Response to ZBM Serious Case Review by Bristol Safeguarding Children Board

Introduction

This serious case review (SCR) concerns the death of CB and her baby, ZBM. CB left a maternity hospital with her baby and subsequently took her own life and that of ZBM.

The SCR was commissioned by Bristol Safeguarding Children Board (BSCB). The criteria for undertaking a SCR was met because of the circumstances in which ZBM had died. The BSCB and Bristol Safeguarding Adult Board (BSAB) recognised there would be potential learning for professionals within both children and adult services. Consideration was given to undertaken a joint SCR and Safeguarding Adult Review (SAR) and advice was sought from the National Panel on whether this should be undertaken. Following this consideration a decision was made to undertake a SCR but leaders from adult services were involved throughout the review process and learning will be shared with BSAB.

There have also been a number of reviews already undertaken and changes made within agencies. These processes and changes were not the focus of the SCR in order to avoid repetition. However having a number of investigations and reviews has also had an impact on the practitioners that worked with CB and ZBM both in reviewing practice again and the emotional impact.

The scope of the review sought to establish

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

This report is being published by BSCB following consultation with family members. Unfortunately the father of ZBM who made a valued contribution to the review was not able to be contacted prior to publication.

An action plan is being developed by the Board in response to the review's findings as they apply to Bristol. The BSCB accepts and agrees with all the findings within the independently authored report.

BSCB and partner agencies have not awaited publication of the report before making changes. Improvements and developments already made as a result of learning identified in this case include:

• The review of ward layout and security undertaken and changes to prevent women leaving the ward unchallenged implemented at Hospital 2.
• A review of perinatal mental health was undertaken by Mental Health and Midwifery Commissioners and Providers which resulted in the launch of the Specialist Community Perinatal Mental Health Team.
• A review of Mental Health Services by Mental Health Commissioners has taken place.
• There has been a change in practice within the Pregnancy Advisory Service regarding contact with mental health services and domestic abuse specialist services.
• There has been a change in practice within the Mental Health Trust Recovery Team regarding cover of caseload when care coordinators are on leave.
• There has been a change in practice around the support of service users who have a part time Care Coordinator in the Mental Health Trust
• Improved access so appropriate staff in obstetric staff and midwives teams can access mental health records.

Findings

Finding 1

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

Summary

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

Questions for the Board and Organisations

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

BSCB Response

The BSCB Training team are embedding a 'Think Family' approach across their training offer. Practitioners will be supported to 'Think Family' by considering the family and community networks that support individuals referred to their service at all stages of their

intervention. We will improve inter-disciplinary knowledge and skills by including practitioners who work with adults in developing and delivering our training offer and offering attendance at our Child Protection training more widely across the adult workforce. As an example adult practitioners will be trained in children safeguarding and children practitioners will benefit from training regarding the Mental Capacity Act.

The BSCB ensures that the training it delivers is of a high quality and impactful on frontline services with the training team ensuring there is robust evaluation of all training events.

The BSCB training team measures the impact of training on practice through surveys conducted immediately and then repeated three months after the course. Agency attendance and training quality is monitored by the multi-agency BSCB Training Sub Group and through regular reports to the Board. Briefings on learning are also provided to single-agency trainers to ensure consistency and wide dissemination of good practice.

The BSCB is developing a Perinatal Mental Health Protocol in partnership with the BSAB. This is being developed by subject experts from across the children and adults' workforces to ensure there is a clear understanding of the systems and pathways in place in Bristol to respond to the concerns about perinatal mental health that have been identified both locally through this Serious Case Review, and nationally. The guidance will support practitioners to identify and respond to need at the earliest opportunity, maintaining clear and concise communication between professionals and partner agencies so they all work together to achieve better outcomes for women, babies and their families. Pathways for services and individual agency roles will be clearly outlined. Implementation of the protocol will be monitored through both Boards in coordinated oversight of the dissemination and impact of learning.

Regular reports on the implementation of the Perinatal and Infant Mental Care in the South West will be provided to the BSCB. The agencies who are delivering this pathway locally are represented on both the BSCB and the BSAB Boards and on key sub groups allowing for close oversight. Feedback from service users will be a core part of the expected assurance received by the Boards from partners to ensure that adults accessing the service are kept at the forefront of the Boards' understanding. The progress and impact of the new Specialist Community Perinatal mental health team will be monitored through the Boards' quality and assurance sub groups.

Finding 2

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

Summary

Supervision provides an opportunity for individual practitioners to discuss safeguarding issues in a reflective way with a more experienced practitioner to ensure care and treatment plans are appropriate and effective, and include all relevant professionals and

agencies. This can also provide the gateway for escalation, where practitioners are unsuccessful in their care plan to access additional services.

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

Questions for the board and organisations

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

BSCB Response

The BSCB recognises that models of supervision need to be appropriate for the type and nature of work delivered by our diverse agencies supporting practitioners from across various disciplines. The BSCB provides multi-agency Advanced Safeguarding for Managers training. This covers the core principles of supervision and the important role of supervision in directly safeguarding children and their families.

To ensure oversight we will use statutory audit frameworks to ensure that the model and frequency of supervision used by agencies, and the availability of internal safeguarding teams, are suitably robust for the setting.

Section 11 (s.11) of the Children Act 2004 places a statutory duty on key organisations to make arrangements to ensure that in discharging their functions the organisations have regard to the need to safeguard and promote the welfare of children. Working Together (2015) recommends that LSCBs should assess organisations' compliance with Section 11. The Board undertakes Section 11 Audits with our neighbouring Local Safeguarding Children Boards (LSCB)'s recognising that many local organisations deliver services across multiple borders or are accessed by members of the public from neighbouring local authorities.

An area of enquiry within the Section 11 audit is an organisation's arrangements to provide supervision for all staff. The Board receives a collated report on all the agencies' responses which includes the responses to training and supervision. The most recent S11 audit was undertaken in 2016 and an area for improvement included training and supervision. An action plan has been established to address these issues. Each organisation has to provide evidence to the BSCB of what actions they have taken to make improvements in areas identified for development.

Within the Board's multi-agency audits undertaken to date we have seen good evidence of the use of safeguarding teams across the city providing consultation and advice to practitioners. To ensure greater consistency we will continue to review how safeguarding teams are consulted as part of multi-agency audits.

Finding 3

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

Summary

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

Questions for the board and organisations

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

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

BSCB and BSAB Response

The two Boards are committed to a continuing programme of integration, where appropriate, to build upon multi-agency working across the adult and children's sectors including the creation of a Joint Business Unit supporting the work of the two Boards that was established in September 2016. We recognise the value and importance of ensuring that the agencies in the city are not working in silos and 'Think Family' whenever we are engaging with an individual. The Boards are supporting this work and the implementation of these findings through a number of shared projects where we draw from the significant expertise in the city and trial new ways of sharing skills and resources for the benefit of children, adults and families.

This year we are working on two joint protocols to support this. Work is already underway on developing the Perinatal Mental Health Protocol which will be approved and adopted by both BSCB and BSAB. This protocol will clarify the different pathways and process for identifying lead practitioners. It will set out agreed expectations, roles and responsibilities to ensure that partners can hold each to account to respond effectively, and are able to

escalate and challenge where practice is not to the agreed standard. The multi-agency protocol will focus on an approach that promotes the importance of early intervention to prevent the onset of mental health illness in women and help women known to be at risk, and act quickly when illness occurs.

Secondly this year we will be producing new guidance for practitioners working with children (including unborn) whose parents are accessing adult services including adult mental health services. This guidance will outline expectations for the inclusion of adult services in multi-agency meetings responding to risk as well as provide sources of support for practitioners in intervening effectively. Our Child Protection Strategy Meetings Guidance which is due to be published this month (April 2017) also highlights the expectation for services involved with key adult caregivers to be included in safeguarding meetings and decision making for children.

The adoption of the guidance will be monitored through both the BSCB and BSAB.

The BSAB has developed a multi-agency audit programme based on the six principles of safeguarding which will be delivered over the next twelve months. This audit will consider all adults referred to adult safeguarding services including pregnant women, and findings from the audit as well as resulting action plans will be shared with the BSCB. Single agency audit findings for adult services will also be provided to the BSAB Performance and Intelligence Sub Group over the next year.

Finding 4

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

Summary

Where professionals lack confidence in challenging service users they are inclined to avoid the confrontation, which results in inadvertent collusion. This makes it more difficult for professionals to then make challenges in the future on the issues that really matter, especially in relation to safeguarding the unborn child.

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

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

Questions for the board and organisations

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

BSCB Response

The BSCB is committed to ensuring that services are effective for all children and families and recognise that some individuals will present and communicate in ways that professionals find more challenging than others. We will support professionals to increase their confidence in supporting these children and families through promoting robust supervision and line-management arrangements across agencies, ensuring that our training and policies address skills and approaches that can reduce the barriers that exist for some individuals in accessing services. We will promote effective representation of the range of ways that families communicate with professionals in our work. We recognise there is excellent practice and experience to be drawn upon from specialist teams across the city working very effectively with harder-to-reach individuals. Through our Communications Sub Group we will continue to ensure that the rights of children to be safeguarded are promoted as paramount in decision-making in both children and adults services.

Finding 5

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

Summary

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

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

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

Questions for the board and organisations

• How does the Board monitor the quality of referrals to children's social care?
• How can the Board assure itself that the quality of feedback on referrals is appropriate and received by the referring agencies?

• How is the Board assured that front line practitioners across all agencies have a clear understanding and working knowledge of the BSCB threshold guidance?
• How is the Board assured that referring agencies continue to hold responsibility for referrals that do not meet the First Response threshold and take appropriate steps, including escalating where necessary?

BSCB Response

The BSCB undertakes an annual "Threshold" audit of referrals into First Response. The audit focusses on the quality of referrals, whether the decision making at First Response was considered appropriate and whether feedback was given. Findings and action plans from the annual audit are reported to the Board. The Local Authority also undertakes single agency audits, one of which is referred to within the report. The Board receives all single agency audits and can challenge any findings and request feedback on action plans.

It is already the First Response standard practice to give feedback to referrers on the outcome of their referrals. As the SCR report shows, an audit undertaken to look into this found that in every case audited, the referrer did receive feedback from First Response. However, in order to ensure that the quality of referrals improves over time, the Board will seek assurance that a thorough explanation is given as to why a referral was not accepted, and if necessary, offer targeted support to specific agencies or professional groups where there is a higher rate of referrals not being accepted.

There is already in place a system whereby the midwifery teams at both NBT and UHB have had a link manager who has provided significant input and support about thresholds and strengthening the quality of referrals.

All BSCB training refers to the BSCB Threshold Document and the BSCB monitors and reports on escalations on an annual basis.

Finding 6

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

Summary

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

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

circumstances this can prevent the service user and unborn child meeting the threshold for assessment or service provision.

Questions for the board and organisations

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

BSCB Response

All BSCB training and guidance will engage with practitioners about the need to use precise and unambiguous language. By developing and launching the Perinatal Mental Health Protocol we will provide practitioners with shared terminology. In addition the BSCB and BSAB support team will deliver briefings to multi agency staff groups in order to disseminate the learning from this serious case review and ensure practitioners understand the context in which this finding arose. Practitioners will be encouraged to challenge and check shared understanding in relation to assessments of need and in recording. Individual Board agencies will also be required to disseminate the learning.

Finding 7

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

Summary

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

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

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

Questions for the board and organisations

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

BSCB Response

The BSCB training outlined above will ensure practitioners understand the needs of an unborn child being paramount and the importance of assessing risk to a child (or unborn) considering parent/s' health needs in robust assessments. This will be supported by the Perinatal Mental Health Protocol. The Boards will deliver learning events for children and adults practitioners to attend together where barriers to achieving this balance can be considered and learnt from. We will promote the importance of transparency from adult services about their role in safeguarding children when they become involved in support adults in service.

Finding 8

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

Summary

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

Questions for the board and organisations

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

BSCB and BSAB Response

The BSCB and BSAB will continue to work closely together with a joint support team to ensure findings and learning are cross-disseminated.

The new Perinatal Mental Health Protocol will be a joint protocol with BSAB and will be monitored by both Boards. The protocol will clarify pathways for services and the role for individual agencies.

The findings and action plans from this serious case review will be shared with neighbouring LSCBs and the protocol and new guidance will be available to be adopted by LSCBs across the region.

The BSAB are trialling approaches to improving service user feedback from services including developing links with adult participation groups. We will consult with these groups and survey frontline practitioners towards the end of this business year to monitor how changes are being experienced on the frontline.