeguarding Children partnership has adopted a Family Partnership Model of Practice, a strengths-based, trauma-informed relational practice model emphasising building partnerships with families and communities. It explores why families may find it difficult to work in partnership and provides strategies and reflection points. This helpful document details principles directly related to learning here, such as multi-agency working, information sharing, and guidance about engaging with families experiencing mental health difficulties: **Think Child, Think Adult, Think Family.** [34] The partnership will need to consider how widely this guidance is being applied across organisations and in direct practice.

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[34] adult-and-child-guidance-updated-january-2023-v2.pdf

5.2.10 Inspections and reviews, both local and national, have, for many years, discussed joint working between adult and child services, where adult issues impact children's needs. Ofsted evidenced this in its report, **What about the Children** [35] . The opportunity to link mother's support plan and the child protection plan would have been best practice here and ensured there was a joint thread to clear outcomes and safety for Yvonne. Without direct conversations and discussions with adult colleagues with relevant expertise, it meant that children's services were assessing impact in isolation.

5.2.11 The confusion over understanding how and what adult mental health pathways were best placed to help mother were not understood by the wider safeguarding systems that came together for Yvonne. This led to worry and frustration (re-referrals and challenges to CMHT and adult safeguarding), which created some circular conversations. This was not specific to children's services. The lack of effective communication pathways between adult mental health services and services for children is highlighted as a spotlight theme in the most recent **Annual Report by The Child Safeguarding Practice Review** [36] This review theme mirrors much of the learning here and the importance of *"taking a holistic approach to understanding the wider family circumstances and considering the interconnected nature of issues parents face, including their mental health needs".* Of relevance here for Yvonne is

- Difficulties in consistent parental engagement led to referrals being closed down, despite ongoing concerns about mother's mental health needs.
- Information sharing and misconceptions about consent, indicating differing interpretations of policy, procedures and guidance around information sharing.
- Assumptions being made that because mother had been referred to mental health services (referral doesn't equal treatment [37]) that intervention would mean that the risks were being reduced.
- The treatment options for mother included counselling and social prescribing interventions delivered from a range of voluntary services. Engagement from mother was inconsistent, and different interventions/services were offered. It was unknown that some of these duplicated services, such as children's services, had already been put in place/offered or when they were not taken up.

The Child Safeguarding Panel go on to reflect that "***Reviews analysed this year also highlighted that multi-agency responses to child and parental mental health could have been strengthened with better information sharing, co-operation and planning between services for children and services for adults working with members of the same family"*** It is noteworthy that all of these factors were present here.

Why does it matter?

This matters because key components of effective multi-agency practice include information sharing and communication, understanding of roles and responsibilities, respectful challenge, agreed-upon outcomes, and

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[35] What_about_the_children.doc

[36] Child_Safeguarding_Review_Panel_annual_report_2023_to_2024.pdf

[37] The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

measures of success. [38]. The themes of multi-agency working, information sharing, and triangulation of information and the adult-child interface continue to be cross-cutting themes in learning from the current annual report from the child safeguarding practice review panel.[39] This matters because the input of adult services could strengthen understanding of the impact on children like Yvonne, where adult issues were directly impacting on the mother's wellbeing and functioning, and there was no analysis of what this could mean for a child or one with Yvonne's complexities. This could ensure a clear connection between children and adults' needs, providing a **"child-centred approach within a whole family focus"** [40]

The importance of sharing and seeking information between adult and child services, this can be supported by an understanding of the updated Information Sharing Guidance,[41] which details the importance of joining up adult and children's services, or the purposes of safeguarding. Significantly for this review, it highlights that it may be necessary to share information even if the threshold for services is not met or the person disagrees. Clear systems and agreements must be understood and in place to enable all agencies to comply with Working Together 2023 statutory guidance. This should happen at the point of referral and throughout service involvement, including closure. There was insufficient curiosity here about known child safeguarding procedures and what they looked like from the child's perspective.

Triangulation of information to ensure a whole family approach. Services involved with Yvonne and her mother had knowledge about each other, but did not use curiosity or challenge to help them understand the whole family's circumstances. This siloed response did not support a whole family approach, led to some assumptions, and meant Yvonnes' vulnerabilities were not fully appreciated in the context of her mother's difficulties and by the adult agencies that had relevant expertise. Multi-agency meetings are central to multi-agency working and they bring together the family network and professionals involved to oversee a safe plan for vulnerable children and adults. It is a space to share information and think critically about what is going on for the family. It is hard to understand why there was no challenge in the timeframe to attendance at these meetings by key professionals involved with mother. It was an opportunity to explicitly link assessment, intervention, and safety planning for the whole family.

Understanding the mental health pathway. Uncertainty was shown about the systems and processes to provide mothers with mental health support, including adult safeguarding and mental health pathways. The systems, as identified, worked very separately, and whilst the response was appropriate to individual needs, it did not consider the possible impact on the child, particularly when mother could not consistently engage with services. The partnership is undertaking work around understanding Pathways to mental health support. Where the adult is a parent or a carer, the response should always consider the child, the parent, and the family and services should work together to consider needs holistically and the impact on the child. (NHS Think Family guidelines) NHS safeguarding guidelines promote a whole family approach[42] that is able to balance individual care alongside a whole-family focus. "This means thinking about the child, the parent, and the family, with adult and children's health and social care services working together to consider the needs of the individual in the context of their relationships and their environment." The following diagram from this guidance illustrates this parental/mental health interface.

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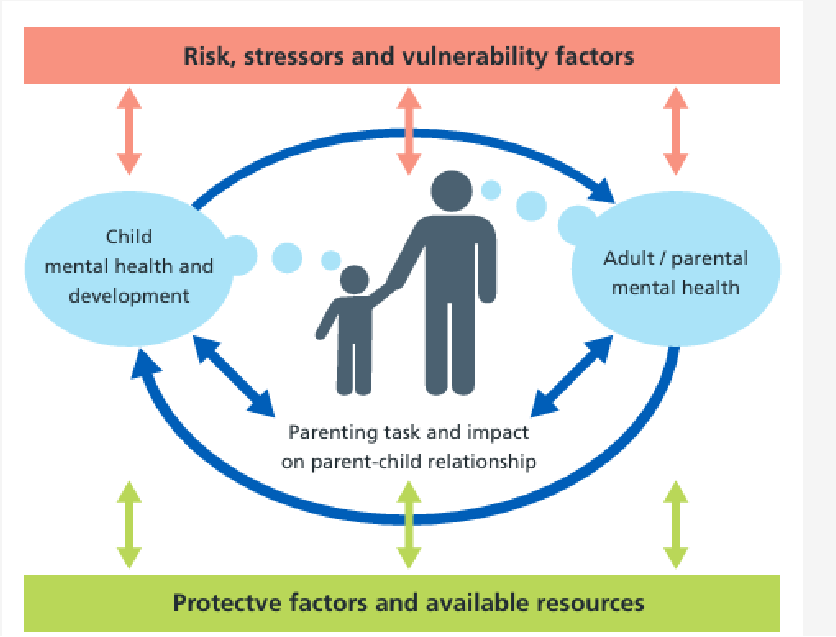
[38] MultiAgencyReform_Kantar_Report.pdf The multi-agency response to children and families who need help - GOV.UK
[39] Child_Safeguarding_Review_Panel_annual_report_2023_to_2024.pdf
[40] Working_together_to_safeguard_children_2023.pdf Chapter 1
[41] Info_sharing_advice_content_May_2024.pdf
[42] Think Family - NHS Safeguarding



It is important that all services, commissioned and voluntary work, adhere to the same principles. Given the known wider risks, stresses, and vulnerabilities, it was important that the systems and processes could think and respond as a whole family in the context of the child's complex needs and circumstances.

	What needs to happen - Learning points
4	Improved understanding of information sharing enables practitioners and managers in adult and children services to fully appreciate what is happening in the lives of children and families. Adhering to the principles of whole family working and statutory guidance[43] [44] The NSPCC's practice principles, "What helps to support effective multi-agency working and information sharing?" cover key issues identified here.[45]
5	There needs to be greater curiosity and challenge about the services involved with the adult(s) and children in the family and the information they hold, by the services and professionals involved with the family members. It is important that adult professionals with relevant expertise about adult issues are included in and actively contribute to multi-agency child protection assessments, planning meetings, and reviews.
6	Establish **whole family working** where identified parental issues impact the wellbeing and safety of children through improved communication and collaboration between adult-focused services and children-focused services to inform family assessment, planning, and review. Managers and practitioners should routinely apply the principles and practice promoted in Salford's Think Child, Think Adult, Think Family guidance.

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[43] Working together to safeguard children - GOV.UK (2023)

[44] Information sharing advice for safeguarding practitioners - GOV.UK (2024)

[45] Practice points for multi-agency working and information sharing | NSPCC Learning (2025)

5.3 How effective was the multi-agency understanding and assessment of parental mental health

5.3.1 This section explores how well agencies and professionals understood mothers' mental health and what this meant for Yvonne. The review has explored Yvonnes' circumstances and vulnerabilities and explored the multi-agency systems and practice to keep her safe. Professionals positively sought urgent help with mother's mental health and suicidal ideation. Whilst it was linked directly to her parent caring role, there was insufficient assessment of what this could mean for Yvonne.

5.3.2 Children's services undertook a Think Child assessment tool[46] family session with mother to explore the impact of parental mental health on Yvonne. This was good practice but was limited because this was not shared or done in collaboration with adult mental health services to inform the referral from the GP, or their assessment. This practice was single agency, although Yvonne was subject to a child protection plan.

> ***"In assessments where there were issues of parent or carer mental ill health, professionals did not routinely approach the assessment as a shared activity between children's social workers and adult mental health practitioners, in which each professional drew on the others expertise. As a result, the majority of assessments did not provide a comprehensive and reflective analysis of the impact on the child of living with parents or carer with mental health difficulties"***
>
> *Ofsted 2013, What about the children*

5.3.3 While referrals were triaged in adult social care and referrals considered by the multidisciplinary team at CMHT, limited curiosity or information was sought about the impact on Yvonne or exploration of the rationale for the child protection process in place. It also became apparent that mother was inconsistent in her prescribed medication from her GP, meaning the efficacy of her treatment plan was compromised. The multi-agency system did not know this information. This meant that the risks and impact on Yvonne were not fully considered. Mothers' needs received an initial assessment/triage, and an individual plan was agreed upon in line with service practice. A holistic assessment was missing, including understanding the family's history, circumstances, child vulnerabilities and the complexities of the parent caring role.

5.3.4 The learning events reflected on the outcomes of referrals to CMHT. Whilst mother's presenting issues did not meet the criteria for her having a 'complex and enduring mental illness', there were aspects of her mental well-being that were significantly affecting her emotional, psychological, and social well-being, this was directly linked to her role as a parent carer. These behaviours, feelings and emotions could be seen to be having an impact on all elements of Yvonne's life given her dependency on her mother as her primary carer. Practitioners reflected that the mother was not in a place to engage with talking therapy, so it was difficult to put in place psychological support. Significant attempts were made to provide a range of interventions based on the social prescribing model, but mother was inconsistent in accessing this support and was subsequently closed. Mother's needs had not changed, and service responses needed to be

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[46] think-family-2023-accessible-pdf-may-2024.pdf

centred around the child and family. There was an opportunity for adult mental health services to work collaboratively with the child safeguarding systems through a shared family framework.

5.3.5 Issues of consent were poorly understood, and curiosity and challenge should have been undertaken with mother who was reported to be saying she did not want information shared with children's services. This also meant that services providing support for the mother were based solely on the mother's self-reporting. There was an opportunity for the expertise of adult mental health services to strengthen the risk assessment relating to the **impact** of the mother's mental difficulties and, in particular, her suicidal thinking, anger, and hopelessness about her situation. Without this collaboration and discussion, it was left to children's services in isolation to evaluate the impact and develop safety planning for the child based on the mental health difficulties of the mother. Children's services did not challenge this position, and there was no critical reflection from these services about why they were not directly involved. There is nothing to suggest that this could have changed the outcome in this case, but it is essential to develop joint working practice.

5.3.6 Filicide -suicide [47] is rare, and research shows that of these, a few parents were under the care of mental health services, suggesting that the perpetrators were either not experiencing serious mental health difficulties or that they had not sought help. The over-representation of mental illness in filicide was a key finding of the study, ***" Identifying associations between mental illness and filicide has clear implications for service providers. It shows there needs to be greater awareness for patients who are parents and especially those with severe mood disorders. This is an increasingly important issue because better mental health care means that more people with mental illness are able to become parents."*** Whilst mother did not have severe mood disorder, there needed to be greater appreciation of the known risk factors for this group of parent carers and significantly consider strategies for building safety and resilience.

5.3.7 For mother, she did not acknowledge she had mental health difficulties, and while she complied with some of the services, her perception of her difficulties was that the services were not meeting her needs. Support, therefore, needs to go beyond providing help and support and try to understand what this might mean for this parent. This thinking has been framed as 'sense checking' and refers to how '*parents draw upon a range of personal, social and cultural experiences to make sense of their situation*."[48] This would have been a helpful place to explore some of mother's feelings and responses; this reflection needs to happen within and across adult and children's services.

5.3.8 Responses to mothers' mental health difficulties were not fully explored or not known by the multi-agency system because they sat separately in adult services. This was further complicated by barriers to information sharing with service providers because some of the therapeutic services in place did not have access to the case history. This has subsequently been helped by services having access to the GPs' EMIS systems to be able to review patient case histories.

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[47] Filicide: Mental Illness in Those Who Kill Their Children | PLOS One

[48] Impact, meaning and need for help and support: The experience of parents caring for children with disabilities, life-limiting/life-threatening illness or technology dependence - PubMed

5.3.9 Of significance is the lack of any risk assessments undertaken by mental health services about suicidal ideation being shared within mental health services and across the multi-agency safeguarding system. Given its causal link to child protection concerns, the lack of challenge from children's services is a concern. It was not possible for children's services to effectively consider mothers' engagement with mental health services, and therefore consider risk and risk reduction if services did not talk and reflect on the family's circumstances. Child protection processes, such as core groups, relied on mothers' self-reporting and presentation.

5.3.10 Learning from situations where parents have a mental health problem[49] show there was a lack of understanding about mental health and diagnosis. Whilst the professionals for Yvonne's mother recognised the issue of behaviour, they relied on the mother's feedback on intervention and outcomes with the adult mental health services. Adult services reported they could not share information because of GDPR; this does not show an appropriate understanding of information sharing (learning point 4). This meant there was no triangulation with professionals involved in her care plan or family about how the mother was. This meant risk assessment or evaluation of progress and outcomes was limited and viewed in isolation. This should have resulted in interprofessional challenge and escalation as needed.

5.3.11 Given the level of support and oversight of Yvonne and her mother by services involved with the family through child protection, the continued reported good care of Yvonne and no further presentation of suicidal ideation, it was reasonable for professionals to believe the risks had reduced. There were different agency views about continuing the child protection plan at the core group prior to the review child protection conference (RCPC) The multi-agency partners in the core group who were in attendance all scaled and recommended CIN; however, the social work analysis and the practice manager section both recommend a further short period on a CP plan. This was to be explored at the RCPC. The conference where the multi-agency decision would have been made was stood down as the mother did not attend. It is difficult to see how the subsequent events could have been prevented.

Why does it matter?

The majority of parents who experience mental health difficulties do not go on to harm their children because of their difficulties.[50] However, the understanding and prevalence of parental mental health in studies of filicide needs careful consideration where it combines with mental health concerns in parent carers of children with complex and long-term health and care needs. Yvonne's mother expressed suicidal ideation relating to her feelings about her care and parenting role and living circumstances.

We have seen prompt and proactive actions by children's services and her GP to find appropriate help and support for mother and provide her with additional support to ease the 'burden' of her caregiving role. Mental health services responded in line with expected practice to support her mental health needs and tried hard to engage her with services that met her needs and would be helpful.

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[49] learning-from-case-reviews_parents-with-a-mental-health-problem.pdf

[50] Tunnard 20024 quoted in DFE-00108-2011-Childrens_Needs_Parenting_Capacity.pdf

Two key areas of importance to build on identified learning focus on how adult and children's services understood mothers' mental health, and the importance of joint working across adult mental health and children's services to understand and respond collaboratively. This means, in practice, sharing holistic assessment and safety planning that keeps the child at the centre. Where there are barriers to this, such as information sharing, there needs to be effective **professional challenge.**

Understanding mothers' mental health. The mother's mental health needs were not fully evaluated or considered by mental health services in the context of her role as a parent and a parent carer, and the complexities of her daughter's complex care and health needs. Whilst it was known that she was a parent by adult and mental health services. She was struggling with the care 'burden' and the loss of what she thought her life was going to be. This was managed in isolation of the child safeguarding concerns and consultation with other professionals involved with the family and who had extensive knowledge of the family's situation. Children's services relied on the services involved with her as an adult to manage this. There was simply no interface between children's services and adult mental health services. This meant the child and the adult were considered separately and not part of the same system. There was some interface between the GP practice and children's services who provided updates to the mental health referrals, but this was not directly aligned with the child protection processes, meaning the risks to Yvonne could not be fully considered as part of the child protection processes.

Collaborative working across children and adult mental health services. Supporting collaborative work will be helped by being clear about what actions are needed to minimise the impact of parental mental health and the role of adult mental health services in this. This requires expertise and input from practitioners across adult and children's services and a whole-family response.

	What needs to happen - Learning points
7	Practitioners and managers across adult and children's facing services strengthen their knowledge and understanding of the impact of mental health difficulties on the care of children and family functioning. This must include shared knowledge, experience and expertise about risk, resilience and creating safety.
8	Improved confidence in critical reflection and challenge across the partnership through existing strength-based processes such as reflective supervision and interprofessional challenge. [51]
9	Mental health support plans and risk assessment should be undertaken by mental health services, including suicidal ideation, where there are children in the family, and shared with children's services. Best practice would be to link the Child Protection Plan with the adult mental health support plan and be explicit about what actions are needed to minimise the impact of parental mental health on the child and the role of adult mental health services in this.

6 Summary

Maternal filicide-suicide is a rare and tragic event. The circumstances around the death of Yvonne and her mother are complex and extremely distressing to the family, community and professionals involved. The purpose of a child safeguarding practice review is not to investigate or apportion blame, but to try to understand the circumstances that led to the incident from a multi-agency safeguarding perspective, to support learning and understanding, identify

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[51] . professional-challenge-and-escalation-procedure.pdf

good practice that could potentially support other families in similar circumstances and consider what preventive actions may help.

In this situation, concerns about the impact of maternal mental health and understanding of the stresses of being a parent carer were identified; there was a comprehensive level of multi-agency support, some examples of strong child-focused practice, and enduring professional relationships. However, the professionals involved faced challenges in understanding the mother's complex behaviours and responses and the interplay of multiple factors. This review has highlighted the importance of collaborative working with adult services to fully appreciate the demands associated with caregiving and the risk for adverse psychosocial effects on caregivers for their role in caring for a child with complex care needs.[52]

Recommendations for Salford Safeguarding Children Partnership (SSCP)

1. The SSCP must seek assurance that Parent-Carer Assessments are routinely undertaken for parents of children with disabilities, are collaborative across adult and children's services, and include an evaluation of parental psychosocial needs in relation to parenting capacity. (learning points 1 & 2)

2. Parent carers of children with special educational needs and disabilities (SEND) should be recognised as a group that may be at increased risk for mental health challenges, including suicidal ideation, due to the complex and demanding nature of their caregiving responsibilities. SSCP should prioritise parent carers in its Suicide Prevention Strategy as a potential high-risk group and ensure that identification and psychological support are in place. **This local learning has national practice and policy implications for this particular group of vulnerable children.** (Learning point 3)

3. The SSCP needs to see assurance of the effectiveness and impact of established good practice relating to reflective supervision. This should include an evaluation of how this contributes to the broader multi-agency approach that enhances critical thinking processes across the partnership (learning points 5 & 8)

4. Salford Safeguarding Adult Board (SSAB) and the Salford Safeguarding Children Partnership (SSCP) work collaboratively to provide strategic leadership and seek assurance on the implementation and impact of Working Together 2023 and the NHS Think Family agenda (learning points 4 and 6.) This should include:

    i. Evaluation of the effectiveness of Salford's Think Child, Think Adult, Think Family approach within organisations and in frontline practice.
    ii. An assessment of how well the core principles are being promoted, understood, and embedded across the workforce.
    iii. Provide evidence demonstrating strengthened multi-agency relationships, increased practitioner knowledge, and enhanced confidence in delivering whole-family safeguarding.

5. The SSCP and SSAB must seek assurance that systems are in place to support collaboration across adult support services (including but not limited to community and hospital services, GPs, and commissioned

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[52] https://rdcu.be/ea3uO Intense parenting: a qualitative study detailing the experiences of parenting children with complex needs.

services) and children's services where there are parental mental health difficulties to support information sharing and assessment. (learning points 4,5,6,7,9) This should include

  i. A shared understanding of statutory information guidance.[53]
  ii. Ensure the inclusion of adult services in child protection processes
  iii. Collaboration of adult mental health and children 's services to ensure a more comprehensive assessment of risk and protective factors
  iv. Alignment of child protection and adult mental health support plans and be explicit about what actions are needed to minimise the impact of parental mental health on the child and the role of adult mental health services in this.

6. The learning from this safeguarding practice review is shared across the SSCP and SSAB to support learning into practice and includes consultation with Salford's Parent Carer Forum (all learning points)

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[53] Information sharing advice for safeguarding practitioners - GOV.UK (2024