Derby and Derbyshire
Safeguarding Children Partnership

CHILD SAFEGUARDING PRACTICE REVIEW

BABY RD

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FINAL
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INTRODUCTION

1. In the Summer of 2020, the police received a call that a woman was missing from home. She had recently given birth to a baby, known to this review known as Baby RD.

2. Baby RD's mother was known to have a history of mental ill-health and some years earlier had been diagnosed with bipolar affected disorder[1]. Both her children had been safely left with a relative and the family were very concerned for her safety

3. To protect identity, the mother is known as Ms RDS and the child's father as Mr RDS. The older child in the family is known as O-RD.

4. A few hours after the call, the police located Ms RDS in a precarious public place, she told the officers she was feeling suicidal.

5. Having made some enquiries, the police officers took Ms RDS to a local psychiatric hospital where she had been treated before. Ms RDS was admitted as a voluntary patient, the hospital has a mother and baby unit (MBU) and a few days later Ms RDS' baby was admitted to be with her. The older child remained at home with their father, Mr RD.

6. The MBU knew Ms RDS, Baby RD and the family from previous admissions and were observant as she settled into the daily routine and was receiving treatment. Within the context of her diagnosis, nothing particularly unusual or unexpected was noted in her demeanour.

7. Two weeks after the admission, Ms RDS was discovered holding Baby RD who was unresponsive; an ambulance was called but sadly, Baby RD died.

8. Ms RDS admitted she had caused Baby RD's injuries and was subsequently charged, convicted, and sentenced.

9. When these events were reported to the Safeguarding Children Partnership, a Rapid Review [2] was instigated and the outcome was to commission a Child Safeguarding Practice Review. (CSPR)

[1] Bipolar Affected Disorder, this is a mental illness characterised by episodes of disturbed mood which may be of depression or elation and which can vary in duration. Episodes of depression are usually more common. There can be long periods of stability of mood between episodes.
[2] Rapid Review and CSPR

SUMMARY OF SIGNIFICANT EVENTS

As a teenager	Ms RDS was diagnosed with bipolar affective disorder.
2018	Ms RDS older child (O-RD) was born, and Ms RDS was admitted to the MBU with post-natal psychosis.[3]
2019	Ms RDS was pregnant with Baby RD. A referral was made by her GP to the peri-natal mental health team. Ms RDS's medication and well-being were monitored and the pregnancy continued without incident.
2020	Baby RD was born, delivery was normal and the baby was healthy. Ms RDS spent 2 weeks in the MBU as a precautionary measure. This was a planned admission and was uneventful.
Two weeks after discharge	Ms RDS' symptoms worsened and she was re-admitted with Baby RD. They remained in the MBU for 7 weeks.
At the same time… Covid 19	During Ms RDS' stay, the COVID 19 pandemic led to severe restrictions.
Six weeks after discharge	Ms RDS self-reported her mental health was deteriorating and asked for an urgent appointment with the psychiatric consultant. A video call was arranged.
10 days after the consultation	Ms RDS was missing from home and suicidal. The police found her and facilitated admission to the MBU.
Two weeks after admission	Baby RD was found unresponsive and died.

[3] Post-natal psychosis also known as postpartum psychosis, or puerperal psychosis, it is a rare but serious and potentially life-threatening mental health issue. It takes the form of severe depression or mania or both.

KEY LINES OF INQUIRY

10. The Rapid Review gathered detailed information about the events and professional interventions with the family, from the notification of Ms RDS' second pregnancy to the date of Baby RD's death, a period of 12 months.

11. The relevant family history, particularly Ms RDS' diagnosis and depression when her first child was born, was also considered.

12. A complaint had been made by Ms RDS' family about the standard of care during her first pregnancy. The subsequent investigation found serious failures and the NHS Foundation Trust issued an apology to the family. The outcome of this complaint was also considered as part of this review, in particular by exploring the standard of care during Ms RDS' second pregnancy with Baby RD.

13. From the Rapid Review the following lines of inquiry were identified as providing opportunities for learning:

    - The potential impact of a parent's significant mental ill-health on their children and in particular the challenge of assessing risk when the illness is of a cyclical nature
    - The role of Early Help for vulnerable parents, making a referral and planning intervention
    - The response to emergency situations, for example suicidal behaviour or attempts to harm a child when the adult concerned is a parent, how embedded is the "think family" message
    - Learning from the response to the Covid 19 pandemic

14. The findings from the Review are for some, new learning, and for others may stimulate thinking and be reminders of good practice.

15. A comprehensive review has also been carried out by Derbyshire Healthcare NHS Foundation Trust (DHCFT). The report is not published but has been seen by the Safeguarding Children Partnership, the findings are consistent with those of this review.[4]

ANALYSIS AND LEARNING

Pregnancy and Birth

16. Ms RDS' older child had been born about 3 years before Baby RD's death. The birth had been traumatic and Ms RDS' family felt that the care she received throughout the

[4] This report is not published but is available to members of Baby RD's family and will form the basis of learning and any agreed policy changes within the DHCFT.

pregnancy had had been inadequate. They made a complaint which was investigated by the NHS Foundation Trust which provides midwifery and obstetric care.

17. The findings indicated that Ms RDS had not been referred (by the midwife) to the peri-natal mental health service, despite her significant mental health history. The investigation concluded that this was a significant omission which impacted on subsequent experience as she became unwell post-natally after the birth of O-RD.

18. Ten days after giving birth to O-RD, Ms RDS had been admitted to the MBU with post-natal psychosis, she received appropriate treatment and recovered. The adult mental health service and the peri-natal consultant reviewed Ms RDS' progress a year after she had given birth and reported that her mental health was stable.

19. When she became pregnant again, Ms RDS contacted her GP early in the pregnancy and the GP, who was aware of Ms RDS' history, made an urgent referral to the peri-natal mental health service. This led to immediate and appropriate intervention from the peri-natal team.

20. Midwifery records are specific to each pregnancy and are not transferred or carried forward, and the midwife was dependent on Ms RDS to share details of her previous pregnancy. Reports suggest that Ms RDS had good insight into her mental health and was generally open with professionals about her medical history, although they also suggest she was not always forthcoming about how she felt on any particular day, tending to minimise any difficulties.

21. During this pregnancy, Ms RDS' health was carefully monitored by the peri-natal service, her medication was kept under review, nothing of significance was noted. This was a very different response from that to Ms RDS' first pregnancy and Ms RDS' family report that they felt the standard of care was good.

22. There were no indications of a need for a pre-birth assessment as Ms RDS had engaged well with the services, had good family support and there were no safeguarding concerns.

23. Baby RD was born just as the Covid pandemic hit the UK and lockdown restrictions were imposed. Ms RDS and Baby RD were admitted to the MBU as a precautionary measure because of Ms RDS' diagnosis, previous history of post-partum psychosis and the high chance of relapse.[5]

Health Visiting

[5] We know from research that about 50% of women with bipolar are likely to have some sort of episode during pregnancy or postnatally. 20-25% of women with bipolar will experience postpartum psychosis (PP), which is more severe and requires emergency treatment usually a stay in hospital.
Bipolar and pregnancy: decision, decisions... | Bipolar UK

24. Health Visiting would normally carry out an ante-natal visit but this didn't happen because of an administrative error by midwifery, which incorrectly recorded Baby RD's due date. It was after the birth that a Health Visitor was allocated and the new birth visit was undertaken when Baby RD was two weeks old.

25. Although there is evidence of discussion, Health Visiting did not utilise any of the tools designed to assess a new mother's mental health because Ms RDS was already receiving care from the specialist in-patient unit.

26. Both children were under the care of the Health Visitor with O-RD continuing to be offered the universal Health Visiting service. Baby RD was assessed and offered a targeted service which was Universal Plus, this acknowledges that the further support, assessment of need and intervention is required. On reflection the service has suggested that considering the family as a whole, a more targeted approach, Universal Partnership Plus Health Visiting[6] would have been more appropriate.

27. Two weeks after returning home, Ms RDS was re-admitted to the MBU with Baby RD and spent seven weeks receiving treatment. Ms RDS reported that she particularly struggled with her mental health when she was sleep deprived and reports suggest that she struggled to care for the new baby and the older child, who was still a toddler. It is not uncommon for patients on the ward to go home during the day and return to the MBU at night and this was the plan for Ms RDS.

28. Health Visiting were kept informed by the MBU and visited again when Baby RD was 12 weeks old. By this time the Covid restrictions had been imposed.

29. Discussion with the practitioners indicate that it is likely that the restrictions would have had a significantly negative impact on Ms RDS. Family support became limited and community resources had closed down. Ms RDS reported that she was unable to participate in many of her usual activities, she missed physical exercise and spending time with friends and other parents.

30. There is no record of a discussion between health visiting and Ms RDS about the change in circumstances or any indication of how this might be mitigated. Her recent discharge from the MBU and the safety plan if she were to experience further symptoms or suffer a relapse, were not discussed with the Health Visitor.

31. The discharge summary from the MBU noted that Ms RDS had good family support and was compliant with taking prescribed medication, showed insight into her illness, and had made good progress.

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[6] Universal Partnership Plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time. These include services from Sure Start Children's Centres, other community services including charities and, where appropriate, the Family Nurse Partnership The service will be available in convenient local settings, including Sure Start Children's Centres, and health centres, as well as through home visits.

32. A few weeks after discharge Ms RDS was in contact with community health visiting through a telephone advice service, Single Point of Access (SPA), when she sought advice on feeding and weaning. During these calls she described finding lockdown difficult but said she felt well.

33. Eight weeks after her discharge Ms RDS told the MBU that her health was deteriorating and requested an urgent consultation with the psychiatrist. In the midst of the Covid restrictions, a video call was arranged and Ms RDS was prescribed additional medication, support from the peri-natal nurse would continue and a follow up would take place in two weeks.

34. Two weeks later Ms RDS was reported missing by her family and subsequently admitted to the MBU.

Learning

- When a parent is admitted to hospital, it is important that practitioners working in the community are up to date with care and discharge planning. In-patient and community health services are equally valuable and effective communication is key to ensuring in-patient and community-based services work together to provide continuity of care.

Think Family

35. The Think Family agenda has been promoted consistently over the past few years, the Safeguarding Adults Board provides key reminders and states:

> "*Think Family means securing better outcomes for adults, children and families by coordinating the support and delivery of services from all organisations.*
>
> *Neither adults or children exist in isolation and Think Family aims to promote the importance of a whole-family approach.*
>
> *Contact with any service offers an open door into a system of joined-up support and coordination between adult and children's services. Services working with both adults and children should take into account family circumstances and responsibilities."*[7]

36. The Safeguarding Children Partnership has "Think Family" embedded within multi-agency training materials and the local safeguarding children procedures. The Early

[7] Think Family - Derbyshire Safeguarding Adults Board (derbyshiresab.org.uk)

Help guidance[8] integrates "Think Family" principles consistently promoting awareness of the whole family approach such as the use of the "Team around the Family".

37. Despite consistent efforts by all agencies to promote this message, a number of practitioners highlighted the lack of consideration of the principles of "Think Family" and the benefits of giving consideration to others in the family when a parent is unwell. The evidence indicated that the Think Family message is not yet fully embedded in practice.

38. This was particularly evident when the police took Ms RDS to the MBU in response to the incident when she had been missing from home.

39. The police are required to send a notification to other agencies, known as Public Protection Notices, PPNs. Their purpose is to alert relevant agencies of an incident and prompt a multi-agency risk assessment and response. It would have been expected that the police would have sent the PPN to Children's Social Care to assess whether there was a need for their involvement.

40. A PPN was completed by the attending officer and recommended referral to "relevant agencies." At the time the police report that an "informal agreement" was in place that if a parent was admitted to the MBU, the MBU would make a referral to Children's Social Care. However, neither agency made a referral and an opportunity to share information and consider whether there was a role for Children's Social Care, was lost.

Learning

- All agencies working with parents, especially at a time of crisis, need to be alert to "Think Family" and the benefits of multi-agency working. Staff must be clear about when and how to refer a family to Children's Social Care and if more than one agency becomes involved with a family, practitioners must agree and confirm who will make the referral.

Early Help and Multi-Agency Intervention

41. Working Together to Safeguard Children 2018 (DfE, 2020b) states that

[8] Guidance for completing a Family Early Help Assessment

"*Providing Early Help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life".*

42. Whilst there is no legislative basis for Early Help, this guidance outlines duties for all partners in identifying, assessing and providing a comprehensive range of Early Help services as part of a continuum of support."[9]

43. The Derbyshire County Council website describes the purpose, *"Where they (the family) would benefit from co-ordinated support from more than one agency there should be an Early Help Assessment."*[10]

44. In this case, there was no Early Help assessment or referral to Children's Services prior to Baby RD's death; case records and conversations with practitioners and managers indicate that the work done with Ms RDS and her family was entirely led by Ms RDS' medical needs.

45. This meant that opportunities for any form of multi-agency assessment of need was lost, access and referral to community support and resources was not considered and the benefit of a multi-agency risk assessment when Baby RD was in his mother's care in the MBU, was missed.

46. During Ms RDS' pregnancy and Baby RD's life, there were several occasions when a referral to the Early Help Service or Children's Social Care might have been considered, however, at no point did health professionals or the police consider this.

47. Practitioners and managers have suggested some reasons why a referral was not considered including that:
    - The assumption that the threshold for intervention was not met
    - Ms RDS had good family support
    - An assumption that another professional would make a referral if they felt it necessary
    - Ms RDS had long periods when her mental health was stable
    - There was a reliance on the MBU, who knew Ms RDS very well, to meet all of the family's needs

48. The reasons suggested for the lack of referral indicate that, within Derbyshire, the concept of Early Help is not always well understood. The common misunderstanding,

[9] The current framework for the inspections of local authority children's services (Ofsted, 2018) provides evaluation criteria for early help as "Children, young people and families are offered help when needs and/or concerns are first identified. The early help improves the child's situation and supports sustainable progress. The interface between early help and statutory work is clearly and effectively differentiated".
Research Report SAFEGUARDING PRESSURES PHASE 7 February 2021 The Association of Directors of Children's Services Ltd Home | ADCS

[10] https://www.derby.gov.uk/.../children-and-family-care/early-help-assessment

described in a number of national Serious Case Reviews, is that Early Help is often seen as an *additional* service and the benefit of coordination of help is overlooked.

Learning

- Practitioners should remain mindful of all the children in a family and what support other family members may need. Early Help and the "Think Family" approach set out the benefits of "joined up support" and working toward better outcomes.

- The Association of Directors of Children's Services document, "Safeguarding Pressures, 2021"[1] includes a review of Early Help services and offers guidance on what works well. Practitioners and Managers should ensure they are clear that an Early Help assessment can assess need and coordinate existing services.

Risk Assessment – The Voice of the Child

49. Having been brought to MBU by the police, in order to be admitted, Ms RDS needed to have Baby RD with her. Had Baby RD remained at home with Mr RDS, Ms RDS would have been admitted to a different ward in the same Trust, to an acute psychiatric ward and believed it was in Ms RDS's best interests not to do this.

50. Ms RDS (and her family) was well known to the psychiatric team who had cared for her during and after the birth of both her children. When, with suicidal feelings, she was admitted again, the team's assessment was that she could safely care for her baby.

51. The risk to Baby RD was assessed as part of a "safety assessment" in line with the unit's practice guidance. At the time the assessment was recorded in a standard "tick box" format, which focuses on the mother's presentation. If there are concerns about the safety of a child, a more detailed summary is required. The ward did not have any concerns that Ms RDS posed a risk to Baby RD.

52. The unit describes the assessment as "multi-disciplinary "in practice it involves doctors, nurses, and nursery nurses, all of whom work closely together on the ward. There is no involvement from others, for example a psychologist, community services or Children's Social Care.

53. Discussion with practitioners highlighted the challenge of balancing the medical needs of a mother with safety of the baby placed with her. In this situation, this was Ms RDS' fifth admission, staff had treated Ms RDS over a number of years, and each time had witnessed her recovery; they were completely confident that her needs were best met by their unit and based on Ms RDS' presentation, they had no concerns about Baby RD's safety.

Parental Responsibility[11]

54. While Baby RD was with his mother on the ward, the baby's status was that of "visitor" and although supported by ward staff, responsibility for his care rested entirely with his mother. The assessment of Ms RDS' parental capacity was carried out by the medical team and was based on their knowledge of her history and how she presented on the ward, which was a safe and supportive environment.

55. The baby's maternal family were consulted and the MBU noted that they agreed that admission was the best option. On reflection, the MBU staff acknowledge that the family views were not thoroughly explored. Mr RDS reports that he was against the idea of the baby remaining with Ms RDS and concerned about safety, but felt his views were ignored by the MBU.

Assessing Parenting Capacity

56. Despite the restrictions imposed by the pandemic, one person from Ms RDS' family was able to visit her and Baby RD almost daily. For them, the frustration was that they felt kept at arms-length from the psychiatric team and were not able to discuss Ms RDS' demeanour and progress in the same way they had in previous admissions.

57. Ms RDS' parents were conscious that Ms RDS' health didn't seem to be improving. Because of restrictions Ms RDS was spending significant amounts of time alone in her room with Baby RD and they were concerned that she tended to "push herself" to care for the baby and was not open with staff about the depth of her struggles.

58. Ms RDS' family and the ward staff were aware that she was having difficulty forming a relationship with Baby RD (which was very different from her experience of parenting O-RD) and work to promote attachment was part of her treatment. In discussion as part of this review, Ms RDS' family indicated that they felt that more attention should have been given to the nature of the mother and baby relationship.

[11] Parental Responsibility is a legal term which defines
all the rights, duties, powers, and authority that by law a parent has in relation to his or her child. If a man and woman are married, they automatically both have parental responsibility.

Learning

- Whilst the benefits of strong leadership and effective team working is well recognised, it is important that the system remains open to other information, skills and experience. A multi-agency risk assessment would be enhanced with the addition of other disciplines, to allow the voice of the child to be clearly heard and avoid fixed thinking or over-optimism.

- When a parent is in the midst of a mental health crisis and staff are considering risk to a child, the view of the other parent and close family members must be part of the risk assessment and clearly recorded. This ensures that the "voice of the family" is included along with the voice of the child.

Response to Emergency Situations

59. When Baby RD was found to be unresponsive, clinical staff began CPR and an ambulance was called. The ambulance arrived within the recommended response time but sadly, Baby RD died.

60. The Rapid Review identified a number of communication difficulties in the period between the ambulance being called and Baby RD being attended to by the ambulance crew. Whilst it seems likely that by this time Baby RD's life could not have been saved, a separate review has examined the process and made a number of recommendations which will improve the response to an emergency in the event of a similar situation occurring.

61. In summary, the learning identified the need for a minimum number of people present at the scene, with the right skill mix and clearly ascribed roles; for example, one person on the scene takes responsibility for communicating with the ambulance service call handler, another remains with the patient and priority is given to relaying pertinent information to the ambulance crew to allow for full assessment, treatment and transfer. All staff should know where emergency equipment is stored, and it should be easily and quickly accessible.

Impact of Covid 19

62. It is clear from the information gathered in this review that the Covid 19 pandemic and the subsequent restrictions impacted greatly on both Ms RDS and her family and on the practitioners who continued to provide services. One of the practitioners described the impact as "catastrophic" when relating how service delivery was forced to change and face to face meetings were stopped or severely limited.

63. Certainly, during Ms RDS' last admission, her family felt communication between them and the ward staff was very different from her previous admissions. They considered that the Covid restrictions kept everyone separate and lack of opportunity to share information hindered the risk assessment.

CONCLUSIONS

64. Although the death of a child in these circumstances is rare, the challenges faced by the staff are those common in safeguarding practice.

65. For mothers with acute mental health diagnosis who are admitted to an MBU with their babies, the question remains how the team treating the parent can ensure the that the risk assessment is robust and that the safety of the baby is paramount and is given priority over the parents' medical needs.

66. The role of community health and community services should not be underestimated. Practitioners can provide valuable insight into the strengths and needs of the whole family, ensure referrals are made when appropriate and that there is a continuity of care. The "Think Family" message applies to everyone.

67. Whilst the key finding of this Review is to highlight the benefit of multi-agency assessment, planning and intervention, there is no way of knowing if there was anything which could have been done to prevent Baby RD's death. Resources are finite and it may be that is not practical or appropriate for every parent who is admitted with a baby to be referred to Children's Social Care; however there a number of ways in which social workers and other specialist practitioners can work with medical services with the overall aim of strengthening safeguarding systems.

68. The Derbyshire Health Care Foundation Trust (DHCFT) Review examined in detail the service provided by the medical team and has made a number of recommendations for management and operational development. The report is not published but has been made available to the Safeguarding Children Partnership who will consider the recommendations, alongside those from this review, and will closely monitor progress.

SUMMARY OF LEARNING

- When a parent is admitted to hospital, it is important that practitioners working in the community are up to date with care and discharge planning. In-patient and community health services are equally valuable and effective communication is key to ensuring in-patient and community-based services work together to provide continuity of care.

- All agencies working with parents, especially at a time of crisis, need to be alert to "Think Family" and the benefits of multi-agency working. Staff must be clear about when and how to refer a family to Children's Social Care and if more than one agency becomes involved with a family, practitioners must agree and confirm who will make the referral.

- Practitioners should remain mindful of all the children in a family and what support other family members may need. Early Help and the Think Family approach sets out the benefits of "joined up support" and working toward better outcomes.

- The Association of Directors of Children's Services document, "Safeguarding Pressures, 2021" includes a review of Early Help services and offers guidance on what works well. Practitioners and Managers should ensure they are clear that an Early Help assessment can assess need and coordinate existing services.

- Whilst the benefits of strong leadership and effective team working is well recognised, it is important that the system remains open to other information, skills and experience. A multi-agency risk assessment would be enhanced with the addition of other disciplines, to allow the voice of the child to be clearly heard and avoid fixed thinking or over-optimism.

- When a parent is in the midst of a mental health crisis and staff are considering risk to a child, the view of the other parent and close family members must be part of the risk assessment and clearly recorded. This ensures that the "Voice of the family" is included along with the voice of the child.

RECOMMENDATIONS FOR THE SAFEGUARDING CHILDREN PARTNERSHIP

69. In order to disseminate and consolidate the learning from this review the following actions are recommended:

A. The practice of creating and sharing of PPNs did not work in this case and led to a missed opportunity for a referral to Children's Social Care. A review of the process is underway by the police and the Partnership should satisfy itself that the review is concluded and the outcome is clearly communicated to all relevant agencies.

B. That the Safeguarding Children Partnership considers how best to promote and embed the Think Family agenda and seeks information from each agency about how they evaluate the effectiveness of the initiative.

C. This Review indicates that the value of an Early Help assessment was not well understood by the agencies working with this family. The Partnership should obtain assurance that all agencies, including adult services, are fully engaged with the use of Early Help assessment.

D. In order to ensure the voice of the child is not lost in the midst of parent's mental health crisis and medical treatment, the Partnership should engage in discussion with commissioners of service about developing and strengthening the team working on the mother and baby unit. The introduction of different skills and experience will help to ensure a multi-disciplinary approach to risk assessment.

E. That the Safeguarding Children Partnership seeks assurance from the Derbyshire Healthcare Foundation Trust that an effective protocol is in place which addresses the response to a medical emergency. All staff must be familiar with the content and its application within their working environment.