

# Torbay Safeguarding Children Board

## Serious Case Review

C 18

## Executive Summary

15<sup>th</sup> November 2010

Working together to ensure every child stays safe in Torbay

# Serious Case Review

Relating to a child (referred to as C18<sup>1</sup>)

Born 2010  
Died Aged 10 days

Ethnic Origin: White British

Executive Summary

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<sup>1</sup> This is a system of notation used by Torbay LSCB to maintain anonymity of children

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## 1. Introduction

- 1.1. This is an Executive Summary of a Serious Case Review undertaken in accordance with Chapter 8 of HM Government Guidance *Working Together to Safeguard Children (2010)*. The Serious Case Review considered the circumstances of Baby C18 who died in 2010.
- 1.2. Regulation 5 (1.e) of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of *Working Together to Safeguard Children (2010)*<sup>2</sup>. This states that: "When a child dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family" Para 8.9.
- 1.3. C18 died aged 10 days, the cause of death, established through post mortem examination, was 'fatal asphyxiation'. C18's mother had a mental health problem whilst she was pregnant and after the birth. At the time of writing, criminal proceedings are in progress against the mother and she continues to receive psychiatric treatment.
- 1.4. The decision to hold a Serious Case Review [SCR] was made by the Chairperson of Torbay Safeguarding Children Board on 18<sup>th</sup> May 2010 on the recommendation of the Torbay Safeguarding Children Board (TSCB) Serious Case Review Sub-group. This group also set out the terms of reference for the review.
- 1.5. As described in *Working Together to Safeguard Children 2010 (8.5)*, the purpose of a Serious Case Review is to:
  - establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
  - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
  - improve intra- and inter-agency working and better safeguard and promote the welfare of children.

## 2. Serious Case Review Process

- 2.1. The SCR was carried out under the guidance from *Working Together to Safeguard Children, 2010, Chapter 8*. A Serious Case Review Panel (the panel) was established to oversee the process of the review. The panel was made up of senior representatives of agencies represented on Torbay Local Safeguarding Children Board. All panel members were independent of operational management of the services under review.

Panel Members represented the following services:

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<sup>2</sup> *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children (2010)* HM Government, London

Devon & Cornwall Police, Public Protection Unit	Detective Chief Inspector
Torbay Council Children's Services	Safeguarding Manager
Devon & Cornwall Probation Trust	Senior Probation Officer
Education	Head Teacher
Torbay Care Trust	Designated Nurse

- 2.2. The panel chair was appointed by Torbay Safeguarding Children Board as someone of experience and authority and independent of each of the reporting agencies. The role of the independent chair is to ensure that the SCR process is completed in as timely way as possible and is responsible for quality assuring the process and reports and requiring changes and further work where necessary, including challenging where there appears to be insufficient or missing information. The independent chair is responsible for ensuring that there is sufficient independence in the process.
- 2.3. The panel met on six occasions to confirm the Terms of Reference, to brief the IMR and independent Overview Report authors, to consider the agency reports and chronologies, to agree the conclusions and recommendations of the overview report and to draw up an action plan to ensure that the recommendations are translated into action and changes implemented.
- 2.4. The Overview report was written by someone entirely independent of all of the agencies involved and had appropriate experience and expertise.
- 2.5. Individual Management Reviews (IMRs) were requested of all agencies involved with the family in accordance with Working Together guidance. It was ascertained that the only agency involved in the care of the family was health and IMRs were requested from the following health organisations:
  - South Devon Healthcare NHS Trust – midwifery services
  - Devon Partnership NHS Trust – mental health services
  - Torbay Care Trust – primary care, health visiting service and service commissioning. The latter also constituted the health overview report
- 2.6. The Police and the Ambulance Trust also provided information about their only contact at the time of C18's death.
- 2.7. Each agency produced a chronology and report of its involvement with C18's family based on a review of its records and interviews with relevant staff. Each report provides conclusions and recommendations for the individual agency. Action plans for putting the recommendations into place were also drawn up. IMR authors were independent of any line management responsibility for services provided to the family members.
- 2.8. The purpose of an IMR is to look openly and critically at individual and organisational practice, to establish whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about. Any significant concerns identified relating to practice should be responded to as soon as possible to ensure that all children receiving a service are safeguarded.
- 2.9. The IMRs and the Overview report and the Action Plans were submitted to the Torbay Safeguarding Children Board on two occasions for their agreement of the content and the recommendations.

2.10. The review covered the time from the start of the mother's pregnancy with C18 until his death.

### **3. Family Involvement**

3.1. Due to the mother's illness and the criminal proceedings it was not possible to involve her directly in the review.

3.2. The chair of the panel and the overview author met with the father of C18, his paternal grandmother and his maternal grandparents. Family members had the basis, background and processes involved in the SCR explained to them. They were asked to discuss their perceptions of the events and to make any comments they wished about agency involvement with their family in relation to C18.

### **4. Background to the case**

4.1. C18's parents are a white British married couple who lived in their own home in a small coastal town. The mother had been working as a teacher before and during her pregnancy. The mother had a history of mental health problems dating back to when she was a student. She had been on anti-depressant medication for much of her adult life. She did not disclose this to her husband and did not want him to know. She stopped taking her medication when she became pregnant. She was reluctant to tell some of the professionals working with her about her mental health problems.

4.2. During the latter stages of her pregnancy her mental health deteriorated, her family were very concerned and very supportive of her. She was referred by her GP to the mental health services and she was assessed by professionals from that service. She was registered with a GP where she had lived prior to her marriage and did not change GPs until after C18 was born. She was again prescribed anti-depressant medication and was referred for specialist mental health intervention whilst she was pregnant and specialist psychological therapy after the birth.

4.3. C18 was born without any complications and mother and baby were discharged home. They received follow up at home from the midwifery service but from a different team from that which saw her during the pregnancy. Mother and baby registered with a new GP in the town where they lived. The mother's mental health became worse again soon after C18 was born. She saw her GP and family members contacted the mental health service to express their deep concerns about her condition. Contact between the mental health services and the mother was arranged for afternoon of the following day. Tragically the mother suffocated C18 on the morning of the following day.

### **5. Key issues**

5.1. **Confidentiality and Information Sharing** - C18's mother was very reluctant for information about her mental health condition to be shared. She denied that there was a problem to the midwife at the beginning of her pregnancy and also when she was in hospital for the birth. This resulted in practitioners having to make decisions about whether they could or should breach the mother's confidentiality and share information with other practitioners and family members. All health practitioners are bound by a duty of confidentiality and although there is guidance about when this can be breached without the patient's consent it is dependent upon the practitioner considering that this threshold is reached. In this instance the potential concerns about the welfare of the baby were not given sufficient weight when practitioners considered the need to share information.

- 5.2. **Continuity of Care** – The mother was registered with a GP practice before and during her pregnancy in a different location to her home address. This resulted in her being cared for by different teams and an increased number of practitioners. This meant that practitioners were less able to identify changes and especially deterioration in her mental state. There were a number of instances highlighted in the review when the transfer of care and information was not as good as it could have been.
- 5.3. **Inter-agency Working** – Although only health organisations were involved in the care of this family there was evidence of deficits in the liaison and communication between them. During the time period of the review a clinical network and pathway was in the process of development, had it been in place it would have provided practitioners with a structure that would have meant that the services offered to this mother may have been better co-ordinated. There was some communication between practitioners from different services but it was patchy and not always documented. Although the South West Child Protection Procedures have a protocol for addressing situations where there are concerns about unborn babies this was not used as it was not identified that the situation met the threshold at which it should have been put in place. The mother's need for confidentiality also inhibited communication and co-operative working.
- 5.4. **Focus on the Child** – the unborn baby was not the centre of focus for practitioners, the needs and wishes of the mother tended to outweigh the needs of the unborn baby. Had there been more focus on the child practitioners may have been more likely to use the planning mechanisms that are in place and more likely to have shared information in the best interests of the child, in spite of the mother's wishes. They may also have felt more able to engage with family members, particularly the child's father in planning for the mother's care.
- 5.5. **Involvement of the wider family** – family members were very involved in supporting the mother and in attempting to highlight concerns to practitioners. Their views were not given as much consideration as they might have been. A 'Think family'<sup>3</sup> approach, as per the policy initiative of the same name, may have improved the communication and involvement of wider family members who had more knowledge of the mother and were providing the day to day support and care of mother and baby.

## 6. Good practice

- 6.1. The antenatal input by the health visitor and the visit after the birth was additional to the standard service specification.
- 6.2. The input of the GP who saw the mother after the birth of C18 was thorough, painstaking and beyond the expectations of the commissioned service, especially in light of the paucity of available information, albeit that the outcome suggests that the conclusion may have been misjudged.
- 6.3. The use by the midwifery service of the Inter-agency communication form provided a systematic way of sharing information between and within services; it could helpfully have been used earlier than it was.

## 7. Lessons to be Learned

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<sup>3</sup> Think Family Toolkit: Improving support for families at risk; Strategic overview (2009) DCSF

- 7.1. Practitioners attached a high priority to maintaining the mother's confidentiality based on the belief that her mental ill-health did not reach a threshold for breaching confidentiality without consent. There was a failure to consider whether the risks to the unborn child justified information sharing with other practitioners and family members without the mother's consent. When a practitioner is requested by a service user to maintain their confidentiality and by so doing there are potential implications for the welfare of a child (born or unborn), but the professional judgement of the practitioner is that the public interest/safeguarding threshold for breaching confidentiality is not met, the practitioner should seek advice and consultation with their supervisor or another senior practitioner with safeguarding expertise e.g. a named or designated professional. The decisions and the processes involved in making the decision must be fully documented. There is a need for practitioners to "be curious and to think critically and systematically"<sup>4</sup> in order to understand what is happening to children and families. The threshold for seeking supervision about these situations should be low.
- 7.2. There is indication that practitioners were to some extent influenced by the socio-economic status of this family. Practitioners must guard against what has been described by Dingwall et al<sup>5</sup> as 'cultural relativism, having elastic norms linked to cultural differences'. Although this concept normally relates to practitioners lowering standards with respect to families where expectations are low, it also is relevant in this situation where practitioners were influenced by the professional status of the service user and consequently less willing to challenge them. Professional or clinical supervision can support practitioners in challenging their thinking and attitudes to families and situations.
- 7.3. There was a strong focus on the needs of the mother, in some instances, to the exclusion of the needs of the baby. When working with pregnant women the needs of the unborn child must always be given paramount consideration and where there are potential safeguarding issues the threshold for information sharing, including without consent must be lower than would otherwise be the case. This is especially true with respect to fathers who should, unless there is overwhelming reason otherwise, for example domestic abuse, be involved in decisions about their unborn child.
- 7.4. If parents fail or refuse to co-operate with assessments, are hostile, non-compliant or display disguised compliance and there are concerns that the needs of a child, including unborn, are not being met practitioners must be assertive and authoritative in their approach to ensure that children's needs are not subsumed by the needs and wishes of the parent(s). They also need to be supported by robust supervision.
- 7.5. There were a number of services involved with this family and within each a number of practitioners had contact. This resulted in some fragmentation of care and practitioners were working without access to all relevant information. For some users of services it is important that continuity is provided by consistency of worker and the 'continuous caring relationship', this was initially available to the mother through the GP and to an extent the health visitor. However it is not generally a model of care that is either possible or ideal in the provision of specialist care, the appropriate specialist practitioner must provide the care. What is essential however is that care is delivered

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<sup>4</sup> Brandon, M et al (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005, DCSF

<sup>5</sup> Dingwall, R., Eekalaar, J. and Murray, T. (1983) *The protection of children: state, intervention and family life*, Oxford: Blackwell.

in a way that is integrated and seamless, so that service users do not have to repeat their history over and over again and that practitioners have easy and direct access to all information that is relevant to the delivery of care to that individual. This requires clear, systematic planning of care and good documentation of basic facts, assessments, decisions, actions, treatment plans and outcomes. There were obvious deficits in this respect illustrated in this case.

- 7.6. Multi-agency intervention with parents of unborn children for whom there are potential safeguarding concerns should be systematically planned using appropriate protocols and care pathways. Working within a multi-agency system requires information sharing and co-ordinated planning. The cross organisational perinatal mental health care pathway, which is in the process of being developed within the area, has the potential of providing a framework that, had it been in place, would have been very influential in the management of this case. It is essential that the drift in its development, described in the health overview/commissioning report does not continue.
- 7.7. A number of gaps in the maintenance of sufficiently detailed and robust records were identified within IMRs. These gaps were particularly evident with respect to informal contact between practitioners. This led to uncertainty about whether or not actions had been carried out or completed.
- 7.8. Sharing of information between practitioners both within the same service and in an inter-agency context must be clear, consistent and well-documented on all occasions. This is even more important when there are risks to a child or where there are professional dilemmas, such as breaching confidentiality.
- 7.9. Practitioners need constantly to consider the influence, roles and responsibilities of fathers and wider family members in the care of children, even before their birth and seek, as far as possible and safe to involve them in assessment, planning and intervention.
- 7.10. It is important that lessons learned from previous SCRs, both nationally and particularly locally are embedded into practice. There are some resonances between this case and previous SCRs undertaken by Torbay SCB especially in relation to information sharing, failure to use the South West Child Protection Procedures Unborn Baby Protocol and disguised compliance. The timeframe of this review overlapped with that of previous Serious Case Reviews, therefore the actions and changes in practice resulting from these had not come into effect during the period of this review.

## **Recommendations**

### **8. Inter-agency Recommendations**

- 8.1. To ensure improved outcomes for children Torbay Local Safeguarding Children Board (SCB) should endorse the recommendations and action plans of the individual agency IMRs and ensure that there is a robust mechanism for monitoring their implementation and evaluating their effectiveness.
- 8.2. To ensure that there is planned, co-ordinated and comprehensive child and family focussed intervention Torbay SCB should, by working with partner agencies, holding them to account and having strategic oversight, ensure that there is a clear multi-agency pathway for working with families where there may be concerns about the

mental health of parents and carers. This should be embedded in practice guidance and training available for practitioners across all agencies.

- 8.3. To promote improved and co-ordinated services to pregnant women with mental health concerns and thereby safeguard their babies Torbay SCB should ensure, by holding partner agencies to account, that work currently underway in health organisations to develop a care pathway and network with respect to perinatal mental health is completed and implemented and fully takes account of other legislation, multi-agency procedures and guidance, especially those contained within the South West Child Protection Procedures and specifically the Unborn Baby Protocol.
- 8.4. To support practitioners in providing safe care for children Torbay SCB should ensure that all safeguarding training, both single agency and inter-agency, clarifies the circumstances when the need for information sharing to safeguard children and unborn babies takes precedence over the duty of confidentiality to adults. It should also emphasise the importance of comprehensive documentation of decisions, the reasons for decisions and actions taken.
- 8.5. To improve the outcomes for children whose parents and carers have mental health problems Torbay SCB should ensure that agencies have clear standards, focussed on the needs of children and unborn babies, for professional supervision for front line workers which identify clearly the circumstances in which case supervision must be accessed.
- 8.6. To strengthen the process of Serious Case Reviews Torbay SCB should develop guidance and briefing for senior managers in partner agencies to define and explain their roles and responsibilities with respect to the timely submission, 'sign off' and engagement in IMRs and to provide appropriate welfare support for involved practitioners.

## 9. IMR Recommendations and recommendations for individual agencies

### 9.1. South Devon Healthcare NHS Foundation Trust

#### Review

- To update the organisational policy on the care of pregnant women with mental illness. To include a multi-professional / multi-agency clinical pathway that provides support and guidance to professionals caring for this group of vulnerable women.
- Through audit of documentation and staff survey review the use of the SWCPP 'Unborn Baby Protocol' within the maternity service
- To update the departmental policy regarding communication between professionals to include:
  - the gathering of information from GP's following the first contact in pregnancy to identify any undisclosed risks
  - the handover of care between midwifery teams, formalising the process for practitioners

#### New

- To develop an education and training programme for practitioners within the maternity service regarding implications of mental illness on pregnant women and their families.
- To work in collaboration with the commissioners in the development of a perinatal mental health network locally to support the clinical pathway

## 9.2. Devon Partnership NHS Trust

### **New**

- A multi-agency Perinatal mental health service should be developed across Devon and Torbay that has a clear care pathway for pregnant mental health users informed by the NICE guidance. By March 2011
- 'Think Family' is incorporated in the DPT Safeguarding Children Implementation groups current work plan and the group will prescribe how it is to be implemented in current practice. By March 2011

### **Review**

- Where there are significant or complex risks identified in an assessment the Devon Partnership NHS Trust Clinical Risk Assessment and Management Policy must be followed. By March 2011

All significant alterations and amendments made to documents within the service users records must be identified to enable them to be tracked. By Dec 2010

## 9.3. Torbay Care Trust – Health Visiting

### **Reviews**

#### **Policies and Guidelines**

- Child Protection Supervision Policy – all Specialist Community Public Health Nurses (SCPHN) must access Child Protection Supervision three monthly, and bring with them to discuss children who are subject to Child Protection Plans, Children in Need and any other cases they deem as of concern
- A re-launch of the policies should be done to ensure practitioners are aware of what is available and how to access them. This will be done to coincide with the launch of the Safeguarding Children Team intranet web page

#### **Record Keeping**

- Practitioners need to be aware of the Record Keeping Standard and adhere to it at all times.
- Records must be contemporaneous, legible, dated, timed and signed by the practitioner who is identifiable by their signed and printed names
- All records should contain the reason for contact, a plan of care, outcomes and reviewing arrangements
- Records should reflect all conversations with other professionals, including the

“corridor conversations” identified within this review

- Ongoing Record Keeping Audits are essential to ensure compliance with the standards, and to inform any training that is required. An audit is currently being completed, and training on the issues that arose from the last audit is ongoing

#### **New Communication**

- A process must be implemented whereby all Specialist Community Public Health Practitioners meet regularly with GPs and Midwives to discuss families of concern. Where appropriate this forum should be opened to partner agencies such as mental health services.

#### **Policies and Guidelines**

- A care pathway for pregnant mothers who present with a history of mental illness or onset during pregnancy must be developed

#### **Training**

- TCT must consider what training is required to give practitioners a basic understanding of parental mental illness and its impact upon children

### **9.4. Torbay Care Trust – General Practice**

All actions to be completed within the next 12 months.

#### **Review.**

- Ensure South West Child Protection Procedures 2010 (SWCPP) are in place and GP's are conversant with them and they are embedded into practice. GPs must be conversant with the **Unborn Child Protocol** and what to do when mental illness is diagnosed in pregnancy. GPs must have the unborn child protocol on their intranet or equivalent.

**Action:** by Named Professionals and Medical Director

- A system of compliance for National Patient Safety Alerts which are disseminated to GP practices should be put into in place to ensure they have been read and embedded into practice.

**Action** TCT Governance team and GP leads

- NICE guidance 45 (Antenatal and postnatal mental health) must be disseminated and embedded into practice. GPs must have systems in place to assess the potential risk to children when mothers have mental illness.

**Action:** Medical Director of TCT and the TCT Governance team.

- A protocol needs to be developed for the transfer of patients between GP practices when there are safeguarding concerns about children and unborn babies

**Action:** TCT Primary Care Lead and Medical Director

- The unborn child protocol; mental illness in a parent; confidentiality and information sharing in pregnancy must be included in the safeguarding training for independent contractors.

**Action:** Named Professionals and TCT training team.

**New**

- A multi-agency, multi-professional care pathway for pregnant women with existing mental illness must be developed to include the development and implementation of written plans and key working for any woman with severe mental illness alongside appropriate mental health assessment prior to the birth of a baby. Plans to include thresholds for referral to Children's Services.

**Action:** TCT and Medical Director for TCT

- A supervision policy for GP's must be developed.

**Action:** TCT and Medical Director

- A formal communication process needs to be implemented between GP's, Midwives and Health Visitors taking into account relevant medical history

**Action:** GP lead, Medical Director, Named Midwife and Named Nurse

## 9.5. Torbay Care Trust – Commissioning – Health Overview

- Re circulate NICE guidance CG45 'perinatal mental health' to all providers and independent contractors through NICE dissemination routes.(TCT NICE facilitator)
- Specific feedback to commissioners, from SCR findings, with focus on outcomes and transition planning (Designated Dr)
- Commissioners to report compliance of providers with Level 2 & 3 training, to safeguarding team.
- Specific reference to information sharing policy within contract monitoring meetings (commissioners).
- That Child protection policy be amended to reflect commissioning roles and responsibilities (Designated Dr)
- That the overall commissioning process (a process map) is undertaken to identify any opportunities to speed up, simplify and ensure senior supervision of the process (Dir Commissioning)
- Ensure completion of the perinatal pathway, including points for supervision and the process including clinical involvement and senior oversight (Dir Commissioning).
- That a review of the needs assessment, service redesign and specification

production elements of the commissioning cycle are undertaken (particularly to map with national and provider governance processes and with safeguarding processes). (Dir Commissioning)

- To establish the pathway for completion of GP IMRs and monitoring of action plans to completion (Chair of PEC, GP commissioner and TCT Exec Lead Safeguarding)
- Recommendation to the Children's Trust that there is a clear multiagency governance structure, including audit contribution to complex pathways by partner agencies (TCT Exec Lead safeguarding).
- That the action plan is monitored through CQIPS and reported back to TSCB.