Solihull Local Safeguarding Children Board

Serious Case Review

SC17 Unborn Baby A

Review Report

Independent Author: David Peplow

CONTENTS

1. INTRODUCTION TO THE CASE REVIEW

1.1. On 1st April 2019 a young woman was found hanged at her own home. She was 28 years old and 37 weeks pregnant. Emergency services attended as a priority and she was transferred to hospital. Efforts were made to resuscitate her and a caesarean section was carried out. The baby was stillborn and the mother died.

1.2. The hospital's safeguarding matron made contact with children's social care and a decision was made that a rapid review, in accordance with the transitional arrangements for Local Safeguarding Children Boards (LSCB), should take place. Relevant notifications and requests to agencies were made on 10th April 2019 and the review took place on 29th April 2019.

1.3. In considering if the case should be notified and considered under this process, Solihull partners had regard to the Infant Life (Preservation) Act 1929 which says amongst other things "… any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction…"

1.4. The rapid review members concluded that the criteria for a serious case review as defined by Working Together 2015 was met in that, abuse or neglect was known or suspected and a child had died. (A child as defined in the above mentioned Infant Life Preservation Act 1929). The LSCB Chair agreed with this decision and the National Panel were notified.

2. PROCESS FOR CONDUCTING THIS REVIEW

2.1. Whilst some agencies had worked with the mother there was very limited learning. This was all identified during the rapid review process and any additional work would not reveal further learning. It was felt that the process that had taken place was proportionate and work on the identified actions could start.

2.2. The rapid review was not conducted with a view to publication, nor was it carried out by anyone who was "independent of the case under review and of the organisations whose actions are being reviewed". In that regard the review is not compliant with Working Together 2015.

2.3. Following correspondence with the National Panel it was agreed that the Independent Chair could use the rapid review as the basis for a publishable report that would then achieve the requirements for a serious case review.

2.4. It was decided that publication should await the result of the coroner's inquest and finalisation of the action against the recommendation. The inquest concluded in mid August 2019 and found that the mother's death was by suicide.

3. RELEVANT CASE HISTORY

3.1. University Hospitals Birmingham.

3.1.1. In October 2018 mother had an antenatal appointment with a midwife. She appeared to be open in disclosing her history. This included talking about cocaine use, an intentional overdose and self-harming in 2012 and 2005 respectively. A referral to mental health services was offered but declined.

3.1.2. A few days later some checks were made to establish what partner agencies may know. There had been an incident in the South West, the reporting author from the hospital comments that this was an omission.

3.1.3. In early November there was an antenatal appointment where a sample was taken to analyse for drugs. A wide range of issues was discussed including smoking and previous medical history. A referral was made to the specialist substance misuse midwifery team. A few days later the drugs screening test was reported as Nothing Abnormal Discovered (NAD) meaning no drugs were detected.

3.1.4. The first substance misuse clinic appointment was missed but as the recent sample provided was negative, the follow up was to send out another appointment.

3.1.5. On 12th December 2018 mother was seen in the substance misuse clinic. A further sample was obtained for drug testing; this was negative when the result was reported later. A plan was put in place to maintain the specialist monitoring. Mother declined a referral to drug misuse services. There was a conversation about making a referral to children's services and it was said that the midwife would talk to mother before making a referral.

3.1.6. On 21st December the substance misuse midwife had a conversation with children's social care. Overall it was agreed that the midwifery plan to conduct drug tests was sufficient but there should be a referral if required.

3.1.7. At the next substance misuse clinic mother reported that she was not smoking or drinking alcohol and had not used drugs. She reported having had a conversation with a social worker; this was as a result of the conversation between services as above. A further sample was taken for drugs testing. A week later on 13th February 2019 it was reported that the test showed cocaine use.

3.1.8. This information (drug use) was conveyed to the community midwife and it was also said that the substance misuse midwife was to contact mother to discuss a referral to children's services. Mother made contact a few days later seeking to rearrange an appointment; during the conversation she denied using cocaine.

3.1.9. On 14th March 2019 midwifery made a referral to the Multi Agency Safeguarding Hub (MASH). The response was for a social worker to carry out an assessment detailed in section 3.2 below.

3.1.10. Appointments were continuing at the substance misuse clinic. One took place the day after the mother met with a social worker. Whilst at the clinic remorse was expressed and the midwife offered and discussed a referral to Solihull Integrated Addiction Services. Mother was left to think about this.

3.1.11. On 1st April 2019 the hospital obstetric services were alerted to mother being brought to hospital by ambulance having been found suspended.

3.2. Children's Social Work Services

3.2.1. The first contact with Social Care was on 10th December 2018 by midwifery services. There was a disclosure from mother that prior to knowing she was pregnant she was taking cocaine. There was an agreement between CSWS and midwifery that midwifery service would monitor the situation monitor and there would be no further action by CSWS.

3.2.2. On 14th March 2019 CSWS received another referral from midwifery as mother had tested positive for cocaine. The MASH screened the case on 18th March and the mother was allocated a Social Worker on 20th March.

3.2.3. The Social Worker met with the mother on 21st March; at the meeting the mother denied using drugs and disputed the test results. She spoke about a previous relationship which was abusive and compared this with her current relationship with the baby's father which was described as 'perfect', going on to say there were no drugs, no alcohol and no domestic abuse. Mother said she was looking forward to her life with her partner (baby's father).

3.2.4. On 25th March there was another positive drugs test this indicated drugs had been used in the previous 72 hours.

3.2.5. The Social Worker had a planned appointment with her on the 28th March 2019 mother did not attend. This was followed up with an unannounced visit to the property. The mother was not at the property but a woman present there advised the Social Worker that mother was at her boyfriend's property. Social Worker attended the boyfriend's property but once again was told by the boyfriend that she was not in. They subsequently spoke on the phone and an appointment was made for the morning of 1st April 2019.

3.2.6. On the morning of the appointment mother contacted the Social Worker and moved the appointment to the afternoon. She did not attend.

3.2.7. On 3rd April CSWS were informed by the hospital safeguarding matron that mother had died.

3.3. West Midlands Police.

3.3.1. The police hold very little information. The mother had been a victim of domestic abuse with a different partner, which was about two years earlier. There were no recent police incidents other than the critical event leading to the review.

3.3.2. The police system held a warning marker that was ten years old that mother might self-harm. There was no other information as to how this had originated available to the review.

3.3.3. The police were part of the MASH process following a referral received in March 2019 concerning mother's drug use.

3.4. Solihull Community Housing.

3.4.1. Mother had failed to attend her first appointment on 24th Jan 2019 and then made contacted a few days later. She did not disclose anything in relation to drugs or alcohol. Solihull Community Housing was actively trying to find accommodation for her.

3.5. Birmingham and Solihull Clinical Commissioning Group.

3.5.1. Very limited information was held. All the midwifery contacts are appropriately recorded within the GP records.

3.6. Education.

3.6.1. Education services had knowledge of the extended family some of whom were in the same household as mother.

3.7. Other agencies.

3.7.1. Requests for information were made to the following agencies all of which held no information: Birmingham and Solihull Mental Health Foundation Trust, Coventry and Warwick Partnership Trust, The National Probation Service, South Warwickshire NHS Foundation Trust, CAFCASS, The Community Rehabilitation Company.

4. ANALYSIS

4.1. The midwifery team identified the maternal history of drug use and an earlier deliberate overdose. An appropriate offer was made for a referral to mental health services but was declined.

4.2. The mother was correctly placed on the pathway for substance misusing mothers. This was appropriate and it identified that there was continued substance use in pregnancy based on the results of samples taken for drugs screening.

4.3. There were some episodes of failures to attend appointments with the substance misuse midwives and these resulted in follow up appointments being offered and in mother being contacted to re-engage her. This was successful in that there was re-engagement.

4.4. In March 2019 there was a referral to children's social care due to a positive drug test (cocaine). This information was available in mid-February and it could have been more promptly shared with social care, however this was delayed as the specialist substance misuse midwife was attempting to contact mother to discuss the need for referral, something she had told mother she would do before a referral.

4.5. Attempts to discuss the referral were initially unsuccessful and the substance misuse midwife eventually got a call back from mother on the 14th March 2019. The specialist midwife felt that she was acting within guidance in discussing the referral and obtaining consent for it with mother. The delay this caused was significant and exposure of an unborn infant to cocaine could result in significant harm. This is addressed by recommendation 1.

4.6. There is no record of a referral to Solihull Integrated Addiction Services following the positive drugs test. Mother had previously declined such a referral (see 3.1.5 above) when it was offered by the specialist midwife when her drugs test was negative. However, because the referral was not made between February and March the mother did not receive any form of specialist support to help her stop using cocaine. This is addressed by recommendation 2.

4.7. The MASH response to the concerns identified by professionals was adequate and proportionate. There is evidence of positive partnership working between children services and midwifery.

4.8. The timeliness of the response to the concerns identified on the 14th March 2019 was what would have been expected. The case screened on the 18th March and allocated to a social worker on the 20th March 2019. The social worker's visit to mother was completed within 24 hours of case allocation.

4.9. The social worker made appropriate decisions and several attempts to maintain contact with the mother in order to progress the social work assessment.

5. CONCLUSION

5.1. The review panel found there was significant evidence of strong practice, particularly in relation to prompt follow up when the mother did not attend or could not be contacted, by the midwife, social worker and housing officer. Practitioners worked hard to retain strong engagement and provide a thorough service.

5.2. The mother was placed on the pathway for substance misusing mothers, which was appropriate, and this identified that there was continued substance use in pregnancy based on toxicology results. It was also noted that throughout mother was reassuring practitioners that she was not subject of abuse or exploitation by anyone, and she was in a stable and safe relationship with the child's father. There was no evidence available to partners to the contrary.

5.3. The only indicator of an increased risk to her and her child's wellbeing was the positive test for cocaine. The mother did disclose a previous suicide attempt and was offered mental health referrals in pregnancy but declined to take up this service.

6. RECOMMENDATIONS

6.1. The substance misuse midwifery team should consider with immediate effect the 'up front' conversation with women on the substance misuse pathway, that a positive toxicology result will result in a referral to social care.

6.2. The MASH manager, SIAS manager and the midwifery manager to meet to conduct a review analysing current referral processes and pathways.