**Malika and Rosza**  
**Learning Review 2017**

**Welcome** to this Learning Review Briefing to help practitioners and their managers understand the key messages from the review undertaken about Malika and Rosza. This review complements recent reviews including the ‘Patrick’ and the Thematic Serious Case Review (SCR) in particular the identification of neglect and hearing the voice of the child and/or young person.

**Who should read this?** Anyone whose work brings them into contact with children, young people and their families. The messages are as important for those working in adult services (where service users are parents or carers). The term ‘children’ includes children and young people up to 18 years of age.

**Why learning review?** Although this case did not meet the threshold for a SCR Bedford Borough Safeguarding Children Board (BBSCB) agreed that there was sufficient learning to be gained about how agencies worked together to merit a review of practice. The case showed how difficult it is for agencies to retain a child-centred focus when assessing the impact of parental physical and mental illness, particularly in relation to non-stereotypical perceptions of what constitutes neglect and when a parent has the ‘louder’ presenting issues.

**Family context** – their circumstances were unusual, the mother was morbidly obese and diagnosed with a variety of physical illnesses. The family appeared to have lived very separate lives, ‘virtually’ via the internet. The children described as ‘quiet and self-sufficient’ and excellent school attenders. The eldest child’s school was identified as a young carer and referred to the Multi-Agency Safeguarding Hub (MASH) for an assessment of need.

During the next four months, the children’s stepfather and younger half-brother returned to their home country. Their mother made two serious suicide attempts in quick succession and then successfully committed suicide, eighteen days after discharge from Mental Health Services.

What the Review identified was the importance of universal services in early intervention and of identifying need when thresholds were met. There was however, a mixed picture when different agencies communicated with each other. The use of multi-agency assessment processes was inconsistent and confused, particularly at known risk points such as discharge of mother from the protective settings of the psychiatric ward.

Across all agencies, practitioners who were involved with the family were inclined to take what both the children and their mother said at face value despite other evidence of possible emotional and physical neglect of the children. An attitude of professional curiosity requiring practitioners to think beyond their usual role and examine the lived experience of the children was often missing.

The needs of the mother overshadowed the needs of the children.

Although the mother’s eventual suicide was predictable the review did not find it was preventable. The main findings were as follows:

- The Single Assessment Process (SAP) is not used effectively enough.
- Confusion between practitioners about the use and purpose of multi-agency strategy meetings especially at hospital discharge.
- What families told practitioners is not triangulated with other data available.
- Child protection information is not consistently shared between those staff who know the children best.
There was good practice identified especially around incidents. Practitioners understood and worked to agreed thresholds of need.

Early identification of need (including risks) is beneficial to both children and parents; but agencies did not appear to fully consider the impact of the loss of their sibling on Malika and Rosza or on their mother, nor the cultural implications of her origins.

Some of the available information, (e.g. that there were more than three computers in the household) conflicted with other more stereotypical indicators of physical neglect.

There was not an effective ‘Team around the Family’ approach. The Single Assessment Process was not used as a two way process to share information between agencies.

Multi-agency meetings were not held after each serious suicide attempt and the impact on the children was not consistently considered.

Practitioners were confused about the purpose of the strategy meeting held at the point of discharge of mother from hospital and this focused on process and the needs of the mother rather than the needs of the children.

Schools play a crucial role in children’s welfare but safeguarding information was not consistently shared with staff who knew the children best. This was exacerbated due to suicide attempts happening during school holidays.

The report can be found on BBSCB website www.bedford.gov.uk/lscb on the Learning from cases and audits page and we recommend that you read it in full.

Visit our website www.bedford.gov.uk/lscb for more information and access to the child protection procedures

These include:

- **A Child Centred System:**
  Understanding Thresholds Information on early help, prevention, and statutory services for everyone working with children and families which includes an indicator of need matrix to assist practitioners in decision making.

- **The Early Help Strategy 2015-2018**
  which includes a list of the types of services available to support families with early help.

The issues highlighted in this review are not unique to Bedford Borough. The references listed below are recommended as essential reading for those providing services to young carers and their families:

- **Pathways to protection: a triennial analysis of serious case reviews 2011 to 2014** emphasizes the importance of ongoing information sharing and confusion around strategy meetings and highlights the following learning points:
  - Child protection agencies must feedback promptly to referrers and others participating in safeguarding.
  - Information must be triangulated and verified.
  - Keeping the family in mind: a briefing on young carers whose parents have mental health problems Barnardo’s (2005).

**No Health Without Mental Health**
Department of Health (2011)

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