Suffolk Safeguarding Partnership

Serious Case Review

Andy and Arin

Overview Report

October 2020

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Contents

1. Introduction

1.1 This joint Serious Case Review overview report has been commissioned by the Suffolk Safeguarding Partnership following two cases of filicide[1] and maternal suicides which occurred within a two-month period between 06 March and 26 April 2019.

1.2 The Serious Case Review (SCR) process provides an opportunity to address the questions set out in the terms of reference and more broadly allows for exploration, analysis and reflection on the lives of those involved, identifying opportunities to learn from their tragic deaths in an effort to reduce the likelihood of it happening to others.

1.3 **Initiation of the Serious Case Review (SCR)**

Working Together 2015[2] sets out the SCR criteria where:

A. abuse or neglect of a child is known or suspected; and
B. either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.4 After the initial referrals were made to the Suffolk Case Review Panel, the Chair of the Panel made the decision to initiate an SCR in both cases based on the fact both children were killed by their mothers who then took their own lives, and information was known to agencies which warranted further exploration. After the second case was reported, it was decided to conduct a joint review.

1.5 The Department of Education and Ofsted were notified about the case of Andy on 08 March 2019 and of Arin on 30 April 2019. The Chair of the Child Safeguarding Panel Review Process was notified on 09 April 2019 (Andy) and 04 June 2019 (Arin). Neither case is to be considered by the National panel.

[1] Filicide – Filicide is the deliberate act of a parent killing their child (Wikipedia)

[2] Working Together to Safeguard Children. Dept of Education 2015. The 2018 guidance was not used as it had not been fully adopted in Suffolk at the time of the decision to conduct the SCR.

2. The Approach Used

2.1. The Terms of Reference[3] for the review were agreed in June 2019 and the full version can be found in appendix one of this report.

2.2. The child subjects of this SCR are Andy and Arin. The scope of the review is between June 2015 and April 2019. This is the timeframe that covers the period of time between the births and deaths of both children. Each agency prepared an agency timeline of significant events (chronology) together with an analysis of relevant context, issues or events.

2.3. The full chronology of agency involvement was made available to the report author in addition to the Sudden Unexpected Death in Infancy and Childhood notes (SUDIC), Rapid Review notes and the Suffolk Safeguarding Childrens' Board Referral forms. The police allowed access to the reports prepared for H.M Coroners Inquests in respect of both children and their mothers.

2.4. The report author sought additional information from Children and Young People Services and Health during the review process and conducted open research in respect of academic studies into cases of filicide.

2.5. The families of Andy and Arin were invited to engage with the review process. In January 2020, meetings were held and attended by family members, the Suffolk Safeguarding Partnership Manager (SSPM) and report author.

2.6. The key themes for this review are:

1) The support provided to both the mother and father (as teenage parents for Andy), particularly around their emotional health and wellbeing.
2) The impact of the parent's emotional health and wellbeing on their parenting capacity.
3) The influence of the father and any support provided by him. (Andy).
4) Any concerns raised by multi-agency partners about the mothers or children leading up to their deaths.
5) To consider what life was like for the children – what was their lived experience?
6) To consider if there were any cultural issues which may have prevented the families seeking support
7) Understand any emerging themes from murder/suicides nationally.

2.7. The review was undertaken by an independent author, Tracy Hawkings. Tracy is a retired Senior Police Officer and has previous experience in Child Protection, Public Protection and Major Investigations. She was supported by a multi-agency Review Team who oversaw the analysis and debated the key learning identified and its implications for improving practice.

[3] Terms of Reference Vs 2 Agreed June 2019

3. The Background to the Children and their Families

3.1. This review will examine the cases of Andy and their mother who died on 06 March 2019, and Arin and their mother, who died on 26 April 2019.

Case of Andy

3.2. The parents of Andy met at a local school where they were both pupils. They were in different year groups with the mother of Andy being 17 months older than Andy's father. They were both teenagers (and children themselves) when Andy was conceived and born. The mother of Andy was aged fifteen when she fell pregnant and aged sixteen when she gave birth and their father aged 14 years old. The parents of Andy are not believed to have been in a relationship at the time of conception but did subsequently form a relationship which lasted up until three days before the tragic incident.

3.3. Following the birth on 13 March 2016, Andy's mother continued to live at home with her mother and teenage brother. At some later point, Andy's father also went to live with them at the family home. Although Andy's maternal grandfather did not reside within the family home, having previously separated from his grandmother, he maintained a close loving relationship with his children and Andy.

3.4. The mother of Andy, enrolled as a student at a local college, eight months after she had given birth. She also held a part time job. Andy's father was still at school throughout this period.

3.5. On 03 March 2019, the relationship between Andy's parents ended and Andy's father moved out of the house.

3.6. During the late afternoon of 06 March 2019, the maternal grandfather and the Uncle of Andy, arrived at the home address. It was they who discovered Andy and Andy's mother hanging suspended from the stairwell bannister. The ambulance and police service were called to the address and the paramedics in attendance certified their deaths.

3.7. Andy was aged 2 years and eleven months old at the time and the mother of Andy, aged 19 years old.

3.8. A search of the house discovered a number of notes/letters, written by the mother of Andy, in which she mentioned her struggles with mental health and alluded to being the victim of domestic abuse and coercive controlling behaviour at the hands of Andy's father. The notes also recorded that threats of harm had been made towards Andy by his father.

3.9. This case is being treated as a murder and suicide. The forensic post-mortems revealed the cause of death to be compression of the neck. A report has been prepared by the police for the Coroner's Inquest, which has not yet taken place.

Case of Arin

3.10. The parents of Arin both originate from the south west region of India. They met and married in 2013 and Arin was born in 2015. Arin's mother was 24 years old when she gave birth.

3.11. Prior to her marriage, the mother of Arin had studied in India and was awarded an engineering degree. She had previously, attended a pre-university educational establishment and achieved a distinction in Physics, Chemistry, Mathematics and Biology.

3.12. The parents of Arin had an arranged marriage which was facilitated with the assistance of the local high priest. The couple originally communicated through skype, as Arin's father was working in the UK. In July 2013, they met in person for the first time.[4] They married in September 2013 and Arin's mother, moved to England (Leeds) to join her husband in October/November of the same year.

[4] Source – Police report for Her Majesty's Coroner.

3.13. In 2014, after trying to conceive, the mother of Arin fell pregnant. She returned to India as she wanted the support of her family during her pregnancy and following the birth of the baby. Arin was born on 21 April 2015. In December 2015, she returned to Leeds with Arin, then aged eight months old to be with her husband.

3.14. The father of Arin was employed as a technical accounts manager for a software engineering company. Arin's mother was initially a full-time mother and later worked part time at a fast food outlet. The family lived in an end of terrace two bedroomed house.

3.15. At 17.52 hrs on 26 April 2019, the father of Arin returned home from work to find his wife and child dead. He immediately contacted the emergency services who arrived soon afterwards. Both were certified dead at the scene by the paramedics in attendance.

3.16. A note written by Arin's mother was found in the house and the case is being treated as a murder and suicide. A post-mortem examination revealed the cause of death to be incised wounds to the neck in association with neck compression.

3.17. The Coroner's inquest in respect of Arin was held on 06 January 2020. The Coroner concluded that Arin had died unlawfully and that the circumstances of Arin's death could not have been foreseen.

4. Summary of agency involvement with Andy and Arin

4.1. In respect of Andy and their parents, the scoping exercise revealed information was held by the following Suffolk agencies: - Children and Young Person's Service, Health (GP, Health Visitor and Ipswich Hospital, Emotional Well-being Hub), Early Years, Police and Ambulance.

Children and Young People Service (CYPS)

4.2. Prior to her pregnancy, the Children and Young People Service (CYPS) had minimal contact with Andy's mother. On 13 December 2013, a referral was made to them which resulted in an intervention from the Early Help Team who were asked to conduct some work with her in respect of healthy relationships, internet safety and keeping safe at work. She was seen at her school for a one-off session.

4.3. The father of Andy first became known to the CYPS in August 2006 (aged 5). This was following a Domestic Abuse incident between his parents over contact arrangements. His mother was physically assaulted by his father, the information recorded suggests he was not present at the time of the incident. An initial assessment was undertaken that did not raise any other concerns.

4.4. In July 2013 a referral was received advising of a verbal argument between Andy's paternal grandmother and a new on/off partner. Andy's father was not present when the argument took place. The CYPS wrote a standard letter to Andy's grandmother advising of the risks to a child who is present around Domestic Violence and advising her to get in contact if she wished to receive any further support. Just two months later another referral was submitted advising of a further verbal argument between Andy's grandmother and the same partner with whom she had been in a relationship for three months at that point.

4.5. On 08 October 2015, CYPS received a referral from the community midwife notifying them of the pregnancy of Andy's mother. Although the identity of the child's father was not known at this stage, it is recorded he was of a similar age. It was also recorded that they were no longer in a relationship. A referral was also made in respect of the unborn child. Background information revealed Andy's mother, had a history of violence and had received two community resolution tickets for common assault and Actual Bodily Harm (ABH). A threshold discussion was held at the MASH and a decision taken to allocate the case to the Child in Need Team to conduct statutory assessments on the mother and unborn child. It is also recorded that a referral would be made to the Family Nurse Partnership by the midwife.

Comment

There is no record that the referral was made to the Family Nurse Partnership. The service offers intensive support for up to 2 years for young parents. Hopefully in that time the young parents will have formed a trusting relationship with their nurse and may have been more willing to disclose any emotional distress. This was a missed opportunity to provide an enhanced level of support to both parents. (See appendix two and three for the current FNP referral pathway and proposed future referral pathway transfer guidance documents).

4.6. By 06 November 2015, the statutory assessment on Andy's mother was completed. The key information recorded aspects of her health which included the fact she suffered with asthma and eczema and was a carrier of sickle cell anaemia. She engaged well with the assessment, attending all scans and other appointments. She appeared confident and self-aware. She stated she was a calm person and had no anger issues albeit she did acknowledge the two incidents of assault for which she received community resolution tickets and was excluded from school as a result. Her new school reported her behaviour was good but noted that she did not socialise with other students. The school commented on the fact that, although Andy's mother had a poor working memory which meant it took longer for her to understand things, she was predicted to be capable of achieving 5 to 6 GCSE's.

4.7. At the conclusion of the assessment, the mother of Andy had not disclosed the identity of Andy's father stating he was not supportive and did not want to be part of the child's life. She did say he was aged 16 years old, which was later found to be untrue. She also reported she had no problems with her mental health, but the review has discovered she received support from a 4YP support programme, whilst still at school, because she self-harmed. The outcome of the statutory assessment was to close the case and initiate a pre-birth assessment in respect of the unborn baby.

4.8. By 30 November 2015, the pre-birth assessment had been completed. It concluded that Andy's mother had engaged well, and no problems were identified. A 'Child in Need' meeting was to be arranged due to her age (16 years).

4.9. The 'Child in Need' meeting was held on 11 December 2015, which was attended by Andy's mother and grandmother, her midwife and the deputy head of her school. Andy's mother received praise from all professionals for engaging well and being mature. No concerns were identified. She was asked about the child's father but did not disclose his identity. It is not unreasonable to surmise that she may have feared police involvement due to the fact he was under the legal age for consent. A referral was made to the children's centre based on the fact she was a single parent and a 'Child in Need'. Many positives were recorded but it was noted she had previous anger issues and had not disclosed the identity of the child's father.

4.10. On 15 January 2016, a second Child in Need meeting was held. No concerns were recorded, but it is reported that although the mother of Andy would not reveal the identity of the father, he did want to be part of the child's life. Andy's grandmother revealed she now knew who the father was and had met both him and his family. During the meeting, it was explained that because professionals did not know the identity of the unborn child's father, he could not be invited to or take part in the meetings or assessment process.

4.11. On 25 January 2016, CYPS received a referral from a school about one of their pupils who was thought to be the father of the unborn child. A strategy meeting was held on the basis he was aged 14 years old and was believed to have had sex with a 16-year-old female. There were no other concerns raised about him and there was a recommendation that the school nurse should have a discussion with him and his parents about safe sex. There would be no further action taken by the CYPS.

Comment

The Review Panel has subsequently expressed the view that, whilst consideration was given to Andy's father, in terms of underage sex, his role as a partner to a pregnant girlfriend or father to a new born baby was not considered even though the referral highlighted these factors.

4.12. The pre-birth assessment concluded on 01 February 2016. It included information about the dynamics of the relationship between the parents of Andy. The mother of Andy, disclosed that she had never been in a relationship with Andy's father and they disagreed on most things. Due to the fact the identity of Andy's father had only recently become known, he had not been part of the assessment process. The assessment found no concerns around mental health of Andy's mother, and none of the professionals involved had reported any other concerns. Andy's mother did admit to feeling anxious on occasion about the imminent arrival her baby.

4.13. On 03 February 2016, a social worker conducted a home visit and whilst there, the father of Andy turned up. The social worker had a brief conversation with him, and he admitted he had not really thought about the role he was to play in the baby's life. The social worker gave him their contact details as an offer of support. It was noted in the records that he was only 14 years old.

4.14. On 11 February 2016, a Child in Need meeting was held. No concerns were raised by any party involved. The mother of Andy reported she was uncertain as to the level of support she would receive from the child's father going forwards.

4.15. Andy was born on 13 March 2016. There were no problems with the birth. A case supervision meeting was held on 21 March 2016, and a final Child in Need meeting held on 23 March 2016 where the decision was made to transfer the case to the Team around the Child (TAC) service. it is noted in CYPS records that all was going well, including the fact that the father of Andy was by then offering support. The midwife had informed the social worker that Andy's father was receiving support from his school about becoming a parent.

Comment

The review panel have commented on the fact that there was no liaison with the relevant school to understand how they were managing the support provided to him on becoming a new father, and the fact that he was not considered for assessment as a teenage parent by CYPS.

4.16. At the time of the deaths in March 2019, CYPS were no longer involved with the family unit.

Health Visitor

4.17. The involvement from the health visitor service began from 23 March 2016 when Andy was subject of universal plus care, which is a service that provides support from the health visiting team bringing together a range of services for families who have additional complex needs. This service was offered due to the young age of Andy's mother.

4.18. At the new birth visit on 23 March 2016, a routine assessment of the Mother's mental health was carried out and no concerns were identified or reported. The assessment was repeated on 03 May 2016 and again no concerns were identified or reported. The family were seen again on 07 June 2016 at the 3-4-month check and for the last time on 27 March 2017 for the child's 12-month check.

4.19. By this time, the father of Andy was also living at the home of the maternal grandmother. No concerns were recorded other than some issues with regards to Andy's sleep patterns attributed to the fact that Andy slept in a shared a bedroom with the parents. It is recorded that good interaction between parents and child were observed by the health visiting team at each contact.

Health – GP and Emotional and Well-Being Hub

4.20. Between June 2015 and July 2018, the mother of Andy attended the GP surgery in connection with her diagnosed conditions, routine appointments and ante and post-natal appointments. There is nothing remarkable noted in respect of her medical records up until this time.

4.21. On 17 July 2018, Andy's mother attended the surgery and reported she had been suffering from low mood swings for a number of years, which started when she was about aged ten and were managed by the Suffolk Young Peoples' Health Project.[5] Since having Andy, she reported, her moods had worsened and she was having suicidal thoughts. She stated that Andy, was the reason that prevented her from taking her own life. She disclosed, she could feel herself pulling away from her child. The GP made a referral to the Emotional and Well-Being Hub (EWBH). This is a gateway to accessing mental health services for 0-25-year olds.

Comment

There was no thought or consideration given by those involved, to how the mother's difficulties might be affecting Andy. The Team around the Child service were still involved at that point.

4.22. On 20 July 2018, the GP surgery was sent an e mail from the EWBH to notify them that contact had been made with Andy's mother and a telephone triage assessment had been conducted[6]. During the assessment, she expressed a desire not to engage with in any therapeutic options within wellbeing or mental health services and did not want any onward referrals. She felt she did not respond well to therapy. She wanted to be prescribed medication and would use that in combination with her coping strategies. She gave her consent for the assessment to be sent through to 'Access and Assessment' for advice regarding medication. She was informed she could contact the EWBH directly in the future if needed.

4.23. On 24 July 2018, the GP surgery was sent an e mail by a Doctor from the 'Assessment and Advice Service'. He gave advice that it was appropriate to prescribe an antidepressant such as Sertraline. He also advised that as this appeared to be a long-term problem, it might be appropriate to reconsider involvement of psychological therapy after 6 to 8 weeks. An appointment was made for Andy's mother to attend the surgery to arrange a prescription.

4.24. On 13 August 2018, Andy's mother, attended the GP surgery but walked out without being seen. It is not known why she did this. There was no follow up by the GP surgery to ascertain why she had left the surgery or enquiry as to whether or not she still required the medication.

4.25. On 03 September 2018, an entry was placed on system 1 health visitor records in relation to Andy, to say they were no longer considered vulnerable and would no longer be subject of TAC or CAF involvement. It is not known whether or not, the CAF/TAC were aware of Andy's mother's longer-term mental health problems or her recent contact with her GP and the EWBH.

4.26. The mother of Andy attended the GP surgery on 08 October 2018 for the removal of a contraceptive implant. She stated it was no longer required.

Comment

There was no discussion during this consultation, around her mental health or enquiry as to why she left the surgery without being seen on 13th August in relation to her prescription for anti-depressants.

[5] Suffolk Young Peoples Health Project – Local charity which provides drop-in centre for young people aged between 12 and 25 for emotional and physical well-being.

4.27. Between 13 October 2018 and 31 January 2019, there were another 6 visits to the GP surgery for either Andy (5) or Andy's mother (1) with medical related conditions and again the issue of her mental health was not revisited. There was also one visit to the local hospital as Andy was suffering with an ear infection.

4.28. On 11 February 2019, there is an entry on the GP records that the specialist mental health nurse at the surgery had discussed Andy's mother with the GP following her contact with the surgery reporting low moods and anxiety. She had a telephone consultation with a specialist mental health nurse. This was her first consultation with a specialist mental health nurse, (albeit she had previous contact with staff at the EWBH), she reported suffering with persistent low moods and feeling drained and tired due to abnormal sleep patterns. She also reported she had a history of self-harm (cutting) but was not feeling suicidal. She stated she was currently at college, but her motivation was low, and she had been missing lessons as a result. She was asked but could give no reason as to why she felt this way. She stated she had a happy childhood and a supportive family. She gave information that she was bullied at school and was expelled for fighting, ending up in a pupil referral unit. She was advised to contact the EWBH to learn techniques to manage her mood swings and informed that the GP would be notified with a view to prescribing anti-depressants. The case was to be reviewed again in 2 weeks. Sertraline was prescribed by the surgery for the mother of Andy.

Comment

There seems to be no consideration given to the fact, she had a young child and the potential risks this presented. She disclosed a previous history of self-harm and to currently feeling low and anxious. She was advised to contact the EWBH when perhaps on this occasion, it would have been more appropriate for the SMHN to have made the referral on her behalf.

4.29. On 25 February 2019, there was a follow-up telephone review with a different specialist mental health nurse. Andy's mother reported feeling better and not experiencing any side effects from her medication. She engaged well and appeared bright and cheerful. She had not yet contacted the EWBH but advised she planned to do so.

Health of Andy

4.30. With regards to the health of Andy, they were diagnosed as a sickle cell carrier and suffered with asthma. Andy had other visits with unremarkable child illnesses and immunisations. Andy was usually accompanied to the appointments with their mother.

4.31. On 02 September 2017, Andy was taken to Ipswich hospital and then Colchester hospital. Andy had fallen from a bench the week before and initially could not move their arm. A lump appeared on Andy's clavicle. Andy's mother was advised to see their GP in 4 weeks if the condition had not improved.

4.32. On 08 March 2018, Andy was taken to Ipswich then Colchester hospitals following a fall from a bed. Andy was diagnosed with a buckle fracture of the right arm.

Early Years

4.33. Andy attended a private early years nursery. The nursery recorded 4 incidents where Andy attended with minor injuries.

(1) 10 January 2017, Andy's mother reported Andy had fallen whilst trying to walk and sustained a bang to the head and a grazed nose.
(2) 12 September 2017, a member of staff noticed Andy had a very small bruise on their bottom. Andy's mother was spoken to but could not account for how the injury had been caused.
(3) 07 February 2017, staff noticed Andy had a small bruise under the left eye. Andy's mother was spoken to again and stated Andy had fallen against a bicycle pedal.

(4) 08 March 2018, Andy's mother reported a fall in which Andy had sustained a fracture to their arm. On each occasion the nursery completed an accident report and, on this occasion, also conducted a risk assessment to keep Andy safe whilst in plaster. There was no record of Andy's father ever attending the nursery with him.

4.34. All of these injuries were thought to be accidental injuries appropriate to Andy's age.

Comment

None of the injuries to Andy were considered as non-accidental injuries and no referrals were made. However, consideration could have been given by the professionals involved to the family circumstances and identified there was a possible need for support.

Police

4.35. Andy's mother was known to police, receiving two community resolutions for assault and one for possession of an indecent photo (of herself which she sent to a boyfriend).

4.36. On 08 October 2015, the police received a referral from the community midwife reporting her teenage pregnancy (aged 15 years). There is no information recorded about the baby's father other than he was thought to be of a similar age. The case was discussed at the Multi Agency Safeguarding Hub (MASH) and referred to CYPS for further assessment.

4.37. On 22 January 2016, the Police received a referral from the MASH in respect of the 14-year-old father of Andy. He was named as the victim for an offence involving underage sexual activity. The suspect was recorded as Andy's mother. The Police decided to take no action as the sexual activity was considered to be consensual, and he was to be advised about safe sex.

Police Post Incident

4.38. The post incident police investigation revealed further detail as to the mindset of the mother of Andy in the days prior to the incident. It is clear she was deeply affected by her relationship and break up with Andy's father. In the notes found in her bedroom, she describes being subjected to controlling/coercive behaviour. This took the form of undermining, personal taunts and comments, threats and intimidation. It is clear the relationship with Andy's father, was a significant factor which had a detrimental impact on her mental health.

Agency Involvement with the family of Arin.

4.39. There is very little information known to agencies about Arin or their parents. The review established information was held by Health – GP and health visitor, early years and police post incident.

4.40. The first time the family became known to agencies in Suffolk was in October 2016, following their transfer referral from Leeds. By this time, Arin was aged eighteen months old.

Health

4.41. Between April 2015 and September 2016, the family were under the care of Leeds Community Health Service. The 8 to 12-month review conducted by the health visitor recorded that Arin was meeting all his developmental needs and milestones and was a very happy and sociable child who clearly had a good relationship with both parents. The family lived in a second-floor flat which was described as sparsely furnished but clean. It was cold in the flat which was heated by wall heaters. The health visitor discussed safety measures with the parents who both appeared receptive to advice.

4.42. When the family moved from Leeds to Newmarket, a transfer in visit had been arranged with the health visitor. There appears to be some confusion in the records as to the arrangements for the transfer in visit, but it took place on 20 January 2017.

4.43. Arin and their mother were seen on this date and the records reveal there was good interaction between them. Arin was being taken to lots of local groups and had a good appetite. The records note the fact that Arin's mother had been in the UK for 2 years with her extended family being in India. There were no health concerns identified.

4.44. There was a missed appointment for an immunisation for Arin on 12 June 2017, but Arin was taken into the surgery on 20 June and received the immunisation injection then.

4.45. On 02 August 2017, an appointment was offered to the parents of Arin following the completion of an ASQ[7] questionnaire which identified some minor issues with problem solving skills which focus on understanding. The view of the professionals was this was highly likely to be due to the fact the family were bilingual. Appointments were offered but could not be arranged until December because Arin's father informed the health service that his wife and child had gone to India and would not be returning until November.

4.46. The visit subsequently took place on 08 December 2017 and was conducted by a community staff nurse. The practitioner noted that Arin's immunisations were up to date, but their fine motor skills needed reviewing. The community nurse gave advice as she discovered Arin was sleeping in their parents' bed and appeared to have limited toys in the house. It was noted the family were bilingual, speaking both English and Kannada[8] The notes also recorded Arin attended nursery three times a week. A follow up appointment was to be arranged.

4.47. On 22 November 2017, the mother of Arin attended the GP surgery complaining of back pain, she was referred to a physiotherapist. She had her first physio appointment on 17 January 2018 and reported she had been suffering with pain in her spine and back ache since her pregnancy and her pain was getting worse. She disclosed she had a part time job at a fast food outlet. Another appointment was made for 22 February 2018 which she did not attend and so was discharged.

4.48. On 08 June 2018 the health visiting service contacted the mother of Arin by phone, she reported no concerns. She was advised to attend clinic for some healthy start vitamins.

4.49. On 3rd September 2018 and again on 22nd October 2018, Arin was taken to the GP for their immunisations and flu vaccine. The notes do not record who accompanied Arin on these occasions. That is the last recorded contact with health professionals, but Arin did attend nursery/preschool after that date.

Early Years

4.50. Arin attended a local pre School and was described by staff as a "lovely" and " kind". They had no concerns recorded. Arin was usually collected from nursery and preschool by their mother. Arin had been attending 3 days a week and good interaction between mother and child was observed.

Police Post Incident

4.51. There was no police involvement with the family prior to the tragic events on 26 April 2019. Following the incident, the police found a note which was written by the mother of Arin which provide a very strong indication of her state of mind at the time of the tragedy. It provides a graphic description of a woman in despair, who felt depressed, isolated and lonely. She wrote that she was not prepared for marriage or motherhood and was not coping with life. She stated she had failed as a wife, mother and daughter-in-law. She praised her husband stating he was

[7] ASQ – Ages and stages questionnaire which is a parent completed child monitoring system for social-emotional behaviours.

[8] Kannada is a Dravidian language spoken predominantly by people of Karnataka in Southwestern India and by minorities in other states in India.

loving and supportive and a wonderful father. The note also made reference to Indian culture and how she would be judged for making mistakes.

4.52. The father of Arin described his wife as struggling when she first arrived in England. She was scared to leave the house and do basic things like shopping. He said she always felt inferior to her older sibling who was more outgoing and dynamic and that he told her not to compare herself to anyone She was most happy staying at home watching the television or 'you tube'. This improved over time, particularly when she got her part time job. She had previously tried other jobs such as web design, but he stated she did not have the confidence to persevere with tasks that she struggled with and gave up on things easily. He described her as being a good wife who looked after him and referred to her as perfect. He could offer no explanation as to why she did what she did.[9].

4.53. The work colleagues of Arin's mother were interviewed as part of the police investigation. They described her as being very hard-working and reliable. She was generally a happy person, but they all noticed a change in her personality in the last 6 to 8 weeks of her life and described her as being tearful and depressed. She had lost her wedding ring and was very upset and anxious about it. On 25 April 2019, (the day before the incident), one of her colleagues who was also a former neighbour saw her in the staff room and described her being upset and tearful. She disclosed she was tired of her life and did not want to live anymore. She was concerned that there would be no-one to look after Arin. Her colleague tried to be positive and said she was lucky to have a loving husband and lovely child. In response she stated, her colleague did not understand Indian culture or how difficult it was to be a woman within it.

5. Involvement with the Families of Andy and Arin

5.1. In January 2020, the families of Andy and Arin were sent a letter by the Suffolk Safeguarding Partnership Manager (SSPM) informing them of the SCR process and inviting them to meet with him and the SCR report author. On 15th January 2020, meetings took place with both families.

Meeting with family of Andy.

5.2. The first meeting was held with the maternal grandparents of Andy. Also present was the partner of Andy's maternal grandfather. The review process was explained and in particular the role of family members. The family were invited to express their views on their dealings or knowledge of the professionals who had contact with Andy and their daughter and to give any information which they thought might benefit the review process. A long discussion was held around the use of a pseudonym, and the family are to give this matter some further thought.

5.3. The family did not have any specific comment to make with regards to the professionals involved in this case. They were aware their daughter struggled at times with her mental health which began in her early teens. They thought, in general terms, perhaps more could have been done to have supported their daughter with her emotional well-being. They described her as a wonderful young woman, who faced challenges head on and overcame them with grit and determination. They described her as a wonderful mother who doted on Andy. They stated she was deeply upset by the breakup of her relationship with Andy's father. It was only in the days leading up to the incident that they became aware of the problems within the relationship which, in their view, were made worse through the involvement of the family of Andy's father.

5.4. The family believe their daughters ill treatment at the hands of Andy's father, the breakup of the relationship combined with her fragile state of mind were the contributing factors which led to her actions.

[9] Source – Police report for H.M Coroner

5.5. The report author detailed the key points of learning with the family. They wanted some reassurance; they would be taken seriously and the recommendations adopted and actioned through the Suffolk Safeguarding Partnership (SSP).

5.6. The family did express anger in relation to the late notice of the serious case review process and described how the receipt of the letter came as a complete surprise and caused them further distress. They could not understand why it had not been explained to them earlier and felt they should have been given advanced warning. The SSPM acknowledged this point and apologised for the distress caused. An undertaking was given at the meeting to look at this aspect of the process through the SSP.

Meeting with the family of Arin.

5.7. The second meeting was held with the father and grandfather of Arin. Again, the SCR process was explained and included the important role the family had to play. The father described the family's contact with health professionals in both Leeds and Suffolk in a positive light. He felt it to be far superior to anything his family would have experienced in India.

5.8. The father of Arin was asked whether or not there were any cultural barriers which he felt may have impacted on his wife. He stated, that when his family lived in Leeds, there was a far larger Indian community but that his wife had not really engaged within it. He explained that his wife sometimes lacked confidence, and found it difficult to leave the house in the early days, but this improved when she got her job. She wanted to pursue a career in IT but found the world too competitive and stressful.

5.9. He could give no explanation to explain his wife's actions. He was unaware of her feelings of isolation or unhappiness within the Indian culture.

5.10. The report author detailed the points of learning with him. He agreed with them and felt perhaps more could be done by professionals to try and integrate transient families within the local communities.

5.11. He was asked if he had any observations to make about SCR process and he too, expressed the view that he would have liked earlier notice about the process as it would have prepared him better. He received the letter just before the inquests took place for Arin and his wife and this caused him unnecessary distress. The SSPM acknowledged the point and apologised. Assurance was given that this process would be considered by Suffolk Safeguarding Partnership.

5.12. The father of Arin, also expressed concern about the lack of counselling support he had received. He explained that he had kept himself together for the police investigation and inquest process but could now feel himself entering a void as he felt his life had no meaning or direction. He recognised he needed some counselling support and had discussed this with the representative from the victim support service but had heard nothing. An undertaking was given at the meeting to look at this aspect of the process through the SSP.

6. Analysis (Andy and Arin)

6.1. The review posed 7 key questions which are detailed at paragraph 2.5. The following analysis addresses these points.

Support provided to parents of Andy

6.2. The mother of Andy received excellent support from both the CYPS, GP and Health visiting service during her pregnancy and after she gave birth. Appropriate and detailed assessments were carried out including pre-birth and Child in Need assessments. This led to additional support being provided by the TAC service and Children's' Centre. During this period, she appeared to engage well with professionals and the baby flourished in her care.

6.3. There was limited support provided to Andy's father or any acknowledgement by professionals, that he was a child himself. Any support he did get was provided by his school. He was not considered by the CYPS as a young teenage parent or Child in Need and therefore not subject of any formal assessments which may have provided additional support to him, and the family unit.

6.4. In addition, there was a failure by the midwifery team to make a referral to the Family Nurse Practitioner Team (FNPT), which would have provided additional support to the family. Referrals to the FNPT could also gave been considered by the GP or health visitor.

Comment

It has been acknowledged that sometimes referrals were not made if it was known the FNPT were up to capacity. This issue has already been identified by the team and a new referral pathway has been drawn up and will be considered for adoption by the policy team by the end of 2019.[10]

6.5. In July 2018, the mother of Andy contacted her GP and disclosed she was suffering from low moods and anxiety and was feeling suicidal. She was appropriately referred to the Emotional and Well-Being Hub who engaged with her by telephone, in a timely fashion and in accordance with their policy. She was offered counselling but declined, requesting medication to help her cope. Arrangements were made for her to attend the surgery for her prescription, but she left the surgery without being seen. This was not followed up by the surgery or the EWBH despite the fact there were several opportunities for professionals to do so.[11]

6.6. In February 2019, she again contacted the GP surgery and reported her moods were getting worse. She had her first telephone consultation with a specialist psychiatric nurse practitioner, who advised her to re-engage with the EWBH and arranged for her to receive sertraline medication. She was contacted by telephone by another specialist mental health nurse two weeks later and reported feeling better. She had not made contact with the EWBH.

6.7. During the time Andy's mother was engaging with Professionals around her mental health, the TAC closed the case on Andy stating their mother was no longer a Child in Need. There was clearly a lack of communication between the Professionals involved and no consideration given to making a referral in respect of Andy despite the fact their mother had disclosed feeling suicidal, low and anxious and could feel herself pulling away from her Child. She also disclosed a history of self-harming.

Comment

With the mental health screening consultation document (Appendix 5), there is a section on risk and whether or not consideration should be given to making a safeguarding referral.

6.8. It is of concern, that at no time did Andy's mother have a face to face consultation with a mental health specialist and the onus appears to have been put on her following her contact on January 2019 to make contact with the EWBH as opposed to the professionals reaching out to her.

[10] See appendix 2 and 3 for current and new referral pathways for Family Nurse Partnership

[11] Refer to appendix 4 for the template for the mental health screening consultation process and appendix 5 for the mental health screening consultation document.

Support provided to parents of Arin

6.9. Arin was born in India and spent the first eight months of their life there. Arin then moved to England with their mother and came under the care of the Leeds Community Health team. The family transferred to Newmarket in 2016 and this was the first opportunity to engage with professionals in Suffolk.

6.10. The engagement of the family with professionals in Suffolk was limited and unremarkable. There were some appointments missed within health but follow up appointments were always arranged and attended.

Comment

The review panel has identified, that due to the fact Arin spent the first eight months of their life in India and later returned there with his mother for long periods of time, neither Arin or their parents were afforded the usual service provision from midwifery or health visitors and this is a point of learning.

The impact of parents' emotional well-being on their parenting capacity and influence of the father

Parents of Andy

6.11. The parents of Andy were both children themselves when Andy was born. Andy's mother was 16 years old and their father was 14 years old. In their formative years, they both had difficulties to overcome. In the case of Andy's mother, she had a history of self-harming, exclusion from school and involvement with the police for minor assaults and other matters. Andy's father came from a family where domestic abuse featured. He was also the subject of CYPS referral when aged 12, and again, at age 14 years old, when it became known he was the father of unborn Andy. It is highly unlikely that either of them were prepared for parenthood and required support from both professionals and extended family members.

6.12. The post incident police investigation has revealed concerns that the mother of Andy may have been the victim of domestic abuse in the form of coercive controlling behaviour. This aspect of the case is still the subject of an on-going police investigation. Three days before the incident, the father of Andy moved out of the family home as the relationship with Andy's mother had broken down. The grandmother of Andy, feeling concerned for the well-being of her daughter searched her room and found the letter which has previously been referred to in this report. As a result of finding the letter, Andy's grandfather visited his mother as he was also concerned for her emotional well-being. He did not disclose the letter had been found but expressed concern for her general well-being. During the conversation she opened up to him about the dynamics of the relationship with Andy's father including his alleged ill treatment of her.

6.13. As part of the police investigation, Andy's father was interviewed. He acknowledged that in recent times, he and Andy's mother had argued a lot. He described her as being possessive and that was the main cause for his unhappiness and the reason why he ended the relationship. He was a young man who as a child had experienced living in a household where domestic abuse featured and was now in a relationship himself which was both volatile at times and fragile. He was also having to cope with the challenges of teenage parenthood, without the support any professional agency.

6.14. There is no doubt, the emotional well-being of both of Andy's parents would have had an impact on their parenting capacity. The domestic abuse aspect was not known to the professionals involved at any point prior to the tragedy.

Parents of Arin

6.15. Professionals had limited involvement with Arin and their parents. There were no issues identified with regards to their emotional well-being which may have impacted on their parenting

ability. All agency involvement was positive, and Arin was consistently described as “happy, lovely and lively”.

Any concerns raised by multi-agency partners about the mothers or children leading up to their deaths.

6.16. There were no concerns raised by any multi-agency partners about the mothers or children leading up to their deaths. (Comment has already been made on the disclosure of the mother of Andy regarding her mental health and this should have been raised as a concern with other multi agency partners).

What was life like for the children – what was their lived experience

Andy

6.17. Andy and both parents, lived within the home of Andy’s maternal grandmother. Andy’s mother in particular was always described as a loving parent who engaged well with her child. Her extended family offered a loving home and additional support to that she received from the professionals involved. Andy met all relevant milestones and there were never any concerns identified in respect of the care Andy received from either parent. There were some reported injuries to Andy, the most serious being a fractured wrist following a fall. None of Andy’s injuries were categorised as non-accidental and are consistent with normal childhood bumps and bruises.

6.18. The review has revealed concerns that there may have been domestic abuse within the relationship of Andy’s parents. The three of them shared a bedroom and so it is not unreasonable to assume Andy would have been present and witness to it. Certainly, Andy’s Uncle reported hearing Andy’s parents fighting on occasions and often seeing his sister crying whilst holding Andy. In addition, Andy’s mother was struggling with her mental health and turned to professionals for support. She disclosed Andy was the reason that prevented her from taking her own life but she could feel herself pulling away.

Comment

There can be little doubt, the emotional turmoil of Andy’s mother, may have affected her ability to cope with motherhood. Despite the fact she reached out to professionals for support around her mental health, it appears as though no consideration was given to Andy.

Arin

6.19. Arin’s mother gave birth whilst in India and spent the first eight months of Arin’s life there with her family. Arin was then brought to England to be with both parents, firstly Leeds then Newmarket. There is very little known about the family who had limited dealings with professionals.

6.20. Arin was described as a lovely happy child and seen to interact well with both parents. Arin met all milestones and there were never any concerns identified apart from some minor developmental issues. These were attributed to the fact that Arin was brought up in a bilingual household.

6.21. The mental health/depression of Arin’s mother seems to have significantly deteriorated in the last couple of months of her life. The reason for the deterioration is unknown. No professionals involved with this case were aware she was struggling with mental ill-health.

Did any cultural issues prevent them from seeking support?

6.22. There are no known cultural issues in the case of Andy's family which prevented them from seeking support. They did access services and received support from agencies.

6.23. In respect of Arin's family, there has been significant research conducted in relation to women in particular, who are in arranged marriages and from cultures which would prevent them from seeking support. Perhaps the best indicators of this are contained within the suicide note of Arin's mother and the conversation she had with her work colleague on 25 April 2019 in which she indicated she wanted to die and commented on being afraid of being judged for making mistakes and how difficult it is being from an Indian culture. All of her struggles seem to have been internalised and not verbalised or disclosed to anyone except to a colleague on the day before she took the life of Arin and killed herself. This is an aspect which will need to be considered by Suffolk professionals in the future when dealing with people from minority ethnic groups. At no time, in the limited dealings with professionals did any agency concentrate their interaction on the emotional well-being of Arin's mother, despite knowing she was from a different culture, new to the country and new to motherhood.

6.24. A recent article written about mental health in India[12] describes the stigma attached to those who suffer with mental ill health. A direct quote describes

> *"people with mental illness are likely to avoid discussing their mental health concerns openly due to the fear of being labelled or judged. Furthermore, some people believe that mental illness can only happen to people who are 'mentally weak' and people who have 'too much money and time.' For these individuals, seeking support from a mental health professional is seen to be a sign of 'weakness'."*

Understanding on emerging themes on murder/suicides nationally

6.25. The most recent article on the subject of filicide was published in 2018, an article was entitled "Maternal filicide in a cohort of serious case reviews". [13] The study analysed data from maternal filicide serious case reviews which occurred between 2011 and 2014. These reports identified four key themes as being contributory factors in the cases reviewed. The themes were: domestic violence; maternal mental illness; separation and maternal isolation and the invisibility of the child (i.e. child not known to agencies)

6.26. In nine out of the twelve cases reviewed, the mother had made domestic abuse allegations including direct physical assaults and sustained emotional and sexual violence and coercive control. This culture of violence was noted to have a direct impact on mothers' health and well-being and in some cases was directly linked to deteriorating mental health or to self-harming behaviour.

6.27. While maternal mental illness was highly prevalent in the cases reviewed, severe mental illness was rarely identified before the fatal event and in many cases, there were no indicators of significant mental health or where they were indicators, the signs were missed by professionals.

6.28. Many mothers appeared isolated from their family and community. Among those who were isolated, their situation could be compounded by relationship breakdown, often precipitated by domestic abuse.

6.29. In most cases reviewed, the children killed by their mothers were previously unknown to social services as being at risk. To professionals, they presented as healthy, thriving children with no indicators of concern. The relationship between the mother and the child was typically perceived

[12] https://qz.com/india/1237314/fear-and-apathy-how-indians-look-at-those-suffering-mental-illnesses/

[13] Published by Warwick Research Archive Portal (WRAP) Authors Peter Sidebotham and Ameeta Retzer

by professionals and other family members as loving and warm, with the mother responding well to the physical and emotional needs of the child.

6.30. The paper concludes:

> *"Maternal filicides are, fortunately rare (less than 5 cases a year) They are extremely distressing, and those working in child and family welfare must do all we can to support families at risk. In a systematic review of maternal filicide, Friedman et al (2005) highlighted the limited state of knowledge of maternal characteristics that distinguish mothers at risk of killing their children. The heterogeneous and often hidden nature of these risks emphasises that it will not be possible to prevent all maternal filicides. Nevertheless, a deeper understanding of the characteristics of these cases may facilitate strategies that help minimise risk. Most importantly, practitioners must be aware of the impact of domestic violence on mothers and children, and the need to adopt a supportive but professionally curious stance, to be alert to signs of escalating stress or worsening mental ill-health; and to provide supportive and accessible structures for at risk families".*

7. Conclusion

7.1. This review has considered two cases where mothers have killed their children and then themselves in the most harrowing and tragic of circumstances. A joint review was commissioned to examine amongst other things, whether there were any common factors in both cases which would help inform the future of agency involvement and intervention.

7.2. It was a difficult comparison to make as so little was known about the family of Arin from an agency perspective. However, the post incident police investigation has assisted with the provision of information not previously known, which does establish there are common features in both cases.

7.3. In relation to domestic abuse, there were no concerns or incidents reported to the professionals involved in either case. There was reference to domestic abuse within the notes left by the mother of Andy and this aspect is subject of an on-going police investigation. In the note written by her, she describes being subjected to physical assaults and coercive control at the hands of Andy's father and being made to feel "ugly, worthless, stupid and weak".

7.4. The mothers of both children suffered with depression and mental health issues. The mental health of the mother of Andy was known to professionals and although she received support from her GP and the EWBH, there was little consideration given to the impact this might have on Andy. The mental health of the mother of Arin was not known to professionals and not explored in the limited interaction that she had with them.

7.5. The mothers of both children suffered from feelings of isolation and separation, but these feelings were hidden and not known to professionals. The mother of Andy was deeply affected by her relationship and separation from Andy's father, whilst the mother of Arin was affected by the separation from her family and deep-seated feelings of isolation within her culture. This was evidenced through the heart rending letters left by both women and through conversations with family members or work colleagues in the days prior to their deaths. It is hard to articulate the feelings of absolute desperation felt by both women written in their own words but never disclosed to the professionals who may have been able to help them.

7.6. In a study conducted by Oberman in 2003, he concluded "maternal filicide is committed by mothers who cannot parent their children dictated by their particular position in place and time

and that only when we come face to face with the desperation of these mothers can we begin to devise effective manners of protecting both them and their children. [14]

7.7. Although there were some missed opportunities to support the parents of Andy, there is nothing to suggest the deaths of either Andy or Arin could have been predicted.

8. Learning Outcomes

8.1. The review panel has identified the following as key points of learning;

Case of Andy

(1) Following the presentation of Andy's mother (a teenage parent) to health professionals with a history of self-harm and suicidal thoughts, there was no holistic risk assessment or referral in respect of either parents' ability to meet Andy's needs.
   (a) Professionals must consider the implications and risk for wider family members, especially children, when dealing with vulnerable people with mental ill-health
   (b) Professionals must be aware of the detail of the mental health consultation template which has a section on risk and safeguarding
   (c) Checks must be made by health professionals to establish if the patient, or child are known to other agencies or teams in order to share relevant information **(Recommendation 1).**

(2) The information held by the Primary Care teams and referral to the Emotional Health and Well-being Hub, was not shared with the Early Help team around the child.
   (a) The use of information systems and good practice in sharing information must be part of any procedure and practice guidance within any health settings. (Accountability and assurance framework).
   (b) Serious case reviews have highlighted that missed opportunities to record, understand the significance of and share information in a timely manner can have severe consequences for the safety and welfare of children. (Working ~Together to Safeguard Children 2018 (WTTSC 2018))
   (c) Practitioners should be proactive in sharing information as early as possible to help identify, assess and respond to risks or concerns about the safety and welfare of children. (WTTSC 2018) **(**Recommendation 1)

(3) There was no evidence found that any support was offered to the father of Andy either as a potential protective factor, or for his role as a teenage parent.
   (a) Agencies must review their assessment processes to ensure they include mechanisms to support teenage fathers
   (b) Professionals within the Multi-Agency Safeguarding Hub (MASH) need to consider the emotional/pastoral support of the person subject of the referral, even when criminal conduct is reported or suspected. (Recommendation 2).

(4) There was a lack of professional curiosity as to why the mother of Andy was rejecting all offers of therapeutic support and her subsequent failure to collect prescribed medication.
   (a) Professionals within health, need to be professionally curious as well as dealing with the clinical care of a patient
   (b) Professional curiosity is the capacity and communication skill to explore and understand what is happening within an adult rather than making assumptions or accepting things at face value. Professional curiosity can require practitioners to think 'outside the box', beyond their usual professional role, and consider circumstances holistically. Curious professionals will spend time engaging with

[14] Oberman M (2003) Mothers who kill: cross-cultural patterns in and perspectives on contemporary maternal filicide.

adults. They will ask questions (in an open way) and seek clarity if uncertain and will be open to the unexpected (Recommendation 3)

(5) All support provided to the mother of Andy from mental health professionals was as a result of a telephone consultation process, and the responsibility for follow up contact with the EWBH was left with her to progress.
   (a) The Care Navigator guidelines sets out the process for dealing with patients with mental health concerns and sets out the circumstances when a personal consultation should be offered. This includes someone who is reporting feeling suicidal. (Recommendation 4)
   (b) Professionals should consider making referrals to mental health support services on behalf of the patient or ensure the information is shared with the relevant support service (particularly when the case is open to that team - EWBH in this case). (Recommendation 5)

(6) There was no process in place to follow up the referral to the family nurse partnership.
   (a) Professionals need to be aware of the new referral pathway to the family nurse partnership
   (b) A process to be adopted which ensures the referral pathway is followed in every case involving young parents (Recommendation 6)

Case of Arin

(7) There is no evidence that any agency involved with the family of Arin, gave consideration to offers of support for potentially culturally isolated parents.
   (a) Assessment process for health visitors and midwives must be reviewed to ensure they include professional curiosity around impact and cultural isolation
   (b) Health professionals need to understand the concept of cultural competence which is defined as **-** the ability to understand, communicate with and effectively interact with people across cultures **(**Recommendation 7)

(8) Continuity of health assessments for transient communities
   (a) Health Visitors need to consider the support needs of transient families, particularly when from communities who may be culturally isolated
   (b) Health visitors must ensure greater diligence is paid to ensuring that health appointments are attended, and milestones have been met by children from transient families**.** (Recommendation 8)

Learning as a result of meeting with family members.

(9) The SSP needs to consider the timing and method of communicating the SCR process to family members. In this case, the late notification and invitation to take part caused additional and unnecessary distress. (Recommendation 9)

(10) The SSP must ensure there is a process through which bereaved family members can access appropriate and timely counselling services.

10. Recommendations

10.1. The review panel is making the following recommendations for the Suffolk Safeguarding Partnership and its agencies to implement:

(1) All organisations to review their assessment processes to ensure they include consideration of the impact on individuals, the subject of the assessment, and those they have care and responsibility for. The purpose of which is to identify whether a referral is required to access further support or raise a safeguarding concern. The assessments must include:

a. Consideration of risk to the child and any wider family members
b. Risks must be recorded, and consideration given to
    i. access to other support services
    ii. initiation of the safeguarding process.
c. Checks should be made to ascertain if the subjects are known to other teams.
d. Information must be shared with the other professionals involved with the family.

(2) All organisations to review their assessment processes to ensure they consider the support offered to young parents. There must be equity in the level of support offered to both.

a. This process must be embedded within the MASH to ensure emotional support needs are considered for all referrals.

(3) Professionals to consider the effect of parental mental health or physical needs when planning the level of service to be offered to families. This would require routinely viewing adult care records or discussing the family with services providing care to the parents. This is particularly important for new cases and those about to be closed.

a. Professionals within health, need to be professionally curious with regards to a patient's emotional well-being as well as their clinical needs.
b. Professionals need to explore the impact of mental ill-health on the wider family.
c. Assessments and case notes need to reflect that emotional well-being and risk factors have been considered.

(4) Professionals within Suffolk Primary Health Care, need to be reminded of the Care Navigator Guidelines and the circumstances when a personal consultation should be offered to a person in crisis, particularly those who are presenting as suicidal

(5) Professionals within Suffolk Primary Health Care should consider making referrals to mental health services on behalf of their patients (as opposed to relying on the patient to seek support themselves) and/or ensure the information is shared with the relevant support service.

(6) The new referral pathway to the family nurse partnership to be introduced across Suffolk Primary Health Care and a process implemented which ensures the referral pathway is followed in every case involving young parents.

(7) A Process to be introduced within healthcare, which reviews the level of support offered to newly arrived, transient communities, in particular

a. Support with potential isolation/links to community groups
b. Greater diligence to be paid which ensures that health appointments are offered and milestones met.

(8) A process to be implemented which allows for an ad hoc forum to be convened across adult and children's services for cases (that do not necessarily meet the criteria for a formal review).

(9) Suffolk Safeguarding Partnership to work with Suffolk Police (Head of Major Crime and Family Liaison Co-ordinator) and the Victim Support Service, to agree a process with regards to:

    a. Early notification to family members of the SCR process,
    b. Information being provided to family members with regards to the SCR process,
    c. Identification of the appropriate agency to communicate with family members during the early stages of the SCR Process.
    d. Early notification to H.M Coroner of the SCR process.

(10) Suffolk Safeguarding Partnership to agree and adopt a process which will enable bereaved families, to access timely and appropriate counselling services. This must include services which can offer bereavement counselling and more specialist support, such as counselling, for post-traumatic stress disorder.

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