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Children Board

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# Serious Case Review

Can the Bristol Safeguarding Boards be assured that services to support new mothers with mental health needs are sufficient to ensure that their needs and the wellbeing of their unborn/new-born baby are safeguarded?

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# 1. Introduction

## 1.1. Why this case was chosen to be reviewed

1.1.1. Serious Case Reviews are about learning lessons for the future. They make sure that Safeguarding Boards get the full picture of local systems and processes, including what happened and why. This allows all partner organisations involved to work more closely together to develop and improve their services and practice.

1.1.2. Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children states that:

*“Reviews are not ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children”.* (HM Government 2015, 4:7)

1.1.3. Statutory guidance requires serious case reviews (SCRs) to be conducted in such a way which:

- “Recognises the complex circumstances in which professionals work together to safeguard children.
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.
- Is transparent about the way data is collected and analysed.
- Makes use of relevant research and case evidence to inform the findings”.

(HM Government 2015, 4:11)

1.1.4. It is also required that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- “There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families....should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process”.

(HM Government 2015, 4:10)

- 1.1.5. The Care Act 2014, implemented 1st April 2015, requires the Safeguarding Adults Board (SAB), to arrange a Safeguarding Adults Review (SAR) where a case gives rise to concerns about the way in which local professionals and services work together to safeguard adults at risk. CB's death occurred prior to the requirement of a statutory adult's review, and because Bristol LSCB was undertaking a statutory SCR for ZBM, Bristol SAB agreed not to carry out a SAR but to take note of any Findings relating to the death of CB that could have implications for adult services. Bristol City Council Adult Social Care provided a representative to the review team so that learning could be shared with Bristol SAB throughout the review process.
- 1.1.6. NHS England also recognised the benefit in reducing the number of reviews conducted, and funded a Perinatal Mental Health Specialist as a member of the Review Team in the place of conducting a separate Mental Health Homicide Review

## 1.2. Summary of case

- 1.2.1. CB was diagnosed with a thyroid condition whilst at school. Her father died quite suddenly when she was 15 years old and CB had a history of low mood from that period, developing psychosis from her late teens. She continued to have intermittent relationships with her partner, mother and sister. CB was admitted to a Mental Health Hospital in December 2010 and began to take an anti-psychotic drug which stabilised her condition. She lived for some time in supported housing after her hospital discharge, and finally moved to a private flat in central Bristol.
- 1.2.2. CB was referred to the Community Mental Health Early Intervention Team in 2011 and continued to engage with this service. CB discussed becoming pregnant with her GP practice during late 2013, and in April 2014 became pregnant. She was initially ambivalent but decided to continue with the pregnancy. CB was in an 'on-off' relationship with her partner throughout this time. In May 2014 she began her Community Ante-Natal appointments and initially chose Hospital 1 to give birth, although later changed her mind and eventually chose Hospital 2. CB also had intermittent contact with the local specialist Mother and Baby Unit.
- 1.2.3. When CB was 14 weeks pregnant in May 2014 she contacted the Police accusing her partner of domestic abuse and a referral was made to Children's Social Care First Response, although CB later withdrew the allegation. After responding, Police and Children's Social Care First Response took no further action.
- 1.2.4. In July 2014 at 22 weeks pregnant, CB transferred from the Community Mental Health Early Intervention Team to the Assessment and Recovery Team. She continued to access Community Midwifery, and a Health Visitor made initial contact with CB to follow up concerns raised by the midwifery team.
- 1.2.5. In mid-November 2014 at 39 weeks pregnant, CB told her midwife that she had stopped taking her medication the week before, although she then told other professionals that she had been reducing for five months.

- 1.2.6. CB had her first ante-natal appointment with an obstetrician with an interest in mental health at Hospital 2 in late November 2014, and she gave birth to a healthy baby named ZBM there on 28<sup>th</sup> November 2014.
- 1.2.7. CB and ZBM remained at Hospital 2 for observations on a maternity ward which offers increased support, monitoring and observation of babies who have mothers with complex medical needs, prematurity and mothers' use of substances both prescribed and recreational. CB was subsequently seen by the Mental Health Liaison Team at various points during her admission from 28<sup>th</sup> November 2014, and agreed to restart her medication by 2<sup>nd</sup> December 2014. She refused the dose offered, so never restarted her medication. On the evening of the 2<sup>nd</sup> December 2014 CB left the hospital carrying ZBM and subsequently took her own life and that of ZBM.

## 2. Methodology

### 2.1. A systems based approach

- 2.1.1. A systems approach in SCRs is focused on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the underlying issues that are influencing practice more generally. It is these underlying patterns that count as 'findings' or 'lessons' from a case, and addressing them will contribute to improving practice more widely.
- 2.1.2. Qualitative research methods are required in a systems approach, and data comes from structured conversations with involved professionals, case files and contextual documentation from organisations.

### 2.2. Review team

- 2.2.1. The Serious Case Review was carried out by a Review Team led by two Independent Lead Reviewers. Collectively, the role of the review team is to undertake the data collection and analysis, and author the final report. Ownership of the final report lies with the LSCB as commissioner of the case review.
- Sarah-Jane Leatherland                      Independent Lead Reviewer
  - Julie Pett    Independent Lead Reviewer
- 2.2.2. The review team was made up of senior representatives from different agencies. Review team members did not have any relationship to the case being reviewed; they were independent and are detailed below:
- Detective Inspector, Protect Investigations, Avon & Somerset Constabulary
  - Designated Safeguarding Children's Nurse, Bristol Clinical Commissioning Group
  - Safeguarding Adults Lead Adult Social Care, Bristol City Council
  - Service Manager Children's Social Care Bristol City Council (BCC)
  - Consultant Social Worker, Children's Social Care Bristol City Council (observer for professional development).

- Independent Head of Midwifery, Associate Director of Nursing, Yeovil District Hospital NHS Foundation Trust
- Independent Consultant Perinatal Psychiatrist, Leeds and York Humber NHS Foundation Trust

### 2.3. Structure of the review process

- 2.3.1. When using a systems model, gathering and making sense of information about a case is a gradual and cumulative process. Over the course of this review the Review Team met seven times, including three meetings with the Case group and a day and half of sessions to present the emerging analysis. Attendance at all meetings was good, and the Review Team also accepted comments via email and by phone to ensure as inclusive an approach as possible.

### 2.4. Parameters and mandate

- 2.4.1. In line with qualitative research principles, reviewers endeavour to start with an open mind so that the review is led by the evidence discovered through the process. A research question is used in place of terms of reference to avoid a prescriptive focus.

- 2.4.2. The review team and LSCB agreed the following research question:

*Can the Bristol Safeguarding Boards be assured that services to support new mothers with mental health needs are sufficient to ensure that their needs and the wellbeing of their unborn/new-born baby are safeguarded?*

- 2.4.3. The period under review was April 2014 to December 2014. However, in order to provide context the Review Team also looked at the history of CB's involvement with services prior to these dates.

### 2.5. Sources of data

- 2.5.1. The systems approach requires the review team to learn how those involved in a case saw things at the time and explore ways in which the context may have influenced their work. This is known as the 'local rationality' and requires those involved to play a major part in the review, analysing how and why practice unfolded the way it did and highlighting the broader organisational context.

#### Data From individual conversations

- 2.5.2. The Review Team conducted structured conversations with the following members of staff (the 'Case Group'). At least two members of the Review Team were involved each time:
- Care Coordinator EI Team Mental Health Trust
  - Care Coordinator Recovery Team Mental Health Trust
  - Community Midwife, Hospital 2
  - Consultant, Hospital 2
  - Consultant Social Worker, Children's Social Care
  - Detective Constable, Police Force

- Director Children’s & Families Hospital 2
- General Practitioner
- Head of Midwifery, Hospital 2
- Health Visitor
- Mental Health Liaison Consultant, Mental Health Trust
- Mental Health Liaison Nurse, Hospital 2
- Mental Health Liaison Nurse, Hospital 2
- Pregnancy Advisory Service Nurse
- Advisory Service Lead Nurse
- Pregnancy Advisory Service Doctor
- Specialty Doctor. Mother and Baby Unit, Mental Health Trust
- Team Manager, First Response, Children’s Social Care
- Team Manager, Mental Health Trust
- Ward Sister Hospital 2

Further clarification about commissioning arrangements in Bristol was provided in a conversation between a reviewer and the Programme Director from NHS Bristol Clinical Commissioning Group.

### Data from documentation

2.5.3. The following documentation was available for the review team:

- Electronic CSC records
- GP records
- Maternity Ward records
- RCA Documents already completed by Health Trusts
- Nice Guidelines
- Working Together to Safeguard Children Versions 2013 and 2015
- Agency Reports to the Coroner
- Preventing Further Death reports – Coroner
- New born baby records
- Community maternity records
- Audit of Social Care First Response Decision Making June 2016

Clarification of queries following analysis of this documentation was received from Hospital 1, Children’s Social Care and from the Mental Health Trust.

### The voice of the child

2.5.4. ZBM was unborn for the majority of the time period under review, and newly born at the time of her death, so it is difficult to hear the voice of the child. From the individual conversations and case group meetings ZBM was described as a healthy term baby (born at 42 weeks gestation), and there are many references to breast-feeding.

- 2.5.5. From the ante-natal care provided there is nothing to suggest that in pregnancy there were any concerns about ZBM's growth or development, which suggests that her mother was careful of her own physical health and that of the unborn child.
- 2.5.6. ZBM's Father and maternal Grandmother described her as 'beautiful' and 'perfect', and that she was content both in the care and handling by her mother and father.
- 2.5.7. From the evidence available ZBM was well fed and cared for and attended to by her Mother and Father in the hospital setting, and was a contented baby.

### Data from family

- 2.5.8. The lead reviewers met with CB's partner (ZBM's father) and mother at the start of the review and then with her sister and mother again towards the end of the review process to inform them of the draft Findings. It was helpful to learn that professional's experiences of CB mirrored that of her family. The family's input has meant that the Review Team were able to gain an understanding of both their and CB's experience of the multi-agency system. Their view has profoundly influenced the Findings within this Review and we would like to thank them for their candour and honesty. They helped us to understand a little about what CB was really like as an individual. Unfortunately ZBM's Father was not available towards the end of the review, and so the lead reviewers were unable to share the draft findings with him.

## 2.6. The nature of the findings

- 2.6.1. A serious case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why, and go further to reflect on what this reveals about gaps and inadequacies. The case acts as 'a window on the system' (Vincent 2004: 13).
- 2.6.2. Case Review findings therefore say something more about the Board's area/agencies and their usual patterns of working. The Review Team has selected findings that focus on the systemic patterns of working that most urgently need tackling for the benefit of children and their parents – and these may not be the issues that appeared most critical in the context of this particular case.
- 2.6.3. Some agencies have already identified learning and developed recommendations and action plans, or resolved issues. This review will not duplicate their work. Changes and developments made as a result of learning identified in this case include:
  - The review of ward layout and security undertaken and changes to prevent women leaving the ward unchallenged implemented at Hospital 2.
  - A review of perinatal mental health has been undertaken by Mental Health and Midwifery Commissioners and Providers and plans made to commission community perinatal services in Bristol
  - A review of Mental Health Services by Mental Health Commissioners has taken place
  - There has been a change in practice within the Pregnancy Advisory Service regarding contact with mental health services and domestic abuse specialist services.

- There has been a change in practice within the Mental Health Trust Recovery Team regarding cover of caseload when care coordinators are on leave
- There has been a change in practice around the support of service users who have a part time Care Coordinator in the Mental Health Trust
- Improved access so appropriate staff in obstetric staff and midwives teams can access mental health records.

## **2.7. Methodological comment and limitations**

- 2.7.1. Most professionals involved in the case engaged fully in the review process. The review has benefited from their openness and willingness to speak candidly about the systems in which they work. The review acknowledges that some practitioners were unable to participate fully in the review process, and values the contribution that those practitioners were able to make.
- 2.7.2. This case has been subject to a number of different investigations and reviews including the Coroner's Court. The effect of practitioners reliving their work and involvement in this case may have impacted this review. The Review Team also acknowledges that the case has had a significant emotional impact on all of the practitioners involved in the case and the process of multiple reviews has compounded this.
- 2.7.3. Although two people were identified from Avon and Wiltshire NHS Mental Health Trust to join the Review Team, neither were able to engage with the full SCR process. This meant that it was difficult for the rest of the Review Team to pursue some lines of enquiry and / or understand day to day practice within mental health services in Bristol. This may have impacted on overall learning from this Review.

## 3. The Findings

### *What light has this case review shed on the reliability of our systems?*

#### 3.1. Introduction

- 3.1.1. In the systems methodology, findings are presented as a series of 'Problems and Puzzles' i.e. the multi-agency issues for consideration and local prioritisation, rather than recommendations. The member agencies are asked to note the findings of this report and to take ownership of the learning. This report does not seek to recommend to the Safeguarding Children's Board what actions should be taken in response to the findings of this review, nor tell member organisations how to embed the learning from this review into their practice.
- 3.1.2. The findings are intended to be the start of a process of change where the Safeguarding Board and member organisations work together to effect systemic improvements that will support and protect children and adults from abuse or neglect in the future.

#### 3.2. Appraisal of professional practice in this case – a synopsis

- 3.2.1. The serious case review has found that examples of expected and good practice were demonstrated by individual professionals across the review period. In addition there are examples of professionals who have worked to the best of their ability considering their prior experience and the limitations of the systems in which they operate, as identified in this report.
- 3.2.2. Throughout the review timeline professionals appeared to be more focused on the needs of the adult (Mother) rather than the unborn child. This is explored in Finding 1. Opportunities were missed for professionals to be supported to identify and tackle child protection issues, and this is discussed in Finding 2.
- 3.2.3. Health Professionals did not routinely consult a pharmacist for information to clarify the use of medication during pregnancy and breast-feeding as part of their practice. This practice would be supported through casework support and supervision, as discussed in Finding 2.
- 3.2.4. CB attended her GP practice in April 2014 with her partner because she was pregnant. CB had not met this GP before and appropriate care was given resulting in a referral to the mother and baby unit (MBU).
- 3.2.5. CB contacted the Pregnancy Advisory Service (PAS), which contacted the GP. The GP provided CB with an opportunity to meet alone to discuss her concerns about the pregnancy. Information about CB's involvement with the PAS was not shared with other professionals during the case, and was therefore not interpreted as a potential risk factor by any of the professionals involved. At the time, the PAS did not routinely contact the Mental Health Service about a patient. This practice has now changed and when the PAS are aware that a patient has a history of severe and enduring mental health, a mental health practitioner is routinely contacted.

- 3.2.6. In early pregnancy the concerns for CB were firstly the risk of mental health relapse during pregnancy or post-delivery, and secondly the effects of her medication on her baby. A joint contact by MBU Specialty Doctor and Care Coordinator provided advice on both these issues as would be expected, and also offered a planned admission to the MBU around the due date. At this time the key primary care professionals were proactive and established a good communication network.
- 3.2.7. On 2<sup>nd</sup> May 2014 CB attended her first appointment with a Community Midwife, accompanied by her partner, having decided to continue with the pregnancy. Ante-natal assessments were completed at this time including identification of CB's mental health needs, and the support being provided by MBU and the Care Coordinator. The Community Midwife appropriately notified the Health Visitor of CB's pregnancy, and midwifery care continued throughout. CB's compliance with scheduled midwifery appointments was variable. However, because she had 'regular contact' with midwives this was not perceived to be a risk factor, or as a possible indicator that her mental health could be deteriorating.
- 3.2.8. The MBU initially remained in contact with CB on an informal basis. Whilst this practice had the best of intentions, this later confused other professionals involved with CB, leading to a number of assumptions being made by a range of professionals as to the level of support that was being provided to CB, and who was 'leading the case management'. CB's choice to withdraw from the MBU was not communicated to other professionals involved in the case, and so some professionals assumed that MBU remained involved. This is discussed more fully in Finding 7.
- 3.2.9. In May 2014, when CB was around 14 weeks pregnant, she made a 999 call to the police with an allegation of domestic abuse, and the police attended her flat. Police fully investigated the allegation and completed a DASH (risk) assessment in accordance with local procedures. After investigation, the Police assessment did not meet the thresholds for referrals to either children's safeguarding services or adult safeguarding services. Whilst there is some evidence of communication between Police and Mental Health Services, this was limited, and no plan was made to inform other health professionals such as the Midwife and GP.
- 3.2.10. At this time, a *"request for help form was completed"* [by the Midwife] *"following advice from child protection nursing team"*. The Review Team noted that this is the sole reference to any specific Health child protection professional, i.e. named professional, within the case before CB left the hospital ward with ZBM, and this is discussed in Finding 2. Professionals lost focus on the unborn child, allowing barriers to communication and information sharing to restrict their practice, which is discussed in Finding 1.
- 3.2.11. From June 2014 onwards professionals began to be concerned about CB's mental health. Key professionals found it difficult to therapeutically challenge CB, which is explored further in Finding 4.

- 3.2.12. Communication continued between the Community Midwife and the Mental Health Team, however there was over reliance on obtaining information through CB. This is explored in Finding 7. A lack of analysis and lack of a multi-agency meeting coupled with CB's variable engagement resulted in key professionals being unable to identify the inconsistencies in the information that CB was sharing with different professionals. This is discussed in Finding 8.
- 3.2.13. Furthermore, professionals used every day language and shorthand to describe CB's severe and enduring mental health condition across agencies, which provided a further distortion to the overall picture of the case, creating misunderstanding of the risks involved. This is discussed in Finding 6.
- 3.2.14. CB had remained with the Mental Health Early Intervention Team much longer than was usual, which was a person centred approach. Mental health professionals carefully considered the transfer of CB and eventually an appropriate time for transfer to the Recovery team was identified. It is unclear what consideration was given to the impact of her pregnancy on her mental health and the skills needed to support her in this period of significant change. Finding 1 examines the tension between the strategies of long-term engagement with the service user with the needs of the unborn child.
- 3.2.15. A Care Programmed Approach (CPA) review was held in July 2014 with both Care Coordinators when CB was 22 weeks pregnant. The impact of the pregnancy did not seem to be an indicator for more specialist oversight of CB's care, or for involvement of the medical clinician. The lack of a visible mental health medical lead or a review of CB and her medication except for the involvement of the MBU is worth further consideration and will be explored in finding 4.
- 3.2.16. The CPA review provided a detailed plan with regard to CB's mental health needs but the plan was overly ambitious given their caseload, specifying fortnightly contact between the new Care Coordinator and CB. A weakness within this plan was that no other professionals (e.g. GP, midwife, health visitor, psychiatrist) involved in CB's care were invited to attend or contribute to the plan and decision-making. Whilst this was the practice in Bristol at the time, this means that key professionals that should have contributed to the plan were omitted. Having a lead clinician as discussed in Finding 7 would have supported the planning and decision making at this point.
- 3.2.17. Following this review meeting professionals relied on CB to accurately inform Midwifery of the transfer to the recovery team. Adult Mental Health puts their service users at the centre of their care and in charge of information flow. This case has indicated systems need to be reviewed when the adult is pregnant or caring for children.
- 3.2.18. The GP received a copy of the care plan and noted the change in medication dose. CB continued to collect her medication giving no indication she was altering her own doses. There was no further contact between the GP and CB, or between the GP and any other services including midwifery services. The isolation of the GP and lack of interaction with midwifery is discussed in Learning at the Fringes.

- 3.2.19. In August 2014, when CB was 25 weeks pregnant, CB and her original Care Coordinator had their final contact which was a positive experience and clearly demonstrated that CB was progressing from a mental health perspective.
- 3.2.20. The co-located Midwifery and Health Visiting teams had *"loads of discussions"* about CB and so the Health Visitor commenced ante-natal contact with CB as expected. Whilst co-location can improve inter professional and inter-agency working, there is limited evidence of the Midwife and Health Visitor working together, or having a common recorded text of discussions.
- 3.2.21. The Health Visitor assessment recognised a possible safeguarding risk, reported by CB, relating to *"unsupervised access to the baby by CB's partner"*. Attempts by the Health Visitor to extend CB's support network were thwarted as CB declined, but this did not trigger a concern about a potential increased level of risk. An agreement that the Care Coordinator and Health Visitor would contact each other about further concerns was unrealistic, as this was dependent on each professional being able to identify a concern, and there was no plan to have any regular contact between them at any time.
- 3.2.22. In response to concerns by the Health Visitor, the Care Coordinator appropriately attempted to address the challenges of some aspects of CB's Birth Plan but stepped back in the face of CB's unwillingness to acknowledge these. Following a discussion with her named Midwife about a home birth being unsuitable, Midwifery care continued to be provided by the midwifery team, but with the named midwife withdrawing from direct contact. This was reasonable practice. The difficulties practitioners face in challenging assertive service users is explored in Finding 4.
- 3.2.23. A number of professionals attempted to make referrals to Children's Social Care 'First Response' but were unable to articulate their concerns sufficiently to meet the threshold for services and identify a clear need for social work involvement. This resulted in missed opportunities for a pre-birth assessment to be undertaken. Professionals had a misunderstanding of the role of Children's Social Care First Response, as discussed in Finding 5.
- 3.2.24. In late October 2014, when CB was 36 weeks pregnant, a professionals meeting was held between the Midwife, Health Visitor and Care Coordinator. This had taken some time to organise, and was limited to the professionals that *"knew about each other"*. Whilst a multi-agency professionals meeting is expected practice, this failed to involve any medical practitioner (CB had not been seen by a Mental Health Physician since August 2014), and no invitation was given to a manager, supervisor, named professional, safeguarding team, or children's social care. This was the only multi-agency professionals meeting held during the period under review. Barriers to effective information sharing are discussed in Finding 3.
- 3.2.25. When CB failed to attend an appointment with the MBU and Care Coordinator towards the end of October 2014 due to her confusion about the venue, a further urgent appointment was made, although this had restricted time. The focus at this meeting was about the strategies CB should use to bond with her baby as CB told them she now planned to bottle-feed. CB was 37 weeks pregnant, and even though it was known that she frequently

changed her mind there was not an alternative/contingency plan post-delivery, with the sole plan being admission to the MBU.

- 3.2.26. Midwifery care continued, and suddenly CB changed her plans from delivering her baby at Hospital 1 to Hospital 2. A referral to a Consultant Obstetrician was made because of CB's additional health needs, and she was seen on 11<sup>th</sup> November 2014 at 39 weeks pregnant. Neither Maternity Hospital had access to RIO (mental health recording system) so the information available was limited. CB indicated she was still taking her medication.
- 3.2.27. On 19<sup>th</sup> November 2014 the Community Midwife emailed the Consultant Obstetrician with concerns about relapse as CB had disclosed to her that she had stopped taking her medication. There was confusion about the language being used across agencies - see Finding 6. A final referral was made to Children's Social Care 'First Response', whilst appropriate maternity care was being planned and provided. The organisational practice of generating "green paperwork" (an internal vulnerability alert system for hospital teams) was not commenced in midwifery at this point.
- 3.2.28. Children's Social Care 'First Response' accepted the referral on 19<sup>th</sup> November 2014 and transferred the case to the hospital team, notifying the referrer by letter. At the time ZBM was born the midwifery service at Hospital 2 were unaware that CB and ZBM were an open case at Children's Social Care, and so did not notify them of ZBM's birth.
- 3.2.29. CB delivered her baby (ZBM) on 28<sup>th</sup> November 2014 and they were both transferred to a maternity ward which had higher staff-patient ratios, and allowed for closer observation of the baby's anticipated medication withdrawal. This ward specialised in observing women and babies for withdrawal from substance misuse. Appropriate midwifery care was provided, and on 29<sup>th</sup> November 2014, the "green paperwork" was commenced. CB presented as affectionate towards her baby and commenced breastfeeding. Ward staff were concerned about CB's mental health condition and made an internal hospital referral to the Mental Health Liaison Team, who provided a mental health assessment of CB. The Mental Health Liaison Team had discussions within their team. Over the next 36 hours 5 team members continued to assess and monitor CB, including staff being "doubled up" to ensure continuity and that there was a plan in place. At this point the Mental Health Liaison Team accessed the community mental health records via RIO. CB was physically fit for discharge but it was appropriate that she remained on the ward for observation.
- 3.2.30. The reason for CB's and ZBM's admission to the ward remained unclear, with different professionals thinking it was for different reasons. One reason was for observation of ZBM because of the potential risks of CB's medication, which is discussed in Learning on the Fringes. Professionals remained in contact with CB undertaking their individual roles, but there was no overview of the case, which may have prompted contact with the social care team or a review of the outcome from the social care referral 10 days earlier. Professionals were concerned about CB's well-being, but were not concerned that she posed a risk to ZBM, which was reasonable given their observations of the interaction between CB and ZBM and wider family support. Clinical findings showed ZBM was thriving.

- 3.2.31. CB was visited by her partner on the evening of 2<sup>nd</sup> December 2014, who described CB as affectionate to ZBM. CB fell asleep during this visit, which prompted her partner to leave the ward, allowing CB to rest and informing staff that she was asleep. There was a system for controlling entry to the ward but mothers and their babies were allowed free access throughout the hospital. Each maternity unit can decide on the level of security as appropriate. This allowed CB to leave the ward with ZBM unnoticed and unchallenged. Since this incident ward security has been reviewed and improved, and the ward has also had a reconfiguration of the reception area for improving the patient experience.
- 3.2.32. Once the maternity ward staff noticed that CB and ZBM were missing there was a quick response by the maternity ward staff who contacted the police.
- 3.2.33. This case highlights that “Safeguarding is everybody’s business”, in that CB was able to walk outside at night, in unsuitable clothing, carrying a new-born baby, in a public place, unchallenged by anyone.

### **3.3. In what ways does this case provide a useful window on our systems?**

- 3.3.1. This case, as all cases, has many unique aspects. These include both the local well-known place where CB chose to end her life and that of ZBM as well as the age of ZBM when she died.
- 3.3.2. The Review Team had to set aside these unique aspects and use the case to provide a ‘window on the system’. This provided an opportunity to explore multi-agency interactions and the common dilemmas and tensions staff face when they are required to determine whether to support or intervene in the lives of children (including unborn children) and their mother.
- 3.3.3. Both the Case Group and the Review Team felt strongly that it should be noted that professionals are working in increasingly pressured environments with limited resources, yet being required to deliver services with ever-higher expectations. Within this climate, both supervision and information sharing become a particular challenge and feature in a number of the Findings below. The review team have prioritised eight findings for the Boards to consider:

#### **3.3.4. Finding 1**

The positive strategy of long-term engagement with service users in Mental Health Services has the unintended consequence of creating difficulties when balancing the needs of a pregnant service user against the needs of the unborn child.

#### **3.3.5. Finding 2**

Although Bristol health professionals have access to safeguarding support and supervision; the model of support is inconsistent. This means the possible risks to an unborn child may not be recognised compared to the more immediate needs of the adult.

### 3.3.6. **Finding 3**

Current practice does not identify a lead clinician across services that work with vulnerable adults, including those who are pregnant. This means that case management for service users with complex needs lacks coordination.

### 3.3.7. **Finding 4**

Some professionals may feel intimidated by unpredictable and hostile service users, and become less confident in using their skills and expertise to challenge whilst maintaining support and engage the service user. This impact can be compounded if the service user presents as verbally assertive and challenging.

### 3.3.8. **Finding 5**

Professionals in Bristol are inconsistent in their ability to provide Children's Social Care First Response with a referral that articulates their concerns clearly enough to meet the threshold for a service. Children's Social Care First Response does not consistently provide feedback as to why a referral does not meet the threshold for social care, leading to inaction by referrer and First Response.

### 3.3.9. **Finding 6**

Common terms used professionally to describe a service user's health may have different connotations depending on the professional setting. If they are taken at face value by other professionals this will have a direct impact on practice and decision-making.

### 3.3.10. **Finding 7**

The practice of service users being asked to relay complex information about their treatment or condition verbally to other agencies makes it more likely that this information will be incorrectly relayed or not shared at all. This places the unborn child and service user at increased risk of vulnerability.

### 3.3.11. **Finding 8**

The complexity and range of individual services that work with pregnant women with mental ill health across Bristol makes it difficult to coordinate multi-organisational working.

### 3.4. Finding 1

**The positive strategy of long term engagement with service users in Mental Health Services has the unintended consequence of creating difficulties when balancing the needs of a pregnant service user against the needs of the unborn child.**

#### *Introduction*

3.4.1. For adults with severe and enduring mental health conditions the therapeutic relationship with professionals is allowed to develop over time because it is recognised that the service user will remain with services long term. Usually this is positive and appropriate. However the approach may not be effective when working with a pregnant woman because of the relatively short timescale of pregnancy coupled with the increased risks to both the mother's and baby's wellbeing.

#### *How did the issue manifest in the case?*

3.4.2. In April 2014, CB was technically already overdue to be transferred from the Early Intervention Team (EI) to the North Bristol Recovery Team (A&R) when she became pregnant. The successful therapeutic relationship with her Care Coordinator had developed over time and had supported CB to remain in the community rather than requiring a hospital admission, for over three years.

3.4.3. Consideration was given for CB to remain with the Early Intervention (EI) Team but because she had already overstayed the timescale for this service it was agreed to transfer CB to the Recovery Team at this point.

3.4.4. A Care Programme Approach (CPA) Review meeting was held on 15<sup>th</sup> July 2014 (when CB was 22 weeks pregnant) between both Care Coordinators and CB, and a Care Plan was agreed. The care plan focused on the adult needs and not on any issues related to pregnancy and mental health.

3.4.5. The first meeting between CB and her new Care Coordinator took place on 12<sup>th</sup> August 2014 at CB's flat. The new Care Coordinator raised a number of concerns around CB's home birthing plan, such as the practicality of a home birth, but CB disputed her view and was unhappy about the discussion. The Care Coordinator did not make a future appointment but left it to CB to arrange a subsequent appointment, as would be the usual care plan for the majority of service users. This approach did not take into consideration the changing needs CB would have as the pregnancy progressed or reflect how CB would review their birth plan / home birth.

3.4.6. Later an appointment was made by CB after prompting by CC2 for 24<sup>th</sup> September 2014, but CB did not attend.

3.4.7. There were increasing concerns about CB's mental well-being raised by midwifery to the Care Coordinator, who discussed these with Midwifery and the Health Visitor as well as the Mother and Baby Unit Specialty Doctor and CB's mother.

3.4.8. The Care Coordinator made a number of attempts to contact CB and spoke to her on 8<sup>th</sup> October 2014. Further attempts to speak to CB following her failure to attend a further appointment on 21<sup>st</sup> October 2014 were made. Finally, CB was seen by the Care Coordinator and MBU Specialty Doctor on 28<sup>th</sup> October 2014, some two and a half months after the meeting in August 2014.

*What makes it underlying rather than an issue particular to the individuals involved?*

3.4.9. During the individual conversations three mental health professionals said that the aim of their role was to develop and maintain a therapeutic relationship over time. This means amongst other things that service users decide how regularly they meet their Care Coordinator and are encouraged to actively manage their own symptoms. This generates a decrease in clinical care and promotes self-management. This strategy was confirmed by the experience of the Review Team.

3.4.10. Mental health professionals do not routinely work with women who become pregnant so there will always be a proportion of mental health workers that will have never worked with a pregnant woman. For example, neither Care Coordinators nor the Team Manager had worked with pregnant women previously although they were aware of the post-pregnancy risk of relapse in maternal mental health.

3.4.11. It is not unusual for adult service users to miss or decline appointments, but as caseloads in the A&R Team are much larger compared to the EI Team there is less flexibility for A&R Care Coordinators to reschedule visits quickly.

3.4.12. The A&R Case Coordinator in this case for example had a Case Load of 23 while working half time compared to the full time EI Care Coordinator with a Case Load of 15. The reason for this is partly due to the differences in the focus of each team. The Early Intervention Team aims to intensively work with younger people who have had a first psychotic episode over a relatively short time period. Only a minority of service users are then transferred to the Recovery Team which works with service users who require longer term support.

3.4.13. Some other agencies such as Midwifery have the flexibility to transfer face-to-face contact with the service user, if there is likely to be disengagement, to another practitioner within the team, whilst maintaining responsibility for their care. For the Recovery Team with only the Care Coordinator as sole point of care, this is not possible, although service users are able to access Crisis support.

3.4.14. However, since this case in 2014, there has been a positive change in practice within Bristol Mental Health Services so that part-time Care Coordinators receive support from a staff member graded at Band 4, which is a 'support worker' role, more junior to the Care Coordinator.

*What is known about how widespread or prevalent the issue is?*

3.4.15. Current Mental Health practice nationally uses a Recovery methodology to give service users control over their own care. The Care Programme Approach (CPA) provides a framework for effective mental health care for people with severe mental health problems.

- 3.4.16. The introduction of the National Service Framework for Mental Health in 1999 saw the development of specialist teams to provide targeted services within tight criteria, e.g. individuals experiencing their first episode of psychosis in Early Intervention (EI) Teams. The lower caseloads and additional services offered to EI service users has proved in the main successful, with typically only 20% of EI Service users moving on to long term recovery teams and the majority returning to the care of their GP.
- 3.4.17. However, Gilburt, H. et al., 2014 (Service Transformation: Lessons from mental health. London: The Kings Fund), identifies that nationally this increase in specific services has created an unmet need among some individuals with long-term care needs. For example, there is an assumption that there will be time to develop the therapeutic relationship and this strategy is pursued because Recovery Teams do not have the capacity to be as flexible as the more intensive service provided in Early Intervention.
- 3.4.18. Parental mental ill-health is recognised as one element of the ‘toxic trio’ within child protection. This includes perinatal mental health (Ofsted 2010; Brandon et al 2012), Ofsted (2010) Learning lessons from serious case reviews 2009 – 2010, Manchester: Ofsted).
- 3.4.19. The Strategic Clinical Network Report, Perinatal and Infant Mental Health Care in the South West: Improving Care Pathways, (June 2015) states that:
- “Because the support network for women with perinatal mental health issues is complex and involves many agencies, there is an even greater need for each agency to be constantly alert to the safeguarding needs of the unborn child or infant. This thread should run through all care planning”*
- 3.4.20. Nationally there is little consistency of approach although multi-disciplinary perinatal pathways have been developed in some parts of the country, for example in Dorset and Leeds. In Bristol, a multi-agency perinatal pathway will be developed as part of the commissioning process for the new community perinatal service currently being commissioned.

#### ***What are the implications for the reliability of the multi-agency child protection system?***

- 3.4.21. Mental health professionals support people with a severe and enduring mental health conditions by developing strong relationships with service users over time. This is appropriate for the majority of service users; however, this approach does not match the relatively short time scale of a pregnancy.
- 3.4.22. The impact of the mother’s mental health on both mother and baby combined with the limited time scales to make assessments and implement care packages to improve parenting outcomes requires a different approach to developing the therapeutic relationship in order to mitigate risks to mother and baby.

## Finding 1

### Issue for consideration by the board

**The positive strategy of long-term engagement with service users in Mental Health Services has the unintended consequence of creating difficulties when balancing the needs of a pregnant service user against the needs of the unborn child.**

### Summary

For adults with severe and enduring mental health conditions the therapeutic relationship with professionals is allowed to develop over time because it is recognised that the service user will remain with services long term. Usually this is positive and appropriate. However this approach may not be effective when working with a pregnant woman as there are varying degrees of disconnect between timescales of the adult and the unborn child. This leads to possible increased risks to both the unborn child and mother's well-being.

### Questions for the Board and Organisations

- How can practitioners be supported to focus and intervene with the safeguarding needs of the child (including an unborn child) whilst at the same time support the needs of the mother?
- How should the Board monitor the implementation of the Perinatal and Infant Mental Health Care in the South West: Improving Care Pathways?

## 3.5. Finding 2

**Although Bristol health professionals have access to safeguarding support and supervision; the model of support is inconsistent. This means the possible risks to an unborn child may not be recognised compared to the more immediate needs of the adult.**

### Introduction

3.5.1. Reflective supervision is one of the key factors that improves decision-making and drift in cases. The lack of structured safeguarding supervision in all health services can have implications for service users and their children as it is difficult for a single professional to prioritise and articulate complex layers of risk without support, especially where practitioners are newly qualified, lack experience in a specific area of clinical practice or carry high caseloads. The challenge is to ensure that staff are able to reflect and recognise the cases they need help and support with when they are busy. Providers of services need systems in place to monitor that staff are being supported in their work around safeguarding. This is especially important when staff are working with new client groups e.g. pregnancy in mental health teams or mental health in midwifery teams. Effective supervision enables staff to develop clear thinking about a case.

### How did the issue manifest in the case?

3.5.2. Although CB was discussed at the Mental Health Trust Multi-disciplinary Team's (MDT) meeting early on during the period under review there is no documented evidence that she was ever discussed at 1:1 sessions by any staff even during periods when professionals had safeguarding concerns e.g. when CB alleged domestic abuse or when referrals were made to First Response.

- 3.5.3. Several staff from different health disciplines told the Review Team that they felt intimidated by CB yet there does not appear to be a system in place to reflect on both the clinical and safeguarding needs for CB. If there was, it does not appear to have been used.
- 3.5.4. It is notable that discussion with a Lead Professional for Safeguarding occurred only once during the period under review, on 16th June 2014. The next entry for a safeguarding professional is not until 3rd December 2014 after CB and ZBM had gone missing from the ward.
- 3.5.5. In addition although “concern” was raised in the referrals to Children’s Social Care there was a lack of clarity between whether concerns were about CB’s relationship with her partner, her mental health, her ability to care for a baby, risk to the baby from her partner and/or the relationship. This lack of a full assessment would have benefited from a full discussion which includes decision and actions and is documented in the patient’s records and shared appropriately.
- 3.5.6. Nobody seemed to be able to be clear about this and develop a coherent referral; supervision may have assisted this.

*What makes it underlying rather than an issue particular to the individuals involved?*

- 3.5.7. During conversations and at the follow-on meeting on 11th April 2016 the Case Group told the Review Team that supervision is variable across services. In no health organisation is there a system to review all cases in a caseload in a systematic way over time. In all health organisations practitioners rather than supervisors self-select cases.
- 3.5.8. In contrast, embedded supervision review processes exist within the Police e.g. Crime Review Structure, and within Children’s Social Care where there is a full case load review with the first line manager (usually consultant social worker in Bristol). In addition there is weekly data shared with the first line manager, unit coordinator and service manager which highlights areas of drift e.g. assessments not completed on time.
- 3.5.9. Of course, unlike Social Care, Health is a universal service, and caseloads tend to be correspondingly higher. Supervision is in place in high risk areas, and practitioners are supported to raise concerns when they identify them. However, this approach to self-selection does have its own subsequent risks. This case indicated there may be a varied approach to staff accessing safeguarding support and supervision. It would also be important to recognise if there are any barriers to staff seeking out support, advice and supervision.
- 3.5.10. Where supervision occurs, most agencies rely on a mixture of one-to-one clinical and/or line management meetings between supervisor and supervisee, or discussion of cases in team meetings. However, cases are self-selected for supervision and for discussion at Multi-Disciplinary Team meetings.

3.5.11. For example, health visiting has always had structured supervision. The Clinical Commissioning Group monitor Health Visitor (HV) and School Health Nurse supervision, which is 1:1 every 4 months, and reviews the CP/CIN/ and UPP cases and any cases the HV has raised in the last 4 months so they can discuss this in a reflective way. It is positive that there is now some evidence of structured supervision being instigated in other settings. Community Midwifery Teams in Hospital 2 began monthly 'group' supervision with the named professional in April 2016.

#### *What is known about how widespread or prevalent the issue is?*

3.5.12. Supervision can take a variety of forms. Supervision may include informal or ad hoc case discussion, one-to-one clinical reflection on cases, group supervision, observation of practice, or direct instruction of activity. Bishop (2007), NMC (2016).

3.5.13. In addition there are a number of specialist social care child systems available e.g. Signs of Safety (Turnell 1999) which is primarily based around child protection but can be used effectively to address risk assessment during supervision. At the time the case unfolded, the Signs of Safety model in Bristol was in the early stages of implementation and not consistently embedded in practice across all agencies. The provision of Multi-agency training had commenced at this time.

3.5.14. The Review Team are aware of the proactive use of specialist safeguarding staff being used as a resource by practitioners routinely in Health organisations nationally, as defined in their statutory roles, which includes supporting staff with casework, and safeguarding supervision. (HM Government 2015, RCPCH 2014).

3.5.15. A system of structured supervision could help staff escalate their concerns about capacity and case load waiting. For universal services, however, this may not be realistic such as with Health Visitors having caseloads from 150 to 350 and being unable to transfer or discharge due to being a universal service. Instead services need to balance the risks and ensure staff have the tools to identify patients who may be at risk rather than undertake supervision of every case.

#### *What are the implications for the reliability of the multi-agency child protection system?*

3.5.16. When staff hold case responsibility in isolation it means that potential safeguarding risks are not articulated or shared and practice cannot be supported to improve. There are also implications for how confident and supported staff feel when managing complex and challenging cases.

3.5.17. Across health organisations there is no process for reviewing every service user on an individual professional's caseload. This system results in an over reliance on that individual professional to identify issues and concerns to their line manager. This issue is exacerbated if a practitioner is inexperienced or new to a role, or working outside their usual sphere of professional competence, e.g. adult mental health professionals working with pregnancy and midwives working with women with severe and enduring mental health conditions.

3.5.18. In addition, service users perceived to be stable or without complex needs can receive less input from the multi professional team and less support, which in turn reduces opportunities to identify any deterioration. Failure to discuss all service users in supervision could also prevent the identification of those who are indeed stable and well enough to be discharged from individual caseloads. Of course cases, being considered for closure or transfer should routinely be discussed in supervision, to ensure that all safeguarding assessments have been completed and the required action taken.

## Finding 2

### Issue for consideration by the board

**Although Bristol health professionals have access to safeguarding support and supervision; the model of support is inconsistent. This means the possible risks to an unborn child may not be recognised compared to the more immediate needs of the adult.**

### Summary

Supervision provides an opportunity for individual practitioners to discuss safeguarding issues in a reflective way with a more experienced practitioner to ensure care and treatment plans are appropriate and effective, and include all relevant professionals and agencies. This can also provide the gateway for escalation, where practitioners are unsuccessful in their care plan to access additional services.

The absence of safeguarding team involvement for advice, support and supervision can result in missed opportunities to identify the less obvious safeguarding cases which require supervision and support for case management.

### Questions for the board and organisations

- How can the Board support member agencies to improve the overall consistency of their child protection supervision?
- Is the Board assured that models of supervision used lend themselves to best practice?
- How can the practice of consulting with safeguarding teams be embedded systematically?

## 3.6. Finding 3

**Current practice does not identify a lead clinician across services that work with vulnerable adults, including those who are pregnant. This means that case management for service users with complex needs lacks coordination.**

### Introduction

3.6.1. Across Services working with children there is a culture both of identification of a lead professional to oversee the management of the case and of holding multi-agency and multi-agency disciplinary professional's meetings, even when a case does not meet the Child Protection threshold. However in adult services multi-agency meetings rarely happen and a lead professional is rarely identified. It follows that this is unlikely to occur when the adult has an unborn child.

- 3.6.2. Of course, staff in adult services do discuss cases and share information with other agencies but rarely identify a lead clinician or hold professionals meetings except where the adult meets Safeguarding Adult thresholds. This is because when service users have capacity there is an expectation that they will lead and coordinate their own care. This is the case even when the service user is pregnant. This means that different combinations of committed staff are aware of each other's perspective, but not necessarily the entire picture. Therefore the implications of the situation may not be completely understood by all the professionals involved in the case, which in turn limits the strategies that might be applied.
- 3.6.3. A clear definition of who is responsible for a woman's mental health and maternity care once perinatal mental illness is diagnosed or likely would encourage a more focussed coordinated plan of care.

#### *How did the issue manifest in the case?*

- 3.6.4. In this case some professionals assumed that the Mental Health Care Coordinator was the lead professional whilst others assumed it was the MBU Doctor, and still others the GP.
- 3.6.5. Verbal communication about CB was frequent, e.g. between the Health Visitor and Midwives who were co-located. Staff told the Review Team they verbally discussed concerns and actions 'constantly'. Often this was positive because professional care could be amended instantly. Staff clearly worked well together discussing concerns and CB's maternity needs. Some professionals kept comprehensive records of their own actions; However, any decisions or agreed actions were not evident, shared, or not clearly stated in all professional records. This meant that gradual changes in CB's mental health or repeat behaviours could not easily be identified by practitioners and articulated to others.
- 3.6.6. As CB did not meet the criteria for accepted multi-agency adult pathways (e.g. MARAC, Safeguarding Adults, MAPP), no mechanism existed to direct and support the frontline professionals within the case. No referral was made to the safeguarding vulnerable adult's team even when CB alleged domestic abuse, as she did not meet the threshold criteria.
- 3.6.7. The CPA Meeting between CB and Care Coordinators on 15<sup>th</sup> July 2014 was a missed opportunity to involve other professionals working with CB such as the GP, Midwife and Health Visitor and agree an appropriate lead professional. This would have also been an opportunity for services to understand how each other operate and the boundaries around their roles.
- 3.6.8. In addition there were several examples of drift within the case as no one was taking the lead, or checking back and reviewing as to what should be happening, e.g. during August and September 2014 when CB had been discharged from the Mother and Baby Unit at her request.
- 3.6.9. The only multi-agency professionals meeting that took place was between Health Visitor, Midwife and MH Care Coordinator on 22<sup>nd</sup> October 2014, and resulted with only one action, which was to refer to Children's Social Care's First Response, although it was unclear what risk the team had identified or what actions they had wanted from Children's Social Care. There were no recorded decisions about a coordinated approach to care for CB and

her unborn child, or plan if Children's Social Care did not accept the referral and it was unclear what the expected outcome of the referral was.

- 3.6.10. Professionals agreed discharge from hospital would be delayed until a safe plan was in place, but this did not take account of CB requesting early or self-discharge. No contingency plan was ever created for the care and support of CB and ZBM. The offer of a place on the MBU was the only plan devised by agencies despite CB's stated reluctance for admission, and her known aversion to inpatient hospital treatment.
- 3.6.11. A clear plan of mental health care and the care plan for her as a mother with child was only going to be completed at the point of discharge when the baby was born.

*What makes it underlying rather than an issue particular to the individuals involved?*

- 3.6.12. During both the individual conversations and at the Case Group Follow on Meeting on 11th April 2016, the Case Group told the Review Team that they did initiate multi-agency professionals meetings when required. For example, midwifery services provided several examples of this happening recently, which is a positive step. However, multi-agency professionals meetings still appear to be relatively rare and are inconsistent in their use. In addition the examples provided by the case group were initiated at a manager rather than front line level, or when it was a statutory requirement e.g. under Safeguarding Adults procedures. These only provide a short-term opportunity for care planning and not a long-term model.
- 3.6.13. The review team sought to understand why this was so. There is no multi-agency care-planning pathway to provide a forum and process for consistent information sharing, planning and decision making involving all agencies over the longer term.

*What is known about how widespread or prevalent the issue is?*

- 3.6.14. The absence of an agreed multi-agency pathway for decision making and case planning in cases known to a number of agencies who work with adults is not unique to Bristol.
- 3.6.15. In contrast to adult services, during child protection procedures services working with children routinely conduct multi-agency meetings as evidence gathering, and to gain an overview of the case management. This takes place across services in case legal intervention is required to protect the child. This has been embedded in practice for some time, following the Victoria Climbié Inquiry (Laming 2003). Legal intervention is rarely considered in Adult Social Care, and consequently there is no practice of analysing patterns of behaviour or of building evidence running alongside case management. This leads to very few multi-agency strategy or professionals' meetings taking place.
- 3.6.16. The Care Act 2014 was available during the period under review, but was not implemented until 1st April 2015, and so a SAR was not a statutory requirement at the time.
- 3.6.17. One of the most profound implications of the Care Act for Adult Services is around preventative services. Under the general principle of 'Promoting Wellbeing', The Care Act 2014 Guidance 1.13 c. states the important principle of "*the importance of preventing or*

*delaying the development of needs for care and support and the importance of reducing needs that already exist.” The Guidance also states that “At every interaction with a person, a local authority should consider whether or how the person’s needs could be reduced or other needs could be delayed from arising”*

3.6.18. Mental Health services for mothers and children are widely acknowledged to be inconsistent and inequitable across the country yet more than one in ten women will suffer from a perinatal mental illness, spanning from adjustment disorders and stress through to chronic serious mental illness and postpartum psychosis.

3.6.19. Recognising this, the South West Mental Health and Dementia Strategic Clinical Network and the South West Maternity and Children’s Strategic Clinical Network jointly led a review of perinatal and infant mental health services. (Perinatal and Infant Mental Health Care in the South West: Improving Care Pathways, June 2015).

3.6.20. The Review made a number of recommendations including:

*“Clear referral processes at any stage during the perinatal period when there is a history of mental illness, a mental wellbeing problem is suspected or there is the sudden acute onset of mental ill health”*

And developing a care plan for each service user which:

*“Incorporates a clear definition of who is responsible for a woman’s mental health and maternity care once perinatal mental illness has been diagnosed or suspected”*

The implementation of these recommendations would mitigate risk for women with a diagnosed mental health need who are pregnant.

### ***What are the implications for the reliability of the multi-agency child protection system?***

3.6.21. The lack of a clear pathway leaves the service user and their unborn child more vulnerable. A robust system requires both single and multi-agency coordination, and the lack of a recognised multi-agency framework makes it more likely that single agencies will work in isolation and ‘compete’ rather than work together to provide a package of support and care.

## Finding 3

### Issue for consideration by the board

**Current practice does not identify a lead clinician across services that work with vulnerable adults, including those who are pregnant. This means that case management for service users with complex needs lacks coordination.**

### Summary

Not agreeing a 'lead' professional prevents any one professional being able to see the whole and emerging picture and removes the opportunity for coordinating services. Professionals meeting in non-statutory forums to share information and make interagency plans of support would provide early help and support to children, including unborn children and their families. A professional overseeing the whole case management would be able to identify at an early stage where services users and families may not be sharing information or attending services consistently.

### Questions for the board and organisations

- How can the Board support staff to ensure that coordination of care in different services complement each other?
- How does the Board ensure that the relevant multi-agency professionals are involved in complex cases with full engagement across partner agencies?

### Questions for the Bristol Safeguarding Adults Board.

- Is the Board assured that the principles underpinning the Care Act 2014 are being consistently and effectively applied in Bristol to women who are pregnant or a parent?
- How can a culture of multi-agency working, including multi-agency professionals meetings, be established in Bristol?

## 3.7. Finding 4

**Some professionals may feel intimidated by unpredictable and hostile service users, and become less confident in using their skills and expertise to challenge whilst maintaining support and engage the service user. This impact can be compounded if the service user presents as verbally assertive and challenging.**

### Introduction

- 3.7.1. Some professionals can find it difficult to work with service users with unpredictable behaviour and may find it more difficult to challenge the service user's thinking if the service user is making unwise or unsafe choices. Leaving the important issues unchallenged could be interpreted by the service user as implicit agreement with their decision. Undesired behaviour can become more entrenched and therefore more difficult to manage by both that individual professional and other professionals that follow.
- 3.7.2. By assuming that articulate and assertive service users are less vulnerable than others, professionals can underestimate risk factors that impact upon those users and their unborn child or children. This paralyses a professional's ability to utilise their skills, tools and expertise and potentially leaves the service user and their unborn child / new-born baby more vulnerable.

### *How did the issue manifest in the case?*

- 3.7.3. The practitioners who worked with CB described her as unpredictable in her mood and behaviour. For example one professional described CB's sudden change in mood as '*turned on a sixpence*' and that she was '*quite angry and strong*'. She was sometimes '*very hostile*' to other professionals and her engagement with services was variable.
- 3.7.4. Discussions with family members confirmed that CB was '*unpredictable*' and could be volatile and challenging. They tried to maintain contact with CB but it was difficult at times. The family did not always confront CB as a way of maintaining their contact with her because it was '*as CB would allow*'. This strategy was mirrored by professionals, who at times were advised by family members how they could engage CB.
- 3.7.5. When a mental health professional attempted to discuss possible child protection issues with CB, the professional described the experience as; '*It was as if the shutters went down*'. *It was difficult – 'I was in her home she had a way of gazing ...quite fierce.'*
- 3.7.6. When confronted with this unpredictability or hostility many professionals 'backed off' from the confrontation, leaving the issue for another time or other professional to handle without a clear documented plan of how to address these issues.
- 3.7.7. This was compounded by what Case Group members described as CB's intelligence and assertiveness. One professional described CB as 'middle class', 'articulate'. This made it more difficult for professionals to identify the potential risk.
- 3.7.8. When challenged by professionals CB was able to counter their suggestions with cogent arguments. For example, CB declined offered support from the local children's centre and the Health Visitor accepted CB's argument that she had lots of friends with young babies so did not require further support.
- 3.7.9. Professionals also found it hard to shift CB's views, such as when a Midwife challenged CB's desire to have a home water birth because of impracticality due to her crowded small 3rd floor flat. The Midwife did not pursue this challenge, believing there was time during the pregnancy for CB to change her mind. Although there was time to do this it led to a number of changing birth plans and no assessed obstetric mental health support until days before CB delivered.
- 3.7.10. In fact CB's mental health and the consequent risks to the unborn child should have been the priority alongside her desire for a home birth. This fundamental issue was not prioritised by professionals to be consistently tackled together. CB's mental health which was longstanding added an extra layer of uncertainty which did not appear to be reviewed in a coordinated fashion. If a clear multi-agency approach had been taken there may have been an analysis, and consideration of whether this mother's fluctuating ability to cooperate may increase the risk to the child.

### *What makes it underlying (rather than an issue particular to the individuals involved)?*

- 3.7.11. At the case group follow on meeting the Case Group agreed that when working with challenging behaviour or views that you had to *'pick your battles'*. Whilst the Review Team accepted that sometimes this is a valid approach, there was an underlying assumption that sometimes difficult issues could be left to someone else to tackle or they appear to resolve over time (whereas in reality they remain hidden). Instead less important issues are tackled.
- 3.7.12. This may mean that unchallenged risky decisions could become more entrenched and therefore more difficult to manage in the future. Finding 2 shows how supervision can support staff when working with people with unpredictable behaviour and aggression.

### *What is known about how widespread or prevalent the issue is?*

- 3.7.13. Professionals working with adults who have capacity must respect service user entitlement to make informed decisions about their care even if these are considered to be unwise. There is an art to being persuasive but not being coercive, which is not an easy skill for professionals to develop and use. However, when the service user is pregnant, using this skill becomes even more difficult for the professional as the service users' unwise or unsafe decision will have an impact on the unborn child. Concentrating on the service users' decision can result in side-lining or distracting the professional, and therefore reducing the focus on the rather more fundamental issue of safeguarding the unborn child.
- 3.7.14. If professional relationships lack openness and are coupled with professionals feeling intimidated (even though the professional may not recognise this) this can result in professionals maintaining a self-protection mode (T Morrison 2009). Professionals do not challenge the smaller issues which results in the avoidance and inability to challenge more risky issues such as safeguarding in the future. Overall, this results in the unborn child/ new born baby and the service user being at greater risk of harm and increases their vulnerability.
- 3.7.15. Professionals can *"become emotionally battered by clients, colleagues and systems"* (Fletcher 1978). In effect professionals can make an inappropriate response, for example inadvertently colluding with the service user. This is a phenomenon well documented since 1990 as *"professional dangerousness"* (Litchfield 2013, Calder 2016). *"Professional dangerousness"* is when professionals involved in child protection work can behave in a way which either colludes with or increases the dangerous dynamics. Objectivity can be lost, and service users and their children are at increased risk. One protective mechanism for professional dangerousness is recognised to be supervision (Morrison 2010; DfE 2015) which is discussed in Finding 2.
- 3.7.16. There have been many studies of societal stereotypes showing that professionals and non-professionals judge some people as vulnerable but not others (Gilburt et al [2012]). This is linked to a human tendency to associate some types of people with some attributes more than others. Hostile, assertive or articulate people are less likely to be perceived as at risk in the absence of other obvious attributes.

### *What are the implications for the reliability of the multi-agency child protection system?*

- 3.7.17. Challenging unpredictable and hostile people is hard, and staff require a high level of skill and support to do so. It is even harder if this is compounded by the service user being verbally assertive and challenging.
- 3.7.18. The consequences are that the service user's beliefs could become more entrenched and therefore more difficult to manage. By not challenging assertive service users, professionals in Bristol are not adequately assessing risk factors that impact upon those users and their children.
- 3.7.19. In pregnancy this is made more difficult because there is not always time for someone to come around to an idea because other services may need to be involved.

## **Finding 4**

### **Issue for consideration by the board**

**Some professionals may feel intimidated by unpredictable and hostile service users, and become less confident in using their skills and expertise to challenge whilst maintaining support and engage the service user. This impact can be compounded if the service user presents as verbally assertive and challenging.**

### **Summary**

Where professionals lack confidence in challenging service users they are inclined to avoid the confrontation, which results in inadvertent collusion.

This makes it more difficult for professionals to then make challenges in the future on the issues that really matter, especially in relation to safeguarding the unborn child.

Although professionals attempt to support the client in an open and therapeutic relationship, they are inadvertently practicing professional dangerousness through lack of a fully open relationship with the service user.

Professional challenge is made more difficult when service users are verbally assertive.

### **Questions for the board and organisations**

- How can professionals be supported to work openly with all service users even if the service users present as verbally assertive and challenging, whilst maintaining a focus on the unborn child / baby?

### 3.8. Finding 5

**Professionals in Bristol are inconsistent in their ability to provide Children’s Social Care First Response with a referral that articulates their concerns clearly enough to meet the threshold for a service. First Response does not consistently provide feedback to explain why a referral does not meet the threshold for social care, leading to inaction by referrer and First Response.**

#### *Introduction*

- 3.8.1. Laming (2003), said that practitioners’ responsibilities do not end at the point of referral to children’s social care, but ends at the point where their professional concern is resolved. In Bristol, professionals instead tend to default to making a referral to Children’s Social Care First Response when presented with child safeguarding or protection concerns rather than taking action themselves. Professionals use the referral to Children’s Social Care as false reassurance that action has been taken, and appear to lack understanding that this doesn’t discharge their own professional responsibility to take action – either directly with the service user by themselves, or through escalation procedures when their desired outcome is not achieved.
- 3.8.2. If these concerns do not meet the Children’s Social Care First Response threshold criteria (as outlined in the BSCB Threshold Guidance), the perception is that the concern has been rejected, when in reality a decision has been made about service eligibility threshold. The referring service does not always understand why the referral does not meet the threshold for services and so does not change their practice to ensure that future referrals meet the threshold criteria. Rather than addressing the concerns proactively themselves and then providing Children’s Social Care First Response with further evidence, the consequence is inaction and the risks to the unborn / child are not assessed or managed.

#### *How did the issue manifest in the case?*

- 3.8.3. During the period under review different agencies made referrals regarding CB and ZBM to Children’s Social Care First Response on three occasions. Professionals in this case were unable to articulate their concerns succinctly or effectively, so Children’s Social Care First Response interpreted referrals as ‘no new information’ or ‘the same referral’. Although Children’s Social Care First Response did clarify with MH Case Coordinator in one instance, they did not contact the original referrer.
- 3.8.4. When Children’s Social Care First Response did not progress a referral, professionals from other agencies also did not clarify with Children’s Social Care First Response why the referral did not meet the thresholds for services. Professionals accepted the decision of no further action by Children’s Social Care, and did not consider using the Escalation Policy despite their concerns.

3.8.5. When CB disclosed that she had stopped taking her medication, just prior to birth, Children's Social Care First Response did progress the referral from midwifery and transferred the referral to the hospital social work team, where the case was unallocated but managed by their duty system. Children's Social Care First Response informed the referrer by letter dated 19th November 2014, however there is no evidence that this letter was received by the referrer or that the information was passed to the maternity ward. The ward therefore did not notify or involve the social work team in their care and treatment of CB and ZBM post-delivery as they had no knowledge that children's social care were involved, and CB and ZBM were not going to be discharged in the immediate future.

*What makes it underlying (rather than an issue particular to the individuals involved)?*

- 3.8.6. Many professionals in the Case Group demonstrated a lack of understanding of the role of Children's Social Care First Response as they were unable to state what they wanted Children's Social Care First Response to do, both at the time, and at the subsequent case group meetings.
- 3.8.7. There was a perception raised in the Case group that Social Care thresholds are high and cases are rejected without notification and limited clarification e.g. GPs are rarely contacted.
- 3.8.8. Professionals understood that all contacts with Social Care First Response were referrals, yet Social Care perceived some of these to be contacts for information sharing. The review team felt this perception was one that needed addressing, as it may be a barrier to staff accessing help and support.
- 3.8.9. A huge volume of contacts is taken by Children's Social Care First Response - about 1800-1900 a month. These range from Domestic abuse notifications, information sharing where families have a known social worker, requests for information from other services e.g. LA or legal teams and actual concerns from professionals.
- 3.8.10. During the period December 14-November 2015 the numbers of contacts varied from between 1700 and 2200 a month. Of these, 200 (10.5%) were sent to Referral Units, 400 (20%) to the Threshold Decision Unit, 500 (26%) were queries to open cases with 800 (42%) no further action. Some of these contacts may have been classed as information sharing between agencies, particularly if the family identified had involvement with Children's Social Care; however a large proportion were referrals from other agencies that did not meet the threshold for assessment by Children's Social Care.
- 3.8.11. This was a substantial amount of professional time used for no purpose. However, the lack of effective feedback means individual professionals from other agencies do not then learn how to construct an appropriate referral and articulate their concerns to meet Children's Social Care thresholds, as per the Bristol Safeguarding Children Board threshold guidance. A recent audit of 20 random referrals (of which outcomes were selected as 25% referral to Early Help, 25% referral to Social Work and 50% No Further Action) by CSC First Response in June 2016 identified that in all cases referrers were given appropriate feedback. In the cases where there was no further action most of these involved advice and guidance being given before closing. In 16 cases there were follow up enquiries. There were extensive enquiries

on 1 case. In the other 4 referrals a decision was made that comprehensive information had been provided with the referral, the case was referred on directly to the social work unit as clear risk identified and in 1 case the family member refused permission for the FR advisor to contact the school. In 4 cases there were follow up calls to members of the family. In 5 cases there were follow up calls to the referrer to clarify the referral and gain further information. This would evidence that feedback is given.

- 3.8.12. In addition, professionals at the Follow on Meeting were unclear both within and across services of how to follow escalation policies when their referrals are rejected, which may link to Finding 2 regarding use of Safeguarding Leads.
- 3.8.13. In April 2016 Bristol Clinical Commissioning Group undertook a Quality Assurance Review of Health Referrals to Children's Social Care First Response. This provided a snapshot audit of two weeks' worth of health referrals to Children's Social Care First Response. It showed the quality of the referral generally remained variable and the level of cases for 'no further action' remained high. The report highlights some notable improvements from one acute health trust, which has instigated a quality assurance framework and this has improved the quality of the referrals and social care accept these with limited challenge.
- 3.8.14. However, the current referral process lacks consistency, as referrals can be made by phone or on a web based form. The web-based form cannot be saved by the referrer to add to their clinical records, making agency records incomplete. Having more than one route for the referral process leads to confusion for the referrer about the decision-making and action or otherwise by Children's Social Care First Response.
- 3.8.15. Professionals and services referring to Children's Social Care First Response perceive that they are not consistently provided with feedback about whether their concern is being accepted or does not meet the threshold for services, and what actions are being taken by Children's Social Care although this is not evidenced through the small audit discussed above.
- 3.8.16. Although Children's Social Care First Response have clear criteria for thresholds agreed by all partner agencies, this is not consistently understood by professionals in other agencies, especially by those working in areas with few safeguarding concerns, where referral to Children's Social Care First Response is not part of their everyday practice.

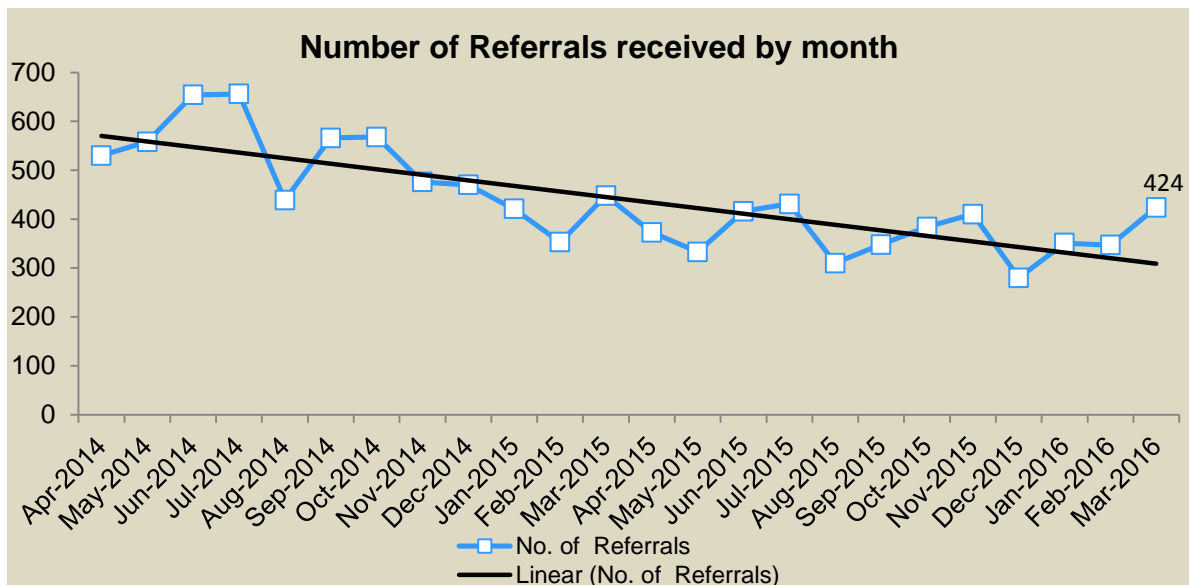
#### *What is known about how widespread or prevalent the issue is?*

- 3.8.17. The Munro review part 1 (2010) recognised that professionals need to make expert judgements about when to make a referral and getting the right balance can be difficult. However if social workers have too many referrals there is a risk that some cases may be missed or assessments delayed because of the volume. Health Professionals can support social care by undertaking the best assessment they can based on the contact they have with the family.
- 3.8.18. Since Baby P there has been a huge increase in referrals to Children's Social Care nationally. A national study of children born in 2009-10 suggests up to 150,000 pre-school children were reported over fears of abuse or neglect, most unnecessarily. Only 25% of referrals were

formally investigated while 10% led to protection plans, the study said. The University of Central Lancashire report by Professor Andy Bilson said staff were wasting time.

(<http://www.bbc.co.uk/news/education-36377293> [25.5.2016])

3.8.19. This is in contrast to the longer term overall downward trend in referral rates in Bristol as shown in the tables below:



3.8.20. This downward trend is despite the fact that over the last decade Bristol has seen the fourth largest growth in the number of under 5s nationally. Bristol’s 82,800 children currently make up almost 19% of the total population, i.e. one in every five people living in Bristol is aged under 16. The number of children in Bristol is likely to continue to grow, with a projected increase of 17,400 children (0-15 year olds) between 2012 and 2037, an increase of 21.6%. (Ref: The Population of Bristol October 2015-Key population trends in the Bristol Local Authority area).

3.8.21. The increase in population, even with the downward trend of referrals, will continue to exert pressure on Children’s Social Care First Response resources.

3.8.22. Nationally there is an issue whereby thresholds between agencies are inconsistent, and in particular between ‘health’ and social care. When interagency professionals make poorly constructed referrals to Children’s Social Care First Response and the referral is not accepted, there is a perception from the referring frontline professional that referrals are “rejected”. Whilst local audits demonstrate this is not the case, the perception remains for frontline practitioners in other agencies. Within the case group meeting there was evidence of professional apathy developing which has the potential for poor interagency relationships. (Ward-Smith, Peggy. "Professional apathy: avoiding and preventing this chronic work condition).

### *What are the implications for the reliability of the multi-agency child protection system?*

- 3.8.23. At an individual level, professionals avoid the frustration of perceived rejection and inaction by Children's Social Care First Response by inaction themselves, leaving unborn children at risk.
- 3.8.24. An inefficiency of working is created for all professionals and services involved as too many safeguarding referrals of poor quality continue to be generated. This causes an increased workload for all practitioners and services through the duplication of work, and lack of learning.
- 3.8.25. There needs to be improved standards across all professionals' assessments and referrals to Children's Social Care First Response with an improved response from them to articulate why referrals have not been accepted. This learning approach is proactive and reduces barriers and perceptions. Children's Social Care First Response do not consistently explain to professionals why a referral does not meet the threshold for social care which can result in the service user being left without a service from either agency.

## **Finding 5**

### **Issue for consideration by the board**

**Professionals in Bristol are inconsistent in their ability to provide Children's Social Care First Response with a referral that articulates their concerns clearly enough to meet the threshold for a service. Children's Social Care First Response does not consistently provide feedback as to why a referral does not meet the threshold for social care, leading to inaction by referrer and First Response.**

### **Summary**

Professionals making referrals have difficulty in consistently articulating their concerns about a case in a manner that will ensure progression of the referral from children's social care First Response.

Frontline workers in children's social care First Response are constantly trying to manage the resulting high proportion of poorly constructed referrals, so the situation is cyclical, generating duplication of work for all services.

The perception of referral and rejection by frontline professionals can result in professional apathy and poor interagency relationships, which can damage rather than build a culture of interagency working, and neither agency learns or develops to improve the situation.

### **Questions for the board and organisations**

- How does the Board monitor the quality of referrals to children's social care?
- How can the Board assure itself that the quality of feedback on referrals is appropriate and received by the referring agencies?
- How is the Board assured that front line practitioners across all agencies have a clear understanding and working knowledge of the BSCB threshold guidance?
- How is the Board assured that referring agencies continue to hold responsibility for referrals that do not meet the First Response threshold and take appropriate steps, including escalating where necessary?

### 3.9. Finding 6

**Common terms used professionally to describe a service user's health may have different connotations depending on the professional setting. If they are taken at face value by other professionals this will have a direct impact on practice and decision-making.**

#### *Introduction*

- 3.9.1. The use of shorthand terms by professionals to describe complex or specialist symptoms or treatment internally within agencies is common. These casual phrases are, in effect, jargon, but may not be understood as such by other agencies who take them at face value. This problem is exacerbated when they are recorded by practitioners in other agencies as the shorthand version without the qualifying explanation of what that phrase or word really means.
- 3.9.2. The potential to misunderstand a shorthand description would be alleviated if multi-agency meetings networking and working practices were held as standard as other professionals would be more likely to receive the full description.

#### *How did the issue manifest in the case?*

- 3.9.3. There were a number of different words commonly used to describe different aspects of CB's health. For example, the use of the word 'well' was used by a variety of professionals. In each case it meant something different.
- 3.9.4. The GP used the term 'well' to describe CB's general physical health whereas 'well' in midwifery terms meant that CB's pregnancy was progressing normally.
- 3.9.5. For Mental Health practitioners 'well' meant CB was managing the symptoms of her illness such as her 'hearing voices', i.e. CB having auditory hallucinations, but functioning in the community. However, even when the use of the term was explained during discussion with other professionals only the term 'well' was recorded. This was then later interpreted and understood as well in the sense that CB was free of symptoms of mental ill health.
- 3.9.6. As a consequence, decisions were made based on inaccurate analysis of the information available and caused drift in the case. One example of this was when the Care Coordinators' view of CB's mental health - that she was 'well' - was accepted by Children's Social Care First Response in August 2014. This also impacted on the length of time between concerns being raised by Midwifery and Health Visitor about CB's Mental Health during August 2014 before a professional's meeting in October 2014.
- 3.9.7. In this case if a full description from a mental health worker of exactly what was meant by "well" had been provided, this may have given a more full understanding to all involved and impacted on practitioners assessment of the case.

### *What makes it underlying rather than an issue particular to the individuals involved?*

- 3.9.8. The confusion caused by use of shorthand terms used as jargon was evident both across agencies and professionals, examples being Midwifery, Children's Social Care First Response, and Health Visiting.
- 3.9.9. During their individual conversations several members of the Case Group explained that Mental Health had described CB as 'well' but were unable to define what this meant in Mental Health terms. Other examples of words that were misinterpreted across agencies were 'recovering' and 'stable'. The Case Group continued to debate this question during the Case Group 'Follow On' Meeting.
- 3.9.10. Professionals are busy and cannot always write up discussions verbatim, but often use accepted shorthand. When they or another team member return to their records there is a reliance on the way that information was recorded. This means that decisions are made on limited information, placing the unborn child and service user at increased vulnerability.

### *What is known about how widespread or prevalent the issue is?*

- 3.9.11. All professionals use shorthand terms which may mean something specific or particular to that profession in addition to the common usage. There have been many studies on the barriers to communication between patients and clinicians caused by use of medical terms or jargon. However, the Reviewers have been unable to find any studies around the use of simplified or shorthand terms as a barrier between professionals. The Review Team speculated that the increased use of everyday terms by clinicians may actually be in response to attempts to communicate better with patients, although this Finding shows the opposite effect.

### *What are the implications for the reliability of the multi-agency child protection system?*

- 3.9.12. When agencies think they understand the language used by another agency but do not and act accordingly, this leaves service users and unborn children at increased risk and vulnerability.
- 3.9.13. Whilst the decision practitioners make at face value appears appropriate, there is an inherent flaw, as the decision is based on a misunderstanding of the actual current situation. Service users may then not be deemed eligible for assessment or service provision from other agencies such as Children's Social Care.
- 3.9.14. It also means that professionals may defer to those seen as experts without exploring possible risks to the unborn child.

## Finding 6

### Issue for consideration by the board

**Common terms used professionally to describe a service user's health may have different connotations depending on the professional setting. If they are taken at face value by other professionals this will have a direct impact on practice and decision-making.**

### Summary

Professionals communicate with a range of individuals on many levels. Communicating with a range of service users and professionals at the same time, simple, everyday phrases are used with service users and professionals, and subsequently recorded in a manner that does not provide a clear picture of the current situation.

Using everyday language with other agencies can give a false impression of the situation, with decisions and practice then based on that false impression. This results in the unborn child and service user being placed at increased risk of vulnerability, and in some circumstances this can prevent the service user and unborn child meeting the threshold for assessment or service provision.

### Questions for the board and organisations

- How can the Board encourage professionals to use precise language to explain their concerns to other agencies in order to ensure common understanding?

## 3.10. Finding 7

**The practice of service users being asked to relay complex information about their treatment or condition verbally to other agencies makes it more likely that this information will be incorrectly relayed or not shared at all. This places the unborn child and service user at increased risk of vulnerability.**

### *Introduction*

3.10.1. It is common practice for adult service users to be asked to pass on information about their condition to other agencies as this allows the service user to remain in control. However, it does raise the risk of the service user misinterpreting that information, restricting the amount of information shared, or even not sharing any information. This is even more likely if the service user has complex conditions or when difficult decisions have to be made.

3.10.2. This is exacerbated when there is no lead clinician to provide oversight and leadership.

### *How did the issue manifest in the case?*

3.10.3. Over the course of her pregnancy, different professionals entered into discussion with CB about use of her medication, particularly about the pros and cons of use when pregnant and subsequently when breast feeding. This information was sometimes passed directly between professionals but often shared only via CB herself.

3.10.4. CB's discussions with the Mother and Baby Unit Specialty Doctor about the use of medication in pregnancy and when breast-feeding were necessarily nuanced and complex.

- 3.10.5. The Specialty Doctor had consistently informed CB that not much was known about the risks of taking her medication in pregnancy. She had also consistently told CB that it was safer to continue with the medication as the risks to baby were greater if CB relapsed. As CB had agreed to bottle feed, their discussion on 28<sup>th</sup> October 2014 focused on alternative strategies to bond with her baby when bottle feeding rather than on the effect of medication on the baby when breastfeeding. This appointment was added to the Clinic because CB had missed her planned appointment.
- 3.10.6. As time was tight at the meeting the case notes sent to the Maternity Hospital had limited detail. CB told the midwives that medication could not be used when breastfeeding and this was her explanation for stopping her medication.
- 3.10.7. It is notable that it was not until CB had given birth to ZBM that any professional contacted a pharmacist to confirm the safety of her medication on ZBM when breastfeeding or otherwise.
- 3.10.8. The Review Team speculated that CB was exhibiting disguised compliance with regard to her medication particularly as she subsequently revealed that she had not been taking it for five months. Outside the period under review CB had previously demonstrated a pattern of coming on and off medication but this risk does not appear to be part of any risk assessment or referral.

*What makes it underlying (rather than an issue particular to the individuals involved?)*

- 3.10.9. At the case group 'Follow On' meeting different professionals continued to offer conflicting accounts about what CB had told them about the safety of the medication during pregnancy and whether it was safe to breastfeed or not.
- 3.10.10. This showed that the issues around the decision to continue taking a drug or not are complex and difficult to interpret. There is often a balance to be made between differing or conflicting factors. Risks are often difficult enough to interpret and articulate by the clinician themselves let alone by service users or other professionals.
- 3.10.11. There is a risk when professionals are busy with increased workloads that this can impact on clinical records, letters and information sharing.
- 3.10.12. Patients may alter their medication in an attempt to have control over their condition. If this is a possibility then this needs to be part of any risk assessment to the unborn.

*What is known about how widespread or prevalent the issue is?*

- 3.10.13. There is no definitive answer about the safe use of the medication in this case as clinical trials are limited about the risks posed by pregnancy and breast feeding. The patient information leaflet from the manufacturer of CB's medication states that the risks must be weighed and the decision made by the clinician. Service users with the capacity to do so will also weigh up the risks themselves.

- 3.10.14. The practice of encouraging adult service users to take control of their illness and self-manage their treatment and information sharing with other professionals is an important part of service user recovery and maintenance. Within Children's Health services information may be shared by parents about their child with other professionals. In general however, unlike Adult Services, practice includes both multi-agency meetings and written communication directly between professionals to share information about decision making or treatment regime. This provides a safety mechanism to ensure that information is routinely shared, and assists professionals in identifying when discrepancies may occur, whether or not these are intentional on the part of the parent.
- 3.10.15. Disguised Compliance is a term used by professionals to describe families who appear engaged with the work of professionals and services, but in reality are not working in partnership. *"Disguised compliance' involves a parent or carer giving the appearance of co-operating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention".* (NSPCC 2010)
- 3.10.16. *"Sometimes, during cycles of intermittent closure, a professional worker would decide to adopt a more controlling stance. However, this was defused by apparent co-operation from the family. We have called this disguised compliance because its effect was to neutralise the professional's authority"* (Reder et al (1993)
- 3.10.17. This can often be difficult for workers to recognise or deal with and is a recognised barrier to achieving good outcomes for children. Disguised Compliance is a term that is frequently used within Children's Services but is not actively and comprehensively considered and understood. Adult Services rarely encounter the phenomenon.
- 3.10.18. Numerous Serious Case Reviews and research papers, since the 1990s, have identified the need for Disguised Compliance to be recognised by professionals as a potential factor in the relationship between agencies and families.

#### *What are the implications for the reliability of the multi-agency child protection system?*

- 3.10.19. The common practice of service users being asked to pass on information to other professionals they are working with is appropriate and reasonable when information is simple and unambiguous, and relates solely to the service user. However, extrapolating this practice to include the passing of complex or nuanced information is unrealistic even if the service user wishes to do this and has the capacity to undertake this role. When this practice also includes an unborn child then the impact of this method of information sharing by the service user leads to increased risks to the unborn child / children.

## Finding 7

### Issue for consideration by the board

**The practice of service users being asked to relay complex information about their treatment or condition verbally to other agencies makes it more likely that this information will be incorrectly relayed or not shared at all. This places the unborn child and service user at increased risk of vulnerability.**

### Summary

The practice of encouraging adult service users to take control of their illness and self-manage their treatment and information sharing with other professionals is an important part of service user recovery and maintenance. However, this can lead to increased risks to unborn children if the service user makes decisions that affect the unborn child.

This is in contrast to children's health services where there are routine governance processes in place to avoid the misinterpretation of information relayed by service users or professionals, which provide additional safeguarding measures to the child.

Whilst it is recognised that the unborn child has no legal 'rights' until birth and is independent of the mother, the actions the service user takes prior to birth can impact on the unborn child both in utero and post-delivery. Professionals do have a statutory duty to consider the needs of the child, including pre-birth.

### Questions for the board and organisations

- How can the Board be assured that the correct balance is established between service user control and independence of their treatment, with the needs of the unborn child remaining paramount?

## 3.11. Finding 8

**The complexity and range of individual services that work with pregnant women with mental ill-health across Bristol makes it difficult to coordinate multi-organisational working.**

### Introduction

- 3.11.1. Adult Services are often difficult to navigate because of the layers of specialisms that are not clearly understood by professionals even within their own agencies. This is compounded when agencies seek to plug the gaps in services themselves. This is particularly evident in Bristol because NHS England specialist commissioning for tertiary and specialist services and local Clinical Commissioning Groups for the provision of local services often commission the same providers.

### *How did the issue manifest in the case?*

- 3.11.2. The Mother and Baby Unit (MBU) was not commissioned to provide community perinatal services and was working with CB informally. This confused other professionals and agencies, as some thought that a MBU Doctor was the lead clinician and expected direction from this perceived lead for CB, and so did not take the lead themselves. At the same time other professionals assumed that the GP was the lead clinician.

- 3.11.3. This was made even more confusing to agencies because CB initially chose to have her baby at Hospital 1 (which is on the same site as the MBU) and then suddenly changed to Hospital 2 in mid-November 2014 just before she was due to give birth.
- 3.11.4. Further evidence of specialists working in isolation is shown from when CB attended a consultation for her thyroid condition at Hospital 1 and there appeared to be no consideration on the impact of her mental health on her pregnancy.

*What makes it underlying rather than an issue particular to the individuals involved?*

- 3.11.5. At the Case Group follow on meeting the Case Group confirmed that they did not understand what other services do, and often which service or agency to contact when a service user had other needs. For example, there are lots of different specialisms and teams within Mental Health services that other professionals did not understand but other agencies lumped them all together as 'mental health'. It was considered by the Case Group even more difficult in Bristol because of the consortium of many different organisations which sit within the 'Bristol Mental Health' Service banner.
- 3.11.6. Within Bristol there are two Maternity Hospitals, each with a Midwifery led maternity unit (i.e. one in each trust) and two Community Maternity Teams providing services. Whilst this is in accordance with providing patient choice through giving women the opportunity to choose which hospital (or home birth) to deliver their baby, and includes the ability for women to change their mind during pregnancy about the place of delivery of their baby, this situation confused both Case Group and some Review Team members.
- 3.11.7. There should be consistency in standards in maternity provision across both services in Bristol. This case has highlighted a systems issue which needs resolving.

*What is known about how widespread or prevalent the issue is?*

- 3.11.8. *"Adults' care needs are often multiple and interrelated with other needs....[and] therefore part of a complex system of related public services and forms of support. How well services meet adults' needs depends on all parts of the system working together"*
- (National Audit Office Adult Social Care in England Overview Report 2014)
- 3.11.9. Locally it is positive that the Multi-Agency Protocol around Mental Health is currently being refreshed. It is also positive that Commissioners have identified the complexity of services as an issue in Bristol and it should be noted that a review of Mental Health Services in Bristol is due to start shortly, which should help to clarify the roles and responsibilities of the different services available.
- 3.11.10. Community Perinatal Services are currently being commissioned by Bristol Clinical Commissioning Group at a cost of £368K pa. At the time of writing (July 2016) recruitment is underway for an interim service. The system remains complex, as multiple services are provided for women from other areas who deliver in either Hospital 1 or Hospital 2 as commissioners in these areas have made separate arrangements. This development is not without risk, as the range of services will be delivered according to post code rather than

clinical need, and has the potential to leave providers at increased risk of managing complex cases in different pathways according to patient geography.

- 3.11.11. Nationally it has been recognised that perinatal care is not consistent across the country. In March 2016 the Government announced that over the next five years an additional £290m will be allocated to the care of women who experience mental ill health during the perinatal or antenatal period. The funding by NHS England is focusing on increasing inpatient beds. In the South West agreement has been given to a further inpatient unit in Torbay and it is hoped that the MBU unit in Bristol will have increased capacity.

*What are the implications for the reliability of the multi-agency child protection system?*

- 3.11.12. Investing in acute care (inpatient units, and crisis resolution and home treatment teams) or targeting services by risk management over services for clinical benefit can address the needs of individuals in crisis, but will not stop the crisis from occurring. However, if professionals are unable to navigate the system effectively because services are too complex or unwieldy this leaves service users and their children vulnerable.

## Finding 8

### Issue for consideration by the board

**The complexity and range of individual services that work with pregnant women with mental ill health across Bristol makes it difficult to coordinate multi-organisational working.**

### Summary

The complexity of services in Bristol means that practitioners may be unable to navigate the complex system effectively. This is compounded when some services attempt to plug gaps on an informal case by case basis. Service users and their unborn child are placed at a greater vulnerability than if there were no service being provided at all, as a 'false reassurance' is provided to other professionals and agencies.

### Questions for the board and organisations

- How will BSCB seek assurance from the BSAB that any changes to the mental health services address the concerns raised?
- How will BSCB and BSAB know that professionals are able to navigate the adult mental health systems they work in?
- How will BSCB, BSAB and CCG work with neighbouring boards to promote consistency of service provision for women with health risks that may impact on safeguarding children.

## 3.12. Learning at the fringes

### 3.12.1. Learning from the SCR process

- 3.12.1.1. As well as the Findings described above, the Review Team consider that there was learning from the review process itself that the Boards should note in order to improve any future review processes, including the impact of multiple reviews and the timing of reviews. This discussion will be presented to BSCB in a separate learning document, as this learning is beyond the scope of the SCR.
- 3.12.1.2. There were also some single agency issues noted that are detailed below as impacting on the multi-agency system.

### 3.12.2. Isolation of GPs from Midwifery Services

3.12.2.1. GPs in Bristol have a limited role in ante-natal care. This reflects the national approach which is that pregnancy is normal for women and should only be medicalised if there are known health issues. Although the rationale is understandable –i.e. pregnancy is not an illness and should not be treated as such, this was surprising to some members of the Review Team from outside of the Bristol area. When pregnant women have complex medical conditions the GP as the primary carer should be included in the discussion and decisions around the women’s care, and this is especially necessary as they will be managing the mother and baby after delivery. GPs are notified of all pregnancies but there does not appear to be any current system for a direct review between midwives and GPs in these complex cases.

- The Review Team suggests that there should be a review of any current pathways or guidance that improves the communication between midwifery and GP services, and that a pathway be developed;
- There needs to be a structure in place that requires communication between the midwifery team and the GP, and other relevant professionals involved in the care of pregnant women where there are other medical conditions including mental health conditions.

### 3.12.3. Observation on Maternity Wards

3.12.3.1. One of the reasons given for admitting CB and ZBM to a maternity ward that specialises in patients whose babies require increased observation due to prematurity, the mother’s medical condition or a mother’s drug use(both medically and substance misuse), was for observation of ZBM’s withdrawal from medication following delivery. Staff continued observation of ZBM for withdrawal of substance abuse rather than medication, even though CB had informed them that she had not been taking her medication for some time.

3.12.3.2. It is unclear if the assessment tool used to consider ZBM's withdrawal symptoms addressed the symptoms specific to the anti-psychotic medication CB had been prescribed. ZBM did not show any signs of withdrawal based on the form used on the ward.

3.12.3.3. The Review Team suggests that there is a process or policy where staff liaise with the pharmacy team to know what symptoms they should be observing when mothers are on medication that may impact on a new born baby. This information should be in place prior to delivery and form part of the birth plan. If there is a risk of withdrawal then an appropriate assessment tool relevant to the medication prescribed or used by the mother should be with the birth plan prior to delivery.

#### 3.12.4. **Observation on withdrawal symptoms for all agencies**

3.12.4.1. Expert advice should be sought in order that professionals recognise what withdrawal symptoms look like for a range of medications and substances as part of a robust pre-birth plan.

### **3.13. Conclusion**

3.13.1. This review has identified that there are a number of significant systemic issues, outlined above, which has provided a window on the system which demonstrates how difficult it is for professionals to work with challenging services users, and within areas of practice that are less familiar to them. This review highlights how easily adult issues and needs can override the paramountcy of the child or unborn child.

## 4. Glossary of Terms

ASC	Adult Social Care
BSCB	Bristol Safeguarding Children Board
BSAB	Bristol Safeguarding Adult Board
CiN	Children In Need
CMHT	Community Mental Health Team
CP	Child Protection
CC	Care coordinator
CCG	Clinical Commissioning Group
CSC	Children's Social Care
CSW	Consultant Social Worker, Hospital Team
EI TM	Early Intervention Team, Mental Health Trust
First Response	Front door for Children's Services in Bristol
FPN	Family Planning Nurse, Pregnancy Advisory Service
GP	General Practitioner
HV	Health Visitor
MARAC	Multi Agency Risk assessment Conference
MAPPA	Multi Agency Public Protection Arrangements
MBU	Mother & Baby Unit
MHL	Mental Health Liaison Service
MW	Community Midwife
PAS	Pregnancy Advisory Service
SA	Safeguarding Adults
SAR	Safeguarding Adult Review
SHN	School Health Nurse
SW	Social Worker