Safeguarding Practice Review
Emily & Jack

1 Critical Events

3 month old baby 'Emily' died in March 2019

In July 2019, the baby's mother admitted killing her child, pleading guilty to infanticide, she was given a Hospital Order (Sec37 Mental Health Act 1983).

The Safeguarding Practice Review considered how services worked with the family, including Emily's older sibling 'Jack'.

2 Safeguarding concerns up to critical event

- During her first pregnancy, Mother disclosed to midwife mental ill-health history including in-patient treatment
- A referral to perinatal mental health services was made but not accepted as Mother appeared stable, a letter was sent to Mother's GP to monitor
- When Emily was 12weeks, Mother was taken to Emergency Department (ED) by ambulance (LAS) because of an ibuprofen overdose
- LAS submitted a safeguarding referral to MASH, referral noted a previous overdose attempt in Mother's country of origin
- Mother was discharged with advice to visit GP and ED sent a letter to GP
- Mother attended GP surgery and prescribed anti-depressants
- Social Services visited Mother but felt a language interpreter was needed to properly discuss issues, a second visit happened two days later
- Social Worker referred to Community Mental Health 3weeks after the overdose incident, referral was considered same day as baby's death.

3 Findings

- Lack of consistent knowledge, use and complete picture of Mother's mental health (MH) history and current needs
- At different points Mother had told services about aspects of her MH and that of her family – such as with midwife and ambulance service. However when asked by her GP about MH issues after the overdose incident, Mother said there were none
- System did not take into account factors which either limited or made Mother reluctant to talk about her MH needs
- It is the role of systems to engage parents, not the other way round, services need to create emotional safety to talk about MH
- Mother told the review she was reluctant to talk about her MH needs for fear of having children removed
- Both parents spoke some English but it was not their first language. There was inconsistent use of interpreters to discuss complex needs such as use of post-natal services, this meant opportunities to provide appropriate support were missed
- Perinatal services did not accept the first referral from midwife which detailed in-patient history and significant family MH, this was an important opportunity missed
- Safeguarding system did not share information well enough
  - Following first perinatal referral, a letter was sent to GP about monitoring needs, later when Mother changed GP, the letter was not migrated
  - Midwifery records held MH information but was not accessed when Mother was at ED
  - Handover of LAS record of previous overdose what not captured by ED when treating Mother
  - Handover to new health visitor (HV) was lacking because records were not read
  - ED note to GP did not mention safeguarding referrals made
- Process dominated over critical thinking, such as opportunity for ED to discuss MH needs with triage nurse and MH team resulting in no referral to MH services by ED
- HV service under-utilised by other professionals to support and assess risks
- Social care discussions with Health partners lacking due to concerns about information sharing
- Agency safeguarding responsibilities to siblings in immediate aftermath need to be clear allocated

4 Learning

- Perinatal MH services to accept referrals involving mother's with previous in-patient treatment (this has been put in place)
- All health professionals need to understand perinatal pathway
- Safeguarding system to provide emotional safety for parents who have previous/current MH needs taking into account what might have them feel reluctant to talk or share information
- Consistent use of up-to-date NICE MH risk assessments in health settings
- Consistent use of interpreters to help services to meet family's needs and avoiding assumptions as to what is understood
- Information exchange and handovers within safeguarding network to take a proactive approach to access information recorded and shared
- Professional curiosity about what is going on beyond immediate presentations needed to explore needs
- Better use of HV services by GP and social care to provide support
- Adult safeguarding teams and approaches when concerned about an adult who is a parent, needs to consider child also
- Trauma informed approach to support bereaved parents and siblings
- Use of strengths based approach to identify sources of resilience and support

5 Achieving Change

Reflect on the findings & discuss the implications for your practice/team

Outline steps you/team will take going forward

The full SPR Report can be downloaded at www.croydonlscb.org.uk

CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP