Independent Investigation

into the

Care and Treatment Provided to Mrs A

by the

Cambridgeshire and Peterborough NHS Foundation Trust,

Commissioned by
NHS East of England
Strategic Health Authority

Report Prepared by the Health and Social Care Advisory Service
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Contents

1. Investigation Panel Preface

1.1 The Independent Investigation into the care and treatment of Mrs A was commissioned by The East of England Strategic Health Authority pursuant to HSG(94)27[1].

1.2 This Investigation was asked to examine a set of circumstances associated with the death of Child 2 who died on 17 June 2009.

1.3 Mrs A received care and treatment for her mental health issues from the Cambridgeshire and Peterborough NHS Foundation Trust and also the Hertfordshire Partnership NHS Foundation Trust. It is the care and treatment that Mrs A received from these organisations that is the subject of this Investigation.

1.4 Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help improve the reporting and investigation of similar serious events in the future.

1.5 Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trust Senior Management Team who has granted access to facilities and individuals throughout this process. The Trust Senior Management Team has acted at all times in an exceptionally professional and open manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

1.6 This has allowed the Independent Investigation Panel to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

2. Condolences

2.1 The Independent Investigation Panel would like to extend their sincere condolences to the family and friends of Mrs A. Her family did contribute to the Investigation and were interviewed. The information they provided was extremely helpful in providing a picture of Mrs A and also of her husband, Mr A.

2.2 Mr A declined to meet the Independent Investigation Panel but some members of his family provided valuable information for which the Panel is grateful.

2.3 The tragedy of the death of a child means that grandparents have lost a grandchild and Child 2 has lost a younger sister. Other relatives have lost a niece or a cousin. Mr and Mrs A have lost a daughter.

3. Background to the Independent Investigation

3.1 HASCAS The Health and Social Care Advisory Service was commissioned by NHS East of England (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance HSG(94)27.

3.2 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the service user in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

3.3 The Terms of Reference (see Section 6) for the Independent Investigation were agreed with the East of England Strategic Health Authority and were to “review the care, treatment and services provided by the NHS, the Local Authority and other relevant agencies from the service user’s first contact with services to the time of her offence.” The main task was to examine thoroughly the care and treatment Mrs A received for her mental ill health. The decision was then made that the Independent Investigation Panel would not interview any staff from the Children’s Social Care Services of Cambridgeshire County Council as they had taken part in the Serious Case Review following the death of Child 2. The Independent Investigation Panel examined the Serious Case Review and used the information gathered to inform the role of the Children’s Social Care Services where appropriate at interfaces with the mental health services and the other agencies involved.

4. Incident Description and Consequences

4.1 Mrs A had a history of mental illness since 1995 and a diagnosis of Bipolar Affective Disorder from 2001.

4.2 Following the birth of her first child (Child 1) on 03 July 2006 Mrs A became ill and was admitted to Fulbourn Hospital, Cambridge, in November 2006 with a recurrence of her Bipolar Affective Disorder. When Mrs A was recovering she had discussed with the Psychiatrist how she had hit Child 1 with a hairbrush causing some bruising to the side of her head, and that she had also held a pillow over Child 1 to try to stop her crying. As a result of these actions Child 1 was placed on the Child Protection Register. Mrs A was transferred to the Thumbswood Mother and Baby Unit at the end of November for specialist perinatal care with Child 1.

4.3 Mrs A was discharged from the Thumbswood Mother and Baby Unit on 23 January after having three weeks leave at home with support from the Home Treatment Team.

4.4 Following a fairly intensive treatment regime at Thumbswood, where on one occasion she had stopped taking her medication, Mrs A was placed under the care of the South Rural Community Mental Health Team. Mrs A and her husband were not in favour of medication and refused to take the prescribed Lithium and Risperidone and could not be persuaded otherwise despite the best efforts of the Community Mental Health Team staff.

4.5 Mr and Mrs A were also reluctant to follow the advice provided by the other agencies working with them. The plan for Child 1 was for her to attend a mother and baby group with her mother, and later a toddlers' group. Mr and Mrs A did not really wish to associate with their local community and preferred to lead a somewhat solitary social life. The concerns of the professionals working with the family were to a large extent offset by the fact that Mrs A's mother was living with the family and was able to help protect Child 1.

4.6 Mrs A was aware that the two greatest risks to her continued good mental health were not accepting the prescribed medication and for her to become pregnant again. Both these factors were present when in January 2009 Mrs A told her Community Psychiatric Nurse, when specifically asked, that she was expecting another baby. As with the first pregnancy the family were very reluctant to accept antenatal care and continued to isolate themselves from the local community and from their extended family, which included Mrs A's mother. Mr

and Mrs A had also become intensely religious with a faith very much of their own creation as they could not find a church or an internet religion with which they could relate.

4.7 Child 2 was born on 03 May 2009 and the family had ignored the agreed Birth Plan and the baby had been born before the midwives were asked to attend. The Mental Health Services, Children's Social Care Services, midwives and health visitors were involved and visited frequently. There were concerns from mental health staff that both Mrs A and her husband could be becoming delusional as their religiosity was becoming more bizarre and on 12 June 2009 they refused permission for the Community Psychiatric Nurse and the Health Visitor to visit them again.

4.8 The two professionals decided that they would keep their next appointment on 17 June to assess the situation and a psychiatrist was planning to visit them the following week. When the Community Psychiatric Nurse and the Health Visitor called at the family home they were allowed into the property by Mr A. He said that Mrs A was upstairs, and they both saw Child 1 was sitting calmly on the stairs. Within about a minute of their arrival Mr A had started praying loudly and shouting for the Lord to help. He then prayed for the Devil to be released from Mrs A. They then heard Mrs A call calmly from upstairs *"What's the matter?"* The Community Psychiatric Nurse called up to Mrs A but she did not reply, but she heard Child 2 *"grizzling"* upstairs. Both professionals decided to leave the house to avoid enflaming the situation.

4.9 A Mental Health Act (2007) assessment was arranged and the Community Psychiatric Nurse, a Social Worker and a Psychiatrist went to Mr and Mrs A's home. The Police were present and informed them that Child 2 was dead and Child 1 was in hospital having been doused in something like methylated spirit. Child 1 made a full recovery.

4.10 Mr A, at some point after the Community Psychiatric Nurse and the Health Visitor had left the family, had taken both Child 1 and Child 2 to the GP. An ambulance was summoned and both children were taken to hospital. Child 2 was later found to have died by her mother sitting on her and putting pages from the Bible into her mouth.

5. Context to the Investigation

5.1 The HASCAS Health and Social Care Advisory Service was commissioned by the East of England Strategic Health Authority to conduct this Investigation under the auspices of Department of Health Guidance EL (94)27, LASSL(94) 4, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

> "*in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved*".

5.2 This guidance, and its subsequent 2005 amendments, includes the following criteria for an Independent Investigation of this kind:

i. When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii. When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii. Where the Strategic Health Authority determines that an adverse event warrants independent investigation. For example, if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

5.3 The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

5.4 The role of the Investigation Panel is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the

practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Panel to form a view of what should have happened based on hindsight, and the Investigation Panel has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

5.5 The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and in the interest of the wider public. This case has been fully investigated by an impartial and Independent Investigation Panel.

6. Terms of Reference

Background

6.1 Under Department of Health Guidance HSG (94)27 (amended in 2005), SHAs are required to undertake an independent investigation *"when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, or specialist mental health services in the six months prior to the event".*

6.2 In June 2009 Child 2 was carried in lifeless into the GP surgery. Mrs A has admitted smothering her. Mrs A was a mental health service user, under the care programme approach (CPA).

Aim of Investigation

6.3 To provide an independent report into the care and treatment provided to Mrs A from her first contact with mental health services up to the time of the offence.

6.4 This investigation is commissioned in accordance with the Department of Health guidance and follows the National Patient Safety Agency Good Practice Guidance for Independent Investigations.

Stage 1

Following the review of clinical notes and other documentary evidence:

- review the Trust's Internal Investigation and assess the adequacy of its findings, recommendations and action plan;
- review the progress that the Trust has made in implementing the action plan;
- agree with the SHA any areas (beyond those listed below) that requires further consideration.

Stage 2

- review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of her offence;
- compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself;

- review the appropriateness of the treatment, care and supervision of the mental health service user's in the light of any identified health and social care needs;
- review the adequacy of risk assessments and risk management, including specifically the risk of the service user's harming herself or others;
- examine the effectiveness of the service user's care plan including the involvement of the service user and the family;
- review and assess compliance with local policies, national guidance and relevant statutory obligations;
- consider any other matters arising during the course of the investigation which are relevant to the occurrence of the incident or might prevent a recurrence;
- provide a written report to the SHA that includes measurable and sustainable recommendations.

Method of Working

- the Panel will examine all appropriate documentation pertaining to the care of Mrs A and seek evidence from those involved in her care, in order to properly carry out its investigation;
- the Panel will agree appropriate communication arrangements with family members and give an opportunity to the families to contribute to the investigation, as the Panel feel necessary;
- the Panel will consider, at the Investigation Chairman/Panel's discretion, recommendations from similar independent mental health investigation reports so that any significant common factors can be identified;
- the Panel will conduct its work in private.

Output and Reporting Arrangements

- the Panel will provide a written report including recommendations specific to the care and treatment of Mrs A to NHS East of England, the Trust and the commissioning Primary Care Trust
- the NHS East of England will make the findings and the recommendations of the Investigation public.

The Terms of Reference for the Independent Investigation were agreed with the East of England Strategic Health Authority and were *to "review the care, treatment and services provided by the NHS, the Local Authority and other relevant agencies from the service user's*

first contact with services to the time of her offence." The main task was to examine thoroughly the care and treatment Mrs A received for her mental ill health.

As the Cambridgeshire Local Safeguarding Children Board had conducted a Serious Case Review into the death of Child 2 it was agreed that the Independent investigation Panel would use that Report, or the information that fed into it, rather than re-investigate the social care involvement. The decision was then made that the Independent Investigation Panel would not interview any staff from the Children's Social Care Services of Cambridgeshire County Council as they had taken part in the Serious Case Review following the death of Child 2. The Independent Investigation Panel examined the Serious Case Review and used the information gathered to inform the role of the Children's Social Care Services where appropriate at interfaces with the mental health services from the Cambridgeshire and Peterborough NHS Foundation Trust and the other agencies it was working with.

7. The Investigation Panel

Investigation Panel Leader and Chair

Mr Ian Allured	Director of Adult Mental Health, HASCAS Health and Social Care Advisory Service

Investigation Panel Members

Dr Liz McDonald	Consultant Perinatal Psychiatrist, East London NHS Foundation Trust
Ms Helen Waldock	Director of Nursing, HASCAS Health and Social Care Advisory Service

Support to the Investigation Panel

Mrs Fiona Shipley	Fiona Shipley Transcription Ltd.

Independent Advice to Panel

Mr Ashley Irons	Senior Partner Capsticks

8. Investigation Methodology

Consent

8.1 Mrs A gave consent to the release of her health and social care records. She wanted to contribute to the Independent Investigation and for the Cambridgeshire and Peterborough Foundation NHS Trust to learn lessons from the scrutiny of her health and social care records.

Communication with Mr A

8.2 Mr A was sent a letter by HASCAS via his brother asking him if he would be willing to meet the Investigation Panel. He sent a note back to the Chair of the Investigation Panel declining the invitation.

Communication with wider family members

8.3 The Chair of the Independent Investigation Panel wrote to Mrs A's mother and aunt who had indicated their wish to be involved in the Independent Investigation to NHS East of England. Both were interviewed and contributed fully to the work of the Investigation.

8.4 The Chair of the Independent Investigation Panel was contacted by some of Mr A's family who wanted to contribute information to the Investigation, and they were formally interviewed with a transcription of their contribution made.

8.5 One member of Mr A's family contacted the Chair of the Independent Investigation Panel by telephone and provided information about him and contact with Child 1 and Child 2.

Initial Communication with the Cambridgeshire and Peterborough NHS Foundation Trust

8.6 The Chief Executive of the Cambridgeshire and Peterborough NHS Foundation Trust was informed of the Independent Investigation. The Director of Nursing and Quality was appointed as the liaison person for the Investigation and relevant policies were requested on 19 November 2010 and were received in early December. The first tranche of clinical records was received from the Strategic Health Authority in November 2010.

8.7 An initial briefing meeting was held on 19 November 2010 with the Trust Director of Nursing and Quality with the Independent Investigation Chair and the HASCAS Director of Nursing to discuss access, process, and involvement. At this stage a preliminary

identification was made regarding further documentary evidence that the Independent Investigation Panel would require.

8.8 It is the practice of the HASCAS Health and Social Care Advisory Service to offer all Trusts subject to Independent Investigation, a clinical witness workshop to provide clarity around the process prior to any interviews being held. A workshop was held on 03 December 2010 when HASCAS provided briefing packs to all identified witnesses and all witnesses were invited to speak with the Independent Investigation Chair if they had any questions or concerns. These packs contained the Investigation Terms of Reference, advice to witnesses, and a letter which detailed the Investigation process and what would be required of them. All witnesses were given a full list of the questions that would be asked of them in advance and were invited to attend their interviews in the presence of either their Union Representative or a work manager for support.

Witnesses Called by the Independent Investigation Panel

8.9 The staff and other people interviewed are shown in the Table below:

Date	**Witnesses**	**Interviewers**
16/12/2010	Dr 3	Ian Allured, Liz McDonald and Helen Waldock
	Social Worker 2 (CPFT)	
	GP 3	
	CPN 1	
	Health Visitor 3	
	Dr 2	
17/12/2010	Midwife 2	Ian Allured, Liz McDonald and Helen Waldock
	Health Visitor 4	
	Midwife 1	
	CPN 2	
	Dr 5	
18/01/2011	Two relatives of Mrs A	Ian Allured
21/01/2011	Mrs A	Ian Allured and Liz McDonald
24/01/2011	2 x Internal Investigation Authors	Ian Allured
	3 x Community Practitioners	
(Various Trust staff)	Six x Senior Managers	
	Relatives of Mr A	Ian Allured
28/01/2011	Telephone interview with a relative if Mr A	Ian Allured

8.10 As can be seen from the Table above, the Independent Investigation Panel interviewed 27 people face-to-face and one by telephone. In addition, there was a meeting with the Chair of the Cambridgeshire Safeguarding Children Board on 29 March 2011 to discuss the process of the Independent Investigation and the interconnections between Health and Social Care.

Independent Investigation Panel Meetings

8.11 The Independent Investigation Panel met together on 30 November 2010, 21 January 2011, 13 September 2011 and on 19 October 2011 by phone conference.

Root Cause Analysis (RCA)

8.12 The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However, it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

8.13 RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

8.14 When conducting a RCA the Investigation Panel avoids generalisations and seeks to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

Salmon Compliant Procedures

8.15 The Investigation Panel adopted Salmon Compliant Procedures during the course of their work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:
   (a) of the terms of reference and the procedure adopted by the Investigation; and
   (b) of the areas and matters to be covered with them; and
   (c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and
   (d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and
   (e) that they may bring with them a colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and
   (f) that it is the witness who will be asked questions and who will be expected to answer; and
   (g) that their evidence will be recorded and a copy sent to them afterwards to sign; and
   (h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Anonymity

8.16 All identities of all clinical witnesses have been made anonymous. All have been identified by their designation and an identifying number as appropriate. Consultant Psychiatrists are referred to as: Consultant 1, Consultant 2, Consultant 3 and so forth and the same for Community Psychiatric Nurses, Community Psychiatric Nurse 1, 2 etc. All other individuals have been identified by their designation. The patient is referred to as Mrs A and the victim Child 2. Mr A's parents are referred to as Mr and Mrs M.

9. Information and Evidence Gathered (documentation)

9.1 The Independent Investigation Panel had access to and used the following documents in compiling this Report:

The Clinical Records concerning Mrs A from the Cambridge and Peterborough NHS Foundation Trust

The Social Care Records for Child 1

The Medical and Nursing Records in relation to the care of Mrs A during her pregnancy with Child 2

The Cambridge and Peterborough NHS Foundation Trust Internal Investigation Report/Independent Management Review

The Cambridge and Peterborough NHS Foundation Trust Internal Investigation Archive

The Hertfordshire Partnership NHS Foundation Trust Internal Investigation/Independent Management Review

Individual Management Review For The Serious Case Review Panel for the Cambridgeshire Local Safeguarding Children Board

Serious Case Review of [Child 2] Executive Summary - Cambridgeshire Local Safeguarding Children Board

The Cambridge and Peterborough NHS Foundation Trust Policies covering:

- Supervision Policy and Procedure: management and Clinical Supervision (12/2008).
- Clinical Risk Management Guidance for Suicide, Self Harm and Harm to Others (02/2006).
- Clinical Risk Management Guidance for Suicide, Self Harm and Harm to Others (02/2008).
- The Care Programme Approach (CPA) Procedural Guidance for Staff (09/2003).
- The Care Programme Approach (CPA) Policy – revising the 2003 edition (02/2006).
- The Care Programme Approach (CPA) Policy (05/2008).
- Safeguarding Adults Policy and Procedure (12/2008).
- Incident and Near Miss Reporting Policy and Serious Untoward Incident Procedure (01/2006).
- Safeguarding Children who have a Parent or Carer with Mental Health Problems: Guidance for Effective Joint Working (08/2011).
- Safeguarding Children Policy (12/2008).

10. Profile of the Cambridgeshire and Peterborough NHS Foundation Trust (past and present)

Prior to June 2009

10.1 The Trust became a Foundation Trust in June 2008, and as part of that development it had undertaken a significant review of the governance arrangements and implemented an integrated governance framework. The Trust had also established an integrated governance team to support this framework. The key components of the framework were patient experience, patient safety and clinical effectiveness. All these domains were reported on through to the Board level Quality and Healthcare Governance committee. At this time the Trust had achieved NHS Litigation Authority (NHSLA) level one. As part of its patient safety arrangements, the Trust had developed safeguarding children structures including a safeguarding children policy in December 2008 and developments to the safeguarding children link worker system. In terms of training and development programmes on parental mental health, and dedicated perinatal CPNs, these were established during 2007-2008.

Parental Mental Health Training

10.2 The Trust had incorporated training on parental mental health and safeguarding children into all of its safeguarding children training programmes, including specialist training on this topic provided on a multi-agency basis.

Perinatal Mental Health (antenatal and postnatal mental health)

10.3 The Trust had strengthened services through the provision of a specialist consultant psychiatrist role and clinical nurse roles for perinatal mental health.

Care Programme Approach (CPA)

10.4 This Trust policy was revised and updated in response to national guidance and was published in July 2008. The CPA forms including CPA assessment, risk assessment and care planning were made available electronically to assist staff in their completion. In addition, sections were added to the CPA assessment to ensure collection of information concerning the needs of children of parents with a mental health problem, and to prompt staff to assess their welfare and safety.

Quality and Governance Developments since 2009

10.5 In general terms, The Trust has continued to strengthen its integrated governance arrangements over the last two years. For example, it has recently established a new role of Associate Director – Patient Experience, to make the quality and governance team more robust. During 2009-2010, the Trust undertook a major review of its serious untoward incidents and the whole process, including serious case reviews. This was to ensure these incidents were being robustly investigated, and that the Trust was implementing learning arising from these investigations.

10.6 In January 2011, the Care Quality Commission published a compliance review report on the Trust following a number of service visits. This review report gave the Trust five major concerns about the CQC outcomes. It has been addressing these through its CQC compliance action plan during this year, and 90 *per cent* of actions are either achieved or on track for completion. The outcomes and progress in implementation are reported on a monthly basis to the Board, and to the lead commissioning Primary Care Trust. The Trust achieved NHSLA level two in February 2011.

Organisational Learning and Improvement

10.7 The Trust has taken forward a range of actions to improve practice and to learn from the Child 2 Serious Case Review. It has completed the implementation of the action plan and this has been overseen by the Cambridgeshire Local Safeguarding Children Board.

The learning and action plan from this review has been widely disseminated, and also incorporated into the Trust's seminar programme 'Learning the Lessons' which covers learning from serious incidents.

Other developments:

Referral and Joint Working Arrangements to Promote and Safeguard the Welfare of Children Who Have a Mentally ill Carer

10.8 This was disseminated to all staff following a serious case review in 2007. The Trust has led on a further revision and updating of this guidance during 2011.

Safeguarding Children Handbook

10.9 As a supplement to Local Safeguarding Childrens' Board inter-agency procedures, the Trust published in June 2010 a safeguarding children handbook for all staff. This handbook includes sections on communicating with other agencies about parental mental health

problems and about consideration of children's needs and safety during discharge planning, and communication with other agencies during discharge planning.

Safeguarding Children Arrangements

10.10 The Trust has continued to strengthen its general safeguarding children arrangements and in particular in 2010 undertook a major review in the light of the Baby P serious case review.[2] As a result of this review, the Trust appointed in September 2010, an additional specialist nurse for safeguarding children to strengthen the safeguarding children team. This has strengthened the capacity of the Trust's Safeguarding Children Team and improved liaison with and support for mental health services in the Trust. In addition, the Trust has rigorously ensured safeguarding children training compliance (now at over 90 *per cent*) and has significantly strengthened its link worker system, whereby each clinical team has a safeguarding children link worker role.

10.11 As part of the national response to the Baby P serious case review (Haringey), the Trust participated in local assurance assessment against national standards for safeguarding children. This process was led by the Strategic Health Authority and in conjunction with NHS Cambridgeshire and NHS Peterborough.

CPA Audit

10.12 The Trust has undertaken periodic case file audits and regular CPA audit to assess compliance with the referral and joint working guidance for safeguarding children. In addition, it has introduced a system for monitoring all safeguarding children cases where a parent or guardian is in receipt of mental health services.

Perinatal Mental Health

10.13 The Trust has reviewed and strengthened its perinatal mental health arrangements and has provided perinatal care pathway guidance for staff and audited clinical practice against National Institute for Health Clinical Excellence (NIHCE) guidance.

11. Chronology of Events (Timeline)

Background for Early Years of Mrs A's Life

11.1 The detailed chronology starts with Mrs A's first admission to a psychiatric hospital in **1995.** Relatively little is recorded about Mrs A's early life and childhood. The following paragraphs are largely derived from Mrs A's mother and her aunt.

11.2 Mrs A was born in South Africa on **08 September 1968** but the family returned to England when she was about three months old. She was described as being shy and quiet and liked being at home. She had a good positive relationship with her mother, but a poor relationship with her father. Mrs A attended mainstream school in Buckinghamshire until the family returned to South Africa in **1982** when she was 14.

11.3 Her mother recalled that Mrs A had had to adapt to several changes of school but had always managed to make nice friends and often a 'special' friend.

11.4 Her mother described her marriage as being very fraught with lots of arguments. Mrs A had appeared to have found it hard to settle in South Africa, and for the first two years she had exhibited some rebellious behaviour towards her teachers at secondary school and had stolen from shops on two occasions. Between the ages of 14 and 16 she had been drinking alcohol, occasionally to excess, and had experimented with cannabis. She was expelled from school but was allowed to return. At age 17 she left school and went to secretarial college and had her first job as a receptionist with Barclays Bank.

11.5 Mrs A had a boyfriend who also wanted to return to England, and when she was 21 she came back to England with him.[3]

11.6 In **1995** Mrs A became mentally ill and was referred to Warley Hospital, Essex by her GP. She was seen in the Outpatients Department and was noted to be psychotic with pressured speech, disordered thinking and paranoid beliefs. The context for the illness was seen to involve the excessive use alcohol and cannabis. Mrs A was prescribed chlorpromazine (CPZ).[4]

11.7 On **18 March 1995** Mrs A was admitted to Warley Hospital as an informal patient. She had the paranoid delusion that people had altered their appearance and were part of a satanic group. She had heard noises coming through the wall and the ceiling but not actual

voices. Mrs A responded quickly to Sulpiride. Mrs A was discharged on **04 April 1995** with a diagnosis of paranoid psychotic episode. One medical report indicated that the paranoia remained and that Mrs A had not had any follow up.[5]

11.8 In the clinical record it is reported that Mrs A was formally discharged from Out-Patients in **February 1996**.[6]

11.9 The next mention of mental health is in **2001** when Mrs A was referred urgently by her GP to the Community Mental Health Team (CMHT). This was due to her excessive use of alcohol, erratic behaviour, talking excessively, lack of sleep, discarding possessions, overspending and getting into substantial debt. She believed that a man known to her was Christ and, that people were regressing into snakes and arranging items on her sofa to create hell.

11.10 The CMHT made several attempts to assess Mrs A but she did not cooperate. In **mid-July 2001** Mrs A was arrested by the Police under Section 136 of the Mental Health Act 1983 (MHA 1983) as she attended a childrens' party uninvited believing that the adults present wanted the children to undress. Mrs A was admitted to Lewisham Hospital and transferred to the Ruskin Unit at Guys Hospital under Section 2 of the MHA 1983. Mrs A was described as being grandiose, irritable and sexually disinhibited. She was treated with Risperidone 6mg daily and was discharged on **14 September 2001** with a diagnosis of bipolar affective disorder and substance misuse.[7]

11.11 Mrs A was followed up by the CMHT which reported that she remained free of psychotic and mood symptoms. In **May 2002** Mrs A stopped taking her prescribed Risperidone due to reported side-effects and then stated that she took it on an *ad hoc* basis but refused to have mood stabilisers.

11.12 On **05 July 2004** Mrs A was discharged from the psychiatric services at The Maudsley Hospital her own request. She had been asymptomatic and had had no medication for the previous seven months. Mrs A reported that she had met Mr A in 2003 and that he had encouraged her to stop taking her medication.

11.13 At some stage Mr and Mrs A had become very involved in New Age culture and disposed of many belongings and went travelling using the money Mr A had obtained from the sale of his house. They lived expensively and the money soon ran out and large debts were incurred on their credit cards. They appear to have left many unpaid bills behind them

including one on a rented property which later caused difficulties with moving to a council house in Cambridgeshire.

11.14 Mrs A married Mr A on **28 September 2005.** She and her husband had visited her mother in South Africa in **February 2006**, when she was four months pregnant. Her mother described Mr A as being very uncommunicative until she had talked to him about university. He then became talkative and more *"alive"* and she formed the opinion that he loved his computer work and that he was far too bright to be able to find an appropriate job in South Africa. She asked Mr A why he did not try to find a job in England where he could utilise his undoubted skills. Within a day he had managed to have three interviews arranged in Cambridge. It was agreed that Mr A should go to England and find a job and then seek accommodation for he and Mrs A in time for her to return to England to have their baby.

11.15 Back in England Mr A returned to Cambridge and London but did not find any suitable accommodation for him and his family. He was allowed to sleep on the floor with friends and they also lent him money. When Mrs A returned she managed to find a house in Cherry Hinton just before Child 1 was born. Friends and family had given them money to obtain the rented house.

11.16 Child 1 was born on **03 July 2006.**

Detailed Timeline from October 2006 to 17 June 2009

First Admission to Hospital in Cambridgeshire

11.17 On **16 October 2006** GP 1 wrote a standard letter to Mrs A stating that since registering with the practice in July 2006 and in view of the fact that Child 1 was 14 weeks old, he noted that she had not returned for a postnatal check. Mrs A was asked to book an appointment with the practice.

11.18 Using the letter from the GP cited above, Mrs A replied on **18 October 2006** stating:

> *"As you will see from the form I filled in when I registered [Child 1] I did NOT tick the box to say that I want you to provide state care for her medical needs. We have our own arrangements. I have also requested in writing to the health trust that letters of this sort are NOT sent pestering us. It would be appreciated if you STOP all such letters. Regards Mrs A"*

11.19 Upon receipt of this letter GP 1 wrote to the Child and Family Team saying that Child 1 was not up-to-date with her immunisation schedule. Child 1 had been referred to the paediatrician on-call for a history of constipation and straining to pass stools. Mrs A had reported that she was treating this with prune juice although glycerine suppositories on a *pro re nata* or 'as required' (PRN) basis had been suggested. Mrs A had not returned to the surgery for any further advice.

11.20 GP 1 asked that the Child and Family Team keep in touch with Mrs A and ensure that *"everything is going well"* with Child 1.[8]

11.21 On **07 November 2006** Mrs A was admitted to Friends Ward at Fulbourn Hospital, Cambridge, under Section 2 of the Mental Health Act 1983, having previously been detained by the Police under Section 136 of the same Act. She was under the care of Dr 1. Mr A had initiated events by calling the Community Mental Health Team as he was concerned about her mental state, and had noticed bruising on Child 1 and suspected that Mrs A had caused it.

11.22 Mrs A had assaulted a Policeman and a male paramedic whilst in custody. Her presentation was bizarre, with her posturing and being unable to hold a conversation. On admission three staff were required to manage her, and she did not respond to PRN Haloperidol or Lorazepam, even when repeated after 30 minutes under restraint. The basic contextual history provided by Mr A indicated that Mrs A and he had been following a New Age diet of offal and dairy produce. It was also noted that Mrs A had not taken Child 1 for any medical or developmental check-ups since her birth in May.

11.23 A Care Programme Approach Assessment was started but the medical situation was difficult to assess as Mrs A was manic, screaming, thought disordered, refused medication and was overtly acutely psychotic. During the Section 2 Mental Health Act 1983 admission Mrs A had screamed that *"she's such a whiney bitch…..oh she really wants to **** her first born"*.[9]

11.24 The Children's Social Care Services commenced a core assessment. Mr A had reported a seven-day decline in her mental presentation with increased in irritability and agitation.

11.25 On **08 November 2006** at a medical review Mrs A admitted to having had difficulty feeding Child 1 and that she *"would put her down heavily".* She also reported that the

previous week she *"had put a pillow over Child 1's face not to kill her, just so she could get calm"*. Initially there was a reasonable rapport but Mrs A became demanding and more thought disordered as the interview continued. The plan was to continue the 1:1 observation and to obtain the previous medical notes. At the ward round it was decided to start Mrs A on Risperidone 2mg and to discuss using an oestrogen patch. A discussion with Mr A was also proposed.

11.26 The same day Mrs A's aunt wrote a letter to Dr 1 explaining that Mrs A had been admitted to a psychiatric hospital twice before, since leaving South Africa in 1989. In **1996** Mrs A had experienced a paranoid episode following cannabis abuse with none of the behaviour of the **August 2001** admission, nor that displayed at the current admission. In **2001** Mrs A was sectioned under the MHA 1983 following a period of very disturbed behaviour when she had been very destructive in her home and had disposed of most of her possessions. She had been agitated and highly abusive.

11.27 Her aunt explained that the couple had married and soon afterwards had visited South Africa for about 10 to 12 weeks having disposed of most of their possessions and given up their flat. They had also built up considerable debts. In South Africa the family were concerned about Mrs A's mental health, and that of her husband, but there were no acute symptoms. They returned to England in **April 2006** and after living with a relation of Mr A had managed to secure their current accommodation. During the week prior to her current admission Mrs A had contacted various family members seeking contact, but had only told her mother that she needed help. Her aunt stated that it was not until **05 November 2006** that she realised Mrs A was ill and was refusing to see her. She had tried to involve the Adult Mental Health Team on **06 November 2006** but to no avail.

11.28 On **10 November 2006** it was agreed that the Section 2 MHA (1983) should remain in place and it was noted that Mrs A had hit Child 1 with a hairbrush. She said she remembered this but could not recall the circumstances. Three days later, Mrs A stated that she had felt Child 1 was strong and invincible at the time that she hit her.[10] Mrs A provided an account of her previous hospital admissions and explained that Mr A had also been diagnosed as having Bi-Polar Affective Disorder and had stood in front of a train and was admitted to hospital but refused antipsychotics. Mrs A thought that they had both been floating above reality, having given up their jobs and had lived on their credit cards, prior to visiting South Africa. Mrs A added that she wished her husband had sought help before she had become so mentally unwell.[11] She accepted that she had been unwell and agreed to remain in hospital and to take her medication.

11.29 At the ward round on **15 November 2006,** Dr 1 thought that Mrs A needed to be on a Mother and Baby Unit, and discussions took place with the Children's Social Care Services to that end. Mrs A had admitted that she had hit Child 1 with a hairbrush and that she had scratched her husband as she thought that he was Satan. Mrs A also stated that she thought Child 1 was strong and that using a pillow was a good way to stop her from crying. She added that she was appalled that she had done this saying *"that was shocking...she did look white afterwards...I'm keen to get everything OK with me so that I can look after [Child 1] properly".*

11.30 Dr 1 advised Mrs A about her medication, Risperidone 2mg BD, being important for her but that it did get into her breast milk in small quantities and therefore he advised her against breast feeding. The overall impression gained from this meeting was that Mrs A was hypomanic with little insight into the gravity of what had happened between her and Child 1.[12]

11.31 Over the next few days Mrs A was very settled and her insight into her condition appeared to improve. Supervised visits with Child 1 were being planned with the Social Worker. Mrs A was attending the ward programme activities and taking escorted walks in the hospital grounds.

11.32 The In Patient Care Plan dated **16 November 2006** stated that the social worker had arranged for a supervised visit for Child 1 with Mrs A and possibly her husband. This visit was to be held in the family room on the ward. Child 1 would be with a social worker and a nurse would also be present.

11.33 From **18 - 21 November 2006** Mrs A appeared happy and settled and was seen to be engaging well with staff and other patients. She was not raising any concerns. Mr A and Child 1 were visiting daily. A Mother and Baby Unit had been identified. The Risperidone was increased to 4mg.

11.34 During the following week Mrs A engaged with recreational Occupational Therapy groups. On **24 November 2006** Children's Social Care Services completed the core assessment and identified their findings. The Report on Child 1's Developmental Needs stated that during the pregnancy Mrs A did not have any antenatal care due to the risks to the baby from scans and because the parents felt they could monitor this by how Mrs A felt and monitoring her weight gain.

11.35 Child 1 had weighed 8.5 pounds at birth having been born at home in the presence of midwives. Mr and Mrs A had decided not to engage with health visitors or their GP. The Social Services involvement had started when Child 1 was seen to have a bruise to the right side of her forehead and another on the inner part of her right arm. Scans and investigations did not highlight any injuries and Child 1 did not require any medical treatment.

11.36 One concern about Child 1 was that she had not received the routine health and development checks offered. Mr A stated that they had their own ideas about health and development and did not want professionals fussing. The parents would not allow Child 1 to be immunised and refused to agree to her to being given Calpol when she had a temperature. Concerns were expressed that the parents might not allow her to be physically examined when she was ill and that could place her at risk.

11.37 The main concern was the fact that Mrs A did hit Child 1 with a hair brush and also admitted that she had placed a pillow over her face to quieten her. Mr A explained that his wife had been getting *"high"* and was *"rough with Child 1 plonking her down on the sofa."* [13]

11.38 The Core Assessment concluded that had professionals been allowed into the home after the birth of Child 1 her injury could have been prevented as professionals would have been monitoring Mrs A's mental health. There was a sense in the Core Assessment that both Mrs A and her husband had put their own health first and that Mr A had not acted proactively as he saw his wife becoming mentally ill, but had tried to manage her mental health himself. Mr A had not acted to protect Child 1 and had only raised the alarm when he knew she had been hit. The Individual Management Review (Children's Services) stated:
"*the injuries to [Child 2] may have been prevented if the parents had been involved with professionals and allowed them to visit after [Child 1's birth]. Through the professionals monitoring and observing the situation the changes and deterioration in [Mrs A's] mental health would have led to intervention sooner. [Mr A's belief that he could manage [Mrs A's] mental health was not realistic and he did not act protectively to his daughter with [Mrs A's] and his needs taking precedence".*[14]

11.39 There were concerns that the mental health of both Mr and Mrs A could have an effect on their ability to meet all the needs of Child 1. It was hoped that the move to the Mother and Baby Unit would enable Mrs A to bond with her daughter and to meet her needs. The couple did agree to be monitored by professionals and Mr A agreed to approach his GP for a mental health assessment.[15]

11.40 On **28 November 2006** a Child Protection Conference was held and Child 1 was placed on the Child Protection Register under the category of Neglect (1) and Physical Abuse (2) for the reasons that:

- Child 1 suffered an injury when Mrs A hit her with a hairbrush;
- Mr A failed to protect Child 1 from significant harm.

Transfer to Thumbswood Mother and Baby Unit

11.41 The following day, **29 November 2006,** Mrs A was transferred to the Thumbswood Mother and Baby Unit in Welwyn Garden City. The discharge letter to GP 1 stated that she was being transferred to the Mother and Baby Unit and that when she was ready for discharge she would be seen by her *"sector out-patient psychiatrist in clinic."* Mrs A should at this time be referred to the CMHT at Auckland Road for further follow-up.[16]

11.42 Cambridgeshire County Council wrote to Hertfordshire County Council on **30 November 2006** informing them that Mrs A and Child 1 were moving to the Thumbswood Mother and Baby Unit. Details of the Key Worker were given and Hertfordshire was asked to place Child 1 on their temporary Child Protection Register. It was made clear that the responsibility for the case remained with Cambridgeshire.[17]

11.43 At the Thumbswood Mother and Baby Unit, Dr 2 interviewed Mrs A on **30 November 2006** and during the discussion Mrs A stated that she was happy to be on the unit and to be getting support. She also said that she had regrets about her behaviour towards Child 1. She added that she was happy to have Child 1 and would like to have more children.

11.44 On arrival at the Thumbswood Mother and Baby Unit, Mrs A did not present as overtly psychotic. She was unable to remember much of the incident, although she did state that she had held a pillow against Child 1's face and that the baby's legs were still moving so she had thought it was alright. Mrs A displayed some remorse at this point, but Dr 2 felt that the full impact of what she had done had not really hit her at this stage. By the end of her stay at Thumbswood Mrs A did accept what she had done.

11.45 It was noted that Mr and Mrs A between them had not really appreciated the impact of her mental illness, and Mr A, who also had mental illness, had not been keen on his wife taking her medication. It would appear that Mr and Mrs A were not seen as a couple at Thumbswood, but there was concern about Mr A and he was asked to see his GP about his mental health. In the event his GP did not consider that he needed to be referred to a CMHT.

The unit staff thought that Mr A wanted his wife to move on and he was not sure that continuing medication would be a positive thing.

11.46 On **04 December 2006** Dr 1 wrote to Dr 3 requesting the allocation of a Community Psychiatric Nurse from the CMHT.[18]

11.47 There was considerable multi-agency involvement with Mrs A and their staff attended some of the ward rounds and all of the care plan meetings. The unit was concerned that Mrs A lacked insight and Dr 2 considered placing her on a Section 3 of the MHA 1983. When she was assessed for this by staff from Cambridgeshire it was felt that she did not meet the criteria for a Section 3. The Section 2 under which she was admitted to Thumbswood was allowed to continue but it was not renewed.

11.48 The Thumbswood Unit and the Mental Health and Social Care Services worked closely together about the contact Mrs A had with her baby. Child 1 slept in the nursery and not with her mother at first, and later the level of observation was reviewed. The Health Visitor, the Social Worker for Child 1, a representative from the CMHT and the Home Treatment Team attended meetings at Thumbswood.

11.49 On **19 December 2006** a Care Programme Approach planning meeting was held at Thumbswood Mother and Baby Unit. It was attended by Mr A, Mrs A and Mrs A's mother. The professionals attending were:

- the Consultant Psychiatrist;
- Staff Grade Psychiatrist;
- the Senior House Officer;
- Child 1's Social Worker (Social Worker 1);
- Health Visitor 1 from Welwyn Garden City (Queen Elizabeth 11 Hospital);
- the Head Occupational Therapist;
- the Charge Nurse;
- the CPA Administrator.

11.50 It was agreed that plans were in place for an overnight leave by Mrs A without Child 1 and for day leave with Child 1. If all went well, it was agreed that Mrs A could have Christmas Day and Boxing Day at home with Child 1 provided there was someone to help with night feeds.

11.51 The ward-level supervision was up-graded to Level 2 with as much support from staff as Mrs A felt she needed. Occupational Therapy activities would continue. The Health Visitor would also continue and Mrs A would start weaning.

11.52 Mrs A started to have leave after a month at Thumbswood. She had leave on **23 December 2006** and had leave daily. At first, leave was with Mr A and not with Child 1, and then later day leave with Child 1, followed by home leave. Overnight leave was often without the baby at first. The medical opinion of the Thumbswood Unit was that the risk to Child 1 had been much related to Mrs A's severe psychosis. Once Mrs A was well she appeared to bond well with Child 1. When Mrs A did have home leave the Home Treatment Team was involved.

11.53 Mrs A did have overnight leave with Child 1 on Christmas Day and Boxing Day, which was reported to have gone well at the ward meeting on **27 December 2006**. While discussing the leave Mrs A reported that she had felt tired and had attributed this to her medication. She decided not to take her medication on Boxing Day.

11.54 The Thumbswood Unit staff were very concerned about the situation should Mrs A have another child, and the importance of taking medication was stressed at care planning meetings and in the discharge summary. Mrs A was prescribed Lithium whilst on the Unit.

11.55 On **03 January 2007** Mrs A and Child 1 were given leave from Thumbswood Mother and Baby Unit. A Clinical review Meeting was held and it was agreed that Mrs A would take Lithium 1000g, and the levels would need to be checked whilst on leave. The Home Treatment Team would monitor the situation during the week 03 to 09 January 2007 and a Key Worker would be allocated from the CMHT.[19]

11.56 A home visit by the Home Treatment Team was made at 17.00 on **03 January 2007** and it was noted that Mrs A's mother was at the home. On **06 January 2007** a home visit was made and Mr A was at home with his wife. The need for Mrs A to have lots of rest was discussed as were signs of relapse. Mrs A commented that she had had a few silly thoughts but dismissed them for what they were and did not allow them to continue. Mrs A had been concerned about a rash and wondered if it could have been caused by the Lithium, but this was not considered the cause when the Thumbswood staff had been consulted.[20]

11.57 On **09 January 2007**, staff from Thumbswood contacted the CMHT to inform them that Mrs A had been reviewed and was returning for another week's leave with a review at

the Unit at the end of the week. The plan was for a further week's leave and for Mrs A to be discharged on **23 January 2007.** The Lithium was increased to 1200g. The Home Treatment Team continued to monitor the situation at home until **16 January 2007.** [21]

11.58 On **11 January 2007**, the Discharge Summary Part 1 was faxed to the Cambridgeshire Mental Health and Children's Social Care Services in order to form part of the referral to them as discharge from the Thumbswood Mother and Baby Unit was planned for 23 January.

11.59 On **17 January 2007**, the Home Treatment Team Social Worker and Social Worker 2 made a joint visit to Mrs A and also met her mother and Child 1. Social Worker 2 was introduced as the Care Coordinator from the CMHT as the Home Treatment Team would be stopping its involvement once Mrs A was discharged from the Thumbswood Mother and Baby Unit.[22]

11.60 On **22 January 2007**, the Home Treatment Team sent a letter to GP 1 with a copy to Social Worker 2 stating that Mrs A had been discharged from the team as a Care Coordinator had been appointed from the South City CMHT (Social Worker 2). It was noted that a Care Programme Approach Meeting would take place on 23 January when Mrs A hoped that she would be discharged from hospital.

11.61 At the **23 January 2007** Care Programme Approach meeting, it was agreed that Mrs A and Child 1 would be discharged. It was attended by Mr A, Mrs A and her mother. The professionals attending were:

- the Consultant Psychiatrist;
- the Senior House Officer;
- Child 1's Social Worker (Social Worker 1);
- the Health Visitor from Cambridgeshire (Brookfields Health Centre Health Visitor 2);
- Social Worker 2, CMHT Care Coordinator;
- the Head Occupational Therapist;
- a Staff Nurse and a Student Nurse.

11.62 The agreed care plan was that:

- Mrs A would be discharged from the Thumbswood Mother and Baby Unit after the meeting;
- her medical care would be transferred to Dr 3;
- weekly support would be provided from the CMHT with Social Worker 2 as Care Coordinator;
- Mrs A would continue with prescribed medication, Lithium treatment with regular monitoring and Risperidone. She had been advised of the importance of continuing to take her prescribed medication;
- Dr 2 had advised Mrs A to access psychiatric support should she decide to have another baby;
- the next Child Protection Conference was scheduled for 07 February 2007 and as Social Worker 1 was leaving Social Worker 3 would be introduced;
- extra support from Home Start had been requested by the Health Visitor 2;
- arrangements had been made for Mr and Mrs A to access GP 1 directly, with support for Mr A as needed;
- Mrs A wanted to have assertiveness sessions in her local area;
- The Home Treatment Team could be contacted out of hours in an emergency.

11.63 The contingency plan was that Mrs A and her family should contact Social Worker 2 (the Care Coordinator) or Dr 3's secretary during working hours. Out-of-hours they should contact the Duty Team, GP 1 or NHS Direct.

11.64 In addition to the above, Family Group Meetings with Children's Social Care Services would be arranged to gain further assessment and these would include Mr A.[23]

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11.65 On **31 January 2007** Social Worker 2 visited Mrs A and met her husband. Mrs A stated that she was getting on well and was continuing to improve and felt less tired. She had started looking into a baby singing group. Mr A said he had given up his job due to stress at work which could not be resolved. The family were planning to move to a three-bed roomed house so that Mrs A's mother could live with them permanently. Her mother was planning to return to South Africa to pack everything up in March.[24]

11.66 The Review Child Protection Conference was held on **7 February 2007.** It was noted that Mrs A was back at home and had the support of her mother. The Child Protection Plan was divided into four sections. The first concerned Child 1 and stated that her health needs

would be monitored by Health Visitor 2 who would visit regularly, and weekly when Mrs A's mother was in South Africa. The Social Workers would continue to assess Child 1 and monitor her welfare. The plan was for Mrs A and Child 1 to have support in socialising with other mothers via a baby singing group or a mother and baby group.

11.67 The second section was for the parents. Mrs A was to engage with mental health professionals who would oversee her mental health and the effectiveness of her medication. Social Worker 2 would provide Mrs A with a mental health care plan and coordinate regular appointments with Dr 3 (Consultant Psychiatrist). The plan stated that Mr A should contact professionals immediately if he should have concerns about his wife's mental health. As part of the on-going assessments by social workers, Mr A's parenting abilities would be examined. It also stated that Mr A should consult with his GP if he, his family or professionals were concerned about his mental health.

11.68 Under Family and Environmental Factors, the supportive role of Mrs A's mother was identified, and that the wider family should help as much as they could. Mrs A would attend community groups when she felt able and the Health Visitor would assist with this. A Family Group Meeting was arranged for **08 March 2007** and a referral to Home Start had been made for the period when her mother would be away. During this period Health Visitor 2 would visit weekly and Social Worker 2 fortnightly. GP 1 would monitor the Lithium levels every three months. If the situation altered or the agreed actions were not completed a Professionals Meeting and/or a Core Group Meeting would be called to agree appropriate action.[25]

11.69 On **21 February 2007** Social Worker 2 visited Mrs A at her home. It was noted that all was going well and Mrs A thought her mental health was good. An appointment with Dr 3 was arranged for **08 March 2007.** The Care Plan was discussed and some changes were made, and the plans for when her mother returned to South Africa on **14 March 2007** were also mentioned. A referral to Home Start had been made and an application for money from the Carers' Grant was suggested. The attendance at a relapse prevention group run by the Psychologist at the CMHT was discussed. Social Worker 2 suggested that Mrs A contact the Citizens Advice Bureau about the family's debt problems, and she also agreed to get information about an assertiveness course. It was noted that Child 1 was looking well. A further visit was planned for **26 February 2007** as the Care Plan had not been completely finished.

11.70 The following day, **22 February 2007**, a Core Group Meeting for Child Protection was held. The participants were:

- Social Worker 7;
- Mr and Mrs A;
- a representative from Home Start;
- Health Visitor 2;
- Social Worker 2, Care Coordinator.

11.71 At the meeting, Mr and Mrs A announced that they were thinking of applying for a council house but were concerned as they had some previous outstanding rent arrears. Child 1 was reported to be more alert and active, so she would be able to go to mother and baby groups. Home Start help was available, and the representative from it gave Mrs A some information about a Trust Fund which might be of help with their debt problems. It was planned for Mrs A to attend the Family Group Meeting on **08 March 2007.**

11.72 Social Worker 2 visited Mrs A at her home on **26 February 2007** when the Care Plan was completed. Mrs A asked about a care home for her grandmother who was also planning to return to England. Social Worker 2 provided the contact details of the Older Peoples' Team. The next visit was made for **07 March 2007** when the Carer Assessment would be carried out for Mrs A's mother.[26]

11.73 The Carer Assessment for her mother was actually completed on **13 March 2007** as Social Worker 2 had been unwell on 07 March. A grant application was made to cover domestic help in the home. Social Worker 2 left information about the Relapse Prevention Group for Mrs A.

11.74 Mrs A had her first meeting with Dr 3 on **02 April 2007**. Mrs A reported that she had reduced her Lithium due to the side effects and when she had reached 800mg she started to feel normal again. She made it quite clear that she did not want to stay on the medication. Mrs A had continued to reduce the Lithium and was taking about 100mg daily.

11.75 Mrs A produced a paper from a firm that claimed to measure mineral deficiencies in hair, and said that she was taking a variety of vitamin supplements that she believed would keep her mood stable. She was not prepared to take medication except for Risperidone provided it was 2mg b.i.d (twice daily) to be taken on an as required basis, essentially PRN

(as required). Dr 3 stressed that having another baby was a real risk factor, and Mrs A said there were no plans to increase the family.[27]

11.76 Dr 3 had also told her that refusing the Lithium and regular Risperidone was very much a second best treatment, but Mrs A was adamant that she would be able to recognise the signs of relapse and manage them.

11.77 The following day, **03 April 2007,** Social Worker 2 visited Mrs A at home and reviewed her care plan. She also took a letter to support the housing application but would not send it until Mrs A told her the time was right.

11.78 A Core Group meeting was held on **05 April 2007** which was attended by:

- Social Worker 7;
- Mrs A;
- a representative from Home Start;
- Social Worker 2,
- a student social worker.

11.79 The meeting learned that Mrs A had not managed to socialise with other mothers and babies as she had been too busy. She told the meeting about the changes in medication agreed with Dr 3. (No Lithium and Risperidone 2mg as required). Mrs A's mother was due back from South Africa on 12 April. The family were emailing and telephoning Mrs A weekly. Home Start had found a volunteer who was able to support Mr and Mrs A until July.[28]

11.80 On **10 April 2007**, there was a written entry on the back of the letter from Dr 3 to GP 2 at the Brookfields Health Centre recording that a relative of Mr A had phoned to say that he made contact and they felt he could be delusional as he had ended his employment *"as it was not God's work."*[29]

11.81 Social Worker 2 made a home visit to Mrs A on **20 April 2007** and her mother had returned from South Africa. Mr A had found another job and was reported to be much less stressed. Social Worker 2 explained that she would be away on study leave for five months from the end of May. A further visit was arranged for **14 May 2007**, but was not made as Social Worker 2 was ill.

11.82 Social Worker 2 telephoned Mrs A on **08 May 2007** to discuss her decision not to attend any more of the Relapse Prevention Group sessions. Mrs A said she had enjoyed the first two sessions but considered that she would not gain any further benefit from them. Mrs A said that she was fine.

11.83 Social Worker 2's final recorded contact with Mrs A was on **16 May 2007** at the Core Group Meeting. Also in attendance were:

- Social Worker 7;
- Mr A;
- Mrs A;
- Mrs A's mother;
- Social Worker 2.

11.84 There were apologies from Health Visitor 2, who had asked the Lead Child Protection Social Worker to tell the meeting that Child 1 was meeting all her developmental milestones and was a very healthy baby. She thought that the meeting should look at not having Child 1 subject to a Child Protection Plan.

11.85 The meeting also considered that Mr A's parenting ability was *"good enough"* from the reports from Mrs A, her mother and Social Worker 7 plus Social Worker 2. As Mrs A's mother was back from South Africa, Health Visitor 2 would not visit weekly and Social Worker 2 asked for the social work visits to be made monthly rather than fortnightly. Social Worker 7 also decided that unannounced visits would no longer be necessary.

11.86 Mrs A said that she had been feeling much stronger and was attending a mother and baby group. Mr A said he had consulted a GP about his mental health and all had appeared to be well.[30]

11.87 Social Worker 4, Social Worker 2's replacement visited the home on **01 June 2007** and met Mr and Mrs A, although he left the house as he had a job interview.

11.88 Mrs A's mother mentioned a couple of reported incidents when Mrs A's behaviour had been a bit high but she had taken Risperidone with good effect. The incidents occurred in the context of Mrs A attending events where there had been lots happening, such as prayer meetings at the local Baptist Church she had joined.

11.89 Social Worker 4 discussed with Mrs A her experience of being a mother and suggested that she might possibly apply for Housing Benefit as they were managing on a low income. The family's past experience of New Age involvement and the effect this had had on her mental state were discussed. The date of the next home visit was made for 05 July 2007.

11.90 On **12 June 2007**, Mr A phoned Social Worker 4's office and a Community Psychiatric Nurse took the call. Mr A was concerned about his wife's mental state as she was behaving in a similar way prior to her admission to hospital in November 2006. Mrs A had been ironing obsessively, watching lots of pop videos, not sleeping and not wanting to take her medication. Social Worker 4 thought that there had been a deterioration since the medication had been stopped, and advised Mr A to contact the Home Treatment Team. This did not happen as the referral to the Home Treatment Team was refused as Social Worker 4 had not seen Mrs A within the previous 24 hours.

11.91 The Home Treatment Team suggested that Social Worker 4 should telephone GP 2 who had contacted Mr A who had felt the situation was calming down and reported that Mrs A had taken some Risperidone. [31]

11.92 The following day, **13 June 2007**, Social Worker 4 discussed the situation with the Home Treatment Team and a joint visit was arranged for the same day. At the home the situation appeared unstable with Mrs A not sleeping and experiencing racing thoughts and erratic behaviour. Her mother was concerned that Mr A had too much control in the household and was pushing his wife to attend Bible classes. He was not encouraging her to take her medication and was not looking for work despite their ongoing financial problems.

11.93 Social Worker 4 prepared a plan for Mrs A which comprised six main elements:

- to make an appointment with the Citizens' Advice Bureau to discuss Benefits;
- daily visits by the Home Treatment Team;
- the Home Treatment Team doctor to visit Mrs A to review her medication;
- for Mrs A to avoid attending Bible classes as they appeared to be too stimulating for her;
- to liaise with Children's Social Services;
- to arrange an appointment with Dr 3 which was fixed for 18 June 2007.

11.94 On **14 June 2007**, Mrs A mentioned during a conversation with a member of the Home Treatment Team that she felt she could benefit from a week away from the home as the situation could be rather intense and difficult for her at times.[32] A member of the Home Treatment Team staff contacted Dr 3 prior to the appointment Mrs A had with him to ask if he could examine why she had not been prescribed with a mood stabiliser.

11.95 The situation was contained by the prompt action taken by Mr A in reporting his wife's mental health deterioration and the action by Social Worker 4 and the Home Treatment Team. Mrs A attended an outpatient appointment with Dr 3 on **18 June 2007.** Mrs A explained to Dr 3 that she had been going high and had had paranoia and distrusted other people. She had thought that her mother could control the world and herself. The pastor of the Christian Community she and Mr A had joined had visited her, and had undertaken a healing anointment procedure. Mrs A said this had made her feel better.

11.96 Mrs A thought that the episode was triggered by some of her concerns regarding the Old Testament, but having resolved these issues in her own mind she felt she was less likely to relapse again. Mrs A acknowledged that the medication had helped her over this period, but remained adamant that she would discontinue this over the next two to three weeks, and would not agree to try any prophylactic regime. She agreed to stay on Risperidone 0.5mg per day and would increase this if necessary. Dr 3 pointed out that this had been her decision and he would recommend no change in the current dosage.

11.97 Dr 3 considered that Mrs A was not presenting any overt sign of psychiatric disorder although he did wonder if her attitudes to her debt and her medication might indicate some residual impaired judgement. Mrs A had agreed to see Dr 3 to review her situation.[33]

11.98 Social Worker 7 visited Mrs A and her husband at their home to check that all was well and that he could visit with Social Worker 4 on 21 June. He considered that Mr A appeared to be taking on a carer role and did not act in a controlling or domineering way.[34]

11.99 On **21 June 2007**, Social Worker 4 and the Social Worker 7 visited Mr and Mrs A. The family appeared to be more stable. Mrs A made it quite clear that she did not want to take a mood stabiliser or long-term anti psychotic medication. She also shifted the focus of the meeting to external stressors to ensure continued engagement. Social Worker 7 suggested talking to their priest about current stressors so that he was aware of the situation, but Mrs A did not want people to know about Child Protection. The Home Treatment Team support would continue but their contact would be reducing over time. The family had met with the

Citizens Advice Bureau about debt management and Mr A was considering whether he should train to become a teacher.[35]

11.100 Social Worker 4 visited Mrs A and Mr A at home on **03 July 2007** where she found the situation more stable. The Home Treatment Team was still visiting and keeping in touch by telephone, but was planning to discharge Mrs A once a discussion with Social Worker 4 had taken place. The next day Social Worker 4 had a discussion with Home Treatment Team and it was agreed that they could discharge Mrs A, which was done by telephone (**04 July 2007**.) Mrs A said she had been depressed the day before but had been pleased to find out how it felt. It was agreed she had a meeting with Dr 3 and that she would continue the medication and maintain contact with the Community Mental Health Team through Social Worker 4.[36]

11.101 On **04 July 2007**, Dr 3 saw Mrs A in his outpatient clinic and noted that she had been discharged from the Home Treatment Team. Mrs A reported that she had been taking the Risperidone on an 'as required' basis either 0.5mg or 1.00mg per day. Since her previous outpatient appointment there had been about four days when she had taken no medication. Following her bout of depression the previous day, Mrs A said that she could accept her diagnosis of *"manic depressive disorder"* fully and stated that *"Today I feel thoughtful and serious."*

11.102 Dr 3 had again stressed the dangers he thought Mrs A would be taking if she did not follow his advice on medication as he considered that it would reduce the risk of relapse. Mrs A was still determined to do things her way but agreed to attend the clinic to review how she was getting on.[37]

11.103 A Core Group Meeting took place on **05 July 2007** which was attended by:

- Social Worker 7;
- Mr A;
- Mrs A;
- Mrs A's mother;
- Social Worker 6:
- Health Visitor 2;
- Social Worker 4 had sent her apologies to the meeting.

11.104 It was noted that the family had done well during Mrs A's recent manic episode. Care Coordinator 4 thought that Child 1 should remain subject to a child protection plan. There was discussion about how the Home Treatment Team could be mobilised quicker in the future.

11.105 The family members described that communication in the family had improved. Social Worker 7 stated how valuable Mrs A's mother was as a support system to her daughter and the family. It was recognised that Child 1 was developing well and Health Visitor 2 would support Child 1 not being subject to a Child Protection Plan. A decision about the future and a revised Child Protection Plan would be taken at the next Child Protection Review Conference which was scheduled for **20 July 2007.**[38]

11.106 Dr 4 from the Home Treatment Team, in his discharge letter to GP 2 dated **10 July 2007** stated that he the Home Treatment Team nurse had visited Mrs A at her home on **14 June 2007** due to the concerns of her husband of her deteriorating mental health. At the onset of this Mrs A had become detached from Child 1 which was out of character. Since then she had again been caring well for Child 1. Mrs A had reported that she had been advised to take Risperidone only on a PRN basis. She had appeared vague about why the Lithium had been stopped.

11.107 In the plan for Mrs A on this day Dr 4 had strongly recommended that she take Risperidone 2mg nocte and 1mg *mane* (in the morning) as she would not agree to a higher dose. The need to remain on medication long term was stressed in order to avoid a further relapse. Mr A and her mother would be with her for most of the time and Social Worker 4 and Social Worker 7 would also be involved.

11.108 Dr 4 saw Mrs A again on **20 June 2007** and she had reduced her dose of Risperidone to 1.5mg daily and was planning to continue reducing it until she stopped taking it.[39]

11.109 On **23 July 2007**, Social Worker 4 visited Mr and Mrs AL to discuss her views of the coming Child Protection Case Conference. Social Worker 4 explained that she was concerned that the mental health framework was no longer fully in place. They discussed the care plan and risk management including the stress factors and crisis plans. Both Mr and Mrs A felt that the side effects of the Lithium outweighed the benefits, and alternatives were discussed. Social Worker 4 considered that there was a high level of vulnerability to relapse

given the present level of medication, and how medication can act as a safety net as evidence that a mood stabiliser was effective.

11.110 At the Review Child Protection Conference on **25 July 2007** those in attendance were:

- Independent Member;
- A Social Worker;
- Social Worker 4, Care Coordinator;
- Health Visitor 2;
- Mrs A;
- Mr A;
- Social Worker 7;
- The Chair, and a meeting secretary.[40]

11.111 The professionals and the family agreed that despite a relapse in the last two weeks of June the situation was stable and that Child 1 was developing well. It was unanimously agreed that the Child Protection element was no longer required as the family were working with professionals and had sought help as Mrs A was noticed to have deteriorated in her mental health in June. Child 1 was removed from the Child Protection Register but was still to remain on the Children in Need category and would have a Child in Need Care Plan. Several of the requirements of the original plan were carried over to the Child in Need Plan to provide continuity.

11.112 During this Conference Mrs A stated that *"it would help if she could clean out her demons."* She felt the atmosphere at home was calmer and that their faith was helping.

11.113 Dr 3 saw Mrs A in his outpatient clinic on **08 August 2007** where she reported being well despite not taking any medication for some time. Dr 3 considered that she was at some risk of relapsing in due course but she would only agree to attend review meetings with him.

11.114 A Child in Need Plan was agreed on **10 August 2007.** The main features of the plan were that:

- Mrs A would continue to engage with the mental health professionals who would continually monitor and assess her mental health and the effectiveness of her medication and arrange regular three monthly appointments with Dr 3;

- Mr A should contact professionals immediately if he had concerns about his wife's mental health;
- Mr A should consult with his GP if he or the family/professionals were concerned about his mental health;
- Child 1 was to be with her parents with the support of Mrs A's mother;
- more distant family relatives would support the family as best they could;
- Mrs A would attend community groups with Child 1;
- Health Visitor 2 would visit about every six weeks or as needed.

11.115 In the discussion at this Child in Need Meeting Mrs A's mother reported that she would have to go to South Africa in September/October as her mother had hurt her back and needed her help. It was agreed that the family might need additional help at this point.[41]

11.116 A Care Programme Approach Review Meeting was held on **14 August 2007.** The Risk Management Plan stated that the risks Mrs A posed to herself when she was mentally unwell were an increased vulnerability, general self neglect and financial misuse in spending money that she did not have. The risks to others were centred on Child 1 who would be at risk of neglect and physical harm, not having her needs met, or not met appropriately, and her mother disengaging from her.

11.117 The reasons for a relapse were listed as being due to Mrs A refusing to be on a mood stabiliser which increased the risk of relapse. The external factors were likely to be social stressors including relationships within the family and around church. Mrs A and her immediate family were aware of her early warning signs. The list of early indicators was:

- changes in sleep pattern which has been the first sign;
- Mrs A being either tired or more energetic;
- not eating properly which has had a serious impact on her mental health;
- not communicating or responding when questions are being asked and misunderstanding them;
- irritability and hostility when very unwell;
- bizarre behaviour;
- getting rid of possessions, clearing out and organising things;
- becoming self-indulgent.

11.118 The interventions which had been found helpful were taking Risperidone, having the support of her family, eating a balanced diet, prayer and having prompt access to services. It was also noted that alcohol and cannabis had been a factor in her being ill in the past.

11.119 The action to be taken should Mrs A begin to show signs of relapse were to review her mental state, arrange a medical review with GP 2 or with Dr 3 and to discuss an increase in her Risperidone as well as considering alternative medication. In addition, contact would need to be made with Child 1's Social Worker.[42]

11.120 The planned intervention was for Social Worker 4 and Dr 3 to provide regular follow up. The Crisis Plan relied on the Home Treatment Team and GP 2, with the Home Treatment Team being prepared to intervene even if Mrs A had not been seen by the referrer within the previous 24 hours.

11.121 The following week, **15 August 2007,** Social Worker 4 visited Mrs A to introduce Community Psychiatric Nurse 1 (CPN 1), who would be the Care Coordinator until Social Worker 2 returned in October, as Social Worker 4 was leaving.

11.122 On **19 September 2007**, CPN 1 visited Mrs A and also met her mother. The opening comment in the record of the visit stated *"My one and only planned appointment with Mrs A".* Both Mrs A and her mother reported that she was well, and that she was getting a great deal of support from religion. A discussion about religion ensued and the difficulties of carbon dating religious relics. (This record was hard to read).

11.123 On **23 October 2007**, Mrs A emailed Social Worker 7 with a copy to Social Worker 2 informing them that the family were moving house the following day. The move took the family out of the South Rural Community Mental Health Team catchment area and into the North Rural Community Mental Health Team area based in Ely. Social Worker 2 also emailed Dr 3 about the move and asked about the transfer to another psychiatrist. Dr 3 replied that he had a meeting planned for **15 November 2007** and he would see Mrs A then and discuss future follow-up arrangements.[43] This outpatient appointment was altered as the Outpatient Department was to be closed on that day so an alternative appointment was suggested for **21 November 2007**. There is a written note on the letter saying that this appointment was cancelled and another was sent for **19 December 2007**.

11.124 Dr 3 wrote to the Milton GP, GP 3, on **02 January** saying that he would have liked Mrs A to have been on a prophylactic regime of medication but that she had declined his advice. He added that *"luckily she seems to have remained well."*

11.125 Dr 3 also wrote separately to Dr 4 saying that he did not feel that at present Mrs A needed regular psychiatric follow-up, but he felt it would be appropriate for the North Rural Community Mental Health Team to make contact with her. He added that it might not be necessary for regular input but he was sure that it would help her management of any further relapse if she were in the system.

11.126 Social Worker 2 replied to Mrs A by letter dated **25 October 2007** and explained that *"unfortunately I will have to transfer your case to the North Rural CMHT at Croylands, Ely. I will let you know when this has been done and, in the meantime, please contact me if you need help with anything."*

11.127 Social Worker 7 emailed Social Worker 2 to inform her that he had contacted the Ely Community Mental Health Team and they had no record of Mrs A having been transferred to them. This was on **17 December 2007**, and three days later Social Worker 2 formally wrote to the North Rural Community Mental Health Team to refer the case. On the same day, **20 December 2007**, Social Worker 2 wrote to GP 3 to inform him of the Ely Community Mental Health Team involvement. She also wrote to Mrs A and said that the Ely Community Mental Health Team would be in touch with her once they had allocated her with a worker. She gave Mrs A the telephone number of the new team base.[44]

11.128 On **25 January 2008**, the new Care Coordinator, a Community Psychiatric Nurse (CPN 2) and a student social worker visited Mrs A and also met her mother, Mr A and Child 1. Mrs A presented as well, although the student social worker who had met her before, thought that she and Mr A appeared to be tense. Mrs A was taking no regular medication, but if she could not sleep she took Risperidone 1mg as required. Mrs A and Mr A were involved with studying the Bible but did not attend church as they did not believe that church had the right attitude, and they were more interested in the social aspects in the Bible.

11.129 CPN 2 proposed visiting the family once a month and Mrs A appeared surprised at this news. CPN 2 explained that there was a Child in Need Meeting arranged for 05 February 2008 when an appropriate care plan would be agreed.

11.130. At the Child in Need Meeting on **05 February 2008** it was agreed that the same plan as agreed on 10 August 2007 would be used with a few alterations. The plan stated that:

- Mrs A would continue to engage with the mental health professional who would visit monthly;
- Mr A should contact professionals immediately if he had concerns about his wife's mental health;
- Mr A should consult with his GP if he or the family/professionals were concerned about his mental health;
- Mrs A's mother would provide on-going support within the family home;
- Mrs A would contact Health Visitor 3 if she thought Child 1 needed it.[45]

11.131 CPN 2 visited Mrs A again on **04 March 2008** when she appeared settled and her mental state was euthymic. She had not needed any Risperidone since 25 January when she was last seen. She was seen on her own as Mr A was at work and her mother was upstairs feeling unwell.

11.132 Mrs A explained the importance of her new found Christianity and how she studied sermons on the internet. She and Mr A did not attend a church. Mrs A was not keen to take Child 1 to a nursery and CPN 2 explained the importance of gradually introducing her to other children to help start her socialising. It was planned to visit again on 16 April 2008, six weeks later. [46]

11.133 A Child in Need Meeting was held at the home of Mr and Mrs A on **16 April 2008.** Mrs A said that she had not needed to take any medication and Mr A said he was well but had taken some days off work as he had felt tired. Mrs A was asked by the student social worker about an incident in December 2007 when a GP had found Child 1 out on the road alone. Mrs A explained that this was prior to Child 1 being able to walk and she did not realise that Child 1 could reach the door handle. The handle had since been made secure so that Child 1 could not open it.

11.134 The student social worker suggested at the end of the meeting that a Child in Need Plan was no longer needed for Child 1 as her wellbeing and development had been going well for a sufficient period as had her parents' mental health. Mrs A's mother provided support. The group agreed with this suggestion. Those attending were Mrs A, her mother, Mr A plus Health Visitor 3, CPN 2 and the student social worker. CPN 2 also visited on **18 April 2008** and said the next visit would be in four to six weeks time.[47]

11.135 The next home visit was on **24 July 2008**. Mrs A reported that things were going well. She and her husband were continuing to study the Bible in depth and to live their lives according to the scriptures. They had found a church and were beginning to develop a social network. Mrs A was still not requiring medication. CPN 2 decided that Mrs A would be discharged to Primary Care.[48] A letter was sent to GP 3 informing him that CPN 2 had closed the case and asking him to re-refer Mrs A should the situation deteriorate. A copy was sent to the student social worker at Social Services.

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11.136 On **15 December 2008**, CPN 2 received a telephone call from Mrs A's aunt. She reported her concerns about Mrs A's religious fervour in that when she had visited their house Mrs A would not let her in and referred to her as *"heathen".* Her mother was no longer living with the family, having moved to Kent to live with her ex-husband. CPN 2 contacted Health Visitor 3 who was aware of the situation as the aunt had also telephoned her, and felt that Social Services should be informed. CPN 2 also contacted GP 3 and the Child and Family Team. The student social worker had left and the senior staff member was Social Worker 7.[49]

11.137 CPN 2 and Health Visitor 3 visited Mrs A on **13 January 2009.** She was at home and was welcoming. It was evident that Mrs A was pregnant but she did not volunteer this information. When asked, she reported that she was pregnant and had not booked in with GP 1 or the midwife. Mrs A wanted a home delivery. Mrs A held extreme religious views and would not accept that there was any other way to behave. She had changed the telephone number so that her *"heathen"* family members could not contact them. Mrs A said they did have friends who they studied the Bible with but this was at home as they did not belong to a church. Mrs A planned to home educate her children.

11.138 Health Visitor 3 was concerned for the safety and wellbeing of the unborn baby due to the non-participation in antenatal care to provide an understanding of its health and condition. She was also concerned about there being no 'booked pregnancy' and ensuring responsibility for a safe delivery, by dating, knowing the condition of the baby and the placental position. Health Visitor 3 thought the resistance to antenatal care appeared to risk leaving the mother and her baby vulnerable and completed a Single Agency Referral Form to Social Care Services.[50]

11.139 CPN 2 planned to visit Mrs A monthly until the baby was born and would then visit regularly to monitor the situation. She also planned to re-refer to the Children's Social Care Services.[51]

11.140 Mrs A's parents telephoned CPN 2 on **05 February 2009** saying that the family were continuing to withdraw from society. They had no telephone and although Mrs A's mother had emailed Mr A at work, she could not make contact with Mrs A. They had thought that Mrs A's baby was due in August, but it was actually due in May.

11.141 CPN 2 visited Mrs A on **10 February 2009** with a Staff Nurse. Mrs A was slightly surprised to see the nurse but allowed her into the house. Mrs A reported that all was fine and that her pregnancy was untroubled as *"God was looking after everything."* She was guarded and dismissive in her responses to questions and gave short answers. She seemed to think CPN 2's questions were foolish because *"God was in charge".*[52]

11.142 CPN 2 informed Mrs A that Children's Social Care Services would be involved again and that Dr 5 would like to see her. (This was problematic as Mrs A did not get out much and did not drive and had no car.) She arranged a visit with Dr 5 for 17 February 2009 and another with Social Worker 5 (Child 1's Social Worker) on **24 February 2009**.

11.143 A relative of Mr A sent a very long email about the concerns they had over Mr and Mrs A in relation to Child 1. It emphasised the level of disengagement being indicative of Mrs A having a breakdown, as did their strong views on religion and how they would not allow toys in the house nor furniture that was coloured or children's books as they were not seen as Godly. The email also mentioned Mr A's past mental health history.[53]

11.144 CPN 2 visited Mrs A with Dr 5 on **17 February 2009.** Dr 5 considered there were two presenting issues. The first was that her history of bipolar disorder including previous psychotic symptoms and the fact that she was currently pregnant with an expected birth date of **02 May 2009** placed her at high risk of a relapse which would need appropriate monitoring and support. The second concern was the extreme religiosity which could represent an on-going psychotic illness. Mrs A gave an account of her mental health history and stated that she didn't think she would become unwell again because of her faith in God as *"mental illness would not serve his purpose".* She also attributed her previous mental illness in part to *"the Devil getting in".* Dr 5 in his letter to GP 3 following this interview did consider that Mrs A did also understand that her mental ill health was an illness and was not conveying that she had been possessed.

11.145 Mrs A said that she and her husband would rule out any church which paid pastors or preachers because this would be against St Paul's instruction not to do it for money. They had tried seven or eight different denominations in Cambridge but had not found one they could relate to. Dr 5 considered that Mrs A was at high risk of having a relapse following the birth of her baby. He thought following the birth there would be a need for very close monitoring on a daily basis by health staff including her midwife, Health Visitor 3, CPN 2, himself and possibly the Crisis Resolution Home Treatment Team. Dr 5 commented that he would liaise with the doctor with a special interest in perinatal mental health. He also thought it would be useful for him to meet Mr and Mrs A together to discuss the risks associated with her mental health and pregnancy.[54]

11.146 On **18 February 2009** the Perinatal Mental Health lead declined involvement in the case.

11.147 A Professionals Meeting was held on **24 February 2009** which was attended by:

- Social Worker 5;
- Midwife 1;
- Midwife 2;
- CPN 2;
- Health Visitor 3;
- Dr 5.

11.148 The current position was described and the estimated delivery date was derived from Mrs A's menstrual dates only and was therefore unreliable. CPN 2 was concerned that Mr A could be exerting a measure of control over Mrs A's activities. He had been tense and on the verge of anger which prevented CPN 2 and Social Worker 5 raising some of the topics they had wished to discuss.

11.149 Dr 5 considered the risk of a psychotic breakdown as greater than 50 *per cent* based on her mental health history and what had occurred following the birth of Child 1. In the light of the risks and the lack of Mrs A's mother providing on-site support it was agreed to request an Initial Child Protection Conference to discuss the risks to Child 1 and the unborn baby.[55]

11.150 Social Worker 5 telephoned CPN 2 to say that a social worker did not gain entry to see Mrs A at her home that morning, **06 March 2009.** Three days later, **09 March 2009** CPN 2 received a letter from Mrs A cancelling the arranged visit for the following day. This was

followed by a telephone call from Mrs A on **10 March 2009** saying she had seen Social Worker 5 and Family Support Worker 1 that morning. She apologised about the cancellation of visits and explained that Mr A and she had prayed over the weekend and they were therefore able to re-engage with services. She said they had become frightened by all the visits, but Mr A had contacted the Community Mental Health Team to make another appointment.[56]

11.151 A Child Protection Conference was held on **12 March 2009**, and both Child 1 and the unborn baby were made subject to a Child Protection Plan. The reasons were the nature of Mrs A's mental health and the strong probability that she would relapse following the birth of her baby as she had in November 2006.

11.152 Some of the main determinants of the decision were that Mr and Mrs A were isolated and were not in touch with their 'earthly' family as they were waiting to meet the family that God had chosen for them. They firmly believed that God would protect them and it was thought possible that their belief structure could be indicative of an on-going psychotic disorder in both of them. The house was clean and tidy, sparsely furnished with no decoration or colour and with quotations from the Bible pinned to the wall. Despite searching for a Church to belong to they had not found one with which they agreed, neither had they located an internet community that matched their faith. It was felt that such isolation was starting to make it look as if their 'faith' was actually an indication of mental illness.

11.153 Child 1 had few toys and these were not age appropriate. As the family were by choice very socially isolated, it was thought that Child 1 had not seen any other person apart from her parents and visiting professionals for possibly several months.

11.154 The formal reasons for Child 1 and the unborn baby being made the subjects of a Child Protection Plan under the category of Neglect were that:

- Mrs A and Mr A needed to build on their resolve to think about how their lifestyle was impacting on Child 1 and the new baby;
- the parents had said they were willing to work with professionals, and this needed to be seen in practice. They needed to accept the support offered.

11.155 A Review Child Protection Conference was arranged for 09 June 2009 with the Core Group to meet on 19 March 2009 and 10 days prior to the next Conference.[57]

11.156 The Key Worker was a social worker from the South Cambridgeshire and Cambridge City Children's Team, Social Worker 5 and the Core Group Membership comprised:

- Social Worker;
- Mrs A;
- Mr A;
- Midwives 1 and 2;
- Health Visitor 3;
- CPN 2;
- Family Support Worker 1.

11.157 CPN 2 visited Mrs A on **18 March 2009** and found her to be settled. Mrs A stated that some family links had started to be built. She had agreed to see the midwife but has refused any blood tests but would allow her to manually palpate her abdomen. Mrs A had taken Child 1 to two local nursery groups but she felt neither was suitable for her.

11.158 Some discussion was had about the family cutting off from the professional help which Mrs A thought had been due to anxiety. She confirmed that they were willing to work with the different agencies involved.[58]

11.159 CPN 2 was going to have leave during the second half of March 2009 and CPN 3 would be visiting Mrs A in her absence. She made her first visit on **01 April 2009** and found Mrs A feeling really well. She explained that they were having to move house because their landlord who had gone to Canada was coming home unexpectedly and needed the house. They were hoping to move to Milton.

11.160 CPN 3 noted that Mrs A was prepared to go into hospital to give birth to the baby if this was suggested by the midwife. It was also noted that Child 1 had some picture books. She visited again on **08 April 2009** and discovered that the move to Milton was taking place on **10 April 2009.** CPN 3 talked mainly to Mr A as Mrs A was upstairs with Child 1. He confirmed his mental ill health history. After 30 minutes Mrs A joined her husband and the birth plan was discussed. CPN 3 stated that she would favour a hospital birth due to previous complications, Mrs A not having accepted full antenatal care and it was not clear if they would accept emergency care given the history of not complying with medication.[59]

11.161 The risk of a psychotic relapse was discussed, and Mr A was very agitated and was unable to articulate his questions and stared around for about five minutes despite prompting

from Mrs A and CPN 3**.** Mr A eventually said *"so if a devil enters her then you want to be called?"*

11.162 CPN 2 visited Mrs A on **15 April 2009** when she appeared well and was happy to have moved house. She knew it was about two weeks until the baby was due and was looking forward to it.

11.163 CPN 2 visited again on **27 April 2009** and met Mr and Mrs A. Mr A had taken time off work for several weeks to help with the birth. It was agreed that CPN 2 would visit the following week on **05 May 2009** but on that day there was a message informing her that Mrs A had given birth on Sunday without a midwife present.

11.164 CPN 2 and Midwife 1 visited Mrs A at home where she appeared to be coping well with the new baby, Child 2. She was well and was not experiencing any psychotic symptoms. Mr A was not feeling well as he stated he reacted badly to disturbed or late nights. He was dressed in his pyjamas and appeared to be anxious.

11.165 Mr and Mrs A had not adhered to the birth plan as they did not call the midwives when the labour had started. They had called at the last minute when Mrs A had already had Child 2. It was agreed that CPN 2 would visit daily for the week and make contact with Dr 5 and GP 3 so that Child 2 could have a new-born check.[60]

11.166 A further home visit was made on **06 May 2009** where Mrs A and Child 2 were resting while Mrs A's mother was with Child 1. Mr A said he was tired but it was hard to rest with having to tolerate so many visitors. It appeared this was said with an edge of irritability. Mr A was difficult to follow at times and he continued to make reference to God being in control and gave scant regard to the precautionary steps that all the health professionals were putting in place. CPN 2 questioned if there had been evidence of some thought disorder. GP 3 was planning to see Child 2 on that afternoon.

11.167 On **07 May 2009**, the CPN 2 and Dr 5 made a joint visit. Mrs A left the room to breastfeed Child 2. They discussed the new baby checks with Mr A who was not in agreement with tests and stated that he *"fundamentally didn't trust the information about altered states induced by drugs that make people susceptible to spirits".*

11.168 Dr 5 wrote to GP 3 outlining the bizarre beliefs expressed by Mr A at the above home visit. It was clear that Mrs A thought the 11-hour labour went well but the birth then had happened quickly. The midwives were present to deliver the placenta and to cut the cord.

11.169 GP 3 visited but was not allowed to examine Child 2. Social Worker 6 (a care-taker social worker) met Mr and Mrs A, and suggested it would be advisable to let GP 3 do the tests and to examine Child 2 due to the Child Protection implications. They then let Child 2 be examined by GP 3, but refused to let her hips be checked and refused screen tests for conditions such as cystic fibrosis and hypothyroidism.

11.170 Mrs A went to breastfeed Child 2, and Mr A then talked to Dr 5 about the World Health Organisation which had the fundamental goal to reduce the world's population and that modern health care was like witchcraft in that the drugs used produced an altered state that made people much more susceptible to spirits. He went on to say that ADHD was an example of this and consequently he preferred to trust in God rather than rely on any aspect of modern health care. Dr 5 emphasised to GP 3 that both Mr and Mrs A remained poorly cooperative with services but the situation needed careful monitoring, particularly Mrs A's mental state but also that of her husband.[61]

11.171 The Discharge Planning Meeting (from the Midwifery Service) took place on **08 May 2009** at Mr and Mrs A's home as she had not gone into hospital. Those attending the meeting were:

- Social Worker 6;
- CPN 2;
- Family Support Worker 1;
- Midwife 2.

11.172 The main concern at the meeting was the safety of the two children, especially Child 2 given the probability of an emergency as after Child 1's birth. The parents said that in an emergency they would pray to God in the first instance, and could not assure the staff that they would call 999.

11.173 It was noted that Child 1 had few toys and that imaginary play was discouraged and that she was not allowed to socialise with her peer group. The plan was to continue daily monitoring by multidisciplinary professionals.[62]

11.174 CPN 2 visited Mr and Mrs A on **11 May 2009** when the situation was calm and settled. Mrs A had been a little 'weepy' the previous day and she slightly criticised her husband for being over-critical, but knew the answer was to pray about things. Warning signs to becoming unwell were discussed and Mr A became slightly irritated and stated that they dealt with Mrs A's symptoms by praying.

11.175 On **15 May 2009**, CPN 2 and Health Visitor 4 visited and were aware of tensions within the house. Mrs A's mother was present and was staying for a few days. Echoes of the previous year were apparent and these had resulted in her mother leaving. Mrs A looked tired and low but she blamed this on the stress of the Core Group Meeting which had been arranged for **18 May 2009**. At this meeting it was agreed that the Child Protection Plan made at the last meeting should be continued. Mr and Mrs A discussed their distress that her mother had lost her faith.

11.176 A further home visit was made on **22 May 2009** by CPN 2. Mr and Mrs A did not engage in the conversation and appeared to be deflecting questions by providing short responses such as *"fine"* and *"well".* CPN 2 asked whether either of them had noticed any unwanted thoughts or feelings to which they responded by saying that their days were spent caring for the children and studying the Bible. The visit lasted for only 20 minutes due to the difficulty in having a meaningful discussion.

11.177 On **01 June 2009**, CPN 2 visited and Mrs A explained that her husband had returned to work and she had taken both children shopping. During the 50 minute visit Mrs A appeared well and calm feeding Child 2. She reported that she had decided not to attend the Review Child Protection Conference scheduled for 09 June 2009, as Mr A would be attending and *"what he thinks I think".*

11.178 CPN 2 made a further home visit on the morning of **09 June 2009** when both Mr and Mrs A were present. They were welcoming but there was a reluctance to engage fully in conversation. They asked CPN 2 how long she would remain involved with them, to which she replied that for the time being it would remain a weekly visit. CPN 2 agreed to visit the following week on 17 June 2009. The Review Child Protection Conference met that afternoon when it was agreed that both Child 1 and Child 2 should remain subject to the Child Protection Plan.

11.179 On **12 June 2009**, Mrs A had left a telephone message for CPN 2 saying that she no longer wanted to have any visits. She had also telephoned Health Visitor 4 with the same

message. Both CPN 2 and Health Visitor 4 contacted Social Worker 5 at the Children and Families Service to report the refusal of visits. CPN 2 also spoke to Dr 5 who said he would visit the following week.

11.180 Three days later (**15 June 2009**) CPN 2 had a further discussion with Dr 5 as she had booked an appointment to visit Mrs A on 17 June 2009. It was agreed that CPN 2 should visit as arranged and then decide what action was appropriate.

11.181 On **17 June 2009**, CPN 2 and Health Visitor 4 visited Mr and Mrs A's home. Mr A opened the door and let them in. He said that Mrs A was upstairs, and they both saw Child 1 was sitting calmly on the stairs. Within about a minute of their arrival Mr A had started praying loudly and shouting for the Lord to help. He then prayed for the Devil to be released from Mrs A. They then heard Mrs A call calmly from upstairs *"What's the matter?"* CPN 2 called up to Mrs A but she did not reply. CPN 2 heard Child 2 *"grizzling"* upstairs. Both Health Visitor 4 and CPN 2 left the house to avoid inflaming the situation.

11.182 **At 14.15** CPN 2 telephoned Dr 5 and left a message for him, and then **at 14.30** spoke to Social Worker 6 about the situation. The plan was to make a visit to Mr and Mrs A to undertake a mental health assessment.

11.183 **At 16.00** Dr 5, CPN 2 and Social Worker 6 visited the home and found that the Police were in attendance. They were informed that Child 2 was dead and that Child 1 was critically ill in hospital. Mr A was in custody and Mrs A was still in the house.

11.184 **At 16.30** Dr 5 informed the Manager of the Community Mental Health Team of the situation. He then went to the GP surgery **at 17.30** and learned that Mr A had visited there with Child 1 and Child 2 wrapped in a blanket. An ambulance was called. It was evident that Child 2 was dead although resuscitation was tried to no avail. Child 1 smelt of something like white spirit. She was undressed and washed but had red skin except for the area protected by her nappy. A separate ambulance was ordered which took her to Addenbrookes Hospital.

12. Timeline and Identification of Critical Issues

Root Cause Analysis (RCA) Second Stage

Timeline

12.1 The Independent Investigation Panel formulated a timeline in table format and also a chronology in a narrative format in order to plot significant data and identify the critical issues and their relationships with each other. Please see Appendix One for the Tabular Timeline and the previous section for the full chronological record. This process represents the second stage of the RCA process and maps out all of the emerging issues and concerns held by the Independent Investigation Panel.

Critical Issues Arising from the Timeline

12.2 On examining the timeline, the Independent Investigation Panel initially identified seven critical issues and junctures that rose directly from the care and treatment that Mrs A received from the Cambridgeshire and Peterborough NHS Foundation Trust and their partner agencies. These critical issues and junctures are set out below:

1. The mental health of Mrs A and her refusal to follow the clinical advice she was consistently given by the Mental Health Services, the Children and Families Service, Midwives and Health Visitors.

2. The lack of a clear coherent crisis and contingency plan should Mrs A relapse which all professionals were aware of and knew exactly what they should do.

3. A lack of assertiveness by agencies after Mrs A was discharged from the Thumbswood Mother and Baby Unit on 23 January 2007 and thereafter.

4. The confusion and over-importance given to the question of whether Mr A and/or Mrs A were suffering delusions in the period prior to, and following, the birth of Child 2.

5. The missed opportunity to undertake a Mental Health Act (2007) assessment with Mr and Mrs A after their refusal to accept visits from staff on 12 June 2009.

6. The loss of information about the ‘Pillow Incident’ with Child 1 in November 2006.

7. Consideration of clinical issues in Mrs A’s Care and Treatment.

13. Further Exploration and Identification of Causal and Contributory Factors and Service Issues

RCA Third Stage

13.1 This section of the report will examine all of the evidence collected by the Independent Investigation Panel. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

13.2 In the interests of clarity, each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below:

Key Causal Factor

13.3 The term is used in this Report to describe an issue or critical juncture that the Independent Investigation Panel have concluded had a direct causal bearing upon the events of 17 June 2009. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user receives, and any subsequent homicide perpetrated by them.

Contributory Factor

13.4 The term is used in this Report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the breakdown in Mrs A's mental health and/or the failure to manage it effectively.

Service Issue

13.5 The term is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this Report, whilst having no direct bearing on the events of 17 June 2009, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made. No service issues were identified.

13.1 The mental health of Mrs A and her refusal to follow the clinical advice she was consistently given by the Mental Health Services, the Children and Families Services, Midwives and Health Visitors

13.1.1 This Section describes how Mrs A and her husband failed to follow the advice they were given, and often verbally accepted. Their refusal to follow the advice from Mental Health Services will be examined first, and then their refusal to follow advice from the other services involved, Children's Social Care Services, Midwives and Health Visitors.

Mental Health Services

First Reported Episodes of Mental Ill Health

13.1.2 A recurring theme throughout the contact Mrs A had with Mental Health Services from November 2006 to June 2009 was her refusal to take advice about medication and the general physical health of herself and Child 1 and the unborn Child 2.

13.1.3 There were earlier signs of Mrs A not taking medication as prescribed. In May 2002 Mrs A stopped taking her prescribed Risperidone due to reported side-effects and then stated that she took it on an *ad hoc* basis and had refused to have mood stabilisers.

13.1.4 On 05 July 2004 Mrs A was discharged from the psychiatric services at The Maudsley Hospital at her own request. She had been asymptomatic and had had no medication for the previous seven months. Mrs A reported that she had met Mr A in 2003 and that he had encouraged her to stop taking her medication. As will be seen, this was a common feature throughout the time Mrs A was receiving care and treatment from the Cambridgeshire and Peterborough NHS Foundation Trust, and when at the Thumbswood Mother and Baby Unit.

November 2006 to July 2008

13.1.5 For the details of this period of Mrs A's treatment and care please refer to the Detailed Timeline in Section 11 of this Report from Paragraphs 11.17 to 11.24, 11.45, 11.52 to 11.59, 11.74 to 11.77, 11.90 to 11.102, 11.106 to11.109, 11.144 to 11.152, 11.163 to 11.170, 11.179 to 11.181.

13.1.6 After her admission to Fulbourn Hospital in November 2006 Mrs A stated that she wished her husband had sought help before she had become so mentally unwell.[63] She accepted that she had not been well and agreed to remain in hospital and to take her medication. Following her transfer to the Thumbswood Mother and Baby Unit on 29

November 2007, Mrs A settled well and was observed to have recovered quite quickly on the prescribed Lithium and Risperidone.

13.1.7 After a trial overnight leave with her husband, but without Child 1, and a trial day leave with her daughter, it was agreed that Mrs A could have some leave in her home over the Christmas period. The leave went well, but at the ward round following her return to Thumbswood Mother and Baby Unit on 27 December 2006, Mrs A reported that during her Christmas leave she had felt tired and attributed this to her medication which she had decided not to take on Boxing Day. During a subsequent leave period Mrs A had been concerned about a rash and wondered if it could have been caused by the Lithium, but following discussion with the Thumbswood Mother and Baby Unit staff this was not thought to be the cause.[64]

13.1.8 This behaviour illustrates how deep-seated the dislike of taking medication had become, so that the Lithium was being blamed so that Mrs A might be able to reduce the current dose. In the event the dose was increased to 1200mg on 23 January 2007. This was further indicated when Mrs A told her GP, Dr 3 that she had reduced her Lithium due to the side effects and that when she had reached 800 mg she had started to feel normal again but she did not want to stay on the medication. Mrs A had continued to reduce the Lithium and was taking about 100mg daily. Mrs A produced a paper from a firm that claimed to measure mineral deficiencies in hair and said that she was taking a variety of vitamin supplements that she believed would keep her mood stable. She was not prepared to take medication except for Risperidone provided it was 2mg b.d. to be taken on an as required basis which is what she had done in 2002.

13.1.9 It was clear that Dr 3 thought that it was important to try to retain Mrs A's engagement and therefore he was prepared, albeit reluctantly, to allow her to not take medication. Mrs A agreed to take 2mg Risperidone if and when she felt the need, but it is a drug to combat the symptoms of psychosis and not an alternative to a more usual PRN medication to calm one down. There is no evidence base to show that Risperidone is effective when used PRN. Dr 3 considered that as Mrs A was not able to be sectioned under the Mental Health Act (1983) it was preferable for her to have some Risperidone to take and there would be some readily available if she did relapse.

13.1.10 Mrs A did have a relapse on 12 June 2007 and told her GP that the medication had helped her over this period, but remained adamant that she would discontinue this over the next two to three weeks, and would not agree to try any prophylactic regime. She did agree to stay on Risperidone 0.5mg per day and would use this as PRN, and would increase this if

necessary. Dr 3 pointed out that this had been her decision and that he would recommend no change in the current dosage.

13.1.11 Mrs A confirmed her refusal to have medication on 21 June 2008 when Social Worker 7 and Social Worker 4 had visited her at home, and she made it quite clear that she did not want to take a mood stabiliser or long term antipsychotic medication.

13.1.12 The attitude of Mrs A to her illness is remarkable in that having had a relapse barely two weeks before when she had been thought disordered, she did not consider the potential danger to her health and that of her baby. Mrs A did not agree to have a prophylactic medication regime which was designed to prevent the reoccurrence of psychotic symptoms, and the potential danger this could pose.

13.1.13 In the plan for Mrs A on 14 June 2007, Dr 4 had strongly recommended that she take Risperidone 2mg nocte and 1mg in the morning as she would not agree to a higher dose. The need to remain on medication long term was stressed in order to avoid a further relapse. Mr A and her mother would be with her for most of the time and Social Worker 4 and Social Worker 7 would also be involved. Dr 4 saw Mrs A again on 20 June 2007 and she had reduced her dose of Risperidone to 1.5mg daily and was planning to continue reducing it until she stopped taking it.[65]

13.1.14 It is perhaps significant that Mrs A did not inform Dr 4 in such a forthright way that she was not prepared to take medication. The Home Treatment Team probably had been more assertive than Dr 3 because they were trying to enable Mrs A to stay at home rather than her having to be admitted to hospital.

13.1.15 At each outpatient appointment Dr 3 had stressed the dangers he thought Mrs A would be taking if she did not follow his advice on medication as he considered that it would reduce the risk of relapse. Mrs A was still determined to do things her way but agreed to attend the Outpatient Clinic to review how she was getting on.[66] Dr 3 saw Mrs A in his Outpatient Clinic on 08 August 2007 where she reported being well despite not taking any medication for some time. Dr 3 considered that she was at some risk of relapsing in due course but she would only agree to attend review meetings with him.

13.1.16 The family then moved house on 24 October 2007 and no further contact with Mental Health Services took place until 25 January 2008 except that Dr 3 did see her on 19 December 2007 for the last time prior to the ‘delayed’ transfer to the North Rural Community

Mental Health Team at Ely. Following this Outpatient Appointment Dr 3 wrote to GP 3 on 02 January 2008 saying that he would have liked Mrs A to have been on a prophylactic regime of medication but that she had declined his advice. He added that *"luckily she seems to have remained well."*

13.1.17 There were no further Outpatient Appointments as Dr 5 had been informed by Dr 3 that there was at present no indication that Mrs A needed regular psychiatric follow-up, but he felt it would be appropriate for the North Rural Community Mental Health Team to make contact with her. He added that it might not be necessary for regular input, but he was sure that it would help the management of any further relapse if she were 'in the system.'

13.1.18 It is somewhat surprising that Dr 3 gave this advice to Dr 5 when transferring Mrs A to his care. Dr 3 had repeatedly stressed to Mrs A the importance of taking the prescribed medication and had consistently told her that in his opinion she was likely to have a relapse without taking a regular prophylactic antipsychotic.

13.1.19 On 28 July 2008 CPN 2 closed her involvement and that of the Community Mental Health Team and Mrs A was referred back to GP 3 for her health needs. GP 3 was invited to refer Mrs A back to the Community Mental Health Team should he feel she was relapsing or needed additional support.

13.1.20 CPN 2 had returned Mrs A's care to GP 3 as far as mental health and their physical health was concerned. This again served to provide grounds for Mr and Mrs A to think that they were right in their apparent belief that Mrs A could manage her own mental health without recourse to medication except on a need to use sparingly basis. They were also greatly boosted by their religious beliefs that God would look after them, which from this period was becoming stronger and really set the tone for the way they lived.

December 2008 to June 2009

13.1.21 On 15 December 2008 CPN 2 received a telephone call from Mrs A's aunt. She reported her concerns about Mrs A's religious fervour in that when she had visited their house Mrs A would not let her in and referred to her as "heathen". Mrs A's mother was no longer living with the family, having moved to Kent to live with her ex-husband who was ill. CPN 2 contacted Health Visitor 3, who was aware of the situation and felt that Social Services should be informed. CPN 2 also contacted GP 3 and the Children and Families Team. The student social worker had left and the senior social worker was Social Worker 7.[67]

13.1.22 CPN 2 visited Mrs A at her home with Health Visitor 3 on 13 January 2009. Mrs A was welcoming, and although it was evident that she was pregnant, she did not volunteer this information. When asked she reported that she was pregnant and had not booked in with the GP or the midwife. Mrs A wanted a home delivery. She held extreme religious views and would not accept that was any other way to behave. She had changed the phone number so that her *"heathen"* family members could not contact them. Mrs A said they did have friends who they studied the Bible with but this was at home as they did not belong to a church. Mrs A planned to home educate her children.

13.1.23 Mrs A was again informed that her pregnancy greatly increased the chances of her becoming mentally unwell again either during the pregnancy or after Child 2 was born. CPN 2 planned to visit Mrs A monthly until the baby was born. She would then visit regularly to monitor the situation. She also planned to re-refer the family to Social Services.[68]

13.1.24 CPN 2 and Dr 5 considered there were two presenting issues. The first was that her history of bipolar disorder affective disorder including previous psychotic symptoms and the fact that she was currently pregnant with an expected birth date of 02 May 2009 placed her at high risk of a relapse which would need appropriate monitoring and support. The second concern was the extreme religiosity which could represent an on-going psychotic illness. Mrs A gave an account of her mental health history and stated that she didn't think she would become unwell again because of her faith in God as *"mental illness would not serve his purpose"*. She also attributed her previous mental illness in part to *"the Devil getting in".*

13.1.25 Dr 5 considered that Mrs A was at high risk of having a relapse following the birth of her baby. He thought that following the birth there would be a need for very close monitoring on a daily basis by health staff including her midwife, health visitor, CPN, himself and possibly the Crisis Resolution Home Treatment Team. Dr 5 commented that he would liaise with the doctor with a special interest in perinatal mental health. He also thought it would be useful for him to meet Mr and Mrs A together to discuss the risks associated with her mental health and pregnancy.[69]

13.1.26 A Professionals Meeting was held on 24 February 2009 where the current position was described and the estimated delivery date of early May was derived from Mrs A's menstrual dates only and was therefore unreliable. CPN 2 was concerned that Mr A could be exerting a measure of control over his wife's activities. He had been tense and on the verge

of anger which prevented CPN 2 and Social Worker 5 raising some of the topics they had wished to discuss.

13.1.27 Dr 5 considered the risk of a psychotic breakdown as greater than 50 *per cent* based on her mental health history and what had occurred following the birth of Child 1. In the light of the risks and the lack of Mrs A's mother providing support within the home, it was agreed to request an Initial Child Protection Conference to discuss the risks to Child 1 and the unborn baby.[70]

13.1.28 An Initial Child Protection Conference was held on 12 March 2009 and both Child 1 and the unborn baby were made subject to a Child Protection Plan for neglect. The reasons were the nature of Mrs A's mental health and the strong probability that she would relapse following the birth of her baby, as she had in November 2006.

13.1.29 The formal reasons for Child 1 and the unborn baby being made the subjects of a Child Protection Plan under the category of Neglect were that:

- Mrs A and Mr A needed to build on their resolve to think about how their lifestyle was impacting on Child 1 and the new baby;
- the parents had said they were willing to work with professionals, and this needed to be seen in practice. They needed to accept the support offered.

13.1.30 On 07 May 2009 CPN 2 and Dr 5 visited Mr and Mrs A at their home. Following the visit Dr 5 emphasised to GP 3 that both Mr and Mrs A remained poorly cooperative with services but the situation needed careful monitoring, particularly Mrs A's mental state but also that of her husband.[71] A few days later (11 May) CPN 2 visited the family and when the warning signs to becoming unwell were discussed Mr A became slightly irritated and stated that they dealt with Mrs A's symptoms by praying.

Comment

13.1.31 The above Section relied heavily on the Chronology in order to illustrate how entrenched the views of Mrs A and her husband had become by May 2009 when Child 2 was born. In many ways Mrs A's refusal to accept medication other than Risperidone as a PRN was a continuation of how she had reacted following her admission to hospital in 2002.

13.1.32 Mrs A was adamant that she was going to control her medication regardless of medical advice and her own experience of having been admitted to hospital on three occasions, albeit not for exactly the same symptoms. Mrs A had also joined a Relapse

Prevention Group but only attended two meetings and left saying she had gained as much benefit as she wanted.

Children's Social Care Services, Midwives and Health Visitors
October 2006 to June 2009

13.1.33 For the details of this period of Mrs A's treatment and care please refer to the Detailed Timeline in Section 11 of this Report from Paragraphs 11.17 to 11.20, 11.35 to 11.40, 11.66 to 11.71, 11.103 to 11.105, 11.110 to 11.115, 11.130 to 11.134, 11.136 to 11.181.

13.1.34 The Report on Child 1's Developmental Needs stated that during the pregnancy Mrs A did not have any antenatal care due to the risks to the baby from scans and because the parents felt they could monitor this by how Mrs A felt and monitoring her weight gain. Child 1 had weighed 8.5 pounds at birth having been born at home in the presence of midwives. Mr and Mrs A had decided not to engage with health visitors or their GP.

13.1.35 On 16 October 2006 GP 1 wrote a standard letter to Mrs A stating that since registering with the practice in July 2006 and in view that Child 1 was 14 weeks old, he noted that she had not returned for a postnatal check. Mrs A was asked to book an appointment with the practice. Mrs A wrote a terse reply saying she and her husband had their own arrangements in place and they did not wish to be pestered by services. As a result GP 1 referred Child 1 to the Child and Family Team.

13.1.36 One concern about Child 1 was that she had not received the routine health and development checks offered. Mr A stated that they had their own ideas about health and development and did not want professionals fussing. The parents would not allow Child 1 to be immunised and refused to agree to her to being given Calpol when she had a temperature. Concerns were expressed that the parents might not allow her to be physically examined when she was ill and that could place her at risk. The Child Protection Conference on 28 November 2006 decided to place Child 1 on the Child Protection Register under the category of Neglect (1) and Physical Abuse (") for the reasons that:

- Child 1 suffered an injury when Mrs A hit her with a hairbrush;
- Mr A failed to protect Child 1 from significant harm.

13.1.37 At the Core Group Meeting on 05 April 2007 Mrs A stated that she had not managed to socialise with other mothers and babies as she had been too busy. Home Start had found

a volunteer who was able to support Mr and Mrs A until July.[72]It was hoped that this would support Mrs A to go out more and socialise with other young/new mothers.

13.1.38 The Review Child Protection Conference on 25 July 2007 decided that, despite a relapse in the last two weeks of June, the situation was stable and that Child 1 was developing well. It was unanimously agreed that the Child Protection element was no longer required as the family were working with professionals and had sought help as Mrs A was noticed to have deteriorated in her mental health in June. Child 1 was removed from the Child Protection Register but was still to remain on the Children in Need category and would have a Child in Need Care Plan. Several of the requirements of the original plan were carried over to the Child in Need Plan to provide continuity.

13.1.39 At the Child in Need Meeting on 16 April 2008 it was agreed that a Child in Need Plan was no longer needed for Child 1 as she was healthy and her grandmother was providing the family with support. In July 2008 CPN 2 decided that Mrs A could be discharged from the Community Mental Health Team to the care of her GP.

13.1.40 The Community Mental Health Team reopened the case on 15 December 2008 following a phone call from Mrs A's aunt. She reported her concerns about Mrs A's religious fervour in that when she had visited their house Mrs A would not let her in and referred to her as *"heathen".* Mrs A's mother was no longer living with the family, having moved to Kent to live with her ex-husband. CPN 2 contacted Health Visitor 3, who was aware of the situation and felt that Social Services should be informed. CPN 2 also contacted GP 3 and the Child and Family Team. The student social worker had left and the senior social worker was Social Worker 7.[73]

13.1.41 CPN 2 and Health Visitor 3, visited Mrs A on 13 January 2009. Mrs A was at home and was welcoming. It was evident that she was pregnant but she did not volunteer this information. When asked she reported that she was pregnant and had not booked in with the GP or the midwife. Mrs A wanted a home delivery. She held extreme religious views and would not accept that was any other way to behave. She had changed the phone number so that her *"heathen"* family members could not contact them. Mrs A said they did have friends who they studied the Bible with but this was at home as they did not belong to a church. She planned to home educate her children.

13.1.42 Health Visitor 3 was concerned for the safety and wellbeing of the unborn baby due to the non-participation in antenatal care to provide an understanding of its health and

condition. She was also concerned about there being no 'booked pregnancy' and ensuring responsibility for a safe delivery, by dating, knowing the condition of the baby and the placental position. Health Visitor 3 thought the resistance to antenatal care appeared to risk leaving both mother and baby vulnerable and completed a Single Agency Referral Form to Social Care Services.[74]

13.1.43 This was an extremely significant factor as Mrs A had not made any attempt to inform GP 3 that she was pregnant and had not registered the fact with the midwives or health visitors. Mrs A had been advised on many occasions that becoming pregnant was a serious matter as it greatly increased the likelihood of her suffering a relapse in her mental health either in the antenatal period or, as with Child 1, in the post-natal period. Dr 5 had visited Mrs A with CPN 2 and had concluded that following the birth there would be a need for very close monitoring on a daily basis by health staff including her midwife, health visitor, CPN, himself and possibly the Crisis Resolution and Home Treatment Team.

13.1.44 On 05 February 2009 Mrs A's parents telephoned CPN 2 saying that the family were continuing to withdraw from society. They had no telephone and although her mother had emailed Mr A at work, she could not make contact with Mrs A. They had thought that Mrs A's baby was due in August, but it was actually due in May.

13.1.45 A Professionals Meeting was held on 24 February 2009 when the decision was taken to call a Child Protection Conference which was scheduled for 12 March 2009. In the period between these two meetings a social worker did not gain entry to the home on 06 March 2009 and on 09 March 2009 CPN 2 received a letter from Mrs A cancelling the arranged visit for the following day. The next day Mrs A telephoned CPN 2 to apologise for missing the appointments and for not wanting to meet the professional staff, explaining that she and her husband had prayed over the weekend and were now able to work with the various services again.

13.1.46 The Initial Child Protection Conference was held on 12 March 2009 and following discussion the formal reasons for Child 1 and the unborn baby being made the subjects of a Child Protection Plan under the category of Neglect were that:

- Mrs A and Mr A needed to build on their resolve to think about how their lifestyle was impacting on Child 1 and would affect the new baby;
- The parents had said they were willing to work with professionals, and this needed to be seen in practice. They needed to accept the support offered.

13.1.47 CPN 2 visited Mrs A who had agreed to see the midwife but had refused any blood tests but would allow her to manually palpate her abdomen. Mrs A had taken Child 1 to two local nursery groups but she felt neither was suitable for her. Some discussion was had about the family cutting off from the professional help which Mrs A had attributed to anxiety. She confirmed that they were willing to work with the different agencies involved.[75] The family did not follow the Birth Plan they had agreed with the midwives as Child 2 was born at home with Mrs AL, Mr A and Child 1 present, but they had not summoned the midwife to attend until after the birth.

13.1.48 A birth plan had been agreed and was described by Midwife 2 as being to call the midwife as soon as Mrs A began to experience labour pains and that if the midwives (as it was felt safer for there to be two of them) considered that a hospital birth was required this would be accepted. In the event, Mrs A and Mr A completely disregarded the agreed course of action and it was during the meeting following the baby's delivery that Mr A said that he had examined his wife whilst she was in labour, and that as she was only 5cms dilated she did not need to go to the hospital at that stage. Mr A stated that Midwife 2 had given him this advice, which she completely refuted in her interview with the Independent Investigation Panel. It was clear that Mrs A and Mr A had waited for all the 11-hour labour until it was too late for her to go to hospital as the birth was too far advanced.

13.1.49 Midwife 1 in her interview with the Independent Investigation Panel reported that, prior to the birth, Mr A had discussed that he and his wife did not see a role for a midwife because in the Bible God always looked after women in labour. After Child 2's birth, the parents wanted to 'salt' the baby. Mr A explained that this involved scrubbing the baby with salt all over its body as they wanted to cleanse the baby in this way. Despite being told that this was potentially dangerous due to the absorption of salt by the baby, Mr A announced to the two midwives who visited after the birth that he had 'salted the baby'. It was again pointed out that this was dangerous due to the possible effects of too much salt absorption.

13.1.50 This total disregard for what had been agreed as being in the best interests of Mrs A and the unborn Child 2 could have been interpreted as their inability to follow professional advice, and as a result have prompted professionals to have been more vigilant during the postnatal period. In a way this did occur as all professions involved did visit the family, but it was not in a carefully planned way so that the family was seen daily and all those visiting knew the full visiting schedule.

13.1.51 The Maternity Discharge Planning Meeting took place on 08 May 2009 at Mr and Mrs A's home as she had not gone into hospital. Social Worker 6, CPN 2, Family Support Worker 1 and Midwife 2 were present. The main concern was the safety of the two children, especially Child 2 given the probability of a psychiatric emergency as after Child 1's birth. The parents said that in an emergency they would pray to God in the first instance and could not assure the staff that they would call 999. Child 1 had few toys and imaginary play was discouraged and she was not allowed to socialise with her peer group. The plan was to continue daily monitoring by multidisciplinary professionals.[76]

13.1.52 One of the midwives mentioned in her interview with the Independent Investigation Panel, that from the perspective of the Maternity Team, Mrs A was thriving when she was discharged and Child 2 was gaining weight. She was visibly pink, healthy, feeding phenomenally well and the relationship with her sister was good. After Mr A's initial stress after the birth he appeared stable, and at the time of discharge they were all regarded as healthy and able to cope.

13.1.53 CPN 2 made a further home visit on the morning of 09 June 2009 when both Mr and Mrs A were present. They were welcoming, but there was a reluctance to engage fully. They asked how long CPN 2 would remain involved, to which she replied that for the time being it would remain a weekly visit. CPN 2 agreed to visit the following week on 17 June.

13.1.54 The Review Child Protection Conference met that afternoon when it was agreed that both Child 1 and Child 2 should remain subject to a Child Protection Plan.

13.1.55 On 12 June 2009 Mrs A left a telephone message for CPN 2 saying she no longer wanted to have any visits. She had also phoned Health Visitor 4 with the same message. CPN 2 contacted the Key Worker from Children and Families (Social Worker 5) and also Dr 5 who said he would visit the following week. CPN 2 had a further discussion with Dr 5 on 15 June 2009 as she had booked an appointment with Mrs A for 17 June. It was agreed that she should visit as arranged and then decide what action was appropriate. Health Visitor 4 had suggested that she would go with CPN 2 as both had been told not to visit.

Conclusions

13.1.56 The evidence that the family did not really want to engage with the services trying to help them is clear throughout the period from November 2006 to June 2009. It was also evident that Mr and Mrs A were not prepared to follow the advice of professionals, preferring instead to put their faith in their own very rigid and untested version of the Scriptures.

13.1.57 Mr and Mrs A both largely ignored the Mental Health Care Plan and also the actions they had agreed to in the Child Protection Plans and later the Child in Need Plans. They did not actively work with any of the agencies involved to deliver the plans made to help Mrs A remain mentally stable, nor the plans designed to provide Child 1 with a greater experience of life through contact with other children. As a consequence the parents did not comply with taking medication, nor alter their style of life to socialise more and provide Child 1 with opportunities to mix with her peers.

13.1.58 It is clear that Mrs A had suffered from Bipolar Affective Disorder since July 2001. She suffered a relapse in November 2006 following the birth of Child 1. During her illness prior to her admission to Friends Ward, Fulbourn Hospital, she had hit Child 1 with a hairbrush and had also placed a pillow over her in an attempt to stop her crying. She removed the pillow before any lasting injury or harm had been caused. The Independent Investigation Panel considered this to have been a 'near miss' in that the suffocation of Child 1 could have resulted from this action.

13.1.59 Mrs A responded well to the care and treatment she received from Fulbourn Hospital in November 2006, and also the specialist help from the Thumbswood Mother and Baby Unit from the end of November 2006 to 23 January 2007.

13.1.60 Mrs A did not fully engage with the mental health services she received as she refused to follow the advice to take the prescribed medication despite having been informed very clearly the risks she had of relapsing without taking it. She was also informed that a relapse would be far more likely if she became pregnant yet she still did not accept the need for medication.

13.1.61 Both Mr and Mrs A became very involved with religion. They could find no established church or religious organisation with which they could agree as they did not conform to their own fundamental interpretation of the Bible. This belief ran their lives and became stronger and they could also find no internet religious website which taught their beliefs.

13.1.62 Mrs A's mental state deteriorated and whilst significant concerns had been documented with regard to the on-going safety and wellbeing of her children, Mrs A was allowed to disengage from services to the ultimate determent of her children's health and wellbeing.

- **Causal Factor Number One. Mrs A refused to follow the clinical advice she was consistently given by the Mental Health Services, the Children's Social Care Services, Midwives and Health Visitors. However individual workers responded as rapidly as they could in the lead up to Child 2's death and a direct causal link cannot be attached to an act or omission on the part of the individuals involved. However the system was not robust enough to ensure a safe delivery of service.**

13.2 The lack of a clear coherent crisis and contingency plan should Mrs A relapse which all professionals were aware of and knew exactly what they should do.

13.2.1 For the details of this period of Mrs A's treatment and care please refer to the Detailed Timeline in Section 11 of this Report from Paragraphs 11.41 to 11.64, 11.90 to 11.98, 11.123 to 11.130,

November 2006 to August 2007

13.2.2 It is important to examine the crisis and contingency planning during the time Mrs A was receiving care and treatment from the Cambridgeshire and Peterborough NHS Foundation Trust and across the multi-agency response to the needs of Mr and Mrs A and their family in order to put the final lack of a coherent crisis plan in 2009 into context.

13.2.3 The fact that Mrs A might suffer a relapse of her Bipolar Affective Disorder was a known possibility since her admission to Friends Ward at Fulbourn Hospital on 07 November 2006. It was also known from the time of this admission that Mrs A had harmed Child 1 by hitting her with a hair brush. Mr A had initiated events by calling the Community Mental Health Team as he was concerned about his wife's mental state and had noticed bruising on Child 1 and suspected that his wife had caused it.

13..2.4 At the ward round on 15 November 2006, Dr 1 thought that Mrs A needed to be on a Mother and Baby Unit, and discussions took place with the Children's Social Care Services Department to that end. Mrs A had admitted that she had hit Child 1 with a hairbrush and that she had scratched her husband as she thought that he was Satan. She had also stated that she thought Child 1 was strong and that putting a pillow over her face was a good way to stop her from crying. She added that she was appalled that she had done this saying *"that*

was shocking...she did look white afterwards...I'm keen to get everything OK with me so that I can look after [Child 1] properly".

13.2.5 The Discharge Care Programme Approach meeting on 23 January 2007 agreed a Care Plan which stated that:

- Mrs A would be discharged from Thumbswood Mother and Baby Unit after the meeting;
- her medical care would be transferred to Dr 3;
- weekly support would be provided from the Community Mental Health Team with Social Worker 2 as her Care Coordinator;
- Mrs A would continue with her prescribed medication of Lithium, with regular monitoring, and Risperidone. Mrs A had been advised of the importance of continuing to take her medication to reduce the chance of her having a relapse;
- Dr 2 had advised Mrs A to access psychiatric support should she decide to have another baby;
- the next Child Protection Conference was scheduled for 07 February 2007 and as Social Worker 1 was leaving Social Worker 3 would be introduced;
- extra support from Home Start had been requested by Health Visitor 2;
- arrangements had been made for Mr and Mrs A to access their GP directly, with support for Mr A as needed;
- Mrs A wanted to have assertiveness sessions in her local area;
- the Home Treatment Team could be contacted out of hours in an emergency.

13.2.6 The contingency plan was that Mrs A and her family should contact the Care Coordinator or the Consultant's Secretary during working hours. Out-of-hours they should contact the Duty Team, GP 1 or NHS Direct.

13.2.7 In addition to the above, Family Group Meetings with the Children's Social Care Services would be arranged to gain further assessment of the couple's parenting ability and these would include Mr A. Whilst not specifically mentioned in the Care Plan, a key safety measure was that Mrs A's mother would be staying with the family to provide help and support to her daughter and granddaughter. In the period from 14 March until 12 April 2007 when her mother went back to South Africa the family had support from Home Start and also funding for some domestic cleaning help. The family had stated that they would try to move to a three bed-roomed house so that Mrs A's mother could move in with them permanently.

13.2.8 The lack of an agreed Crisis and Contingency Plan was evident when Mrs A did suffer a temporary relapse in June 2007. On 12 June 2007 Mr A phoned Social Worker 4's office and a Community Psychiatric Nurse took the call. He reported that his wife was behaving in a similar manner to that she displayed prior to her admission to hospital in November 2006. Mrs A had been ironing obsessively, watching lots of pop videos, not sleeping and not wanting to take her medication. Social Worker 4 thought that there had been a deterioration since the medication had been stopped, and advised Mr A to contact the Home Treatment Team. This did not happen as the referral to the Home Treatment Team was refused as Social Worker 4 had not seen Mrs A within the previous 24 hours. Mr A had been advised to phone the GP which he had done. This lack of response by the Home Treatment Team could have had serious repercussions had the relapse been more severe.

13.2.9 The Home Treatment Team suggested that Social Worker 4 telephoned the GP who had contacted Mr A. By this time Mr A had felt the situation was calming down as Mrs A had taken some Risperidone. [77]

13.2.10 This episode showed that Mrs A could relapse quite quickly without medication but she remained adamant that she would not take any, and for the sake of retaining her engagement with services this was tolerated by Dr. 3. At a Core Group Meeting on 05 July 2007, the family members described that communication in the family had improved. Social Worker 7 stated how valuable Mrs A's mother was as a support system. It was recognised that Child 1 was developing well and that Health Visitor 2 would support Child 1 not being subject to a Child Protection Plan.

13.2.11 The crisis and contingency plan was somewhat limited in that the action to be taken should Mrs A begin to show signs of relapse were to review her mental state, arrange a medical review with GP 2 or with Dr 3 and to discuss an increase in Risperidone as well as considering alternative medication. In addition contact would need to be made with Child 1's social worker, Social Worker 3[78]

13.2.12 The planned intervention was for Social Worker 2, the Community Mental Health Team social worker, and Dr 3 to provide regular follow-up. The Crisis and Contingency Plan relied on the Home Treatment Team and GP 2, with the Home Treatment Team being prepared to intervene even if Mrs A had not been seen by the referrer within the previous 24 hours. [This had caused a delay in help being available in June as the referral criteria for the Team had stated that the referrer must have seen the service user within the 24 hours prior

to the making of the referral.] Given the situation with Mrs A and her family, it was good practice for the Home Treatment Team to adjust its rules for the specific needs of the family.

September 2007 to January 2008

13.2.13 It is noticeable that there was no crisis and contingency plan should there be a further relapse with a check list of what all staff should do and who should be alerted. Much depended on Mrs A's mother being with the family, both for the support she provided but also her ability to confirm and corroborate how the situation was at their home.

January to July 2008

13.2.14 At the Child in Need Meeting on 05 February 2008 it was agreed that the same plan as agreed on 10 August 2007 would be used with a few alterations. The plan stated that:

- Mrs A would continue to engage with the mental health professional who would visit monthly;
- Mr A should contact professional help immediately if he had concerns about his wife's mental health;
- Mr A should consult with his GP if he, the family or professionals were concerned about his mental health;
- Mrs A's mother would provide on-going support within the family home;
- Mrs A would contact Health Visitor 3 if she thought Child 1 needed it.

13.2.15 Considering how concerned professionals had been to the danger of Mrs A having a relapse, and Mr A possibly becoming ill should he come under too much stress, the level of contact was relatively low. The Child in Need Meetings were also taking place.

13.2.16 In the period from 25 January 2008 to 24 July 2008 when the medical care for Mrs A was transferred back to her GP (GP 3) there had been six contacts by the services involved.

Mental Health Visits	**Child In Need Meetings**
25 January 2008	05 February 2008
04 April 2008	16 April 2008
18 April 2008	
24 July 2008	
Total 4	**Total 2**

13.2.17 As far as it is possible to tell from the clinical records Mrs A continued to be on the Enhanced Level of the Care Programme Approach which would normally signify that more

regular contact should have been provided. There was no real joint action plan by the Mental Health Services and the other agencies involved to coordinate visits and formal meetings.

December 2008 to February 2009

13.2.18 CPN 2 had transferred the health responsibility back to GP 3 on 24 July 2008 and she was therefore unaware that Mrs A's mother had moved out of Mr and Mrs A's home in October 2008. She had been with the family almost continuously from December 2006 to October 2008 apart from two relatively short absences when she returned to South Africa. Her departure went unnoticed by the Mental Health Services and left the family more isolated than before.

13.2.19 In response to a telephone call from Mrs A's aunt informing CPN 2 that Mrs A appeared to be relapsing as she was cutting all ties with the family, CPN 2 and Health Visitor 3 visited Mrs A at her home. At this visit Mrs A informed them that she was pregnant, but only volunteered this information when asked directly if she was.

13.2.20 Health Visitor 3 was concerned for the safety and wellbeing of the unborn baby due to the non-participation in antenatal care to provide an understanding of its health and condition. She was also concerned about the lack of a 'booked pregnancy' and ensuring responsibility for a safe delivery, by dating, knowing the condition of the baby and the placental position. Health Visitor 3 thought the resistance to antenatal care appeared to risk leaving the mother and her baby vulnerable.[79]

13.2.21 CPN 2 planned to visit Mrs A monthly until the baby was born and would then visit regularly to monitor the situation. She also planned to re-refer to Social Services.[80]

13.2.22 Mrs A's parents telephoned CPN 2 on 05 February 2009 saying that the family were continuing to withdraw from society. They had no phone and although her mother had emailed Mr A at work she could not make contact with Mrs A. They had thought that Mrs A's baby was due in August but it was actually due in May.

13.2.23 The knowledge that Mrs A was pregnant should have alerted all the services to the fact that her chances of having a relapse had increased. It could happen at any time and could have a rapid onset. The most likely time was thought to be after the baby was born and might follow the same timescale as with Child 1.

13.2.24 Each agency involved had its own visiting schedule and all agencies communicated well with each other about how the situation with Mrs A and the family was. The staff working

with the family worked well together and shared information appropriately and often contacted each other to update agencies on any issues that had emerged from a home visit. This was good practice and did ensure that all visiting staff were kept informed of the overall situation. The development of a visiting plan so that staff did not all arrive at the home at the same time did not take place, and an opportunity to ensure visits were evenly spaced without too long a gap between a professional visiting the home was lost.

13.2.25 During February 2009 it became clear to the staff visiting Mrs A and her family that religion was playing an increasing and significant part of their lives. It is true to say that their interpretation of the Bible was shaping the way they lived their lives. It was also apparent that Mr and Mrs A were isolating themselves from their wider family and also from the community in which they lived.

13.2.26 Dr 5 considered that Mrs A was at high risk of having a relapse following the birth of her baby. He thought following the birth there would be a need for very close monitoring on a daily basis by health staff including her midwife, Health Visitor 3, CPN 2, himself and possibly the Crisis Resolution Home Treatment Team. Dr 5 commented that he would liaise with the doctor with a special interest in perinatal mental health. He also thought it would be useful for him to meet Mr and Mrs A together to discuss the risks associated with her mental health and pregnancy.[81] Dr 5 had identified the need for a detailed visiting plan to make sure that the family had a visit every day to ensure that any signs of a relapse were noticed as early as possible.

March to June 2009

13.2.27 An Initial Child Protection Conference was held on 12 March 2009 and both Child 1 and the unborn baby were made subject to a Child Protection Plan. The reasons were the nature of Mrs A's mental health and the strong probability that she would relapse following the birth of her baby as she had in November 2006.

13.2.28 Some of the main determinants of the decision were that Mr and Mrs A were isolated and were not in touch with their earthly family as they were waiting to meet the family that God had chosen for them. They firmly believed that God would protect them and it was thought possible that their belief structure could be indicative of an on-going psychotic disorder in both of them. The house was clean and tidy, sparsely furnished with no decoration or colour and with quotations from the Bible pinned to the wall. Despite searching for a Church to belong to they had not found one with which they agreed, neither had they

located an internet community that matched their faith. It was felt that such isolation was starting to make it look as if their "faith" was actually an indication of mental illness.

13.2.29 All agencies involved were represented at the Child Protection Conference so they all knew the current situation and the plans that had been made. The issue was that Mr and Mrs A did not fully engage with the plans that were agreed. They did not engage fully with services and totally ignored the birth plan by failing to call the midwives until Child 2 had been born. Considerable time and effort was given to try to help the family and to prevent Mrs A having a psychotic episode as had happened following the birth of Child 1.

Conclusions

13.2.30 Following the birth of Child 2, all agencies were visiting regularly and were keeping each other up to speed on the overall situation. There was a great deal of activity, all of which was appropriate and necessary but there was no overall plan to make the best use of the considerable resource which was visiting the family. The Mental Health Services were visiting without reference to when other agencies were visiting and this was true of the Children's Social Care Services, the midwives and the health visitors, although each agency involved had its visiting plan. The one coordinating factor which was lacking was an overall visiting timetable based on the need for each agency to visit and when, but linking this to ensure that Mrs A and her family were visited daily, or once in the morning and once in the afternoon regularly, with no gaps.

13.2.31 Some staff had been informed of the sort of symptoms they should look for, but this had not been shared with all the agencies involved. The Care Programme Approach Plan listed the signs of relapse, but there was no one person or agency taking the overall responsibility for the whole situation. As a result there was no clear Action Plan which clearly stated *"if you see this type of behaviour then you should immediately do this"*. The visiting by all agencies lacked an overall plan with one manager acting as the coordinator/project manager ensuring that there was a visit a day planned and that it did take place. After Mrs A had told CPN 2 and Health Visitor 4 on 12 June 2009 that they should no longer visit, no one visited the family from that date until CPN 2 and Health Visitor 4 went for a planned visit on 17 June 2009.

13.2.32 On 17 June 2009 when CPN 2 and Health Visitor 4 visited Mrs A, despite having been told not to visit, they faced a situation which they both immediately recognised to be serious, as Mr A was shouting for God to remove the Devil from his wife. The two staff assessed the situation as best they could and decided from the limited evidence they had

that a Mental Health Act assessment was required. Despite the unreality of the situation they heard Mrs A call quite calmly to her husband *"What is wrong?"* They also heard Child 2 *"grizzling"* upstairs and saw Child 1 sitting happily on the stairs so they decided that they should go and summon the professionals needed to undertake a Mental Health Act (2007) assessment.

13.2.33 If there had been a crisis plan of action, the action taken by CPN 2 and Health Visitor 4 could well have been the plan. It might perhaps also have suggested calling the Police if there was any evidence of violence being displayed or if someone was in immediate danger. However, there was no clear evidence of violence or risk during this visit on 17 June. Because there was no such overall contingency plan, the two staff did their best and agreed that they should summon the Mental Health Services, and within two hours the necessary staff to effect a Mental Health Act (2007) assessment had been assembled and went to Mr and Mrs A's home.

13.2.34 Sadly CPN 2, Dr 5 and Social Worker 6 were too late to prevent Child 2 being killed. It must not be forgotten in this particular Serious Untoward Incident that there were effectively two such incidents. The death of Child 2 and a 'near miss' for Child 1, who was taken to hospital and made a full recovery. It is possible that if CPN 2 and Health Visitor 4 had acted differently that Child 1 might also have died. No one will ever know. What is known is that in the two hours after CPN 2 and Health Visitor 4 left the family, Mr A took both Child 1 and Child 2 to GP 3's surgery where Child 2 was found to be dead but Child 1 was alive but soaked in something like methylated spirit. She was taken to hospital by ambulance where she made a full recovery.

13.2.35 Following the birth of Child 2 the various services involved developed their own visiting arrangements. This meant that the family could have several visitors one day and few or none the next. The services were the Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services, the Cambridgeshire Children's Social Care Services, the Midwifery Service from the Cambridge University Hospitals NHS Foundation Trust and the Health Visiting Service from the Cambridge Community Services NHS Trust. They all shared their observations of the family and made sure that all the professionals visiting Mr and Mrs A were kept informed about the current situation and had their individual agency visiting plans.

13.2.36 The vital ingredient which was lacking was a common timetable for all four services so that the visits could be arranged so that at least one visit to the family was made each

day. This would have ensured that each day someone could report on how Mr and Mrs A were, and would be able to alert other professionals if they had any cause for concern. Similarly there was no Crisis and Contingency Plan so that staff would know what to do should they arrive at the home and find that Mrs A or her husband had relapsed, and who to contact. Such a Plan would also have identified what action to take should Mr and Mrs A refuse to let professionals visit them.

13.2.37 The presence of a crisis and contingency plan may have ensured more assertive and timely interventions between 12 June and the 17 June visit. As it was the staff visiting on June 17 did act responsibly and sought to arrange a Mental Health Act (2007) assessment but sadly by the time the necessary staff arrived at the family home it was too late.

13.2.38 The lack of a clear, coherent crisis and contingency plan was a contributory factor to the lack of a timely response being given but did not of itself directly cause the death of Child 2.

- **Contributory Factor One. There was a lack of a clear and coherent crisis and contingency plan should Mrs A relapse of which all professionals were aware in order to inform them of what to do. The failure to provide this made a contribution to the deterioration of Mrs A's mental health.**

13.3 A Lack of Assertiveness by Agencies after Mrs A was discharged from The Thumbswood Mother and Baby Unit on 23 January 2007 and thereafter.

13.3.1 It is evident, from reading the clinical records of Mrs A, how the active and assertive approach taken by Mental Health Services following her admission to Friends Ward at Fulbourn Hospital and during her subsequent transfer to the Thumbswood Mother and Baby Unit was quickly dissipated following her discharge on 23 January 2007.

November 2006 to July 2008

13.3.2 The Independent Investigation Panel did question whether having a social worker as her first Care Coordinator was a good choice given that it was known that Mrs A did not comply with medication. A Community Psychiatric Nurse might have been able to better advocate the benefits of taking the medication, although as stated above Dr 3 was unable to

achieve this and reluctantly agreed with her wishes. He felt that her having some Risperidone was at least keeping some medication available, and there would be some in her home should she start to relapse. He realised and told Mrs A this was not his choice of treatment and she should follow the prescribed medication advice. This effectively meant that Mrs A was being allowed to plan her own treatment against the known and very real concerns of the medical teams which knew her well and had treated her since 06 November 2006.

13.3.3 It was also thought by the Independent Investigation Panel that consideration might have been given to the use of the Assertive Outreach Team. This team might have had more success in forging an alliance and relationship with Mrs A and her husband than the Community Mental Health Team, as it would have more experience of working with people who were reluctant to take their medication and who did not wish to engage fully with services, indeed this was their *raison d'être*. As part of the National Service Framework for Mental Health: Modern Standards and Service Models[82], there was a Policy Implementation Guide which provided details of a set of new services which it was considered might better meet the needs of some groups and categories of service users unable to make best use of traditional community mental health teams.[83]

13.3.4 In the Policy Implementation Guide, Assertive Outreach Teams were described as being for service users who displayed some of the characteristics listed below:

- *"a severe and persistent mental disorder (e.g. schizophrenia, major affective disorders) associated with a high level of disability";*
- *a history of high use of inpatient or intensive home based care (for example, more than two admissions or more than six months inpatient care in the past two years);*
- *difficulty in maintaining lasting and consenting contact with services;*
- *multiple, complex needs including a number of the following:*
    1. *a history of violence or persistent offending;*
    2. *a significant risk of persistent self-harm or neglect;*
    3. *a poor response to previous treatment;*
    4. *a dual diagnosis of substance misuse and serious mental illness;*
    5. *having been detained under Mental Health Act (1983) on at least one occasion in the past two years;*
    6. *having unstable accommodation or homelessness."*

13.3.5 An Assertive Outreach Team was designed to work with people with severe mental health problems and complex needs who have difficulty engaging with services and often require repeat admissions to hospital. The main outcomes expected from such services would be to improve engagement with services, reduce hospital admissions, and increase stability in the lives of service users and their families and to improve social functioning.

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13.3.6 There would have been no guarantee that such an approach would have worked with Mr and Mrs A, but it could have been tried given the sometimes tenuous link they had with the local Mental Health Services, and the loose acceptance of the Child Protection Plans and Child in Need Plans put in place by the Children's Social Care Services.

13.3.7 Mrs A had a minor relapse in June 2007 but quickly recovered following the involvement of the Crisis and Home Treatment Team. She thought that the episode was triggered by some of her concerns regarding the Old Testament, but having resolved these issues in her own mind felt that she was less likely to relapse again. Mrs A acknowledged that the medication had helped her over this period, but remained adamant that she would discontinue this over the next two to three weeks, and would not agree to try any prophylactic regime. Mrs A agreed to stay on Risperidone 0.5mg per day and would increase this if necessary. Dr 3 again pointed out that this had been her decision and that he would recommend no change in the current dosage.

13.3.8 It appeared to the Independent Investigation Panel that Mrs A feeling better after the intervention of the local Pastor demonstrated that she had no understanding of the nature of her mental illness, and therefore would not accept the advice of Dr 3 or other members of the Community Mental Health Team. During this relapse Mrs A did have contact with the Home Treatment Team and appeared to have more respect for their approach than that of the Community Mental Health Team. This may have been because they were more 'hands on' at a critical time and as they may have represented the opportunity to stay at home and not be admitted to hospital.

13.3.9 Once again the response from the Community Mental Health Team was less than assertive. The Home Treatment Team discharged Mrs A on 04 July 2007. Dr 3 saw Mrs A the same day in his Outpatient Clinic where she reported that she had been taking the Risperidone on an 'as required' basis either 0.5mg or 1.00mg per day. Since her previous Outpatient Appointment, there had been about four days when she had taken no medication. Following a bout of depression the previous day, Mrs A said that she could accept her

diagnosis of *"manic depressive disorder"* fully, and stated that "*Today, I feel thoughtful and serious.*"

13.3.10 Dr 3 had again stressed the dangers he thought Mrs A would be taking if she did not follow his advice on medication as he considered that it would reduce the risk of relapse. Mrs A was still determined to do things her way but agreed to attend the Outpatient Clinic to review how she was getting on.[84]

13.3.11 When Mrs A informed Social Worker 7 and Social Worker 2 on 23 October 2007 that the family were moving house the following day the lack of assertiveness increased. The move took the family out of the South Rural Community Mental Health Team catchment area and into the North Rural Community Mental Health Team area based in Ely.

13.3.12 A referral should have been sent immediately to the North Rural Community Mental Health Team but for some unknown reason this did not occur. The Cambridgeshire and Peterborough NHS Foundation Trust Care Programme Policy states that *"in routine and planned transfers, the referring team retains responsibility for providing and coordinating care until the transfer has been agreed. It is the duty of the referring service to provide adequate notice and information, including the transfer summary form, a referral letter and full CPA documentation."* The Independent Investigation Panel concluded that, because the clinical management of the case remained with Dr 3 as he was planning to see her again in Outpatients in November, muddied the waters and left Mrs A without any contact in her new local area until 13 January 2008. It is noted that Dr 3 did write to Dr 5 to transfer her care to him.

13.3.13 Dr 3 also wrote separately to Dr 5 saying that he did not feel that at present Mrs A needed regular psychiatric follow-up, but he felt it would be appropriate for the North Rural Community Mental Health Team to make contact with her. He added that it might not be necessary for regular input but he was sure that it would help the management of any further relapse if she were 'in the system.'

13.3.14 The level of concern for Mrs A and Child 1 should she have another psychotic episode is extraordinary as the consultants had acknowledged that she was in need of prophylactic medication and that the nature of her illness made it very likely that there would be a future relapse. Leaving Mrs A and her family for three months with only one Outpatient Appointment and no formal handover to another team demonstrates a lack of concerted

action to assist a vulnerable service user on the Enhanced Level of the Care Programme Approach and her vulnerable daughter.

13.3.15 In reading through the clinical record, the difference between the approach when Mrs A was an inpatient on Friends Ward, and during her time with the Thumbswood Mother and Baby Unit and the period with the Community Mental Health Teams from 23 January 2007 to 05 February 2009, is marked. The urgency and repeated giving of advice was replaced by a far less assertive and robust approach to maintaining contact and gradually visiting less frequently and to closing the 'case' in July 2008.

13.3.16 In July 2008, Mrs A did appear well and there may well have been good grounds for closing the case. It was, however, known that the family did not follow medical advice and that Mrs A was not taking any viable prophylactic medication. Where professionals know that a service user is vulnerable, and that if she suffers a relapse her child could be placed at risk, there is a duty of care to continue to seek to make a difference. It is accepted that the Community Mental Health Team were not aware that Mrs A's mother was no longer living with the family after October 2008, although they did know she was spending more time with her ex-husband. Community Mental Health Teams have many duties and are not able to hold apparently stable situations for long periods, but knowing the dangers of Mrs A having a relapse perhaps some monitoring should have been maintained. The regular Outpatient Appointment could have been continued as a means of maintaining some slight on-going contact. The family did not use their GP very frequently so there would be little information available from GP 3.

December 2008 to June 2009

13.3.17 When the Community Mental Health Team CPN 2 and Health Visitor 3 discovered that Mrs A was pregnant again Health Visitor 3 was concerned for the safety and wellbeing of the unborn baby. This was due to the non-participation in antenatal care to provide an understanding of its health and condition. She was also concerned about ensuring responsibility for a safe delivery, by dating, knowing the condition of the baby and the placental position. Health Visitor 3 thought the resistance to antenatal care appeared to risk leaving the mother and her baby vulnerable.[85]

Conclusions

13.3.18 A more assertive approach was adopted by the services once Child 1 and the unborn baby were made subject to a Child Protection Plan. Once this had been put in place the Mental Health Services, the Children's Social Care Services, Midwifery and Health Visiting Services visited the family and tried to engage them and to influence the way they viewed their situation.

13.3.19 Once Mrs A was discharged from the specialist perinatal Mother and Baby Unit the level of support decreased and the community mental health staff were unable to force Mrs A to take her prescribed medication as she refused to accept that it did her any good.

13.3.20 The staff faced a dilemma in that they knew the risks associated with Bipolar Affective Disorder but were unable to persuade or convince Mr A or Mrs A that this treatment was essential in order to help prevent a relapse. On the other hand, the staff also knew that they needed to remain in contact with Mrs A and therefore felt they could not push her too far and face having her completely disengage. If this had occurred they would have no opportunity to monitor the situation.

13.3.21 The Independent Investigation Panel concluded that services should have been more proactive and assertive in trying to ensure Mrs A's adherence to a care and treatment programme. It would also have been reasonable to expect them to try alternative approaches to see if they would work, rather than let Mrs A dictate her own medication regime. It was also understood that the professionals had to work within the current Mental Health Legislation.

13.3.22 The lack of a means by which the mental health staff were able to ensure that Mrs A took her medication was a contributory factor to the breakdown in the deterioration of Mrs A's mental health but did not of itself directly lead to the death of Child 2.

- **Contributory Factor Number Two. A Lack of assertiveness by Agencies after Mrs A was discharged from the Thumbswood Mother and Baby Unit on 23 January 2007 and thereafter contributed to the deterioration of her mental health.**

13.4 The confusion and over-importance given to the question of whether Mr A and/or Mrs A were suffering delusions in the period prior to, and following, the birth of Child 2

13.4.1 It is clear from the Chronology that great attention was given to the task of determining if Mrs A was delusional and to whether she was exhibiting any symptoms which could signify the start of a relapse in her mental health. To a slightly lesser extent the same issues were being considered in relation to Mr A's mental health.

13.4.2 These questions would be relevant if the staff working with the Community Mental Health Team were contemplating the use of the Mental Health Act (1983 & 2007) to admit either Mrs A or Mr A to psychiatric hospital against their wishes on the grounds of it being for their safety or the safety of others, the others being Child 1 and Child 2.

13.4.3 The other professionals involved in the multi-agency approach to meet the needs of the family were not so involved in the mental health of the couple, except if they felt either's mental health was deteriorating. It was difficult for the staff working with the family to fully understand whether their rather strange and rigid religious beliefs were a valid creed or whether they were evidence in themselves of a delusion so removed from reality as to be symptomatic of a psychotic illness and therefore potentially a danger to the two children.

13.4.4 It was evident that both Mr and Mrs A held a deep religious faith, *"but it was not to their minds compatible with any more organised and publicly recognised denomination or modern 'house group' religion or sect".* Their adherence to the religion they professed was absolute and they used it to inform the way they lived their lives. They had a very fundamentalist approach to the Bible and read it factually with no acceptance that it was possible to interpret it within the context of the world today rather than the world 2000 years ago.

13.4.5 Some of the 'teachings' Mr and Mrs A took from their strict observance of the Bible were not in the best interests of Child 1. She was at an age where she needed stimulation and the opportunity to mix socially with other children of her own age. The need for her to go with her mother to mother and children groups to facilitate such socialisation was apparently anathema to her parents because the other families were not 'faithful enough' to their view of the wishes of God. Some of the action plans from the Children in Need and Child Protection Plans were quite specific in what they expected the parents of Child 1 to do to demonstrate

that they were meeting her needs. For example, at The Review Child Protection Conference held on 07 February 2007, the Child Protection Plan was divided into three sections. The first concerned Child 1 and stated that:

- her health needs would be monitored by the health visitor who would visit regularly and weekly when Mrs A's mother was in South Africa;
- the social workers would continue to assess Child 1 and monitor her welfare;
- Mrs A and Child 1 would have support in socialising with other mothers via a baby singing group or a mother and baby group.

13.4.6 Child 1 appeared *"desperate for interaction",* and was fascinated by the visitors' handbags and clothing. Dr 5 was planning to meet Mr A and to offer him an assessment of his mental health, and would also see Mrs A. He also said he would discuss the situation with the consultant with a special interest in perinatal mental health, and arrange daily input from the Home Treatment Team in the postnatal period. Dr 5 also said he thought Mrs A did have mental capacity to make the decisions about a home birth. The meeting concluded that in view of the *"return of some of the more concerning mental health symptoms",* along with the removal of proactive factors such as Mrs A's mother no longer living with the couple and the deliberate severing of ties with the extended family, plus the likelihood of a psychotic episode during pregnancy or following the birth, a Child Protection Conference should be requested to discuss the risk to Child 1 and Child 2 (the unborn baby).

13.4.5 With a 30-month involvement with Mr and Mrs A, apart from the period of just over four months from 24 July to 15 December 2008, the staff of the Cambridgeshire and Peterborough NHS Foundation Trust had ample evidence of the family not complying with the clinical care plan for Mrs A.

13.4.6 In the period from 13 January 2009, when the family were again receiving help and support from the Mental Health Services and the Children's Social Care Services, there were many discussions about the delusions that Mr and Mrs A appeared to have. The question was whether they were really delusional in the sense of indicating the onset of mental ill health, or just the expression of their extreme and unusual religious beliefs.

13.4.7 In some ways the discussion within the Mental Health Services about their delusions and their significance masked the real issues which were whether their religious beliefs constituted a risk to Child 1 and the unborn Child 2. A further issue was whether Child 1 was suffering as a result of her extremely 'cloistered' life with very few social experiences outside

the close knit nuclear family group. The parents had also declined much of the usual antenatal care, examinations and tests, which again was not in accord with the agreed Child in Need Plan. The question which needed to be asked and then answered was: Are Mr and Mrs A following the Mental Health, Child Protection and Birth Plans, and if not, is the effect on the children damaging and is Mrs A's mental health at risk of relapse? If so, how should the services involved intervene? In practice this was only partially achieved with all services visiting, but not in line with an overall contingency plan which was being monitored by all the agencies involved.

13.4.8 Some of the health staff in their interviews with the Independent Investigation Panel commented that they felt there was a deprivation of the usual stimulation a young child would get from toys and books. In addition, they voiced concern that there was a social deprivation for Child 1 as she had an extremely limited experience of having playmates and mixing with other children her age.

13.4.9 There was some awareness from Mr and Mrs A that they had to engage with the services because there could be consequences. One worker described Mr and Mrs A as sitting in the Child Protection Conferences and having a sense that they engaged only at a superficial level, maybe verbally or non-verbally some of the time, state that they would comply with the plan, but in the end they would do exactly what they wanted.

13.4.10 The Child Protection Plans and the Child in Need Plans were not effective, and it was clear that Mr and Mrs A were not trying to meet the targets they were being set in terms of exposing Child 1 to a broader experience of life and a wider social network with her peers. After the birth of Child 2, it was again all too apparent that the agreed Birth Plan had not been followed by the family. Mr A had deliberately delayed in calling the midwives despite both parents having at some point agreed to the Birth Plan. At the meeting on 11 May 2009 Mr A stated that if there was a crisis and his wife needed help he would pray to God for help and would probably not seek help from the Health and Social Care services.

13.4.11 One of the main findings from both the Internal Investigation and this Independent Investigation was the lack of a clear plan of action should Mrs A relapse. It was recognised that the family would need to be monitored but there was no overall timetable for visiting. Visiting was left to the individual practitioners involved with the family, and there was therefore no overview to ensure that they were seen every day so that any signs of a relapse could be observed quickly. In the event, despite the evidence discussed and highlighted above, it was not until 17 June 2009 when CPN 2 and Health Visitor 4 visited the home,

despite the family having said they would rather not be visited, that the situation became exposed with Mr A obviously praying to God to remove the devil from Mrs A. This could have come to light sooner had the staff involved visited to an agreed common timetable to ensure there was at least one visit to the family every day.

Conclusions

13.4.12 The Independent Investigation generally concurs with the Cambridgeshire and Peterborough Foundation NHS Trust Internal Investigation and the Cambridgeshire Local Safeguarding Children Board Serious Case Review. There was a failure to collectively recognise the extent to which this family were a risk to their children once they were mentally unwell, and to act more assertively to address their non-compliance with medication following Mrs A's discharge from the Thumbswood Mother and Baby Unit. This lack of a forceful response by services was again evident when the Child in Need Plan and the Child Protection Plan were not being adhered to by Mr and Mrs A.

13.4.13 It is clear from the Chronology that great attention was given to the task of determining if Mrs A was delusional and to whether she was exhibiting any symptoms which could signify the start of a relapse in her mental health. To a slightly lesser extent the same issues were being considered in relation to Mr A's mental health.

13.4.14 The mental health staff visiting the family were very concerned about the extreme religiosity of Mr and Mrs A and whether this was a psychotic delusion. An equally important question was to determine the effect the home environment was having on Child 1 and her new baby sister and whether they were adequately protected and the plans agreed with the family at the Child Protection Conference being adhered to. The Mental Health Service was unsure whether the extreme was a symptom of psychosis and the Child Protection Workers did not know the relapse signature of Mrs A. There was no shared understanding between the agencies involved with the family of what to do if certain behaviours were identified.

13.4.15 The confusion and over-emphasis on the possibly religious delusions appeared to obscure the need to be sure that the two children were not being harmed by their environment and the failure of their parents to implement the actions they had agreed in the Child Protection Care Plan. The relapse signature of Mrs A was well understood by mental health staff but had not been shared with the staff from the other agencies. The Independent Investigation Panel considered that this was a contributory factor in the breakdown of the Child Protection Plan but did not of itself directly lead to the death of Child 2.

- **Contributory Factor Number Three. The confusion and over-importance given to the question of whether Mr A and/or Mrs A were suffering delusions in the period prior to, and following, the birth of Child 2 led to delays in the assertive management of the case. This contributed to the breakdown in Mrs A's mental health.**

13.5 The missed opportunity to undertake a Mental Health Act assessment with Mr and Mrs A after their refusal to accept visits from Staff on 12 June 2009.

13.5.1 It is always easy to be wise after the event and the Independent Investigation Panel has attempted to understand the issues of hindsight when examining all the health and social care records. The Panel assessed the position from what the professionals knew, or should have known, at the time they made their decisions

13.5.2 The fact that the overall situation within Mr and Mrs A's home was deteriorating was known, but the extent of that deterioration was not known. The relapse signature of Mrs A was well understood and had been shared with the other staff from Social Services and the Midwifery Service and the Health Visiting Service attending the Care Programme Approach meeting on 14 August 2007. The indicators of a relapse in mental health for Mrs A were:

- changes in sleep pattern which has been the first sign;
- Mrs A being either tired or more energetic;
- not eating properly which has had a serious impact on her mental health;
- not communicating or responding when questions are being asked and misunderstanding them;
- irritability and hostility when very unwell;
- bizarre behaviour;
- getting rid of possessions, clearing out and organising things;
- becoming self-indulgent.

13.5.3 In addition, it was also recognised both by staff and her family that another sign of relapse was that Mrs A tended to isolate herself even more than usual and to push family away and not want contact with them.

13.5.4 Some of these signs were apparent, as was the knowledge that the family had not complied with the advice from professionals from health and social care. On 12 June 2009, Mrs A left a telephone message for CPN 2 saying she no longer wanted to have any visits. She had also phoned Health Visitor 4 with the same message. Both workers contacted Social Worker 5 from the Children's Social Care Services and also Dr 5, who said he would visit the following week.

13.5.5 CPN 2 had a discussion with Dr 5 on 15 June 2009 as she had booked an appointment with Mrs A for 17 June. It was agreed that she should visit as arranged and then decide what action was appropriate. It was positive to ignore the message from Mrs A not to visit, but perhaps a visit earlier than 17 June would have been more appropriate.

13.5.6 The Independent Investigation Panel, having considered all the information which was available at the time, concluded that this represented an opportunity to use the Mental Health Act (2007) to gain entrance to the home in order to undertake a Mental Health Act (2007) assessment either on Friday 12 June or the following Monday (15 June). Mrs A's refusal to see staff was a sign that she was cutting herself off from services and was becoming more isolative. An opportunity to intervene was missed.

13.5.7 It is noted that such a statement about not wishing to have any further visits had occurred before, on 6 March 2009, and that the position had been reversed fairly quickly, on 10 March 2009. The difference was that on that occasion Mrs A had not just recently had a baby, one of the strong indicators that she could relapse as she had in November 2006 with Child 1.

13.5.8 It is impossible to know what the outcome of a Mental Health Act (2007) assessment would have been. It is known that both parents required acute psychiatric admission following the death of Child 2 on 17 June. CPN 2 and Health Visitor 4 were concerned enough by what they found at Mr and Mrs A's house on the afternoon of 17 June 2009 to themselves leave and arrange a Mental Health Act (2007) assessment. It was known that Mrs A could relapse quickly and become very unwell, but she had appeared to be calm on that afternoon although she had only been heard talking from upstairs. It was Mr A who raised the greater concern to CPN 2 and Health Visitor 4 as he was praying to God asking him to remove the devil from his wife. It was known that this was his 'code' for Mrs A being unwell and he had earlier stated to Dr 5 (on 08 April 2009) that "if a devil enters her then you want to be called?" Dr 5 had shared the details of his home visit in a detailed letter to GP 3 and copied to CPN 2, Midwife 2 and a Senior Social Work Manager.

13.5.9 A Mental Health Act assessment was then arranged within two hours but this proved to be too late to prevent the death of Child 2.

Conclusions

13.5.10 The fact that the overall situation within Mr and Mrs A's home was deteriorating was known, but the extent of that deterioration was not known. The relapse signature of Mrs A was well understood by mental health service workers but had not been fully shared with the staff from the other agencies involved. One of the major indicators of relapse was Mrs A trying to isolate herself from social contact.

13.5.11 Within the context of the situation within the family home on 12 June 2009, the refusal to allow staff from the Health and Social Care agencies to visit should, in the opinion of the Independent Investigation Panel, have triggered a Mental Health Act assessment. There is no guarantee that this would have assessed either parent as having a serious mental illness such as to be a danger to themselves or others, but it would have allowed someone to enter the home with a clear role to assess the level of illness and thereby have an idea of the level of risk to Child 1 and Child 2.

13.5.12 A Mental Health Act (2007) Assessment would have provided the opportunity to assess the mental health of both Mr and Mrs A. It would also have provided the opportunity to assess the health and wellbeing of Child 1 and Child 2. The failure to achieve this in a timely manner contributed to the delay in assessing the family dynamic and safety of the children.

- **Contributory Factor Number Four. The missed opportunity to undertake a Mental Health Act (2007) assessment with Mr and Mrs A after their refusal to accept visits from staff on 12 June 2009 meant that their mental health continued to deteriorate without appropriate assessment and placed their children at risk.**

13.6 The Loss of Information about the 'Pillow Incident' with Child 1 in November 2006

13.6.1 While Mrs A was an inpatient on Friends Ward at Fulbourn Hospital in November 2006 following her admission due to her Bipolar Affective Disorder breakdown, she had talked to the Senior House Officer (SHO 1) on the ward. Mrs A said that before her admission, she and her husband were *"both tired and agitated and her baby kept crying. She felt her baby was strong and invincible. She admitted to hitting the baby on the head with a hairbrush, she didn't know why but didn't mean to hurt her. She also spoke of holding a pillow over her daughter's body to stop her from crying, to teach her not to cry. She held delusions that there were two teams out to get her. She was muddled and confused and repeatedly heard a song going around in her head."* SHO 1 described the incident in a letter sent to Dr 3 dated 29 November 2006 as part of a Confidential Case Summary Part 1 and 2. It was also sent to the relevant CMHT and the Thumbswood Mother and Baby Unit.

13.6.2 At the Initial Child Protection Conference on 28 November 2006, it was reported that once Mrs A was detained she mentioned to a doctor at Fulbourn Hospital that *"she had put a pillow over Child 1's face, out of frustration, not to harm [Child1]. She said she had quickly removed the pillow."* In the Chair's Summary, the report states *"[Child 1] suffered physical injury when Mrs A was ill. Another potential incident was when a pillow was put across her face but quickly removed."*

13.6.3 The Decision on Registration was unanimous and it was agreed that Child 1 would be placed on the Child Protection Register under the category of Neglect (1) and Physical Abuse (2) for the following reasons:

- Child 1 suffered an injury when Mrs A hit her with a hairbrush.
- Mr A failed to protect Child 1 from significant harm."[86]

13.6.4 The same incident is mentioned again in the Core Assessment Record under 'Ensuring Safety' which states *"Mrs A informed a doctor that she placed a pillow over Child 1's face when she became very frustrated with Child 1. Mrs A also told the doctor that she had no intention to kill or harm Child 1 and therefore removed the pillow."*[87]

13.6.5 At the Thumbswood Mother and Baby Unit (Dr 2) interviewed Mrs A on 30 November 2006 and during the discussion Mrs A stated that she was happy to be on the unit and to be getting support. She also said that she had regrets about her behaviour towards Child 1. She added that she was happy to have Child 1 and would like to have more children. Dr 2 raised the incident with the pillow and Mrs A said that she was unable to remember much of the incident. She did state that she had held a pillow against Child 1's face and that the baby's

legs were still moving so she had thought it was alright. Mrs A displayed some remorse at this point, but Dr 2 felt that the full impact of what she had done had not really hit her at this stage. By the end of her stay at Thumbswood, Mrs A did accept what she had done.

13.6.6 On 11 January 2007, SHO 2, working with Dr 2 at the Thumbswood Mother and Baby Unit faxed the Discharge Summary Part 1 which contained a reference to the incident with the pillow. It stated *"Mrs A thought baby was invincible and put a pillow over Child 1's face to stop her crying. Baby was four months old at that time."*

13.6.7 At the Review Child Protection Conference on 05 February 2007, the report lists the causes for concern as Mrs A hitting Child 1 with a hairbrush and her husband not protecting her. No mention was made of the pillow incident.[88]

13.6.8 The seriousness of the use by Mrs A of the pillow to prevent Child 1 from crying was seen as extremely important and relevant to any risk assessment by the staff at the Thumbswood Mother and Baby Unit, and also by the Perinatal Consultant on the Independent Investigation Panel. It was more significant than the quick throwing of a hairbrush and required more actual physical contact and was potentially more dangerous. The Part One Discharge Summary appears to be the last time that the holding a pillow over Child 1's face is mentioned.

13.6.9 The event 'dropped from the collective consciousness' remarkably quickly, and most of the staff involved with Mrs A when she was pregnant with Child 2 were totally unaware of the incident and were shocked when they discovered it during the Internal Investigation or when it was made available to them. Staff interviewed did comment that they thought they would have been more vigilant if they had known this information.

Conclusions

13.6.10 When Mrs A was mentally unwell in November 2006, before she was admitted to Fulbourn Hospital, she had assaulted her four-month old daughter Child 1 on two occasions. On the first occasion she had hit her on the side of her head with a hairbrush and she also had a bruise on one arm. She told staff on admission to Fulbourn Hospital that she had also become so frustrated and agitated by Child 1's crying that she had placed a pillow over her to prevent her crying.

13.6.11 The Independent Investigation Panel considered the second assault with the pillow to be the more serious of the two incidents. It was surprising that after having been mentioned at the Child Protection Conference and in the Discharge Summary from Fulbourn

Hospital and the Part One Discharge Report from the Thumbswood Mother and Baby Unit, this important fact was 'lost'. Staff interviewed during the course of the Independent Investigation had been unaware of this information, and thought that had they known it would have altered their perception of the level of risk Mrs A posed to her new born daughter.

13.6.12 This was again assessed as a contributory factor which did not of itself lead to the death of Child 2.

- **Contributory Factor Number Five. The Loss of Information about the 'Pillow Incident' with Child 1 in November 2006 meant that Mrs A was not assessed in the context of her full psychiatric history and that the risks to her children were not understood in the light of her past behaviour. This contributed to the lack of assertive and timely intervention.**

13.7 Examination of Clinical Issues in Mrs A's Care and Treatment

Diagnosis

13.7.1 Bipolar Affective Disorder was the appropriate diagnosis and there had been a documented history of this from 2001.

Postpartum Psychosis in Bipolar Disorder

13.7.2 The link between childbirth and mental illness has been recognised for hundreds, if not thousands, of years[89]. The concept of puerperal or postpartum psychosis (PP) has a long history and the triggering of severe episodes of illness by childbirth remains a significant public health problem, tragically illustrated by cases in which women suffering from puerperal psychosis have killed themselves or harmed their baby[90]. Suicide is a leading cause of maternal death in the United Kingdom and it is clear that a high proportion of maternal suicides occur in women with an acute onset of affective psychosis in the early postpartum period[91]. Postpartum Psychosis is not a disease in its own right, rather episodes are best conceptualized as women with a bipolar diathesis acted on by a puerperal trigger. In fact, the triggering of bipolar episodes following childbirth is one of the strongest and best-established associations known in psychiatry[92,93] The occurrence of severe bipolar episodes with onset in the immediate postpartum is clearly of great clinical importance, the stakes are high and the early recognition and prompt treatment of women who become ill is vital.

13.7.3 There is consistency in the literature with regard to admission rates following childbirth with the large Danish register studies finding rates of approximately 1 in 1000. Episodes of postpartum psychosis have a dramatic onset shortly after childbirth. The symptoms of these episodes include a wide variety of psychotic phenomena such as delusions and hallucinations, the content of which is often related to the new child. Affective (mood) symptoms, both elation and depression, are prominent as is a disturbance of consciousness marked by an apparent confusion, bewilderment or perplexity. The clinical picture often changes rapidly with wide fluctuations in the intensity of symptoms and severe swings of mood. Studies consistently demonstrate that the majority of puerperal psychotic episodes are affective, with mania particularly common in the 2 weeks following childbirth[94].

13.7.4 There is strong evidence for a close relationship with bipolar disorder. Symptoms of mania are common in postpartum psychotic episodes and further evidence for the link comes from studies examining the natural history of postpartum psychosis episodes. The condition has an excellent prognosis but work has demonstrated that women remain at high risk of developing further puerperal and non-puerperal affective episodes[95]. Women diagnosed with bipolar disorder are at particular risk in the puerperium with episodes following 25-50% of deliveries[96]. The magnitude of risk to bipolar women is underlined by analysis of Danish Registry data that reports the relative risk for an admission with bipolar disorder in the month following first pregnancies to be 23 – over four times higher than the relative risk for admission with schizophrenia or unipolar depression[97]. Although a range of disorders can occur in relationship to childbirth, there is consistent and compelling evidence of a specific relationship with bipolar disorder. Studies have demonstrated that postpartum psychotic episodes are not merely due to bipolar women stopping or changing medications or due to the social and psychological factors that play an important role in less severe postpartum mood episodes[98,99]. Rather the weight of available evidence suggests that biological factors are of primary importance[100].

13.7.5 As the Chronology illustrates, Mrs A had her first recorded episode of mental ill health in 1995 following a lifestyle of excessive cannabis and alcohol abuse. On 18 March 1995, Mrs A was admitted to Warley Hospital as an informal patient. She had the paranoid delusion that people had altered their appearance and were part of a satanic group. She could hear noises coming through the wall and the ceiling but not actual voices. Mrs A responded quickly to Sulpiride. She was discharged on 4 April 1995 with a diagnosis of a paranoid psychotic episode. In the clinical record it is reported that Mrs A was formally discharged from Outpatients in February 1996.[101] The cause of the psychotic episode was attributed to her use of cannabis.

13.7.6 The next mention of her mental health was in 2001 when Mrs A was referred urgently by her GP to the Community Mental Health Team due to her erratic behaviour, talking excessively, lack of sleep, discarding possessions, overspending and getting into substantial debt. She believed that a man known to her was Christ and that people were regressing into snakes and arranging items on her sofa to create hell.

13.7.7 The Community Mental Health Team made several attempts to assess Mrs A but she did not cooperate. In mid-July 2001, Mrs A was arrested by the Police under Section 136 of the Mental Health Act 1983 (MHA 1983) as she attended a children's party uninvited believing that the adults present wanted the children to undress. Mrs A was admitted to Lewisham Hospital and transferred to the Ruskin Unit at Guys Hospital under Section 2 of the Mental Health Act 1983. Mrs A was described as being grandiose, irritable and sexually disinhibited. She was treated with Risperidone 6mg daily and was discharged on 14 September 2001 with a diagnosis of bipolar affective disorder and substance misuse.[102]

13.7.8 This diagnosis was made when Mrs A was admitted to Fulbourn Hospital in November 2006 and was corroborated following the detailed assessment she had at the Thumbswood Mother and Baby Unit from 29 November 2006 to 23 January 2007.

Medication

13.7.9 Mrs A was stabilised and was well on Lithium and Risperidone when she was discharged from the Thumbswood Mother and Baby Unit. She rapidly reduced and stopped the Lithium within too short a timescale. The clinical notes do not appear to contain information or advice as to how long Mrs A should have been maintained on this medication that stabilised her. Mrs A also started taking the Risperidone on a PRN basis, which was reluctantly accepted by Dr 3 although he told her it was not his recommended medication and warned her of the dangers of relapse. There is no evidence base to suggest that such a use of Risperidone will provide either prophylaxis or protection against relapse.

Care Programme Approach

Context

13.7.10 The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[103] Since its introduction it has been reviewed twice by the Department of Health: in 1999 (Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach)[104] to incorporate lessons learned about its use since its introduction, and again in 2008 (Refocusing the Care Programme Approach).[105]

13.7.11 *"The Care Programme Approach is the cornerstone of the Government's Mental Health Policy. It applies to all mentally ill patients who are accepted by the specialist mental health services"*[106] (Building Bridges; DH 1995) This is important to bear in mind as it makes the point that the Care Programme Approach is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients.

13.7.12 The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users. This is achieved by enabling effective co-ordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

13.7.13 The purpose of the Care Programme Approach is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention.

13.7.14 The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
    - to keep in close contact with the patient;
    - to monitor that the agreed programme of care remains relevant and;
    - to take immediate action if it is not.

- ensuring regular review of the patient's progress and of their health and social care needs.

13.7.15 The success of the Care Programme Approach is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 service users were placed on either Standard or Enhanced Care Programme Approach according to their level of need.

> **Standard:** for individuals with a recognised mental health problem and a low risk rating, who are able to manage their mental health problem, have supportive social circumstances, and are active participants in their own care. They may require the intervention of one agency or discipline or low-key support from more than one agency or discipline.
>
> **Enhanced:** for individuals with a recognised mental illness resulting in multiple care needs and requiring multi agency involvement. They are more likely to have co-existing physical or mental health problems, disengage with services and present a higher risk to themselves or others. They will require a higher level and intensity of intervention. Care plans at this level will include a crisis plan.[107]

13.7.16 At the time of the death of Child 2, following the national refocusing of CPA in October 2008, service users would either be on CPA or not. Mrs A was on CPA which follows the previous guidance for individuals on Enhanced CPA.

Findings

13.7.17 The Care Programme Approach was utilised appropriately during Mrs A's period in the Thumbswood Mother and Baby Unit. She was placed on Enhanced Care Programme Approach which was appropriate given that she did have complex needs and was known to have a history of not taking prescribed medication and of not fully engaging with services. The Children's Social Care Services was working with the family and Child 1 was made subject to a Child Protection Plan under the category of Neglect (1) and Physical Abuse (2) for the following reasons:

- Child 1 suffered an injury when Mrs A hit her with a hairbrush.
- Mr A failed to protect Child 1 from significant harm.

13.7.18 In addition to Mrs A's mental health meetings, there were regular Child Protection Conferences and Reviews, and Child in Need Meetings when Child 1 had been deemed to require a Child Protection Plan. The meetings recorded are shown in the Table below:

Table: Record of Formal Care Programme Approach Mental Health Meetings and Child Protection Meetings

Mental Health CPA Meetings	**Child Protection Meetings**	**Child Protection Core Meetings**	**Child in Need Meetings**
19 December 2006	28 November 2006	22 February 2007	10 August 2007
23 January 2007	07 February 2007	05 April 2007	05 February 2008
20 April 2007	25 July 2007	16 May 2007	16 April 2008
14 August 2007	12 March 2009	05 July 2007	24 February 2009
	09 June 2009	18 May 2009	
Total 3	**5**	**5**	**4**

13.7.19 From the clinical records, it appears that the Care Programme Approach was not strictly adhered to as there should have been a formal review of the care and treatment of Mrs A every six months. The Table above shows that there were three CPA Meetings from 19 December 2006 to 14 August 2007, but none thereafter. This departed from both local and national policy requirements and as such is a Service Issue for the Trust.

13.7.20 In terms of all the agencies being kept aware of how Mrs A was, the Child Protection Meetings served this purpose, but should not have been used as an alternative for the Care Programme Approach.

13.7.21 One of the key purposes of the Care Programme Approach is to *"is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function is to "minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention."*

13.7.22 These two elements were of fundamental importance with Mrs A as she and her husband generally had a tenuous engagement with mental health services and she consistently refused to take the prophylactic medication she was prescribed. Mrs A also on two occasions refused to allow professional staff to visit them at home. On the first occasion on 06 March 2009 the situation was resolved by 10 March. The second occasion was on 12

June 2009, and when CPN 2 and Health Visitor 4 visited on 17 June 2009, when permission had been withdrawn, they were allowed into the house, they decided the situation warranted a Mental Health Act (2007) assessment but when they returned two hours later Child 2 was already dead and Child 1 was in hospital. It is quite possible that their visiting on that afternoon prevented the death of Child 1. Mr A had taken Child 1 and Child 2 to GP 3's surgery where Child 1 was alive but had been covered in something like methylated spirit. Child 1 was taken to hospital by ambulance and made a full recovery, but Child 2 was already dead.

13.7.23 The Cambridgeshire and Peterborough NHS Foundation Trust Care Programme Approach (CPA) policy covering the period from February 2006 to February 2008 states that CPA *"applies to people who fail to attend appointments, or who are reluctant to engage with services, particularly where a significant level of risk is identified."* It is therefore evident that the Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services saw Mrs A as being eligible for CPA. The policy continues to state that *"while respecting the need for confidentiality of certain personal information, CPA information should be shared between agencies on a 'need to know' basis. This includes the requirement to share information with the relevant Social Services Departments when issues of adult (or child) abuse are disclosed or suspected. This may be necessary even if consent is not given".*

13.7.24 The Cambridgeshire and Peterborough NHS Foundation Trust Care Programme Approach (CPA) policy covering the period from 1 May 2008 to 1 May 2010 also contains the above sections but the final part about the sharing of information is slightly altered and states:

> *"This includes the requirement to share information with the relevant Social Service Departments and Protection of Vulnerable Adults staff when issues of adult abuse are disclosed or suspected. This may be necessary even if consent is not given. The Trust has frameworks for sharing information with key statutory agencies, e.g. Police and probation. The needs of children are paramount. There is a policy framework on child protection issues and child protection staff provide advice and guidance."*

13.7.25 The Mental Health staff working with Mrs A applied these sections of the Care Programme Approach Policy throughout their involvement with the family, and fully contributed to the Child Protection/Safeguarding requirements in relation to Child 1 and subsequently to Child 2 from 03 May 2009. As stated above they did not hold formal Care Programme Approach reviews after 14 August 2007.

Risk Management and Assessment

13.7.26 Risk Management and Assessment is a key feature of the Care Programme Approach. The Cambridgeshire and Peterborough NHS Foundation Trust has two relevant Clinical Risk Management Guidance for Suicide, Self-Harm and Harm to Others Policies. One covers the period from February 2006 to February 2008, and the other from February 2008 to November 2009. Both policies state that the core elements of risk assessment and management are:

"Clinical risk assessment should be undertaken at critical points throughout an individual's care within the Trust in all clinical settings. It is not a one off activity, but is part of good daily practice on a continuing basis. Risk assessment or review should occur:

- *at first contact with a mental health service provided in all settings;*
- *prior to transfer of care from one treatment environment to another;*
- *a change in legal status (e.g. detention under the Mental Health Act);*
- *significant change in life events or upsetting news;*
- *major changes in clinical mental health condition;*
- *following a serious untoward event or incident involving a near miss or actual incident report being filed."*

13.7.27 The undertaking of an initial risk screening on admission or at first contact will be carried out in the context of the existing Care Programme Approach Policy and documentation used within the Cambridgeshire and Peterborough NHS Foundation Trust.

13.7.28 This Policy was followed by the Mental Health Services and the following risk assessments were undertaken during the period from 07 November 2006 to 17 June 2009 as shown in the Table below:

Date	Nature of Assessment/Event Noted
07/11/2006	Admitted following relapse so full Mental Health Act assessment undertaken. Child 1 assessed on a Paediatric Ward.
12/11/2006	While being reviewed on the acute ward following admission Mrs A stated that her husband encouraged her to stop taking medication in 2003 and since that time she believed she had been unwell. She stated that he also had Bipolar Affective Disorder and he had refused medication. She stated that he should have got help for her before she became so unwell.
15/11/2006	During a ward round with Dr 1 Mrs A was informed that all medication goes into breast milk*…"on the whole we recommend that people don't breastfeed when taking antipsychotic medication…as breastfeeding is not*

essential we advise against it". (This kind of statement may contribute to women with known compliance issues being more reluctant to take medication). This could have affected her wish not to take prophylactic medication following birth of Child 2.

29/11/2006 Assessment on admission to Thumbswood Mother and Baby Unit.

19/12/2006 Mr A's GP did not think he needed a referral to Mental Health Services.

05/01/2007 Mrs A saw GP 1 while on leave from Mother and Baby Unit with complaints about a rash and asking if it was secondary to her taking Lithium. (This is another factor which may have affected her compliance and attitude towards medication).

23/01/2007 Care Programme Approach meeting at Thumbswood after a total of three weeks leave (3x1 week). Discharge agreed. Medication was Lithium and Risperidone.

Mrs A met Social Worker 1 (Care Coordinator) for the first time. 'Further period of assessment will include Mr A. CSF Care Protection Conference in two weeks. Social Worker 2 to visit weekly and Mrs A asked for some assertiveness sessions. Health Visitor also to visit as necessary.

Homestart would provide extra support when Mrs A's mother was away.

Mrs A warned that she *"needs to think about further pregnancy very carefully and would need to access psychiatric support to enable pregnancy to be managed safely"*. Will be under care of Dr 3. No date for appointment was made and she did not see him until 02 April 2007

Mrs A was given the relevant contact phone numbers.

It was noted by Dr 2 that there may be compliance issues in the future. Excellent baby care. Deemed to meet 'enhanced criteria for CPA'. Mrs A said she would comply with medication to keep well. Risk Form completed by Dr There was no explicit mention of the attempt to harm Child 1 or of the potential risk for future children.

30/01/2007 Following the Discharge CPA Meeting Mrs A saw Social Worker 2 regularly and the CPA priorities were addressed.

05/02/2007 The Report for the Child Protection Review Conference lists the causes for concern as Mrs A hitting infant with hairbrush and husband not protecting her. No mention of made of the pillow incident.[108]

02/04/2007 Mrs A has her first outpatient appointment with Dr 3. She had come off Lithium completely and was taking Risperidone PRN Dr 3 disapproved of this but allowed her to continue in order to retain some contact. She was advised to take medication by him. Next appointment made for 18 June. Mrs A had sent off a sample of hair for testing for mineral checks. Evidence that she is not carrying out advice from Mother and Baby Unit Team nor Dr 3.

12/04/2007 Mr A was referred to mental health services and Dr 3 asked a colleague

to see him. The letter stated a diagnosis Bipolar Affective Disorder but there was no mention of the assessment.

08/05/2007 Mrs A did not want to attend relapse prevention group anymore.

16/05/2007 Mrs A was informed that she would have a new Care Coordinator who was to ill visit on 01/06/07. This was Social Worker 4

16/05/2007 The Child Protection Plan stated that Mr A was to contact mental health professionals if his wife's mental health deteriorated, and to contact his GP if his own did. Mental Health staff were to monitor the effectiveness of Mrs A's medication although at this point she had disengaged from relapse prevention classes and was not taking regular medication. The meeting that led to the plan reported Social Worker 2 as saying there were no concerns at this time.

01/06/2007 There were some reports from Mrs A's mother that her daughter was being a bit high at times following attendance at prayer meetings. Discussed how in past involvement with New Age movements precipitated relapse. Mrs A took Risperidone PRN No advice was given about this strategy and no plan was put in place.

12/06/2007 Mr A phoned the CMHT to say he was concerned about his wife. She had symptoms similar to those prior to her admission to hospital in 2006. Home Treatment Team refused referral as Mrs A had not been seen within last 24 hours. Further phone call to Mr A by GP 1 who reported that things had quietened down and no action needed to be taken. This gave Mr A considerable responsibility.

18/06/2007 GP 1 contacted Mr A. The situation was described as more settled. A home visit by Home Treatment Team revealed the situation looked unstable. Mrs A had symptoms associated with known warning signs of relapse. Mrs A's mother was angry with Mr A who he said was pushing Mrs A to go to Bible reading classes and he was not encouraging her to take her medication. The Home Treatment Team was to visit.

19/06/2007 Mrs A said to Social Worker 4 that God had advised her to stop taking medication
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21/06/2007 Mrs A saw Dr 3 in Outpatient Clinic and made it clear she would not take long term medication. He again tried to explain the importance of prophylactic medication.

03/07/2007 The situation was more stable. The Home Treatment Team was found to be helpful and the Team planned to discharge Mrs A. She returned to taking medication PRN and told the Home Treatment Team that she did not want to take medication.

23/07/2007 A home visit was made by Social Worker 4 when Mrs A and her husband felt the side-effects of medication outweighed any benefit. Mr A was not convinced that the mood stabiliser was effective.

25/07/2007 Child 1 was removed from the Child Protection Register

09/08/2007 Social Worker 4 informed Mrs A that she would be leaving. She would be

transferred to a new Care Coordinator until Social Worker 2 would return in October. Mrs A's mother was planning to return to South Africa as her elderly mother needed her help.

07/08/2007 Mrs A's husband was referred to a CMHT as the Senior House Officer thought he might be developing a psychosis.

19/09/2007 A home visit was made by CPN 1 when Mrs A claimed to be getting a lot of support from religion. The translation of Bible and the problems inherent in this were discussed.

04/03/2008 Mrs A was preoccupied with religion. She was not keen to take Child 1 to a nursery because of the people she might mix with.

24/07/2008 Mrs A still had a preoccupation with religion and living by the Bible. CPN 2 noted that Mrs A was not thought to have mood or psychotic symptoms so the decision was made to discharge her to Primary Care. GP 3 was the main contact for the family.

15/12/2008 Mrs A expressed concerns about the mental health of her niece. From this time on there are repeated references to Mrs A's religious fervour and the impact of the couple's beliefs on the social functioning of the family. They had isolated themselves from their respective families. They appeared to not have friends and Mrs A wanted to home educate Child 1. When CPN 2 and Health Visitor 3 visited on 13/01/2009 Mrs A's mood was described as stable and said *"God is looking after everything."* On questioning Mrs A admitted that she was pregnant.

During the pregnancy in 2009 there were repeated references to Mrs A's religious ideas, the ideas seemed extreme, there was no associated mood change, and she explained her previous episodes as being caused by the Devil.

17/02/2009 A psychiatric assessment by Dr 5 and CPN 2 highlighted to Mrs A her high risk of relapse in the postnatal period, the need for regular medication and close monitoring post-delivery.

01/04/2009 Mrs A's mental state was reportedly normal but she did not believe that she would get ill as God would look after her.

03/05/2009 Birth of Child 2. It was a home birth as the couple did not contact midwives until after her birth. This was against the agreed Birth Plan.

07/05/2009 Mrs A was seen by Dr 5. Mrs A continued to have overvalued religious ideas. She was not taking medication. Mr A and Dr 5 had a long conversation where Mr A expressed bizarre ideas. In particular he held strange ideas about the World Health Organisation, and modern health care being like witchcraft in that it made people more susceptible to spirits. He didn't believe any information that could not be verified by experience or the Bible and this included any information received from the NHS. He found it better to trust God than to rely on any aspect of modern health care. *"They both remain poorly co-operative with health services"* The plan was to monitor her and *"to some extent"* his mental state.

08/05/2009 Both parents stated that if there was an emergency they would pray to

	God first rather than contact professionals immediately. Daily monitoring by professionals was agreed but no overarching visiting plan was developed.
17/06/2009	CPN 2 and Health Visitor 4 visited. They found Mr A praying for the Devil to be released from Mrs A. Later that afternoon Child 2 was pronounced dead and Mrs A was found to be floridly psychotic. There was no mention that the role played by Mrs A's mother as a protective factor which reduced the risk following the 2006 mental illness had been missing following the birth of Child 2.

13.7.29 It is noticeable from the above Table that the risks were well known and reported throughout the period from November 2006 to June 2009, apart from the gaps in contact described in the chronology from 23 October 2007 until 25 January 2008 due to the transfer problems, and the period the case was closed from July 2008 until 13 January 2009 when CPN 2 visited again following a referral from Mrs A on 15 December 2008.

Use of the Mental Health Act (1983 and 2007)

13.7.30 This was appropriately used in November 2006.

13.7.31 As described in Section 13.6 the Independent Investigation Panel did question why the Mental Health Act (2007) was not used following the cancellation of home visits by Mrs A on 12 June 2009 as it was indicated at this time.

Management of the Clinical Care of Mrs A

13.7.32 There was a lack of clarity as to when Mrs A would be reviewed by a psychiatrist following her discharge from the Thumbswood Mother and Baby Unit. This situation was noted by the Children and Families Service at the Child Protection Review Meeting in February 2007.

13.7.33 There were also issues in October 2007 when the family moved to the catchment area of the Cambridge North Rural Community Mental Health Team but Dr 3 still had an outpatient with Mrs A on 19 December 2007.

Nursing Factors

13.7.34 Mrs A was allocated a Social Worker as her Care Coordinator when she was discharged from the Thumbswood Mother and Baby Unit on 23 January 2007. Social Worker 2 stated at the Care Planning Meeting in January 2007 that Mrs A did not have a Community Psychiatric Nurse, but that she would be referred to one if this was deemed necessary. There were no details describing how, or in what circumstances this would occur.

The Independent Investigation Panel did question whether a service user requiring real support around medication issues, and who was known to have difficulties in complying with medication, should have been managed by a Care Coordinator who was not from a nursing background.

13.7.35 An email from Social Worker 2 to Dr 3 a month after her discharge requested an appointment for Mrs A regarding medication and compliance, but there was no appointment made until 08 March 2007 which then had to be altered to 02 April 2007. This was considered an inadequate arrangement given how ill she had been and the well known compliance issues.

13.7.36 There were three changes in care co-ordination within the first year of discharge from hospital which led to a lack of consistency in her care. The handover of care to CPN 1 was poor and she had not realised or acknowledged that she was expected to take on a full care co-ordination role. It was noted in the Child Protection documents that Mrs A was engaging with mental health professionals. This was true but the reality was that Mrs A was doing this at a level led by her (for example stopping her taking of medication) and not accepting the advice that she needed to take medication consistently.

13.7.37 The Independent Investigation Panel accepts that the professionals involved in the provision of care and treatment for Mrs A and the Protection of Child 1 wanted to maintain contact with her. The question was why she was not challenged more about her non-compliance with advice about the known effective treatment strategies when the risks of not taking medication were known. She had relapsed once in June 2007 and the risks she had shown during her severe November 2006 episode of hospital admission were well documented and fully part of the clinical records.

13.7.38 On 25 July 2007, Social Worker 2 advocated that Mrs A be seen monthly rather than every two weeks by a mental health practitioner, despite at the time having evidence of a lack of adherence to medication; having fluctuations in mental state, and stating that God had advised her to stop taking medication. The Independent Investigation considered whether a referral to an Assertive Outreach Team could have been more appropriate rather

than to have the proposed less contact. It did appear that in some ways the professionals seeing Mrs A were allowing her to plan her care rather than assertively managing and supporting her. At this meeting Child 1 was taken off the Child Protection Register despite some dissenting voices commenting on her recent manic episode in June 2007.

13.7.39 There seemed to be a real lack of understanding that her recent episode was due to the lack of medication, and that while she took some medication to become well, she had then reverted to her plan of PRN medication leaving her at risk of relapse. It seems that the professionals were overly impressed with Mr A having contacted the mental health services, although it was clear that Mrs A's mother was there at the time. The need for regular medication did not appear to have fully understood. It is accepted that the professionals did not want to lose contact with Mrs A and they realised that she was difficult to engage with services, and therefore appeared to make allowances.

Conclusions

13.7.40 It was as if the professionals were in general terms colluding with the family and that the known facts regarding Bipolar Affective Disorder regardless of who one is were being ignored:

- the need for regular prophylactic medication;
- the high risk of relapse following childbirth;
- the incident with the pillow when Child 1 could have been smothered had not been kept in people's minds;
- at a meeting Mrs A spoke of needing to 'clean out her demons'. The significance of this kind of statement was not understood, in that it demonstrated that perhaps her understanding of her mental health was not appropriate.

13.7.41 The Independent Investigation Panel has no doubt that all the professionals working with Mr and Mrs A wanted to help them and were really concerned about the health of both parents and wanted them to be supported and helped to successfully and safely parent Child 1 and also to succeed with Child 2 following her birth. The parents did not make this an easy task by their failure to engage and to follow the professional advice they were given.

13.7.42 However it is evident that significant systems and processes were not adequately in place and as a result Mrs A and her children were allowed to slip through the safety net of care.

- **Contributory Factor Number Six. The failure to implement significant processes and systems such as the Care Programme Approach allowed Mrs A and her children to slip through the safety net of care. This contributed to the deterioration of Mrs A's mental state and the lack of assertive intervention required to manage it.**

13.7.43 The next Section of the Report examines how the Root Cause and the five Contributory Factors combined to prevent Mrs A receiving sufficient and timely health and social care support to identify her mental ill health prior to the afternoon of 17 June 2009.

14. Findings and Conclusions

14.1 Introduction

14.1.1 In order to ensure that the findings are understood within the root cause analysis methodology each finding is placed within one of the three categories below. These categories are as follows:

1. **Root Cause (of which one was found).** The term is used in this Report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal bearing upon the death that occurred on 17 June 2007. In the realm of mental health service provision, it is never a simple or straightforward task to unconditionally identify a direct causal relationship between the care and treatment that a service user receives and any subsequent homicide (manslaughter) perpetrated by them.

2. **Contributory Factor (of which six were found).** The term is used in this Report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Panel to conclude that it made a direct contribution to the breakdown in Mrs A's and Mr A's mental health and/or the failure to manage it effectively.

3. **Service Issue (of which none were found).** The term is used in this Report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing on the events of 17 June 2007, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvement to services made.

Root Cause Analysis

14.1.2 The key question in any investigation into a homicide committed by a mental health service user is 'why did they kill the victim?'. In the situation with Mrs A it is a particularly relevant question as the person she killed was her recently born daughter, Child 2. She was convicted of manslaughter.

14.1.3 Following the manslaughter of Child 2, Mrs A became extremely psychotic as she had after the birth of Child 1. On 17 June 2009, Mrs A killed Child 2 and was sentenced to a Hospital Disposal under Section 37 of the Mental Health Act (2007) and a Restriction Order under Section 41 of the same Act. The Judge decided that Mrs A was suffering from a mental disorder and should therefore be detained in a medium secure hospital rather than in a prison.

14.2 Findings

Root Cause

14.2.1 The Independent Investigation Panel found that the one Root Cause leading to the death of Child 2 was:

- **Causal Factor Number One. Mrs A refused to follow the clinical advice she was consistently given by the Mental Health Services, the Children's Social Care Services, Midwives and Health Visitors. However individual workers responded as rapidly as they could in the led up to Child 2's death and a direct causal link cannot be attached to an act or omission on the part of the individuals involved. However the system was not robust enough to ensure a safe delivery of service.**

14.2.2 It is clear that Mrs A had suffered from Bipolar Affective Disorder since July 2001. She suffered a relapse in November 2006 following the birth of Child 1. During her illness prior to her admission to Friends Ward, Fulbourn Hospital, she had hit Child 1 with a hairbrush and had also placed a pillow over her in an attempt to stop her crying. She removed the pillow before any lasting injury or harm had been caused. The Independent Investigation Panel considered this to have been a 'near miss' in that the suffocation of Child 1 could have resulted from this action.

14.2.3 Mrs A responded well to the care and treatment she received from Fulbourn Hospital in November 2006, and also the specialist help from the Thumbswood Mother and Baby Unit from the end of November 2006 to 23 January 2007.

14.2.4 Mrs A did not fully engage with the mental health services she received as she refused to follow the advice to take the prescribed medication despite having been informed very clearly the risks she had of relapsing without taking it. She was also informed that a

relapse would be far more likely if she became pregnant yet she still did not accept the need for medication.

14.2.5 Both Mr and Mrs A became very involved with religion. They could find no established church or religious organisation with which they could agree as they did not conform to their own fundamental interpretation of the Bible. This belief ran their lives and became stronger and they could also find no internet religious website which taught their beliefs.

14.2.6 Mrs A's mental state deteriorated and whilst significant concerns had been documented with regard to the on-going safety and wellbeing of her children Mrs A was allowed to disengage with services to the ultimate determent of her children's health and wellbeing.

Contributory Factors

14.2.7 The Independent Investigation Panel found six contributory factors. These were:

- **Contributory Factor Number One. There was a lack of a clear and coherent crisis and contingency plan should Mrs A relapse of which all professionals were aware in order to inform them of what to do. The failure to provide this made a contribution to the deterioration of Mrs A's mental health.**

14.2.8 Following the birth of Child 2 the various services involved developed their own visiting arrangements. This meant that the family could have several visitors one day and few or none the next. The services were the Cambridgeshire and Peterborough NHS Foundation Trust Mental Health Services, the Cambridgeshire Children's Social Care Services, the Midwifery Service from the Cambridge University Hospitals NHS Foundation Trust and the Health Visiting Service from the Cambridge Community Services NHS Trust. They all shared their observations of the family and made sure that all the professionals visiting Mr and Mrs A were kept informed about the current situation.

14.2.9 The vital ingredient which was lacking was a common timetable for all four services so that the visits could be arranged so that at least one visit to the family was made each day. This would have ensured that each day someone could report on how Mr and Mrs A were, and would be able to alert other professionals if they had any cause for concern. There was also no Crisis and Contingency Plan so that staff would know what to do should they arrive at the home and find that Mrs A or her husband had relapsed, and who to

contact. Such a Plan would also have identified what action to take should Mr and Mrs A refuse to let professionals visit them.

14.2.10 The presence of a crisis and contingency plan may have ensured more assertive and timely interventions between 12 and 17 June. When the two staff who visited on 17 June 2009 found Mr A acting very strangely they did act responsibly and sought to arrange a Mental Health Act (2007) assessment, but sadly by the time the necessary staff arrived at the family home it was too late.

14.2.11 The lack of a clear, coherent crisis and contingency plan was a contributory factor to the lack of a timely response being given but did not of itself directly cause the death of Child 2.

- **Contributory Factor Number Two. A Lack of assertiveness by Agencies after Mrs A was discharged from the Thumbswood Mother and Baby Unit on 23 January 2007 and thereafter contributed to the deterioration of her mental health.**

14.2.12 Once Mrs A was discharged from the specialist perinatal Mother and Baby Unit the level of support decreased and the community mental health staff were unable to force Mrs A to take her prescribed medication as she refused to accept that it did her any good.

14.2.13 The mental health staff faced a dilemma in that they knew the risks associated with Bipolar Affective Disorder but were unable to persuade or convince Mr A or Mrs A that this treatment was essential in order to help prevent a relapse. On the other hand, the staff also knew that they needed to remain in contact with Mrs A and therefore felt they could not push her too far and face having her completely disengage. If this had occurred they would have had no opportunity to monitor the situation.

14.2.14 The Independent Investigation Panel concluded that services should have been more proactive and assertive in trying to ensure Mrs A's adherence to a care and treatment programme. It would also have been reasonable to expect them to try alternative approaches to see if they would work, rather than let Mrs A dictate her own medication regime. It was also understood that the professionals had to work within the current Mental Health Legislation.

14.2.15 The lack of a means by which the mental health staff were able to ensure that Mrs A took her medication was a contributory factor to the breakdown in the deterioration of Mrs A's mental health but did not of itself directly lead to the death of Child 2.

- **Contributory Factor Number Three. The confusion and over-importance given to the question of whether Mr A and/or Mrs A were suffering delusions in the period prior to, and following, the birth of Child 2 led to delays in the assertive management of the case. This contributed to the breakdown in Mrs A's mental health.**

14.2.16 It is clear from the Chronology that great attention was given to the task of determining if Mrs A was delusional and to whether she was exhibiting any symptoms which could signify the start of a relapse in her mental health. To a slightly lesser extent the same issues were being considered in relation to Mr A's mental health.

14.2.17 The mental health staff visiting the family were very concerned about the extreme religiosity of Mr and Mrs A and whether this was a psychotic delusion. An equally important question was to determine the effect the home environment was having on Child 1 and her new baby sister and whether they were adequately protected and the plans agreed with the family at the Child Protection Conference were being adhered to. The Mental Health Service was unsure whether the extreme religiosity was a symptom of psychosis and the Children's Social Care Services did not know the relapse signature of Mrs A. There was no shared understanding between the Mental Health Services and the other agencies involved of what to do if certain behaviours were identified and as a result they were less concerned about the effects of the home environment.

14.2.18 The confusion and over-emphasis on the possibly religious delusions appeared to obscure the need to be sure that the two children were not being harmed by their environment and the failure of their parents to implement the actions they had agreed in the Child Protection Plan. The Independent Investigation Panel considered that this was a contributory factor in the breakdown of the Child Protection Plan but did not of itself directly lead to the death of Child 2.

14.2.19 The Individual Management Review (Children's Services) concurred with this finding as the chair of the Review Child Protection Conference held on 09 June 2009 commented that based on the monitoring form for the child protection plan that Mr and Mrs A were "*offering minimal commitment to the plan but are welcoming professionals into their*

home…and are continuing to put the children at risk through their rigid religious beliefs and total trust in God to keep them safe".[109].

- **Contributory Factor Number Four. The missed opportunity to undertake a Mental Health Act (2007) assessment with Mr and Mrs A after their refusal to accept visits from Staff on 12 June 2009 meant that their mental health continued to deteriorate without appropriate assessment and placed their children at risk.**

14.2.20 The fact that the overall situation within Mr and Mrs A's home was deteriorating was known, but the extent of that deterioration was not known. The relapse signature of Mrs A was well understood by mental health services but had not been fully shared with the other staff from the Children's Social Care Services, the Midwifery Service and the Health Visiting Service. One of the major indicators of relapse was Mrs A trying to isolate herself from social contact.

14.2.21 Within the context of the situation within the family home on 12 June 2009, the refusal to allow staff from the Health and Social Care agencies to visit should, in the opinion of the Independent Investigation Panel, have triggered a Mental Health Act assessment. There is no guarantee that this would have assessed either parent as having a serious mental illness such as to be a danger to themselves or others, but it would have allowed someone to enter the home with a clear role to assess the level of illness and thereby have an idea of the level of risk to Child 1 and Child 2.

14.2.22 A Mental Health Act (2007) Assessment would have provided the opportunity to assess the mental health of both Mr and Mrs A. It would also have provided the opportunity to assess the health and wellbeing of Child 1 and Child 2. The failure to achieve this in a timely manner contributed to the delay in assessing the family dynamic and safety of the children.

- **Contributory Factor Number Five. The Loss of Information about the 'Pillow Incident' with Child 1 in November 2006 meant that Mrs A was not assessed in the context of her full psychiatric history and that the risks to her children were not understood in the light of her past behaviour. This contributed to the lack of assertive and timely intervention.**

14.2.23 When Mrs A was mentally unwell in November 2006, before she was admitted to Fulbourn Hospital, she had assaulted her four-month old daughter Child 1 on two occasions. On the first occasion she had hit her on the side of her head with a hairbrush. She told staff on admission to Fulbourn Hospital that she had also become so frustrated and agitated by Child 1's crying that she had placed a pillow over her to prevent her crying.

14.2.24 The Independent Investigation Panel considered the second assault with the pillow to be the more serious of the two incidents. It was surprising that after having been mentioned at the Child Protection Conference and in the Discharge Summary from Fulbourn Hospital and the Part One Discharge Report from the Thumbswood Mother and Baby Unit, this important fact was 'lost'. Staff interviewed during the course of the Independent Investigation had been unaware of this information, and thought that had they known it would have altered their perception of the level of risk Mrs A posed to her new born daughter.

14.2.25 This was again assessed as a contributory factor which did not of itself lead to the death of Child 2.

- **Contributory Factor Number Six. The failure to implement significant processes and systems such as the Care Programme Approach allowed Mrs A and her children to slip through the safety net of care. This contributed to the deterioration of Mrs A's mental state and the lack of assertive intervention required to manage it.**

14.2.26 The Independent Investigation Panel had no doubt that all the professionals working with Mr and Mrs A wanted to help them and were really concerned about the health of both parents and wanted them to be supported and helped to successfully and safely parent Child 1 and also to succeed with Child 2 following her birth. The parents did not make this an easy task by their failure to engage and to follow the professional advice they were given.

14.2.27 However it was evident that significant systems and processes were not adequately in place and as a result made a contribution to Mrs A and her children being allowed to slip through the safety net of care.

14.2.28 When considering the issue of causality an Investigation Panel has to consider both what could and should have been done. In the case of Child 1 and Child 2 the risk of neglect

was considered to be very real leading to the children each being subject to a Child Protection Plan. The risk of neglect to the children had been identified as being significantly exacerbated by the presence of Mrs A's severe and enduring mental illness.

14.2.29 Mrs A's mental illness was in turn exacerbated by her lack of adherence to her care and treatment programme. This lack of adherence was hallmarked by her refusal to take medication and engage with the service. This had been identified as being Mrs A's relapse signature. In June 2009 Mrs A had also refused access to the health and social care professionals whose role it was to assess and safeguard the health and wellbeing of her children. If all the agencies involved had had access to all the information gathered about Mr and Mrs A at this stage health and social care professionals had interventions available to them that should have been considered:

1. assessing whether the required threshold had been reached for approaching the Court for an Emergency Protection Order once it was clear Mrs A's mental health had deteriorated and the children were at risk of significant harm;

2. the removal of Mrs A from the family home under the auspices of the Mental Health Act (2007);

3. in view of Mr A's poor mental health, the removal of both the children and Mrs A from the family home.

14.2.30 In the case of Child 2 three safety nets failed to work:

1. The Child Protection Plan;
2. The Care Programme Approach (CPA);
3. The Mental Health Act (2007).

14.2.31 CPA failed by allowing there to be no provision of a contingency plan when Mrs A began to reject services. This led to a break down in her mental health.

14.2.32 The Child Protection Plan failed to protect Child 1 and Child 2 as not all knowledge of the previous history was known and the relapse signature of Mrs A had not been shared with the staff in Children's Social Care Services.

14.2.33 The Mental Health Act was not used in a timely manner to both treat Mrs A and to protect her children.

Management of Bipolar Disorder in the Postpartum period

14.2.34 Women with a known diagnosis and history of Bipolar Affective Disorder require clear, assertive and thoughtful care and treatment during their childbearing years. The risks of relapse post-natally are well documented. Women who have previously relapsed post-natally have a known high risk and clinically it is known that the severity and risks associated with an earlier post-partum relapse will show similar symptomatology and risks during future post-partum relapses. Mrs A had a severe episode following the birth of her first infant and displayed clear and documented physical risks to her infant at that time. Indeed it could also be said that her first infant was exposed to ongoing risk of harm given the nature of the beliefs and social functioning of her parents throughout her time with them.

14.2.35 Women who have access to comprehensive perinatal psychiatric services would with Mrs A's profile have been offered the following:

- following her first post-partum episode she would have been informed of her high risk of relapse with future pregnancies. This information would have been shared with carers, primary care and social services so that all those most likely to learn of any further pregnancies would be alert to the risks as early as possible;

- the patient would have been advised to take her medication consistently following relapse. Refusal to take medication would increase her risk of relapse and risks to self or others especially her infant. Children's Social Services and Primary Care would be alerted to these risks and provision of safeguards for the infant implemented;

- pre-pregnancy counseling would be offered prior to any future pregnancies. The subject of family planning would be discussed frequently;

- it would have been expected that she remain in services with regular psychiatric care and a care-coordinator while she remained non-compliant with medication and in her childbearing years;

- on services and professionals becoming aware of her second pregnancy the patient and her husband would be offered assertive input. Psychiatric and risk assessments would be carried out regularly, documented and communicated

- at 32 weeks gestation a perinatal care planning meeting would be held. Attendees would include the patient, family, health visitor, GP, midwife, social services, Care Coordinator, psychiatrist and specialist perinatal workers. If the patient did not want to co-operate or attend the meeting would go ahead with the professionals. At all times the risk of relapse would be highlighted and the attendant risk to the children held in mind;
- a plan would result from this meeting which would address midwifery, safeguarding and mental health during the pregnancy, intra-partum period, early/mid/late post-partum periods. This plan would be circulated to the patient, primary care, mental health, social services, midwifery etc The plan would be displayed prominently in any case records;

- given her high risk, reluctance to take medication and the absence of another adult in the home who fully understood/accepted the risks consideration would have been given to the implementation of the following:
    - immediate psychiatric assessment following birth;
    - prophylactic admission to a Mother and Baby Unit;
    - home treatment/ crisis intervention that would have the patient assessed once-twice daily. Patients with this risk profile are known to deteriorate rapidly and severely.
    - an adult to live in the home who could monitor mental state and alert professionals to any change eg aunt, mother etc
    - daily visits and support from social services to safeguard the children
    - assertive management of any change in mental state, disengagement from professionals with detention under the MHA being considered early.

- in a specialist perinatal service attempts would have been made to admit a woman with Mrs A's presentation and history post-delivery with the view that relapse would be almost inevitable without treatment. The service would have engaged with Social Services to enable this with it being part of their plan that the baby be in a safe place during the period of high risk.

14.2.36 The services working with Mrs A did some of the above but it was not sufficiently joined up and there was no overall management of an agreed action and contingency plan.

14.3 Conclusions

14.3.1 In a case like this the Independent Investigation Panel cannot assess the effectiveness of the care and treatment offered to an individual service user using the benefit of hindsight. The Investigation Panel has to base its conclusions based upon the decisions that were made and the rationale used to make them. The appropriateness of decision making is assessed in the light of what was known and what should have been known about the case in hand at the time the care and treatment delivery was made. It also has to be concluded whether everything that reasonably could have been done was actually done.

14.3.2 In the case of Mrs A's care and treatment delivery it was apparent that services, which worked diligently to support her and her children, did not work within an effective system. This ensured that Mrs A was allowed to disengage from services and become non adherent with the care and treatment programme that had been put into place in the best interests of both herself and her children.

14.3.3 Statutory procedures, such as those implemented on behalf of the Children Act and the Mental Health Act, were found not to be utilised in a manner that triggered a consistent and effective response to the particular needs of this service user and her family. It was also found that the Care Programme Approach was not utilised effectively and as such an essential safety net of care failed to operate. Had the care and treatment offered to Mrs A been more systematic and assertive then intervention would have been made in a timelier manner and the death of Child 2, and the near miss situation regarding Child 1, could reasonably have been prevented.

14.3.4 Based on what was known, and what should have been known at the time the Independent Investigation Panel therefore concluded that there was causality between failures in the system, which should have provided sufficient protection, and the death of Child 2. Any child who is subject to a Child Protection Plan, and whose mother is **also** on the Care Programme Approach, should be protected by statutory interventions as required. In the case of Mrs A it was evident that she was not adhering to her care and treatment programme and had disengaged with services. These had been identified previously as

significant relapse indicators that would have placed both Mrs A and her children at risk. Intervention was neither coordinated nor timely enough considering the statutory levers (An Emergency Protection Order, Care Programme Approach, the Mental Health Act) in place to prevent the death of Child 2.

14.3.5 The Individual Management Review (Children's Services) concluded that at the Review Child Protection Conference on 09 June 2009 that: "*Visits by professionals were taking place but there was no evidence of change by the parents. It was at this point that there should have been a review within Social Care about whether the Child Protection Plan could adequately protect these children"*[110]

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14.3.6 Other issues for consideration include those set out directly below.

1. Advice to Perinatal Service Users

14.3.7 The information given that all medication goes into breast milk could have affected Mrs A's wish not to take prophylactic medication following the birth of Child The advice given in such circumstances is usually that mothers do not breastfeed when taking antipsychotic medication as breastfeeding is not essential.

14.3.8 The advice given to Mrs A may contribute to women with known compliance issues being more reluctant to take medication. This should be considered if staff are working with women with perinatal mental health issues**.**

2. Management of the Clinical Care of Mrs A

14.3.9 There was a lack of clarity as to when Mrs A would be reviewed by a psychiatrist following her discharge from the Thumbswood Mother and Baby Unit. This situation was noted by the Children and Families Service at the Child Protection Review Meeting in February 2007. An early appointment should have been made to ensure consistent follow up and continuity of care.

14.3.10 The delay could have given the impression that despite all the emphasis on the requirement to take medication and to follow the professional advice given at the Thumbswood Mother and Baby Unit, the matter was not urgent as there was no Outpatient Appointment to see a psychiatrist for almost 10 weeks, from 23 January to 02 April 2007.

3. Choice of Care Coordinator

14.3.11 A service user requiring real support around medication issues, and who is known to have difficulties in complying with medication, should have been managed by a Care Coordinator who was from a nursing background.

14.3.12 There were three changes in the Care Coordinator within the first year of discharge from hospital which led to a lack of consistency in Mrs A's care. It was known that the situation was complex and that the dangers of relapse were high. In such situations attempts to appoint a Care Coordinator who will be available for more than a few months should be made.

15. Cambridgeshire and Peterborough NHS Foundation Trust Response to the Incident and the Internal Investigation

15.1 This section of the Independent Investigation Report examines the Internal Investigation undertaken by the Cambridgeshire and Peterborough NHS Foundation Trust following the death of Child 2 on 17 June 2009.

15.2 As the victim was a baby the Local Authority were required to conduct a Serious Case Review under Paragraphs 8.2, 8.3 and 8.6 of Working Together to Safeguard Children 2006. The purpose was to identify any lessons to be learned about the ways in which the agencies involved in providing services to Mrs A, Mr A, and Child 1 and Child 2 had worked together to safeguard and protect the welfare of Child 2. As a result the Cambridgeshire and Peterborough NHS Foundation Trust combined the requirement of the NHS for an Internal Investigation to be undertaken to learn the lessons for the local health service and its partner agencies, and the requirement to produce an Independent Management Review as part of the Serious Case Review process. In the event the Internal Investigation Report served both functions.

15.1 The Trust Serious Untoward Incident Process

15.1.1 The Cambridgeshire and Peterborough NHS Foundation Trust followed its policy on 'Incident and Near Miss Reporting Policy and Serious Untoward Incident Procedure' which was effective from May 2008 and was due to be reviewed in May 2010. The policy quite correctly states that *"the emphasis of this policy is that incidents and errors are not in themselves evidence of carelessness or neglect, and that the best way to reduce incident and error rates is to target the underlying system failures, rather than take action against individual members of staff. However, performance or conduct which is seriously detrimental or prejudicial to the service, or service users, will be investigated and may be subject to disciplinary action as set out in the Trust's Disciplinary Procedure."*

15.1.2 The Policy takes due account of the National Patient Safety Agency *Being Open* guidance issued in September 2005. All NHS Trusts were expected to have an action plan in place regarding this Guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put

forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

15.1.3 Although the *Being Open* guidance focuses specifically on the experience of patients and their carers, it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

15.1.4 The Cambridgeshire and Peterborough NHS Foundation Trust Policy does state that service users and carers should be involved and be provided with as much information as possible, and are entitled to receive an apology from the Trust for the incident.

15.2 The Trust Internal Investigation

15.2.1 The Cambridgeshire and Peterborough NHS Foundation Trust selected an appropriate team of staff for the Internal Investigation which comprised:

- Senior Manager 1 within the Trust as Review Officer;
- Dr 6, a Lead Consultant, Specialist Perinatal Services, from a London Mental Health Trust;
- Senior Manager 2 within the Trust with knowledge of Safeguarding Children.

15.2.2 The inclusion of Dr 6 was sensible as much of the clinical care of Child 2's mother was perinatal mental health care as she had been a service user at the Thumbswood Mother and Baby Unit following the birth of Child 1. The Cambridgeshire and Peterborough NHS Foundation Trust did not have a full perinatal mental health service and the expertise from a clinician in that specialism was a positive step for the Investigation.

15.2.3 Senior Manager 1 had undertaken a number of Serious Untoward Incident Investigations but this was the first Independent Management Report that he had been involved with. Senior Manager 2 had not completed any investigations before, but had been involved with two Serious Case Reviews and had been a co-author of Independent Management Reviews. He had also had experience of the Cambridgeshire and Peterborough NHS Foundation Trust Internal Investigation process.

15.2.4 The Internal Investigation Panel interviewed Dr 5 twice, on 20 July 2009 and 28 July 2009. The witnesses had prepared statements which formed the basis of each interview. The Senior Managers 1 and 2 had prepared questions with Dr 6 and they wrote notes of the answers next to these during the interviews which were not recorded and transcribed.

15.2.5 In addition to the Cambridgeshire and Peterborough NHS Foundation Trust Internal Investigation, the Hertfordshire Partnership NHS Foundation Trust undertook an Internal Investigation which was also the Independent Management Review of the care and treatment provided to Mrs A and Child 1. This covered the period while they were at the Thumbswood Mother and Baby Unit (29 November 2006 until 23 January 2007 when she was discharged home following a period of leave) and was prepared for the Serious Case Review of the Cambridgeshire Local Safeguarding Children's Board. It had exactly the same Terms of Reference as the Cambridgeshire and Peterborough NHS Foundation Trust's Internal Investigation.

The Terms of Reference

15.2.6 There were two sets of Terms of Reference as the Internal Investigation was serving two purposes as described above, to be the Cambridgeshire and Peterborough NHS Foundation Trust's Internal Investigation but also the Independent Management Report of the Trust to the Serious Case Review of the Cambridgeshire Local Safeguarding Children's Board.

15.2.7 The original Terms of Reference were to:

1. To review the services provided by agencies in Cambridgeshire to Child 2, her parents and her sibling Child 1 from when Mrs A first presented to each agency during her pregnancy with Child 1 in 2006 to the date of Child 2's death on 17 June 2009 by:

    a. gathering all the information available in each agency relating specifically and directly to Child 2, her sister, and her parents during the period under review;

b. constructing a chronology detailing each agency's involvement with Child 2, her sister and her parents between June 2006 and June 2009;
c. establishing the facts of the case focusing in particular on:
    i. what is known during the period June 2006 and June 2009, by professionals and others about the family, their wider social context, their engagement with health services, housing and other public sector services;
    ii. the medical, social and emotional care provided by agencies to Child 2 and her sister;
    iii. the physical and mental health of her parents, their treatment, their care and the assessed risk their mental illness presented to their parenting capacity;
    iv. the way in which agencies worked together and individually to safeguard Child 2 and her sister and their use of formal safeguarding processes;
    v. the actions of agencies from the point of view of first contact in the GP surgery and after the emergency call was received to the death of Child 2.
d. interviewing those individuals involved where Independent Management Review authors or the overview author deem it necessary in order to properly establish any factual matters that are unclear from the written material;
e. identifying and seeking to resolve any gaps in the chronology or the facts of the case that have a direct bearing on the services provided, decisions made and actions taken;
f. establishing what policies, procedures and processes were applicable and the degree to which those policies and procedures were followed.

1. To objectively and critically assess and analyse the material reviewed, in the light of the statutory and organisational policies, procedures and processes applicable, the research and evidence base and the accepted professional expectations and standards of good practice of each agency, the way in which those services worked individually and together to safeguard Child 2 and her sister, to identify any concerns and to act appropriately to secure her wellbeing and safety and to:

a. establish what opportunities to provide effective support were handled by each agency and how well each agency communicated and worked with other agencies on a multi-agency basis in sharing information, co-ordinating activity and providing services;
b. assess and evaluate how agencies worked together to assess, establish and minimise the potential risk to Child 2 and her sister whilst they were subject to a Child Protection Plan, and their approach to work with non-compliant and hostile parents;
c. identify good or outstanding practice by any individual or agency;
d. establish what opportunities were missed by each agency, whether there were any explicit failures by any individual or agency to act in Child 2's best interests either professionally or organisationally and identify what the impact was of those missed opportunities and failures for Child 2, her sister and her family;
e. establish how effectively each agency supported those staff in direct contact with the family, organisationally and managerially and whether there were any shortfalls in their training, Continuous Professional Development, professional or clinical supervision or managerial oversight;
f. note where organisational, structural, procedural, system or resources in any of the agencies involved clearly and directly impacted (negatively or positively) on the support and care provided to Child 2, and on measures taken to ameliorate (or enhance) that impact where necessary;
g. arrive at a view whether, with hindsight, any action taken by any agency could have led to an alternative course of events and different outcome.

2. To draw overall conclusions from the information and analysis.
3. To comment on how well agencies took into account Child 2's religious, cultural and ethnic identity and responded to her parents' non-orthodox religious beliefs in providing support and services to her and her family.
4. To identify the key issues arising from the review for safeguarding practice generally and set out any key themes about multi-agency practice arising from the report that require discussion and consideration by the Local Safeguarding Children's Board and its partner agencies.

5. To state what key points can be learnt from the analysis and assessment of the case, on an individual agency basis and collectively in order to contribute to improved practice and better safeguarding of Cambridgeshire's children and young people in future.
6. To make relevant recommendations for action by the Local Safeguarding Children's Board and by individual agencies, and what outcomes those recommendations are designed to achieve.
7. To take into account the views of Child 2's parents when they are able to contribute should they wish to do so."[111]

15.2.8 The Specific Terms of Reference for the Serious Case Review asked individual agencies to establish the facts of the case and on the basis of those facts to consider in particular:

1. Did practitioners fully understand the very specific nature and degree of risk arising as a result of the parents' mental health?
2. Did practitioners fully understand, and take into account, how the mental illness and changing presentation of both parents interacted and affected their ability to safeguard their children?
3. Did practitioners examine, evaluate and understand the nature of, and the difference between, the parents' belief systems when both ill and well and the effect of those differences on the safety of the children?
4. Did the fact that the parents have a very specific religious belief system obscure and detract from recognition of the nature and risk of the very specific beliefs the children's mother held about the children when ill?
5. How did practitioners from each agency seek advice and gain understanding about the adult mental health issues?
6. Were isolated individual incidents where each child incurred injuries properly identified, assessed and evaluated, discussed on a multi-agency basis, and taken into account?"

15.3 The Findings of the Trust's Internal Investigation

15.3.1 The conclusions of the Internal Investigation/Independent Management Review was divided into two sections covering positive aspects of the care and treatment provided to Mrs A, Mr A and Child 1 and Child 2, and also covered areas which had caused the Panel concern.

The Positive Aspects

15.3.2 Seven positive aspects were identified:

1. Following the periods of puerperal psychosis in 2006 the specifics of the delusional beliefs were noted by both the Inpatient Team at Fulbourn Hospital and the Thumbswood Mother and Baby Unit.
2. There was effective follow-up of Mrs A by both the Home Treatment Team and the Community Mental Health Team Care Coordinator following discharge from the Thumbswood Mother and Baby Unit.
3. Following the telephone call from Mrs A's aunt in December 2008, CPN 2 promptly re-engaged with the family.
4. CPN 2 then promptly referred the family to the Children and Families Team.
5. There is strong evidence of frequent and ongoing multi-agency working, including at the Child Protection meeting in early 2009, and joint home visits, attendance at Child Protection Reviews and Children in Need Meetings and other multi-agency meetings.

   In the view of the external member of the Panel the level and quality of care provided by Dr 5 and CPN 2 was generally of a good standard and better than might commonly be provided by general adult mental health services.
6. Good perinatal awareness by Dr 5 and good mental state assessment. A good understanding of risk of relapse. Clear recommendation for hospital birth (if possible).
7. Generally good documentation and correspondence by the Cambridgeshire and Peterborough NHS Foundation Trust staff with evidence of letters copied to others involved. The use of the Care Programme Approach although somewhat limited was helpful.

Areas of Concern

15.3.3 There were six matters which caused the Internal Investigation Panel concern. These were:

1. The lack of consistent recording of the incident in November 2006 when Mrs A acknowledged that she had placed a pillow over Child 1's face and had held it there for a short time. This was in response to the delusion that Child 1 was strong and invincible. Child 1 had also been hit with a hairbrush. The 'at risk' categories were Risk of Physical Abuse and Neglect, but the pillow incident was described differently and it was not cited as a reason for Child 1 being placed on the At Risk Register, although the assault with the hairbrush is.

   The pillow incident is not mentioned again and CPN 2 was unaware that this had occurred. Dr 5 also in his letters to the GP does not refer to the pillow incident but to Mrs A assaulting Child 1 without describing the incidents. The Internal Investigation Panel considered that if there had been greater clarity about the nature of Mrs A's delusions and the risks arising from them in the event of a relapse, it is possible that the Child Protection Plans would have placed the children at the category of 'Risk of Physical Abuse' and not just neglect.

   Similarly the Care Coordinators in 2007 and 2008 both completed a Care Programme Approach Risk Assessment and Care Plan, but neither appears to have completed the more detailed CPA Assessment Form (Form 2). This may have assisted the team in carrying forward an accurate description of the assaults on Child 1 in 2006.

2. The multi-agency Child Protection Plan was weak, in particular lacking a clear timetabling/coordination which led to a lack of clarity of who was visiting and when.

3. The gap in contact by any service during the period from 09 June to 17 June 2009 was too long given the speed with which relapse can happen. The Crisis Resolution and Home Treatment Team could have been used to increase the level of contact and supervision. The family had received support from this Team previously in 2007.

4. The rationale for continuing with the arranged visit date of 17 June 2009 was reasonable in terms of balancing the need to maintain engagement and managing the risks in the longer term. However, given the known speed with which relapse

could occur, one of the agencies should have visited prior to 17 June 2009 as a means of maintaining the safety of the children.

5. There is emerging evidence from the Confidential Inquiry into Maternal and Child Death; Saving Mothers' Lives,[112] that the stress caused by Child Protection meetings can be associated with relapse in mental illness. This suggests that increased monitoring and support should be in place.

6. It was reasonable that on 17 June 2009 CPN 2 and Health Visitor 4 left the family home because of Mr A's behaviour given the perceived level of threat. They immediately started to organise a Mental Health Act assessment with Dr 5, and this was in place within two hours. They could not have anticipated that a fatality would occur in that time period. There were no grounds to suggest that Mr A was a risk towards his children or indeed Mrs A. CPN 2 heard Mrs A call to Mr A and although this was the extent to which CPN 2 could assess Mrs A there was nothing to suggest anything was amiss with her. CPN 2 could hear Child 2 'grizzling'. Child 1 did not appear upset. CPN 2 was concerned about Mr A's behaviour which was frightening, and took the view that their presence was inflaming the situation."

Key Learning Points

15.3.4 The internal Investigation highlighted five key learning points:

1. Despite a commitment to regular (at points daily) visits and generally good joint working between agencies, there was a lack of clarity about the plan of care, and who was visiting and when. This was particularly notable after the Child Protection Conference on 09 June 2009 when there appear to have been no visits by any agency until 17 June.

2. There is evidence in the documentation of awareness across all agencies of the connection between Mrs A becoming mentally ill, delusional ideas and potential harm to the children. However, greater detail of the potential for physical harm as a result of delusional beliefs would have been helpful.

3. The Child Protection Plans are vague, with only generalised comments about what actions each agency should take. As a document the layout is also hard to follow.

4. The detailed risk history tended to become lost or obscured in the case-notes over time, which in turn can lead to a lack of understanding or appreciation of a risk, especially where there are other complex issues alongside (such as in this case the parents' religious beliefs). Access to accurate historic information is essential.

5. The Child Protection process can be a stressful event for the parents, and there is emerging evidence that increased monitoring and support is needed around the time of Child Protection Conferences.

15.4 Recommendations

15.4.1 The Internal Investigation Panel made nine recommendations which are listed below:

1. The Cambridgeshire and Peterborough NHS Foundation Trust and its partner agencies should develop clear guidelines for the management of mentally ill women through pregnancy, delivery and the postpartum period.

2. The multi-agency Child Protection Care Planning Process for mentally ill women within the maternity and Social Care systems should ensure that there is a clear plan of how to manage a mentally ill mother through pregnancy, delivery and the postnatal period. The process should also ensure that all agencies are involved in the development and implementation of the Plan, and that this information is disseminated. This should include clarifying the role and membership of the Core Group.

3. Multi-agency Child Protection Care Planning needs to be clearer in terms of the intervention plan (specifying who is doing what, detailed home visiting timetable, what to look for etc.).

4. The Cambridgeshire and Peterborough NHS Foundation Trust should examine the current care pathways for mentally ill pregnant women and assess service provision to ensure that there is adequate specialist perinatal mental health expertise within the community mental health teams.

5. The Cambridgeshire and Peterborough NHS Foundation Trust should develop appropriate specialist perinatal health roles that suit the local service structure and

population. This may include revising and refocusing the current perinatal nurse role and developing dedicated consultant psychiatry sessions. The service should examine the interface with Maternity and Community Mental Health Teams, Primary Care and Child and Families Social Care.

6. All staff should receive adequate training on the specific risks posed to an infant when a parent has mental illness.

7. The Cambridgeshire and Peterborough NHS Foundation Trust should ensure that all staff complete the Care Programme Approach documentation, including a detailed Care Programme Approach assessment.

8. The Cambridgeshire and Peterborough NHS Foundation Trust should continue implementing the electronic Care Programme Approach reporting, the aim of which is to increase timely access to past and current Care Programme Approach documents.

9. Staff are to be commended for the amount of effort and time they put in to engage and support the family and staff from other agencies.

14.5 Progress in Implementing the Internal Investigation Recommendations

Recommendation	Action	Staff	Progress	Evidence of Progress
1) That the Trust and partner agencies should develop clear guidelines for the management of mentally ill women through pregnancy, delivery and the postpartum period	The Trust will review and strengthen the care pathway for mentally ill women during the perinatal and post-natal period. This will include the creation of clear guidelines and a review of professional roles	Senior Manager 1	**Completed** The multi-agency document "Safeguarding Children who have a Parent or Carer with Mental Health Problems Guidance for Effective Joint Working", has been updated and ratified by the LSCB. It includes clear guidelines for management of women during the perinatal period.	Consultant Work Plan Joint Working Guidance
2) That the multi-agency child protection care planning process for mentally ill women within maternity and social care systems should ensure that there is a clear plan of how to manage a mentally ill mother through pregnancy, delivery and the postnatal period. The process should also ensure that all agencies are involved in the development and implementation of the plan, and that this information is disseminated. This should include clarifying the role and membership of the Core Group	a) The Trust will fully participate in a multi-agency review of the child protection process for mentally ill women during the perinatal period, including review of the CP planning process.	Senior Manager 1	a) **Completed** Discussed with SASU 20.5.10. The "Joint Working Guidance" has been revised and updated to clarify how perinatal mental health problems should be managed within the child protection process. A number of agencies were consulted about the content, including Children's Social Care and it incorporated feedback from multi-agency events delivered soon after the completion of the SCR. This guidance was ratified by the multi-agency LSCB Policy and Procedure Committee following feedback and amendments. The Guidance is now on Cambridgeshire and Peterborough LSCB websites and is used as the basis for multi-agency training. The Trust has trialled a system for monitoring staff involvement in CP conferences. The Safeguarding Team are now working with the Local Authority Safeguarding Managers to improve attendance and engagement of Trust staff. A joint audit of child protection conferences is also planned for early 2012 with Cambridgeshire Children's Social Care.	Joint Working Guidance

Recommendation	Action	Staff	Progress	Evidence of Progress
3) That multi agency child protection care planning needs to be clearer in terms of the intervention plan (specifying who is doing what, detailed home visiting time table, what to look for etc).	b) The Trust will identify adult mental health team leaders in Hunts, Fens, Cambridge and Peterborough to work with the Trust's Safeguarding Children coordinator to create locality based "working together" events with children's social care. These learning and development events will be focused on parental mental health.	Safeguarding Manager 1	b) **Completed.** A project group consisting three senior managers delivered 3 locality based events during March. A team leader rep from adult mental health services was involved in the planning and attended the events. Additional guidance for Trust staff regarding the child protection process has been developed as a handbook and circulated widely to staff. It includes extra guidance regarding involvement with CP conferences, CP planning and communicating effectively with other agencies regarding parental MH problems	Event flyers, timetable and attendance lists Trust Safeguarding Handbook Staff briefing on how to contribute effectively to child protection conferences
4) That CPFT should examine the current care pathways for mentally ill pregnant women and assess service provision, to ensure that there is adequate specialist perinatal mental health expertise within community mental health teams.	<u>Phase 1</u> The Trust's existing Perinatal Mental Health Development Group will, in association with Cambridgeshire NHS, create a first draft service model and pathway <u>Phase 2</u> Partner agencies and other stakeholders will be invited to comment and develop a final draft care pathway and roles.	<u>Phase 1</u> Senior Manager 2. 1st Draft. 15th Feb 2010 <u>Phase 2</u> Senior Manager 2 Final Draft. 31st March 2010	**Completed.** The Perinatal Mental Health Development Group has produced a perinatal pathway for pregnant women with current serious mental illness. This has been developed into a Standard Operating Procedure (SOP). This group and Safeguarding Children Team have produced a Perinatal mental illness guide for staff. It includes the SOP. This has been circulated widely in the Trust during September 2011. Work is underway to complete an SOP for management of mentally ill women during the post-natal period.	Pathway documents and meeting minutes.

Recommendation	Action	Staff	Progress	Evidence of Progress
5) That the CPFT should develop appropriate specialist perinatal mental health roles that suit the local service structure and population. This may include revising and refocusing the current perinatal nurse role and developing dedicated Consultant Psychiatry sessions. The service should examine the interface with maternity and, CMHT, primary care and Child and Families Social Care	Develop and agree perinatal service model. Implementation and audit		**Partly Completed** Dr 7, Consultant Psychiatrist is now providing two dedicated perinatal sessions a week for mentally ill women which strengthens the perinatal resource in the Trust. She is also a source of support and expert advice for colleagues. The recruitment of a perinatal nurse specialist for Peterborough has been included in the service transformation plans for adult mental health services. The consultation process is currently underway	
6) That all staff should receive adequate training on the specific risks posed to an infant when a parent has mental illness.	a) The Trust will deliver seminars to staff regarding the lessons learned from the SCR. b) Trust staff will be invited to attend the locality "working together" events.	Safeguarding Manager 1	a) **Completed** A number of staff seminars were delivered within the Trust. A 'learning the lessons' seminar for senior Trust staff was delivered on 16.2.10 and feedback has been given separately to the clinical team. In addition the Safeguarding Team contribute to a rolling programme of multi-agency training delivered by the Trust and by Cambridgeshire and Peterborough LSCBs. Dr B also delivers regular workshops and seminars to multi-agency audiences e.g. LSCB Local Practice Groups. b) **Completed.** Three locality based events took place during March attended by Trust staff	Seminar programme Agenda and attendance list. Event flyers, timetable and attendance lists

Recommendation	Action	Staff	Progress	Evidence of Progress
7) That CPFT should ensure that all staff complete the CPA documentation, including a detailed CPA assessment	The Trust will continue to conduct monthly CPA audits which will be monitored through Directorate Management Teams and Clinical Effectiveness Committee	Director 1	CPA monitoring is ongoing. This year the Trust has undertaken a CPA care plan review across inpatient and community settings.	CPA monitoring reports
8) The Trust to continue implementing electronic CPA reporting, the aim of which is to increase timely access to past and current CPA documents	Implement Lorenzo (national electronic care records system)	Director 2 By end 2010	**On-going.** The Trust took the decision not to adopt the national care records system Lorenzo due to circumstances outside its control. The Trust is now in the final stages of a procurement process to buy an alternative system. The system requirements have been developed with clinical input and are designed to improve practice.	
9) Staff to be commended for the amount of effort and time they put in to engage and support the family and staff from other agencies	A letter will be sent to staff involved from the Director of Adult, Older Peoples and Specialist Mental Health Services	Director 1	**Completed**	Letter

Comments

15.5.1 The Cambridgeshire and Peterborough NHS Foundation Trust Internal Investigation/Independent Management Review was a rigorous and thoughtful process which raised many of the same issues as this Independent Investigation. The main differences are that the Trust Review interviewed only four members of staff and therefore did not have the benefit of testing the nature of the involvement of several staff from the same organisations which helped to triangulate our evidence, with staff being able to confirm that their colleagues were following the same treatment plan as them.

15.5.2 As a result of a larger group of witnesses additional issues have emerged in the Independent Investigation, particularly the lack of challenge to the family about their non-compliance with the advice of mental health staff regarding medication and from health and social care staff about their social isolation.

16. Notable Practice

16.1 There were some examples of good practice during the 30 months Mrs A was known to the Cambridgeshire and Peterborough NHS Foundation Trust. The Independent Investigation Panel selected the following examples of notable practice:

- the work of the staff at the Thumbswood Mother and Baby Unit in helping Mrs A understand to the best of her ability the nature of her illness and the consistent and firm way in which they highlighted the main causes of a relapse and the signs to look for as indicators of that relapse;
- the work of the Home Treatment Team which responded well to the relapse Mrs A had in June 2007. The team changed their referral criteria for Mrs A as when first referred her referral from the CMHT had been refused as the Care Coordinator had not seen Mrs A in the 24 hours prior to the referral. The Home Treatment Team also appeared to have more success in discussing the need to take prescribed medication than other services, although this may have been because it was offering an alternative to inpatient admission;
- the action of Dr 5 following the death of Child 2 in going to the surgery of GP 3 to see if he could help in any way and in supporting the staff involved.

16.2 It was also of note that the families of both Mrs A and Mr A tried to help as best they could despite the attempts of both to cut all ties and relationships. Mrs A's mother held the situation together after Child 1 was born and provided added protection despite knowing that she was not really appreciated by her daughter and son in law. The wider family of both Mr and Mrs A also gave support as and when they could. Mrs A's aunt had also provided considerable support to Mrs A when she first became ill in England in 1995 and 2002, and also tried to assist as far as she was allowed by Mr and Mrs A throughout the period from November 2006 to June 2009.

17. Lessons Learned

17.1 The main lessons learned are reflected in the recommendations. Where service users are reluctant to follow professional advice it is important to try to actively engage them and to persist in providing relevant information. Services should be assertive when they know that a service user is likely to relapse but they refuse to take the prescribed medication and try to avoid contact with services.

17.2 Staff working with service users with complex mental health issues, and who are also living in isolated social situations, need to understand the relapse indicators so that they can intervene appropriately and in a timely fashion by using the Mental Health Act. The relapse signature of the service use is a good indicator of their starting to become unwell.

17.3 The loss of a significant fact which if known would have raised the risk level Mrs A would pose to Child 2, and to Child 1, should she relapse in the post partum period. The fact that in November 2006 Mrs A had held a pillow over Child 1 and could have suffocated her was 'lost' after the first Child Protection Conference, and had been mislaid in the way records for midwives and health visitors were stored prior to 2009. Staff accepted that they would have reacted differently had they been aware of this incident.

17.4 The main lesson from the Report is that where several agencies are working with a family and there are concerns about the health and safety of family members a lead member of staff from one of the agencies should be designated as the lead manager so that the arranging of visits can be coordinated to best effect. This may entail ensuring that the family are visited by a professional every day so that the health of the family members can be assessed every 24 hours. There should also be an action plan should the service user be assessed as becoming more unwell which can be brought into action immediately.

17.5 Prior to the birth of Child 2 the Mental Health Services had identified that once the baby was born Mr and Mrs A would require regular home visits at least once a day. The involvement of the Home Treatment Team was proposed but in the event there was little additional visiting after the midwives had followed Mrs A up for the required 10 days from the birth. A daily visit would have allowed the multidisciplinary and multiagency staff to have known how Mr and Mrs A were from the observations of whichever member of staff visited, and this would have enabled them to intervene in an appropriate and timely way.

18. Recommendations

18.1 The Independent Investigation Panel would have made some recommendations about the development of a comprehensive Perinatal Mental Health Service across the Cambridgeshire and Peterborough NHS Foundation Trust area, but is confident that the recommendations made by the Trust's Internal Investigation and Independent Management Report of November 2009 have adequately covered the areas where there was concern. The Action Plan developed to implement the recommendations of that Report has been completed.

18.2 The nine recommendations listed below seek to improve the services provided by the Cambridgeshire and Peterborough NHS Foundation Trust and its partner agencies.

1. Where a person has the care of, or regular contact with, a baby or young child and s/he has a mental illness or it is reasonable to assume that their mental illness is likely to recur:
    - a clear crisis and contingency plan will be required and must be shared with members of the treating team;
    - a plan of action should be put in place addressing the needs and well-being of the child and of the service user;
    - the plan should identify any risk factors or triggers and how these should be monitored;
    - the plan should clearly identify the actions to be taken and by whom when changes in the risk posed by the service user are identified;
    - the plan should be shared with, and where appropriate agreed with, relevant professionals and agencies as recommended by best practice;
    - where appropriate, the plan should be shared with, and where appropriate agreed with, relevant family members;
    - the plan should be shared with and, where appropriate, agreed with the individual;
    - a date on which the plan will be reviewed and who will be responsible for ensuring the review takes place should be identified;
    - the Trust should ensure that a monitoring system is put in place to ensure that this policy is being followed.

2. Where a service user has fundamental and unusual religious beliefs to which they totally adhere, the clinicians might debate what the delusions and ideation of the parents were, but from a clinical perspective should determine whether the Mental Health Act criteria are met. The Social Care Services should concentrate on determining whether the parents' beliefs are impacting negatively on the children and if this requires intervention under the Safeguarding Children Legislation. The following must be considered:
    - the Trust should ensure that a clear protocol is put in place to ensure that these assessments take place in a timely manner;
    - all relevant clinical staff must be provided with appropriate training to ensure that they are equipped to undertake these assessments in a competent fashion;
    - the Trust should ensure that supervision, advice and consultation are available to all clinical staff to ensure that these assessments are undertaken in a safe and competent manner;
    - the Trust should put in place a system to ensure that best practice, as embodied in the protocol, is being followed; these monitoring systems should look at the quality of the assessments as well as the occurrence of the assessments.

3. A relapse signature should be identified for all service users as part of their risk assessment:
    - this should be readily available to all relevant clinical staff;
    - it should be used routinely in monitoring the individual's mental health and the risk s/he poses;
    - the Trust should put in place a system, including an audit system, to assure itself that:
        i. relapse signatures are routinely identified as part of the risk assessment and planning process;
        ii. that these are of an acceptable quality;
        iii. that they are employed in a routine manner when monitoring the individual's well-being and mental health;
        iv. that they are readily accessible to relevant clinical staff and where necessary with the staff of other agencies involved with the family;

4. Families or individuals must not be deprived of appropriate clinical services because their beliefs make them difficult to engage. The following must be considered:
    - the Trust is responsible for ensuring appropriate provision is made to engage those who are reluctant, for whatever reason, to become involved with clinical services;
    - the Trust must ensure that clear protocols are in place to ensure that individuals and/or teams, such as assertive outreach teams, are available to aid in the engagement of difficult to engage individuals and ensure that a service is delivered to those who are difficult to engage;
    - the Trust must ensure that advice, supervision and consultation are available to clinical staff to ensure that they are adequately equipped to deliver clinical services to those who are difficult to engage;
    - the Trust should put in place a system to monitor the effective engagement of service users and assure itself and its commissioners that those needing its services are not being unnecessarily excluded.

5. The Trust must ensure that people who doubt or reject their diagnosis of mental ill health are assertively followed up by community services, especially if they have psychosis and/or are likely to relapse. The following should be considered:
    - work on enabling the individual to recognise the signs of relapse and how this should be addressed should, wherever possible, be begun while the service user is in hospital or under the care of the Crisis and Home Treatment Team;
    - those providing clinical services for such individuals should regularly rehearse with them their relapse signatures and risk factors, and review with them whether these are present and what actions might be taken;
    - the Trust must ensure that clinical staff have appropriate training and supervision;
    - the Trust should put in place a system to assure itself that this is happening, this might include the auditing of plans, the scrutinising of clinical notes and audit of supervision records where these are available.

6. The Trust has a responsibility to ensure that its policies including its Transfer of Cases Policy are being implemented in a consistent and appropriate manner:
    - the Trust should have in place systems, including both regular and unannounced audit, to assure itself that its policies are being consistently and appropriately implemented;
    - this programme should be overseen by the Trust's Governance procedures;
    - systems should be put in place to ensure that staff are aware of, and can obtain advice on, current Trust policies;
    - team managers have a responsibility to ensure that Trust policies are being appropriately implemented within the teams they are responsible for, whether they are realising this expectation should be part of both their supervision and appraisal.

7. The Trust needs to help staff to work with the carer of a service user with mental ill health who is viewed as intimidating and who may be unreliable in summoning help should there be a crisis. The Trust must:
    - develop a protocol; and
    - put in place appropriate training and supervision;
    - the Trust should put in place appropriate monitoring systems to assure itself and its commissioners that service users are not being unnecessarily deprived of a safe and timely service in these circumstances.

8. Where a service user does not comply with clinical advice about their mental ill health and their child is subject to a Child Protection Plan formal steps must be taken to ensure the child's/or childrens' safety needs are met. The following must be ensured:
    - the mental health care needs of the parents should be built into the Child Protection Plan;
    - the statutory levers that S44 of the Children Act 1989 provides if a court is satisfied that there is reasonable cause to believe that a Child is likely to suffer significant harm if he/she is not removed to accommodation; or he/she does not remain in the place in which he/she is then being accommodated.

9. The Trust must as a matter of urgency ensure that all staff are aware that, under the remit of the Mental Health Act 1983 (as amended 2007), if there is concern about a service user relapsing they are legitimately able to undertake/refer for an emergency Mental Health Act assessment. The Trust should provide:

- regular training for all staff on the provisions of the Act and on which best practice guidance should be put in place;
- supervision and advice on the implementation and use of the Mental Health Act should be put in place; and
- the Trust should put in place a monitoring system to assure itself and its commissioners that the Mental Health Act is being implemented in line with best practice.

19. Glossary

The Table below describes some of the more technical words used in this Report such as the function of various mental health teams and the use of various drugs used in the treatment of mental disorder.

Terms used in the Report	Definition
Assertive Outreach Team	A specialist community mental health team specialising in working with people with a severe and enduring mental illness who find it difficult to engage with services.
BD	Twice daily – usually showing when medication should be taken
Bipolar Affective Disorder	A condition where the service user experiences mood swings of greater variation than the norm, and can become manic and also depressed.
Calpol	A brand of medicine for infants and children containing paracetamol for use as an analgesic for teething and other pains and to lower fever.
Care Coordinator	This person is usually a health or social care professional who co-ordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach	A National systemic process to ensure assessment and care planning occur in a timely and service-user centered manner.
Carer Assessment	Since the Carers Act (Equal Opportunities) 2005 and the Carers and Disabled Children Act 2000, all carers have a right to an assessment of their needs. This is mandatory and all Local Authorities have a duty to advise carers of their rights to an assessment.
Chlorpromazine (CPZ)	Better known as largactil and is used as a typical antipsychotic medication to reduce the symptoms. More modern antipsychotic drugs are now used and are atypical.
Community Mental Health Team	A multidisciplinary team of professionals and support staff who provide services to people with mental health problems within their local community.

Crisis and Home Treatment Team	A specialist adult mental health team providing a rapid response to a crisis in the community with the ability to decide if hospital is required, or if the crisis can be treated in the service user's own home. The Home Treatment Team provides an intensive treatment service in the home often visiting and contacting the service user and their cares several times a day as required.
Haloperidol	An anti-psychotic drug which blocks receptors in the brain thus reducing the effects of the psychiatric condition. It can help to regulate mood and behaviour.
Home Start	An independent organisation which aims to increase the confidence and independence of families by visiting them in their own homes and offering support, friendship and practical assistance.
Hypomanic	A mood state with persistent and pervasive euphoric or irritability associated with grandiose ideas and behaviours.
Lithium	It is often used to help prevent the reappearance of severe swings in mood after an acute episode of Bipolar Affective Disorder.
Lorazepam	A benzodiazepine used to treat anxiety disorders.
Mental Health Act (MHA)	The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people.
MHA Section 2 : Admission for Assessment	This allows for admission for assessment (which may be followed by medical treatment) for up to 28 days.
MHA Section 3 : Admission for Treatment	This Section provides for the admission of a patient to hospital and his detention for a maximum period of 6 months (unless the order is renewed).
MHA Section 136 Ability for Police to remove someone they suspect has a mental disorder to a Place of Safety	Ability for Police to remove someone they suspect has a mental disorder to a Place of Safety – usually a special Section 136 Suite at a mental health facility or a Police cell. The former is regarded as good practice.
Mother and Baby Unit	A specialist mental health unit for mothers suffering postnatal illnesses such as post natal depression and puerperal psychosis. The aim is to help the new mother to manage her illness and to be helped to care for her baby.
Mood Stabilisers	Medication used for the treatment of Bipolar Affective Disorder with the aim of maintaining the person's mood at a reasonable level.

PRN	*Pro re nata* – Latin meaning 'when necessary'. Usually to provide tranquillisers when a service user is becoming agitated.
Psychotic symptoms	Symptoms of a psychotic disorder vary from person to person and may change over time. The major symptoms are auditory or visual hallucinations (unusual sensory experiences or perceptions of things that aren't actually present) and delusions (false beliefs that are persistent and sometimes organised, and that do not go away after receiving logical or accurate information).
Risperidone	It is a second generation or atypical antipsychotic. It is used to treat schizophrenia (including adolescent schizophrenia).
Serious Untoward Incident (SUI)	An incident which causes a major problem, usually involving harm to an individual by accident, suicide or homicide. It also includes absconding from a secure ward. Any event which may cause harm to service users, the public or staff.
Sulpiride	An atypical antipsychotic drug.

20. References

1 DoH Guidance EL (94)27, LASSL (94) 27
2 Haringey Local Safeguarding Children Board, Serious Case Review 'Child A' 2008
3 Transcript 1
4 Clinical notes Vol 5 Page 61
5 Clinical notes Vol 5 Page 145
6 Clinical notes Vol 5 Page 61
7 Clinical notes Vol 5 Page 62
8 Clinical notes Vol 4 Pages 146-148
9 Clinical notes Vol 4 Page 16-17 and 48
10 Clinical notes Vol 4 Page 59
11 Clinical notes Vol 4 Page 60
12 Clinical notes Vol 4 Pages 64-66.
13 Clinical notes Vol 4 Pages 90- 93
14 Individual Management Review (Children's Services) Page 13 Para.28
15 Clinical notes Vol 4 Page 97
16 Clinical notes Vol 4 Page 124/125
17 Clinical notes Vol 4 Page 110
18 Clinical notes Vol 4 Page 112
19 Clinical notes Vol 4 Page 41 and 103
20 Clinical notes Vol 4 Page 164
21 Clinical notes Vol 4 Page 105
22 Clinical notes Vol 4 Page 106 and Vol 1A pg 46
23 Clinical notes Vol Ia Page 27
24 Clinical notes Vol Ia Page 46
25 Clinical notes Vol Ia Pages 70-76
26 Clinical notes Vol Ia Page 49
27 Clinical notes Vol Ia Page 382
28 Clinical notes Vol Ia Pages 142-144
29 Clinical notes Vol Ia Page 384
30 Clinical notes Vol 1a Pages 123-125
31 Clinical notes Vol Ia Pages 55-61
32 Clinical notes Vol Ib Page 51
33 Clinical notes Vol Ia Pages 371-372
34 Clinical notes Vol Ia Pages 375
35 Clinical notes Vol Ia Pages 59-61
36 Clinical notes Vol Ib Pages 60/61.
37 Clinical notes Vol Ib Page365
38 Clinical notes Vol 1a Page 179/180
39 Clinical notes Vol 1a Pages 362-364
40 Clinical notes Vol 1a Pages239-245
41 Clinical notes Vol Ia Pages 284-290
42 Clinical notes Vol 1a Pages 325-328
43 Clinical notes Vol 1a Page 315
44 Clinical notes Vol 1a Page 305-312
45 Clinical notes Vol 1b Page 204
46 Clinical notes Vol 1b Page 66
47 Clinical notes Vol 1b Page 67 and 200
48 Clinical notes Vol 1b Page 68 and 238
49 Clinical notes Vol 1b Page 69
50 Clinical notes Vol 1b Page 149
51 Clinical notes Vol 1b Page 70
52 Clinical notes Vol 1b Page 71/72
53 Clinical notes Vol 1b Pages 154-158
54 Clinical notes Vol 1b Pages 73-77 and 232-236
55 Clinical notes Vol 1b Page 151
56 Clinical notes Vol 1b Page 83
57 Clinical notes Vol 1b Pages 111-127
58 Clinical notes Vol 1b Page 84
59 Clinical notes Vol 1b Pages 90-96
60 Clinical notes Vol 1b Pages 98-99
61 Clinical notes Vol 1b Pages 213/214
62 Clinical notes Vol 1b Page 103
63 Clinical notes Vol 4 Page 60
64 Clinical notes Vol 4 Page 164
65 Clinical notes Vol 1a Pages 362-364
66 Clinical notes Vol Ib Page365
67 Clinical notes Vol 1b Page 69
68 Clinical notes Vol 1b Page 70
69 Clinical notes Vol 1b Pages 73-77 and 232-236

[70] Clinical notes Vol 1b Page 151
[71] Clinical notes Vol 1b Pages 213/214
[72] Clinical notes Vol Ia Pages 142-144
[73] Clinical notes Vol 1b Page 69
[74] Clinical notes Vol 1b Page 149
[75] Clinical notes Vol 1b Page 84
[76] Clinical notes Vol 1b Page 103
[77] Clinical notes Vol Ia Pages 55-61
[78] Clinical notes Vol 1a Pages 325-328
[79] Clinical notes Vol 1b Page 149
[80] Clinical notes Vol 1b Page 70
[81] Clinical notes Vol 1b Pages 73-77 and 232-236
[82] National Service Framework for Mental Health : Modern Standards and Service Models; DH:1999
[83] Mental Health Policy Implementation Guide : DH: 2001
[84] Clinical notes Vol Ib Page365
[85] Clinical notes Vol 1b Page 149
[86] Clinical Notes Vol 4 Pages 77 and 81
[87] Clinical Notes Vol 4 Page 92
[88] Clinical Notes Vol 1A Page 75
[89] Jones I, Heron J, Roberston Blackmore E. Puerperal Psychosis. In: The Oxford Text Book of Womens Mental Health. (2010) Eds Cohen. Oxford University Press
[90] Jones I, Craddock N. (2005) Bipolar disorder and childbirth – the importance of recognising risk. Br J Psych186: 453/4
[91] CEMACH The Confidential Enquiry into Maternal and Child Health. 2007. http://www.cemach.org.uk.
[92] Munk-Olsen T, Laursen TM, Pedersen CB, et al. 2006. New parents and mental disorders: a population based register study. JAMA, 296(21),p.2582-2589
[93] Jones I, Green E, Hamshere M, et al. Pathway analysis of vulnerability to postpartum episodes in bipolar women implicates genes known to be involved in pre-eclampsia. Presented at the ISPG Meeting, Athens October 2010.
[94] Brockington IF, 1996. Puerperal Psychosis. In Motherhood and Mental Health. Oxford: OUP. P.200-284.
[95] Robertson E, Jones I, Haque S, et al. 2005. Risk of puerperal and non-puerperal recurrence of illness following bipolar affective puerperal (post-partum) psychosis. British Journal of Psychiatry,186,p.258-259
[96] Jones I, Craddock N. Familiality of the puerperal trigger in Bipolar Disorder: results of a family study. American Journal of Psychiatry.2001;158:913-917
[97] Viguera AC, Nonacs R, Cohen LS, et al. 2000. Risk of Recurrence of bipolar disorder in pregnant and nonpregnant women after discontinuing lithium maintenance. Am J Psych,157,p.179-184.
[98] Dowlatshahi D, Paykel ES, 1990. Life events and social stress in puerperal psychosis: absence of effect. Psychological Medicine, 20, p.655-662
[99] Marks MN, Wieck A, Checkley SA, Kumar R. 1991. Life stress and postpartum psychosis: a preliminary report. British Journal of Psychiatry,158,p.45-49
[100] Munk-Olsen T, Laursen TM, Mendelson T, et al. Risks and predictors of readmission for a mental disorder during the postpartum period. Arch Gen Psychiatry. 2009 Feb;66(2):189-95.
[101] Clinical notes Vol 5 Page 61
[102] Clinical notes Vol 5 Page 62
[103] The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DH; 1990
[104] Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach; DH; 1999
[105] Refocusing the Care Programme Approach, policy and positive practice; DH; 2008
[106] Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DH 1995
[107] Callaghan and Waldock Oxford Handbook of Mental Health Nursing 2006 pg 36
[108] Clinical Notes Vol 1A Page 75
[109] Individual Management Review (Children Services) Page 55 Para.179
[110] Individual Management Review (Children Services) Page 54 Para.178
[111] Cambridgeshire and Peterborough Foundation NHS Trust IMR and SUI Report on Child 2
[112] Confidential Inquiry into Maternal and Child Death : Saving Mothers' Lives – Reviewing maternal deaths to make motherhood safer 2003-2005 (December 2007)