Item 7

Multi-Agency Practice Case Review Executive Summary
E Family (2016)

Introduction
A multi-agency review was commissioned by BANES LSCB following receipt of a Serious Incident Notification Form from a Consultant Paediatrician at Royal United Hospital, Bath. The request was for a formal investigation to establish learning from a case where the parent's mental health presentation caused significant harm to a child.

The case was considered by the LSCB Serious Case Review (SCR) sub group in June 2015. The panel agreed that the case did not meet the criteria for a SCR but did recommend undertaking a joint review of the case. An Independent Chair and author was subsequently identified and draft terms of reference agreed.

Family Members
Child B – born summer 2013
Mum (C) – age 43 when B born
Dad (D) – age 49 when B born
Maternal grandmother – age 73 when B born
Maternal grandfather – age 72 when B
born

Methodology
The key principles used in the review were to engage staff and managers from all agencies involved in the case, including designated and specialist safeguarding staff, the main aim being to gain an understanding on why staff acted in a certain way and what factors contributed to their actions at the time. The process was not about blame but to promote open and transparent learning in order to improve inter-agency working.

There was an initial scoping meeting attended by representatives from different agencies following which agencies were asked to provide further information on their involvement with the family. Each agency was provided with templates to complete in order to achieve standardisation and consistency, as well as ensuring the reports focused on the areas required by the Terms of Reference and Key Lines of Enquiry.

Key Lines of Enquiry:

- How did the agencies recognise and respond to mother and father's mental health and substance misuse issues and the potential impact on B?
- To what extent did agencies, professionals and staff assessments take account of mother and fathers parenting of B?
- How did agencies concerns regarding mothers mental health issues inform the planning and safeguarding of B?
- To what extent did any assessments of C's mental health impact on decisions taken?
- How holistic were agencies assessment of B's needs in relation to the wider family and social isolation?
- How was the decision made to place B with her grandparents and how was this communicated?
- Were there opportunities for agencies, professionals and staff to intervene earlier to safeguard B and promote her welfare and would this have changed the outcome for both B and C?

A further practitioner event was held to look at each agencies involvement with the family and the outcome of the key lines of enquiry. Agencies had oversight of the merged chronology of events and were offered the opportunity for challenge and clarification. All agencies present contributed to the process and were open and transparent in their regard to lessons learned. Unfortunately not all agencies attended this meeting or provided a comprehensive chronology of their involvement with the family, despite the request to do so.

The timeframe for the review was from B's birth on the 26th July 2013 to 18th June 2015 when her mother (C) took her own life. Agencies were also asked to provide relevant information relating to C's pregnancy and ante- natal period.

Background summary and analysis
C had a long history of mental health issues and complex medical needs. She had fibromyalgia which impacted on her mobility and energy levels and caused cluster headaches which were treated on a long term basis with opiate medication. She was also diagnosed with ME.

C had contact with psychiatric services in 1998 following the tragic death of her brother. She took an overdose in 2002 when a student. She saw a Consultant Psychiatrist in 2004 and was discharged from his care in 2010. In 2012 she was referred to Specialist Drug and Alcohol Service (SDAS) due to concern about the amount of opiates she was taking - self-injecting pethidine four times as well as taking oramorph daily to treat cluster headaches. She was seen by several neurologists and was also admitted to hospital for detox which was unsuccessful.

In 2013 when pregnant it was suggested she transfer to Methadone, cutting down dose in 2nd trimester. She registered at a local GP practice when 22 weeks pregnant but spent a lot of time in Oswestry with her parents. There was some confusion about where the family were at any given time, and as there was no allocated worker with oversight of the case, information was often not shared between agencies or lost. There was much reliance on the self-reporting and self-referral. It would have been appropriate to make a referral to Banes CSC using the multi-agency unborn baby protocol, but this did not occur. A referral was made to CSC in Wrexham, an Initial Assessment (IA) being cancelled on two occasions as she was in hospital.

B was born in **July 2013** in Oswestry at 34 weeks gestation by elective caesarean as C had gestational diabetes – B was admitted to NICU. An IA concluded that C had complex health needs and that these needs were likely to impact on her care of her daughter. However, D was described as sensitive and supportive to her and to the needs of their baby. Throughout the review it is noted that a number of different agencies involved with the family commented that D was a protective factor, a 'safe pair of hands' and a stabilising influence in a slightly chaotic situation, but these were assumptions without evidence or an assessment to substantiate this.

A Child in Need (CHIN) meeting was held and it was agreed that the family would need additional support when they returned to Bath. An action included referring the family to both the Adult and Children's Services in Bath but C said that she would prefer to make a self-referral and this was agreed. C, as on previous occasions, was reluctant to engage with services, particularly when not in accordance with her own views and requests.

There was a delay in returning to Bath and B was readmitted to the hospital in Oswestry with Galactosaemia. A letter of introduction was sent from the Health Visitor's in Bath to the family asking them to make contact to arrange a visit and a number of messages and no access visit were recorded. The 'No Access Policy' wasn't accessed as the family appeared to be engaging. The HV was informed by SW in Oswestry that the case had been assessed as CHIN and a package of support offered but the case was closed at C's request.

C started using Morphine again, a GP in Oswestry giving her a prescription. In **June 2014** DHI Needle Exchange in Bath completed an assessment over the phone with C, D then collected and returned equipment C being unable to access the service as she was an intermittent wheelchair user. It is not clear whether this service considered or were aware of C's mental health needs - they did not refer her for a mental health assessment. B's well-being and safety should have been assessed by the staff and a parental risk assessment should have been completed.

In **July 2014** C attended A&E with B and reported that she had fallen and banged her mouth. A torn frenulum was diagnosed but despite C's medical history and drug use there was no mention of safeguarding or parenting concerns, and no suspicion of NAI. C was then admitted to RUH with severe gastroenteritis and treated with high dose of Morphine. Attempts to reduce her dosage post-discharge proved unsuccessful and C suggested she was psychologically and biologically addicted.

In **January 2015** C's GP was contacted by DHI to ask if C could get needles from the surgery along with her medication as her needs outweighed DHI's resources - D was collecting up to 400 needles/visit. DHI suggested referral to the pain clinic.

In **February 2015** C saw her GP to discuss low mood and anxiety. She was not felt to be suicidal and was signposted to local counselling service. On the **13th March** she presented to the practice "suicidal" and an urgent referral was made to Mental Health Services – she expressed plans of suicide by the weekend if she didn't get help. She was contacted by Primary Care Liaison Service and agreed to assessment the following week; and she was given Intensive Team contact details to call over the weekend if the situation deteriorated. She then then gave various reasons for not being able to attend appointments and said that she planned to end her and her child's suffering. There was a discussion with the Manager and it was agreed they would need to inform CSC.

On **17th March** a meeting was held between C, the GP and the Practice Manager where C stated that if she was not given extra Morphine she would kill herself. Her behaviour, described as manipulative, was challenged, her request refused, and she was encouraged to engage with Mental Health Services. Over the next weeks there were numerous calls with GP's and the Intensive Service expressing suicidal thoughts, changing appointments and requesting Benzodiazepine medication to help her sleep - this was refused as she was already prescribed Morphine. She was offered and refused Zopiclone and continued to make threats to end her life if she did not get what she wanted.

The GP practice received a call from AWP saying that C was 'not truly' suicidal and was considered likely to have a personality disorder. A referral was made to CSC by the Intensive Team due to continued concerns from C expressing suicidal ideation. CSC made contact with C and no Further Action was taken as D was deemed to be protective and caring for both mother and daughter.

On the **8th April** C and D attended Bath Police Station to report that their phones had been hacked and personal information stolen. C stated that images of her daughter would appear on google. A police officer contacted the Apple store who confirmed that C had been in the store and was difficult to deal with, and also contacted AWP. The same day C contacted CSC giving the same information. On **9th April** both parents attended Bath Police Station with B stating they had been subject of a burglary and poisoning and that a white van was watching them. C demanded to speak with the paedophile unit and to be placed at a safe house. Police did not contact CSC.

On **10th April** parents arrived at the Police station saying they had been driving around all night while being chased by paedophiles. They reported that needles had been left by the baby's cot. The Intensive Service Team Manager was contacted and felt it likely that C went to the Police as she wanted to be prescribed Morphine and suggested she was sent home. Although C told the Officer she had experienced thoughts of suicide, she denied any current thoughts or plans to harm herself, and she was sent home to resume the joint care of her daughter, with the plan that CSC would visit in the morning to assess B's safety. The need to work jointly with CSC to risk assess the situation was not identified at the time. That same evening an acquaintance of C contacted EDT with concerns about her mental health and capacity to care for her child; she stated that seemed psychotic. She said she did not have immediate concerns as D was at home caring for her. She agreed to visit the next day and contact EDT if concerns remained.

On the **11th April** C reported a death threat letter allegedly aimed at B. Police called an ambulance, and paramedics checked B as it was reported that she had been drugged. She was taken to RUH A+E where staff felt C and D were suffering from a rare paired psychosis, expressing strong paranoid delusions that B had been drugged and assaulted by a paedophile ring. In A + E C was disruptive, screaming and shouting and asking for her child's blood to be tested as she had been poisoned. She attempted to hit the senior sister with her walking stick and a request was made for her to be removed by the police. B was admitted to hospital as a place of safety, although B remained in A + E for 3 hours before being transferred to the children's ward. On admission she was described as watchful and unkempt. Her parents were sent home and C was referred to the Intensive Service.

A referral was made to EDT and the next morning there was a SD where it was agreed that Police Power of Protection should be instigated due to nature of concerns and to provide a legal framework. Had the SD been held earlier this would have enabled EDT and other relevant agencies to share information and make joint decisions about initiating or continuing enquiries under Section 47. A plan was made for B to go to grandparents, who agreed to come and collect her, staying overnight on the ward before returning to Oswestry. A delay in convening the strategy and negotiations around the PPOP contributed to grandparent's late notification that they could collect B and take her home.

Over the next few days C was assessed at home by the Intensive Team and then a Consultant Psychiatrist and an assessment of D was also undertaken. The Local Authority applied for an Interim Care Order. On **30th April** there was an ICPC which D attended but not C due to her mental health - B was made subject of a Child in Need Plan as well as being subject of an Interim Care Order.

Between **April** and **June 2015** there was almost daily contact with C from the Intensive Team to support her and review medication. She did not express any suicidal ideation and was making plans and was focused on her daughter, making appropriate steps to help get her back. She had a mental capacity assessment which indicated that she had the mental capacity to understand the issues within the care proceedings and to instruct her representatives accordingly.

On **9th June** there was a handover meeting with Intensive Team and Recovery where C expressed her on-going distress and concerns about getting B back, but no thoughts around self-harm were reported. On **16th June** C reported that she had met with a Dr who was assessing her around child protection issues. She was tearful and anxious appearing pre occupied with her daughter and worried about court. She was finding the separation from her daughter difficult and reported wanting a quick fix in order to get her child back and regain custody. The Care Coordinator (Social Worker) calmed her down and discussed some relaxation techniques and C thanked her. There was no self-harm or ideation evident.

On **19th June** D made a 999 call at 17.09 reporting that he had found C dead.

On **12th July** a psychological assessment of D concluded that he did not have any diagnosable mental illness, and on **4th September** a parenting assessment concluded that he was able to safely care for B with a package of support.

Key learning points arising from the review

C had complex physical health and mental health issues and intervention was focused on responding to her needs with much reliance on self-reporting rather than an in depth exploration of family functioning. There was a lack of focus on B and of the potential impact of her mother's mental health, drug dependency and parenting capacity. There were missed opportunities in C's pregnancy and subsequently, where agencies should have alerted Children's Social Care of the need to undertake a comprehensive assessment.

Although there was an Initial Assessment undertaken by Wrexham following B's birth, where B was identified as a Child–in-Need, a referral was not made to Children's Social Care in Bath at C's request. Assumptions were made by a number of agencies that D was a protective factor and a 'safe pair of hands'. Whilst there is no evidence to suggest anything to the contrary, the impact on him caring for B and C the dynamics in his relationship with C were never fully explored. An in depth assessment of D's parenting capacity and the identification of support services at an earlier stage may well have prevented the need for a protracted court hearing and the removal of B from her parents care.

Assessments undertaken by AWP were not undertaken jointly. A comprehensive joint risk assessment would have provided an allocated worker to liaise from each agency, particularly in relation to the regular episodes of the family moving between Bath and Oswestry and would have reduced the risks of missed or lost information.

Prior to C's psychotic episode in April 2015 there had been no prior recorded incidents of psychosis. Although she had expressed suicidal ideation on a number of occasions it was thought that she may have been displaying manipulative behaviour in order to have her medication dose increased. The consensus of opinion from Professionals working with C prior to her death was that there were no obvious actions that could have been taken to prevent her from taking her life. She presented as forward looking and wanted to work with agencies to resume he daughters care.

Sharing information is the key to providing effective early help where there is evidence of emerging problems and is essential for identification of the issues, assessment and service provision.

Voice of the family

Working Together 2015 states that families should be invited to contribute to reviews. A letter was sent to maternal grandparents and D explaining the role of the Independent Chair and that the purpose of the review was to look at how both children and adult services had worked together, highlighting good practice as well as identifying areas for improvement.

Both grandparents agreed to meet with the reviewer and made some comments and observations about the treatment of their daughter.

Grandparents think their daughter was 'let down' by professionals:

- poor communication between agencies
- lack of support from some professionals
- lack of respect from some professionals eg daughter referred to as a 'druggie' - some felt she was "making things up" to get more drugs

Grandparents believe their daughter's risk of suicide was not properly assessed:

- previous threats of harm
- lack of funding
- 'not ticking enough boxes' for help
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Grandparents say:

- when it was agreed that B should stay with them there was considerable delay before they were informed they could collect her. They had to stay on the ward overnight and replace a number of items such as car seat, pushchair and clothing
- not were not allowed to see/talk to daughter for 10 weeks while they were caring for B
- it was 'cruel and inhumane' to only let C see B for 1 hour/week, when B was in their care, and she had to travel 334 miles to see her
- they felt excluded from the court process

Report LSCB Recommendations

- Should develop a joint protocol between DHI, AWP (including SDAS) linking with HV's and Mental Health Practitioners
- Should ensure safeguarding training for adult mental health staff includes understanding about the level/amount of information required by CSC to clarify actions needed
- Through training should stress the need for professionals to challenge assumptions
- When there are two or more services responsible for the family's overall needs should ensure robust communication between all parties and a worker allocated with oversight of the case to ensure risks that the parent or carer may pose have been considered
- Should improve the links between services to raise awareness of the need to share information, particularly when an adult is receiving treatment for any health issue that may impact on their parenting capacity
- Should consider how services are viewing and assessing the capacity of individuals to receive distressing information, particularly when experiencing mental health problems

Additional LSCB Recommendations

- All agencies need to be assured that staff are equipped with the right knowledge and understanding to undertake difficult conversations, and are aware of the impact of such discussions on the recipient
- Ensure that staff do make assumptions based on service users presentation and articulation
- Seek assurance that GPs are aware of pain management issues in relation to use of addictive medication
- Action plans to be submitted, with updates, for monitoring by LSCB SCR subgroup

Having read this review what recommendations will you make within your team?

Safeguarding children is everybody's business.

For information on what to do if you are worried about a child or if you want information about safeguarding or local policies and procedures please go to http://www.bathnes.gov.uk/services/children-young-people-and-families/child-protection/local safeguarding-children-board

Executive Summary and learning aid produced by Dr Fiona Finlay (Sept 2016).
Full review report written by Julie Downey (Independent Safeguarding Consultant – commissioned by the LSCB).