Croydon

Safeguarding Children Partnership

Serious Case Review

‘Emily and ‘Jack’

Report Author

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1 INTRODUCTION

1.1 This serious case review was commissioned following the death of a three-month old baby girl in March 2019. The baby's mother admitted killing her child and in July 2019 appeared in court and pleaded guilty to infanticide. She was convicted of this offence and given a Hospital Order under Section 37 Mental Health Act 1983.[1]

1.2 Due to the circumstances of the death Croydon Safeguarding Children Board carried out a rapid review of the information known to local agencies about the family. The review concluded that the case met the criteria for a serious case review under statutory guidance[2].

1.3 The decision to carry out a serious case review took place before 1st September 2019 when Croydon Safeguarding Children Board became Croydon Safeguarding Children Partnership (CSCP). In line with statutory transitional guidance[3], arrangements for initiating and publishing the review remain with the Local Safeguarding Children Board who commissioned two independent lead reviewers, Edi Carmi (review chair) and Jane Wonnacott (report author) to carry out the review.[4] Responsibility for responding to the review and implementing recommendations will lie with the new safeguarding partnership.

1.4 The baby who died will be referred to as "Emily" throughout this review report and her brother, who was thirteen months older than her, as "Jack".

2 THE REVIEW PROCESS

2.1 A panel was appointed to work with lead reviewers during the review process. The panel comprised:

- Designated Doctor, Croydon Clinical Commissioning Group
- Head of QA and Safeguarding, Children, Families and Education
- Named Nurse Safeguarding Children, South London and Maudsley NHS Foundation Trust
- Serious Case Review Team representative, Metropolitan Police
- Safeguarding Lead, London Ambulance Service
- Named Nurse for Safeguarding Children, Croydon Health Services
- Safeguarding Children Board Manager, Croydon Safeguarding Children Board (CSCP)
- Administrator, Croydon Safeguarding Children Board (CSCP)

[1] The courts will issue a hospital order under Section 37 of The Mental Health Act (MHA) if the person concerned has (a) been convicted of a crime that is punishable with imprisonment, (b) has a mental disorder and the court believes they should be in hospital instead of prison.
[2] This guidance was *Working Together to Safeguard Children 2018.*
[3] HM Government (July 2018) *Working Together Transitional Guidance*
[4] Information about the lead reviewers is set out in Appendix 2

2.2 Terms of Reference were agreed and attached at Appendix One. These were extended beyond the time of Emily's death to examine the effectiveness of the system in safeguarding Jack and meeting his needs in the immediate aftermath.

2.3 Chronologies of involvement were requested from the following agencies and authors of the chronologies joined a meeting of the review panel to discuss their findings:

- London Ambulance Service (LAS)
- Police
- GP
- Health Visiting
- Midwifery
- Children's Social Care (CSC) and Early Help
- South London and Maudsley NHS Foundation Trust (SLAM) (including the Peri-natal Mental Health service)

2.4 In addition to providing a chronology, South London and Maudsley Mental Health Trust (SLAM) conducted a serious incident investigation and their report was made available to the review.

2.5 The lead reviewers met with the father of Emily and Jack and also with Mother. We are very grateful to them for their willingness to help with this review and share their perceptions of the way in which practitioners had interacted with them before Emily's death. The perspectives of the family are summarised in section 4 and noted wherever relevant to events throughout this report.

2.6 In order to understand further what happened but also *why* decisions were made and the factors affecting practice at the time, the lead reviewers met with practitioners who knew the family. Discussions took place with:

- Emergency department medical and nursing staff
- Midwives
- Health visitors and nursery nurses
- Social workers and managers
- Police officers
- Mental Health clinicians and service leads
- GP Practice

2.7 A final draft of this report was agreed with the panel and shared with practitioners before being finalised, shared with Mother and Father and presented to the Croydon Safeguarding Children Partnership.

Limitations

2.8 Not all practitioners who had made decisions in respect of the family or known and worked with them were available to contribute to the review. This was due to a variety of reasons including moving employment and being no longer contactable and sickness. This has left some unanswered questions as to why decisions were made at the time.

3 CASE SUMMARY

Events prior to the death of Emily

3.1 The parents of Emily and Jack originate from Eastern Europe. Father has worked in England for several years and Mother joined him in 2016 after their marriage. Most people who have met them consider both Mother and Father to have adequate English language skills on a day to day basis, although complex discussions are best conducted through an interpreter.

3.2 Mother disclosed to the midwife who booked her for her first pregnancy that she had a significant mental health history in her home country. The information that she gave included that she had received in patient treatment. Information obtained since the death of Emily has confirmed that this included multiple admissions and a diagnosis of Bipolar Affective Illness, but this level of detail was not known to professionals before to Emily's death.

3.3 Mother's disclosure prompted a referral by the midwife to the peri-natal mental health service[5]. The referral was not accepted, and a letter was sent to the GP (copied to Mother and the community midwives) to this effect. The reason given for rejection wad that Mother's current mental state was stable, and she did not meet the criteria for secondary care services. The GP was asked to monitor her mental state during the perinatal period, the team offered to see her in the future should input be needed and prescribing guidelines were given for antidepressants pre or post-delivery of the baby. Discussion with current managers has confirmed that a referral which cited previous in-patient treatment should have attracted a red flag and been an assessment and this would be current practice.

3.4 The issue of the use of interpreters is discussed further in Finding One, particularly in relation to how far an apparent grasp of English may have masked both parents' difficulty in understanding more complex information. Practitioners have commented that their decision not to use interpreters at all appointments was because Mother's command of English seemed good and Mother confirmed this, telling the review that it did not occur to her to ask for one as she had studied English at university. As a result, an interpreter was not used for the meeting with the midwife. The parents do not remember a referral being made to the perinatal service, nor the letter explaining that the service would not be offering an appointment. They have told this review that in their home country they would have received a copy of the referral letter and did not realise that this is not the case in England.

3.5 Mother did not refer to her previous mental health history again although this was on her midwifery records and available to the health visiting service when she later declined an ante natal visit from the health visitor. Mother stated that she does not

[5] The Croydon Perinatal Community Service helps women who have mental health difficulties during pregnancy and after the baby is born. These include depression, anxiety or disturbing thoughts and can sometimes affect the mother and baby relationship

recall declining this visit and both she and Father have stressed that they believed that they had accepted all help that was offered to them. The most likely explanation for this discrepancy is a misunderstanding about the offer of a visit from a health visitor; a role that they were not familiar with from their home country. In Croydon resources do not allow for ante-natal visits to all women and Mother had been offered the visit because of her disclosure about her mental health. Ante-natal visits are an opt-in service and it would have been assumed by the health visitor that the midwife was managing the situation.

3.6 There were no further alerts from midwifery and Mother accessed the necessary ante-natal care. Use of interpreters throughout this period was inconsistent, with them more generally being used for medical procedures such as scans. Mother has told the lead reviewers that she accessed her own support with preparing for the birth via the local Eastern European community.

3.7 Following Jack's birth, Mother and Jack were seen for a new birth visit by the health visitor. At this visit Mother's previous mental health history was discussed but as Mother seemed well and spoke of having a good support network she was assessed as needing a universal service. This meant that she would next be seen four weeks later in the child health clinic by a nursery nurse. In a busy clinic where parents attend without appointment there is no opportunity for in depth discussions and the nursery nurse would not have access to previous records. There is no record of a six-week check by the health visitor; most likely because only targeted checks were being undertaken at that time and Jack was in receipt of a universal service.

3.8 About three months after Jack's birth the family moved to another area of Croydon and changed GPs, to a practice with a GP who spoke their language.

3.9 Mother received routine ante-natal care during her pregnancy with Emily. She did not speak about her previous mental health problems or Bipolar diagnosis and told this review that this was deliberate as she thought that if social services knew that she had taken medication in the past they would take her children away. With hindsight Mother now feels that her fears may have been linked to her declining mental health.

3.10 Emily was born by a planned caesarean section and for a short while following the birth Mother had the support of Maternal Grandmother who had come to England to help her. At the new birth visit by the health visitor Mother was reported to be happy, caring well for Emily and the notes record that when asked, Mother told the health visitor that she had no history of depression. Mother told this review that she does not recall being directly asked this question. The health visitor had not had time to read the previous notes where Mother's previous in-patient treatment was recorded but told the review that since a number of years had now passed this information would not have changed the decision that Emily should receive a universal service. Mother and Emily were seen at six and eight weeks after birth and all seemed well.

3.11 When Emily was twelve weeks old Mother was taken to the local acute hospital emergency department by ambulance, having contacted a neighbour to say she had taken an overdose of ibuprofen tablets. The London Ambulance Service completed

an information sheet for the Emergency Department (ED) and provided a verbal handover to the triage nurse. It is usual that this verbal handover informs next steps within the Emergency Department as, due to time pressures, there is no time to read paper records. This issue is discussed further in Finding Two

3.12 The Ambulance Service also made a child safeguarding referral to Croydon MASH[6] which noted that the information from Mother was that she had taken a previous overdose when living in her home country. This had not been recorded on the information sheet given to the Emergency Department and the triage nurse does not recall being informed of this at the point of verbal handover.

3.13 Mother was seen in hospital by the triage nurse who carried out an initial assessment and then was seen later by a doctor. Mother explained that she had not intended to kill herself, but she had a sleepless night, woke up drowsy, took the tablets for pain and, when she realised that she had taken twelve tablets she ran to a neighbour. This explanation resulted in the overdose as being described as "accidental" within the health records.

3.14 The triage nurse made an immediate referral to Croydon MASH and recommended that Mother should be seen by the hospital mental health team. After further assessment, the doctor decided that Mother did not meet the criteria for mental health assessment, and she was discharged home with a diagnosis of depression. The doctor spoke to Father over the telephone asking him to take Mother to the GP the next day to obtain medication as medication would not be prescribed within the Emergency Department. Usual practice within the Emergency Department is that a discharge summary is sent to the GP electronically and it is expected that GPs will screen these summaries on arrival at the surgery. There is no system for marking summaries as urgent. In fact, GPs receive numerous discharge summaries and the system at the GP surgery has to prioritise those that are urgent, and these are seen by a GP the same day. Those not identified as urgent will be placed in a box for GPs to review within a week. Mother's situation was not regarded as urgent as she had not been referred to the psychiatric team and there was no mention of the MASH referral. The discharge summary was not seen by the GP before she attended the GP surgery the next day. The issue of communication within the health system is discussed further in Findings Two and Three

3.15 The next day the GP prescribed anti-depressant medication having been told by Father that the hospital doctor had said that Mother had "mild depression". This GP was not aware of Mother's previous mental health history as the family had not mentioned this and the letter from the perinatal service that had been sent to the previous GP had not migrated across into a new information system installed by the surgery. The health visitor was not notified by the GP but has informed this review that any parent taking an overdose would have received a priority visit from a health visitor. From Father's perspective the events surrounding the overdose were an

[6] The Multi Agency Safeguarding Hub.

opportunity to understand the seriousness of Mother's mental health condition and this episode is discussed further in Finding Two.

3.16 Two days after the overdose and as a result of the MASH referral a social worker spoke to Mother on the telephone and the case was allocated for a home visit within 72 hours to see the children, explore support networks, obtain permission for wider agency checks and agree a safety plan. At the first visit which took place one week after the overdose, the social worker agreed with Mother that a second visit was needed with an interpreter. This took place two days later. Following the home visit there was no contact with the health visitor or GP, but a referral was made (three weeks after the overdose) to the community mental health team via e-mail. This referral noted *she presents as tired, slow in speech with shoulder slouched forward, in my view she seems depressed.*

3.17 The referral from the social worker was discussed at the mental health assessment and liaison referrals meeting the next day (a Thursday). A new record had been opened as Mother's date of birth was incorrect and did not match the previous referral to the perinatal mental health team. The team were not aware of the previous referral and the plan was to:

- Telephone risk screen with an interpreter
- Refer to the perinatal team and if the referral was not accepted to discuss with the team leader
- The team leader to discuss with the Clinical Safeguarding Lead
- To update the referrer.

3.18 The referral was sent to the perinatal mental health team on the morning of the Saturday, the same day of the fatal incident.

The death of Emily and responding to the needs of Jack

3.19 The events following Emily's death are explored further in Finding Three.

3.20 On the Saturday morning Father left work early to return home having been unable to obtain a response from Mother via the phone. On arriving home, he called the London Ambulance Service and the Police to attend. On arrival uniformed police officers and ambulance crew heard Mother comment that she had killed her baby. An officer who could speak the same language as Mother was requested and was available to the family both at the home and later at the hospital although no Family Liaison Officer was allocated as at this stage events surrounding the death of Emily were not confirmed. The Metropolitan Police safeguarding team were notified by the officers at the home as were the homicide team.

3.21 Due to Emily's condition she was taken by ambulance as an emergency to the local acute hospital where she was pronounced deceased.

3.22 Mother, Father and Jack were also taken to the hospital where Mother was later arrested on suspicion of murder.

3.23 The Children's Services Emergency Duty Team had been notified by the Police and discussed with them the welfare of Jack. By this time Father was not thought to be implicated in the death of Emily and was deemed to be able to meet Jack's needs. A social worker from the Emergency Duty team briefly visited the hospital and at that time Jack was in the care of a uniform police officer as Father had been taken to the police station for questioning. The need for Jack to be medically examined was considered and took place the next day.

4 FAMILY PERSPECTIVES

4.1 From the perspective of Father, the main opportunity to help Mother and identify how ill she was, came at the point she took the overdose and he does not understand why she was not sent to a specialist at this point. He told the reviewers that he had no previous experience of psychosis and he believes that the hospital should have seen the signs that something was not right as contrary to the hospital's understanding, his perspective was that she did not know why she took the medication. He did know that she had suffered from depression a few years ago and was in hospital before coming to England and this was because of the loss of her job at the time. Father also knew Mother was missing her home country although family visited to help after the birth of Jack and Emily.

4.2 At no time did Father suspect that Mother would do anything to hurt their children, but he was very worried about Mother's own mental state as she was tearful after the overdose and a "bit down."

4.3 Father felt that midwives, health visitors and the baby clinic were helpful and both he and mother described the GP in very positive terms. At no time did Mother ask for an interpreter for these appointments as she had studied English at university and believed herself to be proficient enough to talk to professionals. She did however ask for an interpreter for ultrasound examinations and this was arranged.

4.4 Mother described feeling very positive about both pregnancies and also telling the midwife when pregnant with Jack that she had suffered from depression in the past. By the time she was pregnant with Emily she felt that she had no depression after having Jack and did not therefore think it would be possible to suffer with depression for her second child. She also believed by this point that if she mentioned taking medication social services would take her children away.

4.5 Mother also told the review that she had enough support from the local community although she was sad that her mother had to return home early after Emily's birth due to illness. She also feels that the one opportunity to help her more was after the overdose and that possibly being kept in hospital for observation and monitoring might have prevented Emily's death. She recognises that it would have been helpful to go back to talk to the GP as she began to feel worse just prior to the tragedy but by this point she was really incapable of doing so.

5 FINDINGS & RECOMMENDATIONS

5.1 The analysis of information in this case identifies three areas where there are lessons for practice:

- The initial response to Mother during her first pregnancy and the subsequent assessment of her mental health needs taking account of her history and cultural background. This is a theme though Findings One and Two and the important role that Health Visitors can play is discussed in Finding Three.
- The response by practitioners both in hospital and the community when Mother was seen in the acute hospital having taken an overdose when Emily was twelve weeks old. This is a key point in the case and is discussed in Finding Two.
- The effectiveness of the system in ensuring that Jack was safe, and his needs were met after the death of Emily. This is discussed in Finding Four.

Finding One

The safeguarding system in Croydon needs to be more effective in working with parents who have previous mental health conditions, taking account of factors that might make parents reluctant to talk about their past and where appropriate facilitate relevant sharing of information between professionals.

5.2 This review has grappled with sometimes competing views as to how far parents should be responsible for sharing of information about themselves, particularly in the light of previous contact with mental health services. The significance in this case was that had there been a more consistent knowledge across the network about Mother's in-patient history in her home country, a different analysis of her needs might have ensued.

5.3 This was not a situation where Mother never spoke about her past, but she did vary in the degree to which she shared information. For example she was open about her past mental health history when she booked with the midwife for her first pregnancy, told the ambulance crew when she was being taken into hospital after her overdose, but then according to GP records did not tell the GP when asked about whether she had any previous history of depression. The panel have discussed the stigma surrounding mental health that can prevent sharing of information, but it is not clear that this was perceived as a main inhibitor by Mother. Instead, she told the review that when she was reluctant to speak openly, the main driving factor was a fear that her children would be taken away. She attributes this reaction to her declining mental health and disordered thought processes. The reasons for her responses in specific situations cannot be determined by this review but it does serve to remind agencies of the need to promote an environment where parental mental health can be discussed openly with a focus on helping parents to access services that can support them in their parenting role. Further work needs to be done to understand how best to facilitate discussion with parents and their families about mental health issues, the

need for additional support with parenting and whether there are cultural factors that might provide additional challenges in this area of work.

5.4 In relation to cultural factors, since the family are an important source of information the review panel have considered whether inconsistency in the use of interpreters has influenced practice in this case, particularly in facilitating Mother's disclosure of her full family and medical history. There is evidence, confirmed by the lead reviewers meetings with the family that although Mother and Father give the impression of having a good understanding of the English language this is not always the case where complex issues are being discussed or the discussion relates to services and systems that would have been unfamiliar to them. It is important that assumptions are not made about expectations of services by people who have lived outside England, or the degree to which parents whose first language is not English understand technical issues relating to the way systems operate.

5.5 In this case, important information about Mother's mental health history was obtained from her home country after the death of Emily. The review panel were unsure how far this would have been easily obtainable to professionals assessing Mother's needs without the catalyst of such a serious incident. The events described in this review confirm the importance of obtaining such information and systems need to be in place to facilitate this.

5.6 Responsibility for sharing and making sense of information must not sit with parents alone. The professional system needs to make sure that information is shared properly with the appropriate consents, and that other information that indicates a parent may need additional support to care for their children is recognised. This is did not always happen in this case due to a combination of factors including:

- Different criteria being used to judge whether a perinatal service was required than would be used today.
- IT system errors resulting in not all information being transferred between GP surgeries
- Difficulties in identifying all relevant factors within an electronic health record
- Difficulties in identifying where an interpreter is necessary when a parent's first language is not English.

5.7 When Mother shared information about her history, the midwife appropriately referred to the perinatal mental health team and recorded that Mother had in-patient treatment in her home country and there was a family history of mental illness. The referral was rejected by the perinatal mental health service although the lead reviewers have been assured that practice today would be to always accept a referral where a Mother has previous in-patient treatment. The importance of this being established practice is confirmed by this review, as there is now evidence that the extent of Mother's mental health treatment in her home country was significant and that her support needs during pregnancy needed to be assessed.

5.8 The lack of perinatal mental health assessment at an early stage had a significant impact on later events.

- During Mother's first pregnancy the health visitor was not concerned when she understood that Mother had declined an ante-natal visit (as discussed in paragraph 3.5) and assumed the midwife was managing the situation. Had there been more involvement by the perinatal service it is likely that there would have been liaison between the perinatal service and the health visitor and more consideration of support needs beyond universal provision.
- If Mother had received "Universal Plus" support for the first pregnancy as result of concerns about her previous mental health, this should then have meant that similar support would have automatically been in place for her second child.
- The note in the midwifery records regarding Mother's history, including inpatient treatment, was not obvious within the acute trust electronic records and did not therefore inform the decision making of the emergency department doctor after Mother's overdose. The doctor accepted Mother's comment that she had previously suffered from depression but was no longer on medication, as being indicative of a non-serious episode. An assessment by the perinatal service may have been more obvious within health records and should have provided more detailed information about Mother's mental health condition.
- The health visitor carrying out the new birth visit for Emily who had not met Mother before, did not have time to read all the records and was not alerted to previous concerns about mental health.
- By the time of the second pregnancy, practitioners told the review that even had they known, because time had passed and Mother had managed well with Jack, they would not have automatically considered the need for further monitoring and review beyond universal provision. This is not in line with expected practice set out in the perinatal pathway[7] and is an area for learning and practice development. It should not have automatically been assumed that because Mother had managed well with one child, all would be well with a second baby born only fifteen months later.

5.9 The GP at the time of the overdose should have been aware of the previous referral to the perinatal mental health team and that Mother had not met the criteria for a service. However, this GP had no information at all about Mother's mental health history as the original letter declining the referral had not migrated into the new electronic records. The GP did ask Mother about any previous mental health issues and she did not tell the GP about her past history.

5.10 The review panel has considered the suggestion from midwives that a history of mental health problems should attract a flag on the records which would be easily identifiable should Mother present at hospital. This is worthy of further discussion but there are several issues to consider:

- What the threshold would be to apply a flag as too many factors warranting a flag in the records might result in a loss of meaning

[7] Croydon Health Services NHS Trust (2016 and 2019) Perinatal Pathway for Health Visitors.

- The organisation needs to agree who can flag and this must be administered properly
- There would need to be discussion about who should be authorised to add a flag about parental mental health
- Any use of flags should not detract from the professional responsibility that practitioners have to read past records in order to inform current decisions.

Recommendation One
Health partners should work together to establish a system to alert practitioners where a parent has previous in-patient treatment for a mental health condition.

Recommendation Two
Croydon CCG should remind Croydon GPs of NICE guidance and best practice in the use of structured risk assessments in situations of parental mental ill health, and their use should form part of the next CCG self-assessment of GP practice.

Recommendation Three
Partners providing services to children and families in Croydon should review the use of interpreters and ensure that provision is adequate and is being used appropriately.

Recommendation Four
The CSCP should seek reassurance that practitioners are encouraged and supported to obtain relevant information from outside the UK and incorporate the response into their assessment practice.

Recommendation Five
Croydon Public Health should work with Mental Health Services and parents to understand any obstacles to sharing information about previous mental health conditions and use this information to develop a positive public health message.

Finding Two
The response to an overdose by a parent must include:

- **an adequate mental health assessment**
- **effective liaison between acute and community services**
- **the prioritisation of responses to mental health concerns of parents with babies and small children.**
- **effective multi-agency assessment**

5.11 The episode when Mother presented at the acute hospital with an overdose highlights several areas for practice improvement and development as well as aspects of good practice by individuals within the system. Despite this good practice the overarching picture is of a system under pressure where “process” and “throughput” was dominating practice with limited critical thinking and discussion with colleagues.

5.12 There was good practice on the part of the London Ambulance Service who submitted a child safeguarding referral to MASH which clarified Mother’s previous mental health history. However, neither the ambulance handover sheet given to the

emergency department, nor the verbal handover included information about the history or that a MASH referral had been made. This was particularly significant in this case as knowledge of a previous mental health history would have changed later assessments and highlights the need for attention to be paid to information exchange at the point of handover.

5.13 The review has been told that although the Ambulance Service procedure is to complete written information to pass to staff in the Emergency Department, the reality is that there is no time in a busy department to read this and the verbal handover is the prime route for information transfer. This appears to be an example of a system developed within one organisation which may not have its desired impact due to the way it is received. A similar dynamic occurred at the point of information transfer out of the Emergency Department to the GP as described in paragraph 3.14 above and discussed in paragraph 5.21 below.

5.14 When Mother was first seen in the Emergency Department the triage nurse was expected to start the completion of the risk assessment matrix and then hand this on to the treating doctor for finalisation and decision making. In this case the triage nurse made appropriate recommendations regarding her medical care based on known information and it was good practice that this assessment noted that that she should be seen by the mental health team and a MASH referral made. The nurse immediately completed the MASH referral form to alert Children's Social Care; this document did not include all the information contained within the London Ambulance Service referral which had also been made to MASH, as Mother had not disclosed previous mental health issues to the triage nurse. Mother does not recall being asked about any previous problems at this point.

5.15 It is of note that this experienced nurse was influenced by her gut instinct which told her that there were underlying issues – she recalls that Mother did not look her in the eyes or engage well and this raised concerns. This serves as a reminder of the importance of integrating intuitive responses with hard information when assessing any form of risk.

5.16 Within the hospital, once the triage nurse made the decision to make the MASH referral, the system within the adult emergency department did not include discussion with the hospital children's safeguarding team who could have then liaised with the health visiting service. The assumption was that a MASH referral would automatically trigger health visitor notification and input.

5.17 Following triage, there was no further discussion between the nurse and the treating doctor. The doctor within the Emergency Department who was responsible for assessing Mother used the same hospital mental health risk matrix as the nurse (which includes a set of risk factors rated red/amber/green) and decided that there was no need for referral to the liaison mental health team within the hospital. The rationale for this decision is not recorded, including why the recommendations of the triage nurse were not followed. From discussions with staff in the Emergency

Department, expectations about the way in which decisions about risk are recorded needs clarification.

5.18 In this case there was no discussion at the time with anyone from the psychiatric liaison team to confirm that discharge home and a GP appointment was the right decision. The doctor concerned was hesitant to refer every overdose to the mental health team feeling that this would not be welcomed unless clear risks were identified. It appears that there was an over reliance on an understanding that the overdose had been "accidental" and Mother had not intended to take her own life. This analysis does not consider the need to understand the mental state of any parent who takes an overdose when caring for very young children, whether or not this was intentional self-harm.

5.19 A discussion with psychiatrists from the liaison team at the acute hospital confirmed from their perspective it is recommended practice that even where an assessment is rated "green" and the patient has taken an overdose and/or is a parent who has self-harmed there should be, at a minimum, a discussion with the mental health team. In fact, in this case there could have been a direct referral from the hospital to the perinatal mental health team.

5.20 One factor underlying decision making in this case appears to be opportunities for doctors in the emergency department to receive training and ongoing consultation in the management of mental health patients. The review was informed that previously consultant psychiatrists had provided input to the induction training programme for emergency doctors and there had been regular group supervision sessions. Both these practices had stopped as due to work pressures it has been increasingly difficult for staff to attend the training. As a result, emergency doctors may not be aware of expected practice and have limited opportunities to develop their knowledge and skills in this area.

5.21 The standard discharge summary that was received by the GP practice from the hospital had no prompt to identify it as urgent (as is usual practice) and was not seen by the GP before Mother's appointment. Information to this review from the Emergency Department is that there is no system for flagging letters as urgent and an assumption is made that GP surgeries screen all discharge summaries on arrival in the surgery. This is not the case and within Mother's surgery only those clearly identified as urgent will be looked at by a GP immediately. The hospital letter noted the overdose but because Mother had not been referred to the psychiatric team and the letter did not mention the referral to MASH there was nothing to alert the GP to the possible seriousness of the situation.

5.22 The GP carried out their own risk assessment which is not based on any recognised guidance and from this concluded that Mother did not need a referral to mental health or other services. Mother said she had no previous mental health problems and felt that Father was able to offer enough support. The GP has informed the review that counselling was offered which Mother refused, preferring regular sessions with the GP who spoke her language. The GP is not a trained counsellor and these sessions

were intended to provide general support. From mother's perspective she does not recall being offered counselling by the GP at this stage.

5.23 The specific response to the MASH referral within Children's Services is discussed further in Finding Three below. Once allocated to a social worker it is positive that there was a referral to the mental health assessment and liaison team; although the referral also lacked a reference to Mother's mental health history in her home country which had been contained in the referral from the London Ambulance Service. A more appropriate course of action at that time would have been a direct referral to the perinatal service. This would not be an issue today as the current system in mental health provides a single point of access which would have allowed for a quick decision to be made within mental health services as to the most appropriate team to respond to the referral.

5.24 The referral from the social worker contained enough information to prompt a speedier response by mental health services than occurred at the time. Within the mental health assessment and liaison team there was no link made with the previous referral to the perinatal service as Mother's details (date of birth) on the social work referral did not match. The review has not found that this was anything other than a genuine mistake. The review of mental health services carried out under the NHS serious incident framework[8] confirms that the teams screening tool was not used and there was no follow up with either the social worker or the GP to clarify the nature of the overdose and how medication was being managed. The significance of a referral from a social worker (which is an unusual event) in relation to a Mother with two small children was not recognised as a priority and was instead discussed at the regular referrals meeting the next day (Friday) and the plan actioned on Saturday; the same day as the incident. The reason for the slower than expected response is identified in the serious incident review is that the team were under pressure and only had capacity to respond to severe presentations. The referral from the social worker did not reach that threshold. Action has now been taken to improve staffing and the protocol has been updated to ensure that any referrals that should be assessed by the perinatal team are sent the same day.

Recommendation Six
The risk assessment matrix used in the emergency department should be reviewed and amended to specify that where a patient presents with post-natal depression and/or an overdose there must be a referral to the psychiatric liaison team.

Recommendation Seven
Protocols and training within the emergency department should be revised to ensure that where a MASH referral has been made by the emergency department due to concerns about a patient's mental health, there should always be a referral to liaison psychiatry and notification to the hospital safeguarding team. The MASH referral should always be noted in discharge notifications to GPs.

[8] Mental Health Investigation Report (September 2019) South London and Maudsley NHS Foundation Trust.

Recommendation Eight
Within the Emergency Department all staff, including junior doctors on rotation, should receive mandatory training in expected practice where a patient presents with mental health concerns and ongoing opportunities for reflection and practice development in this area.

Recommendation Nine
Croydon Health Services should review points of information transfer to make sure that assumptions about the way information is being received are realistic and understood by all involved. Specifically:

- Discharge summaries sent by the Emergency Department to GPs.
- Written information given by the Ambulance Service to staff in the Emergency Department.

Recommendation Ten
Croydon Children's Services should work with mental health services to review and develop the role of the MASH mental health worker in order to support effective decision making at the point of referral.

Finding Three
Where parents of young babies have emerging mental health concerns, the skills of health visitors should be recognised by the professional network and utilised as part of a plan to provide support and assess potential risk.

5.25 In this case there were three opportunities for health visitors to be made aware of Mother's overdose, but information did not reach the health visiting service prior to the death of Emily. The opportunities were:

- When Mother was seen in the Emergency Department
- When Mother visited the GP the next day
- When the social worker responded to the MASH referral.

5.26 Had health visitors been aware of a parent with a young child presenting at hospital with an overdose they would have prioritised a home visit to assess what support might be required.

5.27 Within the hospital, the system for notifying the safeguarding team where the concern is about an adult as a parent does not work as effectively as the system where the child is the focus of the concern. In this case there was no automatic notification to the safeguarding team who could have then liaised with the community health visitors. This issue has been addressed in recommendation six above.

5.28 The MASH referral was assumed by hospital staff to trigger a multi professional response including notification of the health visitor. In fact, there was no contact by a social worker with either the GP or the health visiting service as part of the information gathering process, or later once the case was allocated for assessment. Information given to this review suggests that social work practice in Croydon does not always adequately involve communication and discussion with GPs and health

visitors. These discussions appear to be constrained by concerns about permission to share information. Government guidance on information sharing[9] promotes a positive approach to sharing information, seeking consent as appropriate but always considering the safety and wellbeing of the child.

The GDPR and Data Protection Act2018 place duties on organisations and individuals to process personal information fairly and lawfully; they are not a barrier to sharing information, where the failure to do so would cause the safety or well-being of a child to be compromised. Similarly, human rights concerns, such as respecting the right to a private and family life would not prevent sharing where there are real safeguarding concerns. (p7)

5.29 Information gathering from partner agencies should therefore always be possible with parental permission and practice standards within Croydon Children's Social Care state that:

All assessments will include multi-agency contributions and participation…and…Partner agencies are part of all ongoing planning and intervention for the family[10]

There is little evidence that these standards informed practice in this case either at the point the MASH referral was received, or during the Child in Need assessment process. As a result, this contributed to the health visitor and GP not having the full picture. Further work is needed to understand whether this is a more general social work practice issue in Croydon.

5.30 The review has also been informed that there is a mental health practitioner whose role is to work closely with MASH, but they were not involved in discussions about this referral because it is not a full-time post.

5.31 The GP who saw Mother the day after the overdose did not consider involving the health visitor in a situation such as this and health visitors told the review that they have only tenuous links with GPs. The GP practice does not hold multi professional meetings where patients with vulnerabilities can be discussed and the role of health visitors in working with parents with emerging mental health issues is an area for development.

Recommendation Eleven
Health visitors in Croydon should be supported and given permission to take the time required to review family history prior to a new birth visit.

Recommendation Twelve
Children's Social Care should improve the information sharing culture by clarifying expectations and promoting a positive approach to information gathering, information

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf
[10] Practice Standard 2

sharing and collaboration with families and professionals within the safeguarding network.

Recommendation Thirteen
The Safeguarding Partnership should ask relevant organisations to test the current relationship between health visitors and GPs and develop a consistent approach across Croydon for information sharing and face to face discussion about children who may need a service beyond universal provision.

Finding Four
The system designed to make sure that a surviving sibling is safe needs to include effective co-ordination within the police and between police, health and children's social care.

5.32 In this case Father has provided good care for the surviving sibling but on the day of the incident, although individuals did their best, here was insufficient co-ordination and planned focus on making sure Father was both physically and emotionally able to ensure Sibling's needs were met. It was not always clear to everyone who had overall responsibility for coordinating the response within the hospital and the situation was affected by a lack of presence by the police safeguarding team. This issue was compounded by the fact that the incident took place at a weekend when there is minimum social work cover.

5.33 From the perspective of the Consultant Paediatrician the protocols for managing the suspicious death of a baby in Croydon, including the relative roles and responsibilities of the various police teams and health and social care staff are not clear and easily accessible at a time of crisis. The detectives from the homicide team cover the whole of London and may take some time to arrive, and this left the paediatrician in this case with uncertainty as to how to proceed. This would have been clearer had there been an officer from the police safeguarding team available at the hospital.

5.34 Expected practice within the Metropolitan Police in these circumstances is that a Detective Sergeant from the safeguarding team should attend the scene and/or the hospital until such time as the homicide team can arrive. This did not happen in this case and as a result uniformed officers were left managing a complex situation involving a murdered baby plus a surviving sibling, although they did request the presence of safeguarding officers. There were no system pressures on that day that should have prevented this happening and action has now been taken by the police to make sure that relevant individuals are aware of expectations.

5.35 There is a record of a telephone strategy discussion between the Police Sergeant and the children's out of hours team which confirmed that there were no immediate safeguarding concerns in relation to Father, he could continue to care for his son and Children's Social Care would arrange emergency accommodation near the hospital. However, at this stage no safeguarding professional had seen Father, the full facts of

the case were not known, and this should have informed the plan. In any event, Father was in a state of severe shock and had no family support nearby and the impact on him of the death of his baby could not be known, including how this might affect his emotional capacity to care for his son.

5.36 In addition, access to interpreters via language line could have assisted the out of hours social work team as they were communicating with Father over the phone at a point when he would have been very distressed. Language line is available to social workers only during office hours which results in service users who need this service out of hours receiving an inferior response.

5.37 The decisions at this stage did not set out a clear plan for a medical check and when Father was taken for questioning at the police station it was assumed by the Detective Sergeant that Sibling at been admitted to hospital and was therefore the responsibility of medical and nursing staff. In fact, Sibling remained for some time in the care of a uniformed police officer until Father returned. He then went into hostel accommodation with Father (as the home was a crime scene) and was medically examined the next day. Medical and nursing staff were not aware that Jack had left the hospital with Father and at first were not sure where he was. Jack was safe but this might not be the case in other similar situations, and it is important that there is greater clarity as to who has overall responsibility for coordinating the plan and communicating with relevant staff.

5.38 The hostel accommodation provided for Father and Jack is approved by Croydon Housing as suitable for emergency housing for families. Although practitioners acted with the best of intentions the description of the hostel given by Father is of accommodation that was unsuitable for a recently traumatised parent who was caring for his young child. No one accompanied Father to the accommodation to check its suitability or that he had the necessary money and clothes. The system at this point did not have sufficient resources or flexibility to respond to these unusual circumstances in a way that provided good standard accommodation and made sure that father had all he needed to care for his child.

5.39 It is important to stress that the above analysis does not blame any individual but is intended to highlight a potential gap in the system. Steps were taken to provide practical support to Father and there is no suggestion that he could or should not care for his child. However, he had no family support and in addition to the practical response provided, no one person had the role of providing the emotional support that a bereaved parent might need in these circumstances.

Recommendation Fourteen
Croydon Safeguarding Children Partnership need to ensure that comprehensive guidance is available to all professionals when a child has been killed by a family member and that professionals are trained in its use. This must include clarification of roles, responsibilities and expectations of staff from the Metropolitan Police, Children's Social Care and all relevant health professionals in acute and community services and address the issue of emotional support for a bereaved parent.

6 SUMMARY OF RECOMMENDATIONS

Recommendation One
Health partners should work together to establish a system to alert practitioners where a parent has previous in-patient treatment for a mental health condition.

Recommendation Two
Croydon CCG should remind Croydon GPs of NICE guidance and best practice in the use of structured risk assessments in situations of parental mental ill health, and their use should form part of the next CCG self-assessment of GP practice.

Recommendation Three
Partners providing services to children and families in Croydon should review the use of interpreters and ensure that provision is adequate and is being used appropriately.

Recommendation Four
The CSCP should seek reassurance that practitioners are encouraged and supported to obtain relevant information from outside the UK and incorporate the response into their assessment practice.

Recommendation Five
Croydon Public Health should work with Mental Health Services and parents to understand any obstacles to sharing information about previous mental health conditions and use this information to develop a positive public health message.

Recommendation Six
The risk assessment matrix used in the emergency department should be reviewed and amended to specify that where a patient presents with post-natal depression and/or an overdose there must be a referral to the psychiatric liaison team.

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assumptions about the way information is being received are realistic and understood by all involved. Specifically:

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Health visitors in Croydon should be supported and given permission to take the time required to review family history prior to a new birth visit.

Recommendation Twelve
Children's Social Care should improve the information sharing culture by clarifying expectations and promoting a positive approach to information gathering, information sharing and collaboration with families and professionals within the safeguarding network.

Recommendation Thirteen
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7 APPENDIX 1 – TERMS OF REFERENCE

CSCB TERMS OF REFERENCE

Serious Case Review Emily & Jack

1. SCR decision

Following presentation to the March 2019 Serious Case Review Sub Group, consultation the SCR National Panel and feedback from SCR sub-group agencies, it was agreed that a Serious Case Review should be undertaken.

2. Child & Family details

Emily

Jack

Mother

Father

Address: Croydon.

First language: Eastern European

3. Circumstances

In March 2019 London Ambulance Service received a 999 call regarding a three month old baby not breathing. The baby was found to be in cardiac arrest. The baby was pronounced dead at the Hospital and the summary of the cause of death is Suffocation, although the Post Mortem results are awaited. Mother reportedly told LAS staff 'I've killed my baby'.

4. Serious Case Review Criteria & Purpose

In accordance with the Local Safeguarding - Transitional Arrangements 2018 Croydon Safeguarding Children Board continues to have a statutory duty to commission Serious Case Reviews. The criteria for serious case reviews are detailed in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006:-

5 (2) A serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Working Together (2015) states: Reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

5. Learning outcomes

- To gain an understanding of the factors that led to this child's death
- To identify learning from all aspects of the history and engagement with the family
- To promote any learning from this SCR across the safeguarding partnership

Specific Questions:

- How well are Professionals in all agencies equipped to assess need and provide resources for people from different cultures.
- How do Professionals and services assess what support within the community is being accessed by a family.
- What consideration is given to ante and post-natal support, and what knowledge do Practitioners have of the range of services available locally?
- How confident are Professionals in exploring physical and mental health history in ante and post-natal care and subsequently assessing need.
- What is the level of understanding of mental health issues in Midwives, GPs and Health Visitors?
- Was mother's history taken into account in SLAM's decision to reject the perinatal referral?
- Was father engaged with agencies?
- Was there an understanding of any need for and use of interpreters? Was there an over-reliance on father to be the interpreter?
- What is the quality of multi-disciplinary working within Health agencies as regards information sharing and the coordination of services, and the responsibility of agencies when cases don't meet threshold for service provision (both the referring agency and the agency that declines to provide a service).
- How well did the agency respond to the safeguarding needs of the family in the immediate aftermath of the tragedy. What factors help and what gets in the way of good practice?

6. SCR Author and Chair

Independent Consultant Jane Wonnacott has been appointed as SCR author. Jane is an SCR author recommended by the National Safeguarding Review Panel and a recognised expert in safeguarding and in conducting reviews. Edi Carmi, Independent Consultant has been appointed as Chair of the SCR Panel. Edi has extensive experience in Safeguarding Children with specialist knowledge in Serious Case Reviews and has led other case reviews and studies of local authority systems and practice.

7. SCR Review Panel

The SCR Review Panel will play a pivotal role in providing scrutiny and challenge to the review, of both their own agency and that of partners. They will ensure their agency is complaint with the requests of the SCR and within the specified timescales. They will actively contribute to the SCR report and assist in the identification of relevant practitioners for any practitioner enquiries and learning events.

SCR Panel Membership is drawn from representatives from all relevant agencies:

- Croydon CCG & CHS – Designated Doctor for Child Protection (incl. GP)
- Croydon CHS – Head of Safeguarding
- South London and Maudsley
- London Ambulance Service
- Met Police
- Croydon Social Care & Early Help
- Any other relevant agency

8. Methodology

This SCR will use a hybrid model which includes:

- Chronology of individual agency involvement with the family using the Chronolator tool,
- Summary of findings and learning from each Agency
- Individual agency staff groups meetings with Chair and Author
- Practitioner Learning Event
- Scrutiny of SCR report

Learning event - Practitioners

Participation/learning events will be held for those involved from the relevant services, with the aim of capturing multi-agency views about the learning areas outlined above. It will also provide an opportunity for reflection and constructive ideas about these complex issues**.**

Timeline

- Partners are asked to record their engagement with the family for the period 1 January 2017.to 6 March 2019 using the Chronolator Tool
- Partners are asked to summarise, in bullet point form, any contact with the family for the month after 6 March 2019, using the Chronolator Tool
- Partners are asked to include any other relevant information outside this timeline, again using the Chronolator Tool

9. Family

The family will be informed of the Serious Case Review and invited to take part in the Review with a view to gaining their views about services or support provided or that have engaged with them over the review period.

This will be facilitated by the CSCB team and undertaken by the Chair and Author. This is likely to include both parents and relevant grandparents.

10. Password

Please ensure that any confidential documents transmitted electronically are protected using this password.

11. Appendix

Information gathering documents included in the first SCR panel meeting:

- London Ambulance Service
- Police
- GP
- Health Visiting
- Midwifery
- Children's Social Care & Early Help

Questions

If you have any questions about this process please contact Maureen Floyd (CSCB Manager) on maureen.floyd@croydon.gov.uk or Board Administrator Nia Lewis on nia.lewis@croydon.gov.uk

8 APPENDIX 2 – DETAILS OF LEAD REVIEWERS

Edi Carmi (review chair)

Edi Carmi, qualified as a social worker in 1978 and after a career as a practitioner and manager in both statutory and voluntary sectors, has worked independently for 19 years. During that time she has focused primarily on the safeguarding of children, undertaking serious case reviews as well as writing policy and procedure. She was the lead author of the first pan London child protection procedures, as well as the procedures throughout the South East. Since 2009 she has been working with the Social Care Institute for Excellence (SCIE) in the development and implementation of the Learning Together methodology for learning from practice and more recently leading the national audit of diocesan safeguarding for the Church of England and author of the 3 published overview reports.

She has considerable experience on learning from reviews where there are multiple victims, involving both non recent and recent abuse; this has included reviews into cases of child sexual exploitation, child on child abuse, the early deaths of 13 care leavers in Somerset and the abuse of children within adopted families. She has a particular interest in institutional abuse and was the author of a report for the Diocese of Chichester, subsequently known and published in 2014 as the 'Carmi' report, into the abuse of choristers. She was also a joint lead reviewer, with Jane Wonnacott, on the serious case review into Southbank International School London and was Chair of the St Paul's School Serious Case Review.

Jane Wonnacott (report author)

Jane qualified as a social worker in 1979 and has an MSc in social work practice, the Advanced Award in Social Work and an MPhil as a result of researching the impact of supervision on child protection practice. She has significant experience in the field of safeguarding at a local and national level. Since 1994 Jane has completed in excess of 150 serious case reviews, many of national significance. She has a particular interest in safeguarding practice within organisations and was the lead reviewer for two reviews into abuse in nurseries and the serious case reviews into St Paul's School and Southbank International School London. She has contributed to the literature exploring effective safeguarding education settings. Jane is a member of the national Child Safeguarding Practice Review Panel pool of reviewers.

As Director of In-Trac Training and Consultancy, Jane has been instrumental in developing a wide range of safeguarding training and oversaw In-Trac's contribution to the development of the "Achieving Permanence" training materials for the Department of Education. She has a long-standing interest in supervision and developed a national supervision training programme for social workers with the late Tony Morrison. She has recently worked with colleagues to apply this model in school settings.