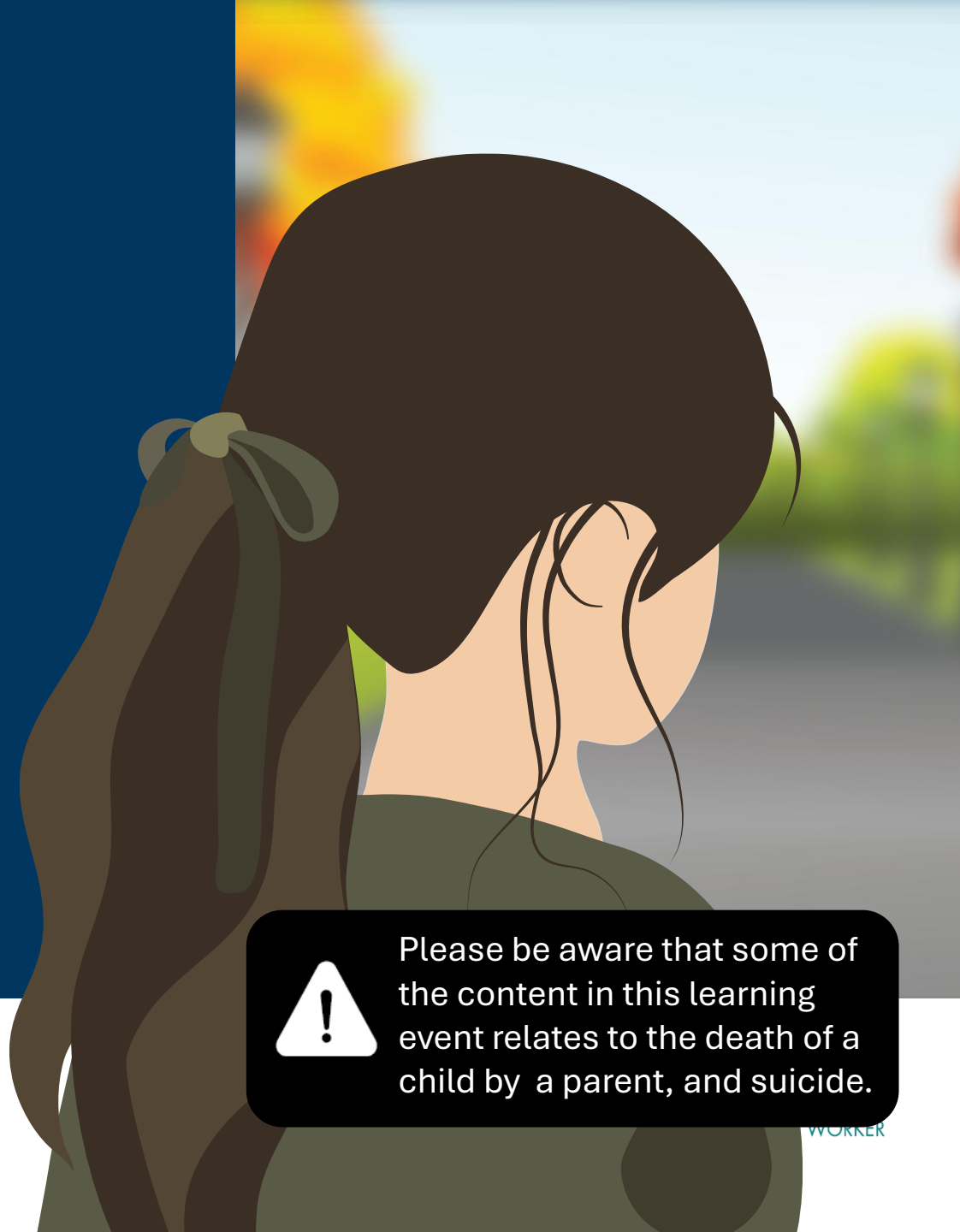
SSCP Multi-Agency Learning Event ‘Yvonne’

Salford
Safeguarding Children Partnership

Strengthening Support to Parent Carers

Reflecting on the learning from Child Yvonne Local Child Safeguarding Practice Review

Suzy Kitching MBE Independent Author



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What to expect from this learning

Session 1
Whole family working and mental health needs

- Why are we here?
- What did we learn: why does it matter
- Adult mental health needs
- Group activity and reflection

Session 2:
Suicide and homicide in parent carers

- Group activity and reflection
- Practice themes to make a difference
- Q&A with Panel: Next Steps
- Comments and reflections
- Useful information

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Learning outcomes

Reflect on Yvonne and her mother's life systemically.

Strengthened collaboration and communication between adult mental health services and children's services.

Improved understanding of the factors that influence suicide and homicide in family carers and what can be done preventatively.

Improved parent-carer assessments that work across adult and children's services, which fully appreciate the emotional impact of caring for children with long-term complex needs.

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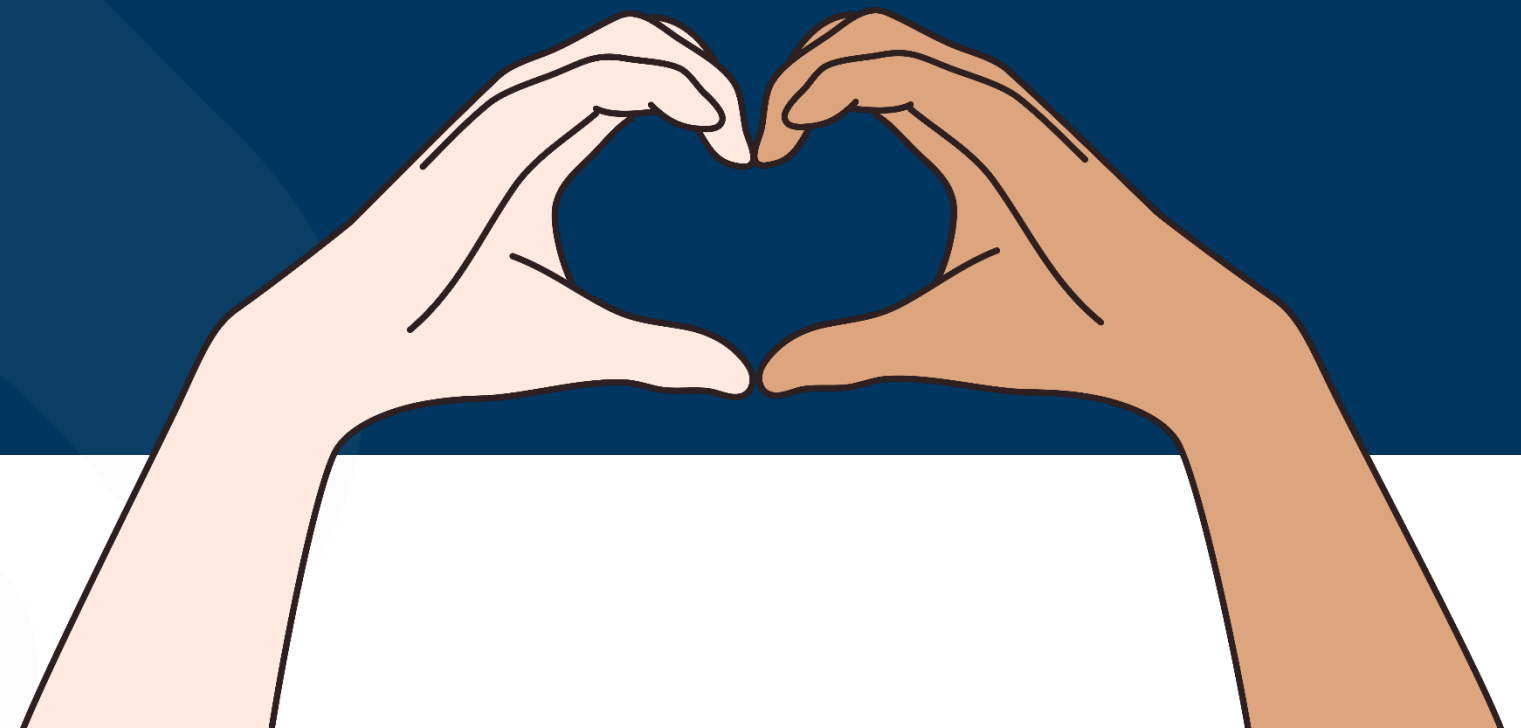
Why are we here?

To acknowledge and honour the lives of Yvonne and her Mother, and to share the findings and multi-agency learning from their tragic loss.



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Why do we Undertake LCSPR?

The purpose of child safeguarding practice reviews: Practice reviews | Salford Safeguarding Children Partnership

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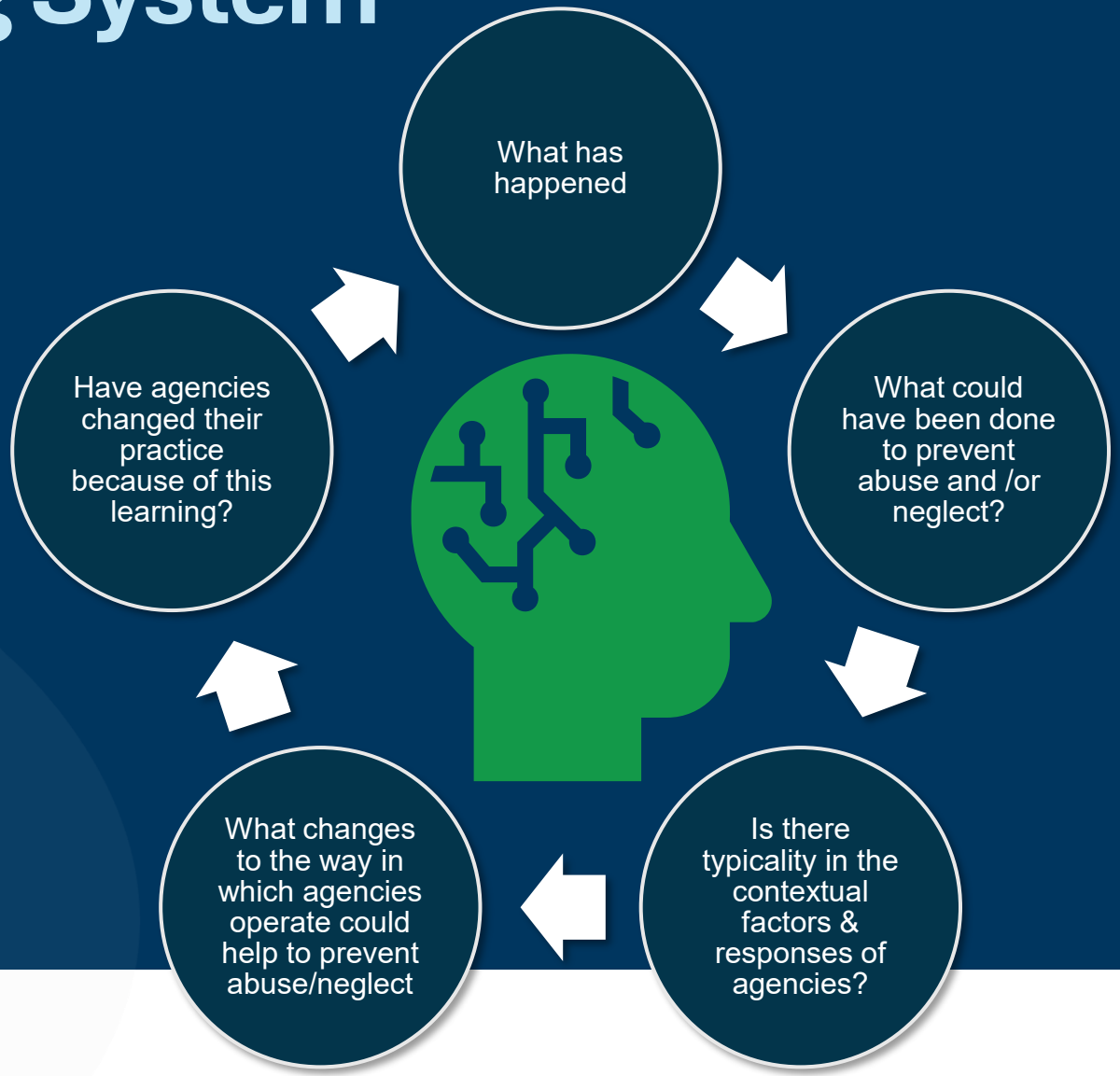
The Learning System



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Understanding the family

Yvonne was an only child who lived with her mother, who was her primary caregiver.

She had no contact with her father

Her maternal grandmother was an important part of her life

The family were of Polish-Italian heritage

Yvonne had a rare genetic condition resulting in complex physical, sensory, and learning needs, which meant she was identified as having a disability

Yvonne was entirely dependent on her mother for daily care and support, and a comprehensive multi-agency care package was in place.

Yvonne attended a special school full-time and had an Education, Health, and Care Plan (EHCP)

What did we learn?

Why, and what does it mean for practice?

Thematic analysis

1
How was Yvonne's voice and lived experience understood?

2
The effectiveness of multi-agency support across adult and children's services

3
Understanding parental mental health.

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Yvonne’s lived experiences

Yvonne was described as a smiley, playful little girl with a sense of humour who found joy in her interactions with familiar adults, particularly her mother

Yvonne was well-loved and was making good developmental progress.

Her mother’s care was central to her well-being.

Strength-based records focused on Yvonne as a ***child first***

Professionals showed warmth, care, and strong relationships

There was evidence of enduring relationships with Yvonne, particularly with health professionals and the school

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Yvonne's Mother's lived experiences

Mother shared her feelings of loneliness. She was conflicted about her role as a carer, and that nothing would change for her

Professionals recognised mother's strengths and care of Yvonne

They recognised the **'burden of care'**

Concerns about her mental health and suicidal thoughts led to a multi-agency Child Protection Plan (Emotional Harm)

A Carer's referral was made, but not progressed

The GP was persistent in referrals to adult mental health services for assessment

Limited family/community support due to disengagement.

A comprehensive support package was in place.

What does this mean for practice?

Key Learning Point 1

Parent carers of children with complex needs face increased mental health risks, including suicidal ideation.

Parent carers must be prioritised in suicide prevention strategies.

Importance of parent carer assessments that:

Understand the parental experiences of caring for children with complex and long-term needs- *'burden of care'*

Appreciate the psychosocial and physical impact on parent carers

Consider how these feelings may have contributed to the mother's feelings of shame, consequent isolation, and internal challenges

Multi-agency support across adult and children's services

Strong information sharing across CSC health, education, and GP

Prompt action was taken in response to initial concerns about maternal mental health

Family supported through a multi-agency Child Protection Plan

Multi-agency support across adult and children's services

Poor communication pathways between adult mental health services and children's services mirror national learning

- Case closures despite ongoing mental health concerns
- No adult mental health input into child protection processes
- Confusion over consent, differing interpretations of information-sharing
- Risk assumed reduced by referral alone
- Inconsistent engagement meant uncoordinated, overlapping voluntary interventions

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What does this mean for practice?

Key Learning Point 2

Developing a child-centred approach within a whole family focus

- Consistent, purposeful multi-agency information sharing
- Shared understanding across adult and children's services of the causal factors affecting parent carers, and the impact on Yvonne
- Clearly understood adult mental health support pathways
- Greater curiosity about who's involved and what they know
- Whole-family approach but understanding that this can unintentionally increase feelings of entrapment and risk for the parent carer

Understanding parental mental health

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Understanding parental mental health

Key Learning Point 3

Recognise the importance of conducting a holistic assessment that includes family history, child vulnerabilities, adult needs, and the complexities of the parent-carer role

There were some immediate responses to mother's suicidal ideation

The threshold for detention was not met, and mother declined assessment and support

There was a lack of clarity about the mental health referral pathways

Referrals were triaged by adult social care and the community mental health team, but there was limited exploration of the family situation

Issues of consent were misunderstood

Assessment of mother's mental health was undertaken in isolation

Mother self-reported her progress to children's services - no triangulation

What does this mean for practice?

Key Learning Point 4

It is important to understand the specific risks faced by parent carers, and to implement proactive strategies that promote safety and build resilience.

Although mother didn’t meet the criteria for complex mental illness, her mental well-being was significantly impacted by her role as a parent carer.

Mother's view was that mental health services were not meeting her needs.

This led to repeated disengagement from services, which was neither explored nor fully known.

What do we know ?

Recognise that even good, caring parents can kill their children, and indeed, for some parents, death may feel like the ultimate act of care

Filicide-suicide is rare; only a few involved parents were under mental health care

Suggesting either an absence of severe mental health issues or that they had not sought help

Consideration of suicidal ideation in parent carers must reflect the impact of complex and long-term care responsibilities

Suicidal ideation must be recognised as a risk for homicide, when a parent wants to die but does not want to leave their child behind

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Adult mental health services Learning from Child Yvonne

Helen Williamson

Safeguarding Families Lead
Greater Manchester Mental Health NHS Foundation Trust

Salford
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NHS
Greater Manchester Mental Health
NHS Foundation Trust

Mother –Mental health diagnosis?

Mother did not have a mental health diagnosis on her clinical records.

Her distress and depression were seen as contextual i.e., mental and emotional well-being issues in the context of challenging circumstances.

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Greater Manchester Mental Health
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Referral pathway

Referral pathway for mental health services in Salford

GP is always the first port of call

GP refers to the Referral and Assessment Hub

The hub triages the referral

- Living Well
- CMHT

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NHS Greater Manchester Mental Health NHS Foundation Trust

GMMH – internal review

Think Family strengthened in revised SOP

Team senior social worker to connect children and family teams to improve joint working and relationships

Structured notes to include a prompt to record and consider other services involved with the adult/ family

Professional curiosity at the point of referral and assessment

- Professional curiosity training was developed by the division for community teams
- Learning from Patient Safety Event 'Risk Formulation & Professional Curiosity' event held

Safeguarding Families Lead Role

Salford Safeguarding Children Partnership

NHS Greater Manchester Mental Health NHS Foundation Trust

What should have happened? –Learning

A Think Family perspective - what risk looks like in a child's life.

Knowing who is working with a family. Mental health services should have informed children's social care that they were involved and, when they were discharged, mum.

They should have been invited and involved in child protection meetings. Their information was crucial

Safety plans, risk assessments and care plans (adult and child/ family) should be dynamic - developed and reviewed frequently and jointly

What did mother need? The voice of the adult. Are interventions working? If not, why not?

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Mind the gap: tabletop activity

Use the Ecological Systems theory and Yvonne Timeline to support your discussions about whole family working.

1. Identify where support and systems helped Yvonne and her mother? How were the adult mental health risks understood? What got in the way?
2. How did mother's mental health influence interactions across systems?
3. Tell us what could be improved and how?

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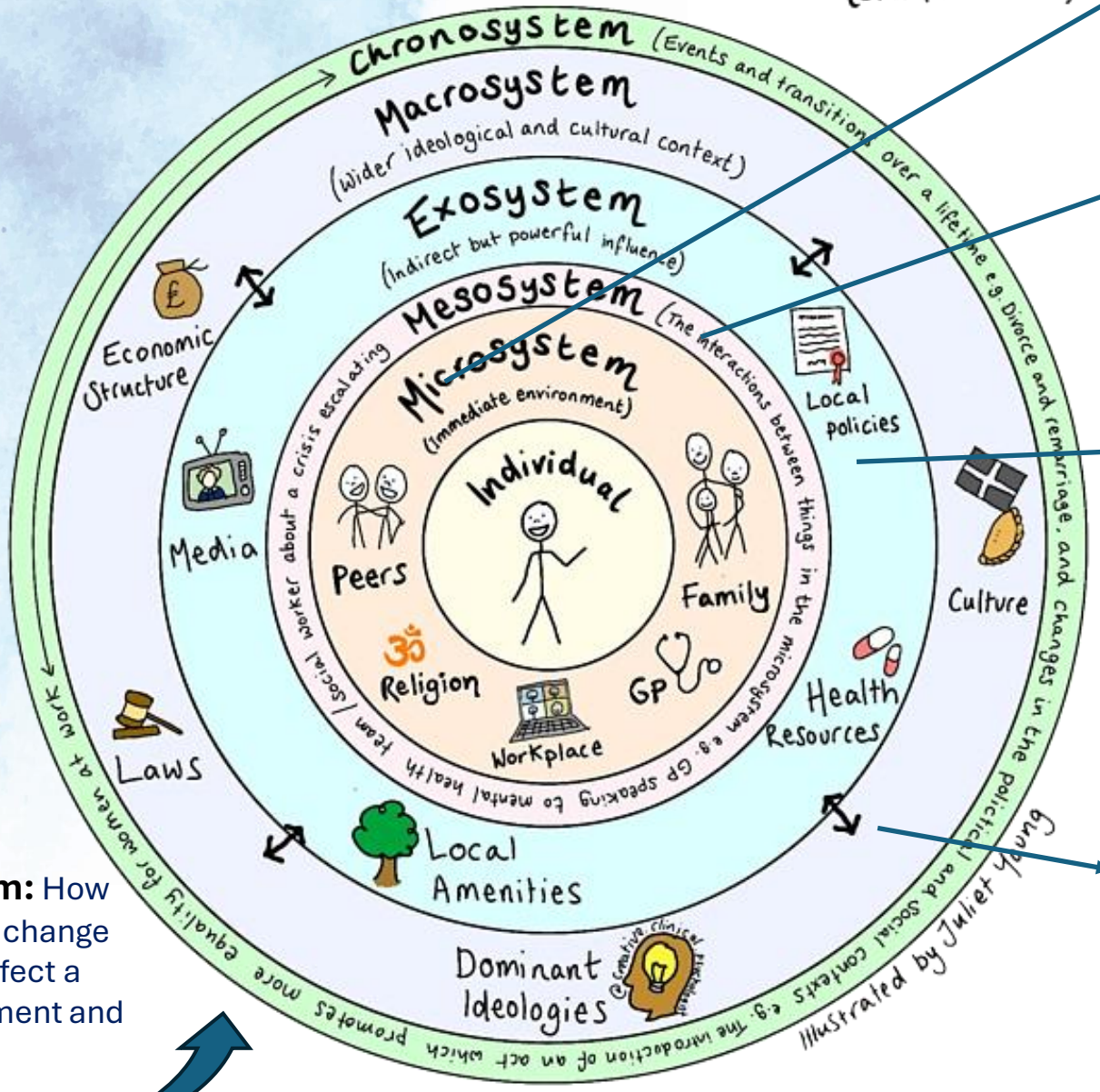
Ecological Systems Theory

(Bronfenbrenner, 1979)



Microsystem (immediate environment)
This is the **child's daily life**: their family, school, and healthcare. These are the people and places the child interacts with directly.

Mesosystem (professional connections)
This involves **how professionals work together;** for example, how school staff talk to social workers or how health professionals share concerns with family support services.

Exosystem (broader contexts)
These are things that **affect the child indirectly**, such as decisions made by professionals (e.g., GPs, commissioning providers) and local processes that impact the family, even if the child isn't directly involved.

Macrosystem (wider social, cultural and political environment). This includes **society's values, laws, and policies,** such as how we view disability, ethnicity, carers, and child protection, as well as what support is available for families' facing challenges.

Chronosystem: How time, life events change over time and affect a child's development and well-being

Time-line: Yvonne and her mother

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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.
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.**

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

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Understanding the Evidence on Suicide and Homicide in Carers

Dr Siobhan O'Dwyer
Associate Professor of Social Care
University of Birmingham

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Putting These Deaths in Context

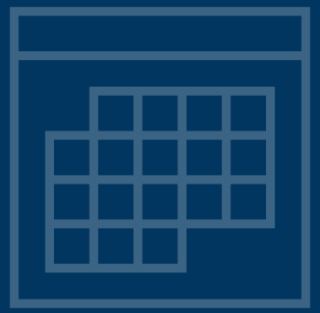
41%

of parent carers have thought about suicide

Of those:

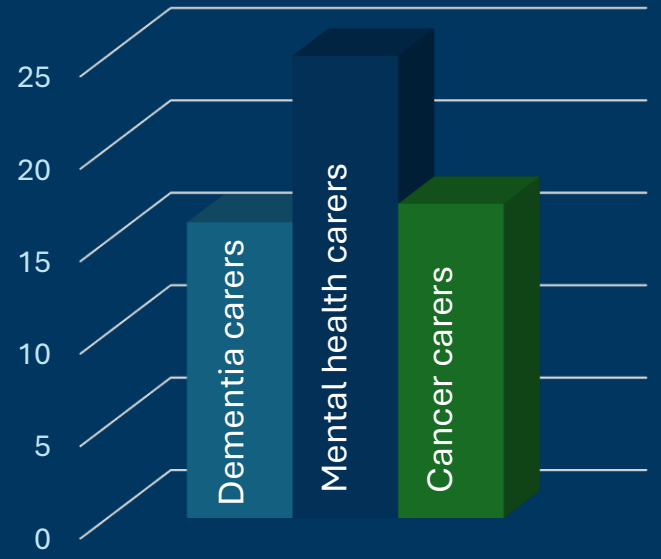
Two-thirds have thought about suicide in the last 12 months

One-third have made a plan to kill themselves in the last 12 months



Other groups of unpaid carers:

16% of dementia carers
25% of mental health carers
17% of cancer carers



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Risk Factors - Suicide

- Current or pre-existing mental illness
- Dysfunctional coping strategies
- Dissatisfaction with caring role
- Lack of support
- Conflict with family or professionals
- Entrapment

Also linked to thoughts of homicide...

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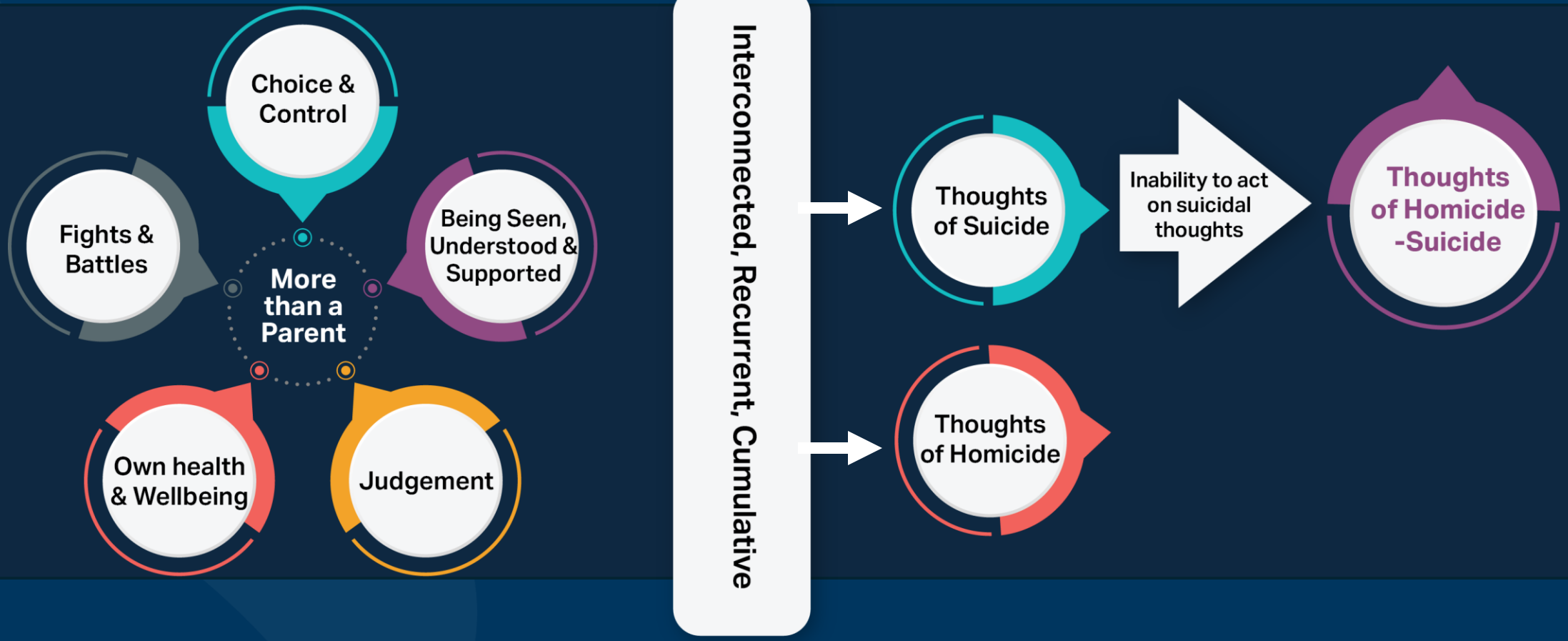
Risk Factors - Suicide



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Homicide

One homicide each month

Seven distinct types:

- Ending Suffering
- Burden of Care
- Neglect
- Pre-Existing Mental Illness
- Exploitation
- Carer as Victim of DVA/CC
- Carer as Perpetrator of DVA/CC

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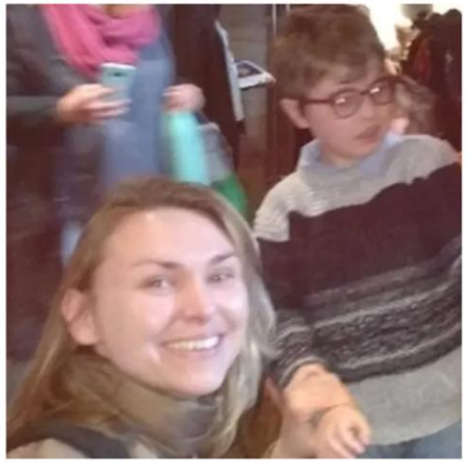
Dylan Freeman: Mother admits killing disabled son

25 January 2021



Police found Dylan Freeman in his mother's bed surrounded by toys

A woman has admitted suffocating her severely disabled son after suffering a breakdown.

Mother who killed two of her children was

LIVE FILM CATEGORIES NEWS MY LIST

CALENDAR | SHEFFIELD | Friday 28 August 2020 at 4:51pm

• Report by David Hirst

A woman who murdered her two eldest children and plotted to kill the other four was seen by professionals involved with the family as "a loving, caring and competent mother", a serious case review (SCR) has found.

Tania Clarence sentenced for children's manslaughter

18 November 2014

Tania Clarence was sentenced at the Old Bailey

A woman who killed three of her children by smothering them has been detained under a hospital order.

Tania Clarence, 43, of New Malden, south-west London, admitted the manslaughter of three-year-old twin sons Ben and Max, and daughter Olivia, aged four, due to diminished responsibility.

The children, who all had type 2 spinal muscular atrophy, were found at their home on 22 April.

Mum jailed for murdering five-year-old son at home

FAMILY HANDOUT

Lincoln Button was an "all-round" happy kid who loved trains and his toys, his family have said

Alex Stevanovic, at Basildon Crown Court and **Lewis Adams**, Essex

17 October 2025

A mother who murdered her five-year-old son while suffering a mental health crisis has been jailed for a minimum of nine years.

Claire Button, 35, attempted to take her own life after she killed her son, Lincoln, at the family home in South Ockendon, Essex, on 15 December.

She had been suffering from a mental disorder due to the "relentless demands" of the youngster, who was autistic and non-verbal, Basildon Crown Court heard.

Devoted mother from Hove spared prison after poisoning late son

by Frank le Duc — Sunday 31 Jul, 2022 at 12:50PM

A devoted and desperate mother from Hove has been spared prison after she was convicted of poisoning her profoundly disabled 10-year-old son before he died.

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Missed Opportunities

- Act on obvious warning signs
- Recognise the enormity of the caring role
- Recognise the caring role at all
- Understand that homicide can occur *without* a history of abuse or neglect
- Act on concerns raised by others
- Communicate across services

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Disclosure

Majority of carers have never disclosed

- Shame
- Stigma and judgement
- Fear

Those who disclosed say nothing changed

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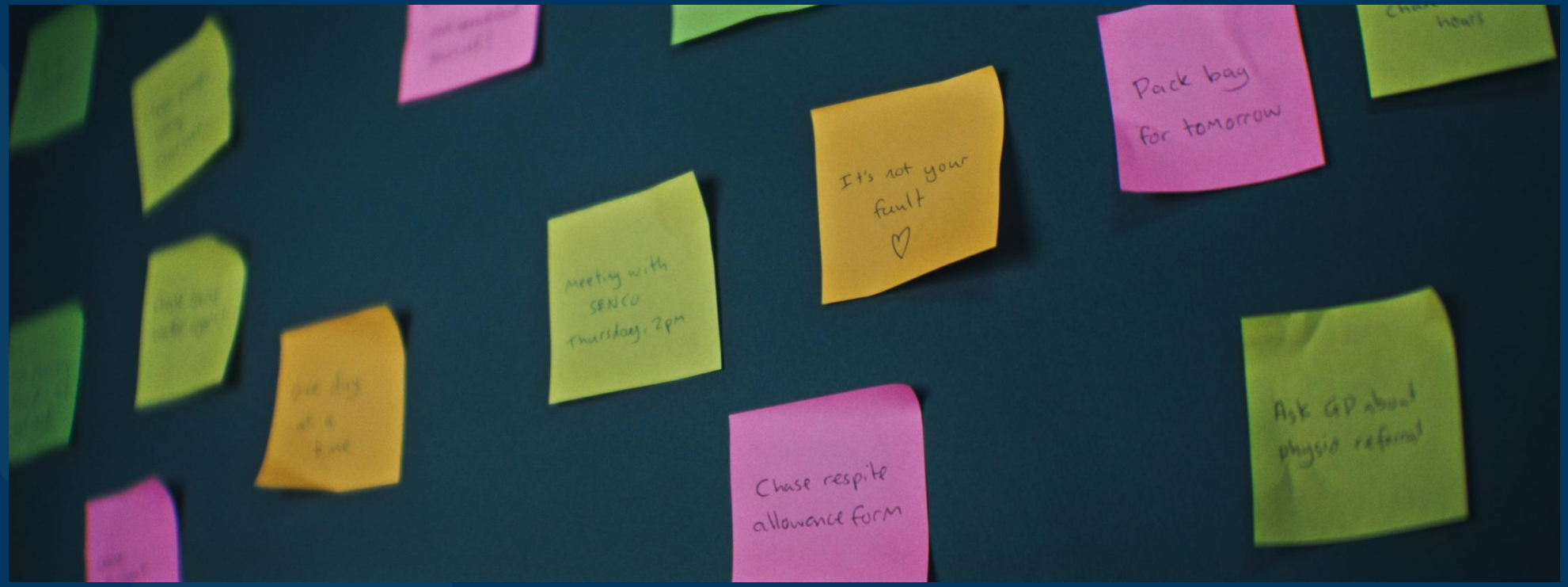
Invitations to Ask



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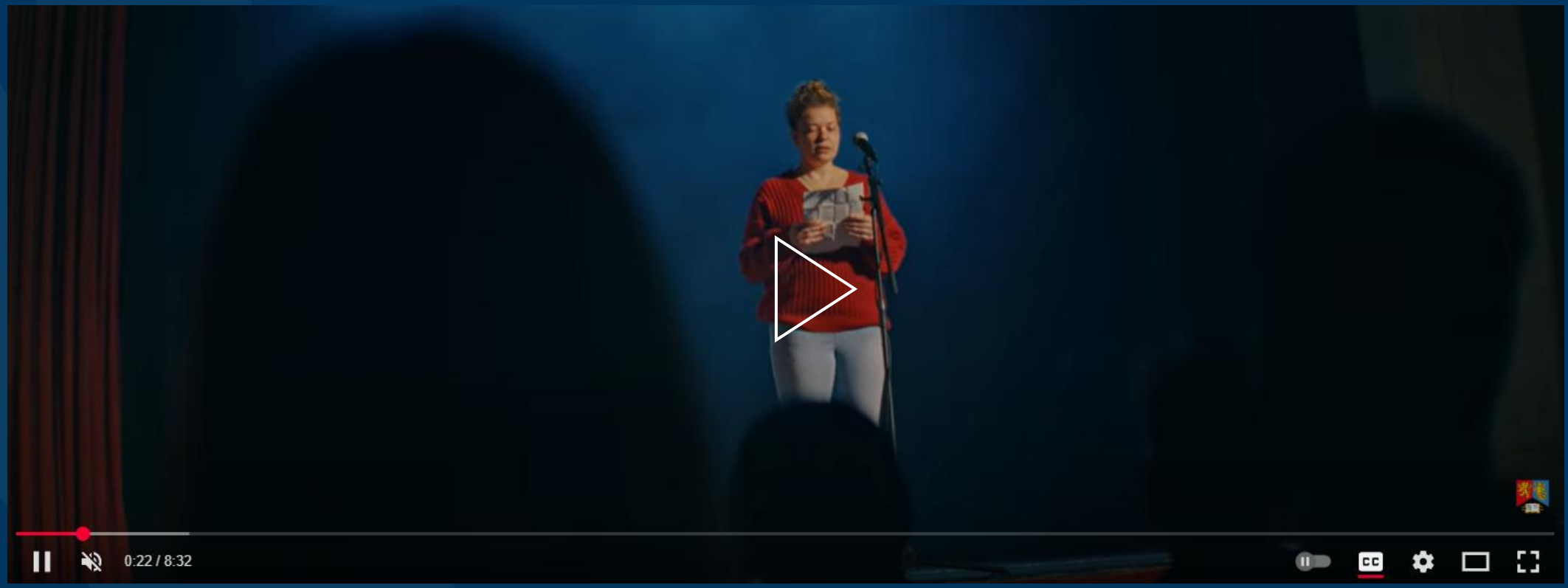

More than a parent

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National Issues

- Lack of funding for NHS, social care, and SEND
- No national Carers Strategy
- Carers not recognised in national Suicide Prevention Strategy
- No routine data collection
- Professionals not rewarded for good practice
- Courts & media representation

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This Case

- Mental health issue vs normal reaction to system problems
- Referrals to peer support and social prescribing
- Closing cases and failure to meet thresholds
- Missed connection between suicide & homicide risk
- Section 4 of the Mental Health Act
- Reluctance to ‘punish’ a good mother
- Hoping love would be enough

Reflective discussion

How confident would you be to ask a carer about…

- Suicide
- Homicide

What would worry you about, or stop you, asking?

What are you already doing well?

What would you need to take your good practice even further?

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Summary learning
Practice themes to make a difference

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Access these resources

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