Nottinghamshire SAFEGUARDING CHILDREN Board

silp™ Significant Incident Learning Process

Serious Case Review

Child JN15

OVERVIEW REPORT

Lead reviewer: Nicki Pettitt

Presented to the NSCB: 26 May 2015

CONTENTS

1 Summary of the lessons learned from this case

1.1 The lessons to be learned from this review are limited. It has been established that the professionals working with the family had no contact with Mother at the time that she developed a perinatal psychosis. The family were receiving a universal service from the health professionals involved and Mother had not disclosed that she may be suffering from postnatal depression. No signs of this condition were noticed when professionals had seen Mother and when the standard assessments were undertaken.

1.2 The baby (JN15) was 5 months old and was the second child in this family. There were no concerns about the first pregnancy and perinatal period, and there was no known mental health history for Mother or in her wider family. It was concluded that she would not be considered high risk for this type of mental illness.

1.3 No professionals were alerted to the deterioration in Mother's mental health in the days and hours before the death of JN15. The parents state that it was not evident that Mother was seriously ill.

1.4 Despite this some learning has been identified in this report, and the lessons are:

Lesson 1:
Nottinghamshire Police followed procedures by informing Children Social Care of a domestic abuse incident in April 2013. The health professionals who were the only people having contact with the family were not informed. It is not current policy to share police notifications with a standard risk with health visitors, school nurses or GPs. The receipt of a police domestic abuse notification could increase the input to a family from universal to targeted. A recommendation has been made in regards to this.

Lesson 2:
When pregnant a woman is more at risk of domestic abuse. The current national risk assessment tool in use includes pregnancy as a risk factor; however, on its own this does not automatically increase the level of assessed risk.

Lesson 3:
While information sharing locally was good, information regarding the call out for a domestic incident in another geographical area was not available to Nottinghamshire Police either at the time or for the purpose of this review. The NSCB may wish to inform that area LSCB of this matter.

2 Introduction to the Significant Incident Learning Process (SILP)

2.1 SILP is a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in the Working Together to Safeguard Children (2013 and 2015).

2.2 The SILP model of review adheres to the principles of;

- proportionality
- learning from good practice
- the active engagement of practitioners

- engaging with families, and
- systems methodology

2.3 It has been generally accepted that over recent years the Serious Case Review agenda had become over-bureaucratic and driven by Ofsted ratings. The practitioners in the case had often been marginalised and their potentially valuable contribution to the learning has been under-valued and under-utilised.

2.4 SILPs are characterised by the relevant practitioners, managers and Safeguarding Leads coming together for a Learning Event. All the agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then invited to a Recall Event to study and debate the first draft of the overview report, and to make an invaluable contribution to the learning and conclusions of the review.

2.5 Nottinghamshire Safeguarding Children Board (NSCB) has requested that the SILP model of review be used to consider the circumstances surrounding the death of a child known as JN15. This systems review is being undertaken in order to learn lessons about the way that agencies in Nottinghamshire work together to safeguard children.

2.6 Working Together 2013 (the guidance at the time the decision was made to undertake this review) states that SCRs and other case 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.

2.7 This serious case review (SCR) has been undertaken using the SILP model, which ensures that these principles have been followed and provides a systems review of the case.

3 Introduction to the Case

3.1 The subject of this review is JN15, a 5 month old boy who died in 2014 of a currently unclear cause. The post mortem stated that the cause of death was inconclusive. The investigating officer told the lead reviewer that it had been stated that the death could have been caused by 'accidental/overlay/soft smothering'. At the time of the baby's death JN15 was in the care of his Mother who had previously unrecognised or diagnosed mental health illness.

3.1 JN15 had one sibling who was 4 years old at the time of the death. JN15 lived with the parents and Sibling throughout his life. Sibling was not at home at the time of the death of JN15.

3.2 The family were known to a number of agencies for a universal service. Other than the response to one telephone call made to the Police by Mother regarding an alleged domestic abuse incident before the birth of JN15, the family did not receive any services due to identified safeguarding, child in need, or early help issues.

4 Family Structure

4.1 The subject child is to be referred to JN15. The sibling is referred to as Sibling. There are no other children in the immediate family.

4.2 The parents of the subject children are referred to in this report as Mother and Father.

4.3 The children and both parents are of Middle Eastern origin and practicing Christians. Father had always been a Christian and Mother had converted from Islam. They were regular attendees at an evangelical Christian church which Mother told professionals was her main source of support other than Father and she appeared to be committed to the religion.

4.4 The family's ethnic group and religion were recorded appropriately on agency records. The parents can be described as affluent and educated. They both work as health care professionals.

4.5 A genogram was produced to aid the review.

5 Terms of Reference

5.1 A detailed Terms of Reference and Project Plan guided the conduct of the review. The purpose, framework, agency reports that were commissioned and the particular areas for consideration are all described there.

5.2 It was agreed that the timeframe for this review would be from a date in 2010 (around the time of Sibling's birth) to the date of JN15's death in 2014. It has been identified that there may be further learning from the months following JN15's death, however this will be explored by the NSCB outside the remit of this SCR.

6 Process

6.1 The parents of JN15 were contacted in order to ensure that their views were considered and heard as part of the review. A letter was sent and the author, along with a Nottinghamshire Safeguarding Children Board representative, visited the family on 23 February 2015 and 5 May 2015. The parents understood the requirement to complete the review and were cooperative. The information provided by them has been included throughout this report.

6.2 The Department for Education (DfE) expects full publication of Serious Case Review overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information may not be disclosed in this report. It is written in the anticipation that it will be published, and contains all of the information that is relevant to the professional responses and contact with JN15 and his family. The decision to disclose information has been taken with reasonable caution to prevent the identification of the children concerned and other family members, and to protect the right to an appropriate degree of privacy for the family.

6.3 A meeting for authors of Agency Reports was held on 23 February 2015, where the SILP process and expectations of the agency reports was discussed. A Learning Event took place on 14 April 2015. The agencies involved were represented by both the report author and the majority of staff, including managers, who had been involved during the scope period.

6.4 All the agency reports available had been circulated in advance, to ensure all staff attending were able to fully understand the multi-agency information and focus of the review.

6.5 The Recall Event was held on 5 May 2015. Participants who had attended the Learning Event, and some additional practitioners who had been unable to make the first meeting, considered the first draft of this report. They were able to feedback on the contents and clarify their role and perspective. All those involved contributed to the conclusions about the learning from this review. The final version of this Overview Report will be presented to the Nottinghamshire Safeguarding Children Board on 26 May 2015.

6.6 The Coroner is investigating the death of JN15 and this SCR is running parallel to the Coroner's enquiries. The inquest is due to be heard prior to publication of this report. The Coroner is aware that this review is being undertaken. They have requested that this report be shared with them. *(Since this report was finalised the Coroner's inquest has taken place and a narrative verdict given).*

6.7 The NSCB has been informed that the police investigation has been concluded and that no charges are to be brought in this case.

6.8 The sibling is currently living with the parents, and was the subject of a child protection plan. There is currently a child in need plan in place. The parents have cooperated with all professionals since the death of JN15.

6.9 The reviewer in this case and report author is Nicki Pettitt, an independent child protection social work manager and consultant. She is an experienced chair and author of SCRs, and is a SILP associate reviewer. She is entirely independent of NSCB and its partner agencies.

6.10 Working Together 2013 does not require the completion of a health overview report which considers the commissioning of health services and in some circumstances may be helpful in pulling together the related health information. It was agreed with the NSCB that an additional review of this type is not required in this case, as there were no complex health issues identified prior to the death of JN15 that needed to be addressed.

6.11 This process has been effectively administered by the NSCB.

7 The background prior to the scoped period

7.1 Agency authors were asked to consider all of the records held on the subject child, and relevant records on other family members. While they were asked to provide detail and analysis on the period of the scope of this review, they were also asked to provide a summary of information known to them from before the period in question in order to ensure that relevant and pertinent background information was available to the review.

7.2 The family have lived in Nottinghamshire since just after Sibling was born. Prior to that they lived in other areas of the UK. They had lived in Britain for a number of years before having a family.

7.3 Father disclosed to social workers after the death of JN15 that the police were involved briefly in another area of the country after a neighbour alerted them to an argument between Mother and Father. They attended the couple's home but no further action was taken. Despite efforts to establish the details, this review has been unable to establish any further details of the incident.

7.4 Services for adults or children have no further details about either parent that is of concern during the period prior to the scope of this review.

8 Key Practice Episodes

8.1 The period under review has been divided into two key practice episodes. Key practice episodes are periods of intervention that are judged to be significant to understanding the way that the case developed and was managed by professionals. The term 'key' emphasises that they do not necessarily form a complete history of the case but are a selection of the activity that occurred, and includes the information that is thought to be key in informing the review.

8.1 The first key practice episode covers from 2010 to 2013. This is the time prior to the birth of JN15 and includes information about the sibling.

8.2 The second episode covers from 2013 to 2014. The period from the birth of JN15 until his death.

Key Practice Episode 1: 2010 to 2013. (The period prior to the birth of JN15, and including information about the sibling).

8.3 The pregnancy with and birth of sibling were unremarkable. The Midwife told the reviewer at the recall event that there were no indications of mental illness or domestic abuse. Mother was usually seen on her own.

8.4 Mother told the health visitor she was sharing her bed with Sibling, and advice was given about the dangers of co-sleeping. Mother continued to sleep with the baby. Other than this Mother was cooperative and the family were assessed as requiring a universal health visiting service[1].

8.5 Mother and Sibling received routine support including baby massage sessions. They attended clinics and received advice on weaning. As part of the exploration of support available to new mothers the health visitor discussed the family's church and Mother stated it was a large part of her support network and that she enjoyed attending. It was identified that Mother had little home support other than Father however, which was again noted by the health visitor when Mother was pregnant with JN15.

8.6 The parents consulted their GP a number of times regarding the sibling both before and after the birth of JN15. Appropriate advice and treatment was sought and provided.

8.7 When Sibling was nearly a year old they were referred to the Community Paediatrician due to a concern identified by the parents and health visitor that Sibling's weight had fallen from the 75th to the 25th centile. Around this time the parents had concerns about Sibling's regular bouts of diarrhoea and vomiting which they believed was due to Sibling recently starting to attend nursery. There was good information sharing between the heath visitor and GP and a decision was made to refer to a paediatrician. The health visitor also agreed to review Sibling on a three weekly basis. The support that was given included an acknowledgement of the fact that Sibling was a fussy eater and that Mother was anxious about introducing solid foods.

[1] The Universal service is the core offer or minimum number of visits to a family i.e. where no additional area of support or need is identified during the comprehensive Health Needs Assessment (HNA). It consists of an antenatal contact (this was targeted in 2010/11 but is now universal), a birth visit by 14 days (10-14 days in 2010/11), a 6-8 week contact, 8-12 months review and 2-2.5 years review. Additional contacts would be client initiated and at drop-in Child Health clinics.

8.8 Sibling was taken to A&E on occasion and information sharing between A&E and the community health professionals was appropriate.

8.9 In 2013 Mother was asked by her midwife about domestic abuse. The midwife recorded from a pick list that Mother had answered 'no, never'. The question was not asked again, although it is noted by the agency report author that best practice sets out a requirement that a woman is asked at least three times about domestic abuse by midwives. This didn't happen, despite it being recorded that Mother was seen alone on a number of occasions. Mother was also asked routine questions about mental health (her own and her family history) during her pregnancies with JN15 and Sibling, and she said there were no issues.

8.10 Later in 2013 Sibling was seen by the Community Paediatrician. As weight loss and feeding was no longer of concern Sibling was not seen again, but an open appointment for easy contact should concerns emerge was given to Mother.

8.11 The following month Mother made a 999 call to the Police and said that Father had kicked and punched her and that she was 21 weeks pregnant. Around five minutes later she rang back and said Father had left the home, that she was fine, and so she no longer required the Police. She was insistent that they did not attend, but eventually accepted that they had to. The Police established that there had been no previous incidents at the address, but an officer was sent to do a 'safe and well' check around 30 minutes later. When the police officer arrived Father had returned to the address but was packing a bag to leave. It was established that the argument had been about whether to give Sibling antibiotics. Mother would not discuss what had taken place, would not confirm there had been a physical assault, and no injuries were observed. Sibling was said to be safe and well and Mother stated she was not scared and was not at any risk. The sibling was not seen by the officer, but it was confirmed that this is not unusual as children are often in bed at the time of the incident.

8.12 In light of the lack of any complaint, no injuries evident and no indication of other risks, the police officer decided the case was standard risk. As is normal practice, the domestic risk assessment completed was checked by the police risk assessment team based within the domestic abuse department and it was agreed that standard risk was appropriate. This is despite Mother being pregnant at the time.

8.13 It should be noted that standard risk assessment notifications of a domestic abuse incident are not shared with health professionals. They are however shared with Children's Social Care. In this case health professionals were the only ones involved with the family, so the information about the incident was not shared with those who knew the family and the child, or the midwife who was working with Mother during her pregnancy. As the risk was deemed standard the information was not shared with either parent's employer, although they both work in notifiable positions[2].

8.14 The police officer did not ask Mother why she had stated on the telephone that she had been physically assaulted. When the family were visited for this review Mother stated she had not been assaulted and that it was purely a verbal argument. Mother did not recall

[2] The Notifiable Occupations Scheme relates to professions or occupations which carry special trust or responsibility, in which the public interest in the disclosure of conviction and other information by the police generally outweighs the normal duty of confidentiality owed to the individual.

that she had told the 999 operator that she had been kicked and punched, but said she probably said this as she was angry with Father.

8.15 Sibling broke their arm in 2013. It was reported that they had been jumping on the parent's bed and fell off. As a result of the fracture Sibling was seen by the orthopaedic consultant seven times in the coming months. A letter was sent to the family's GP stating that both parents were health care professionals and that they 'remain very anxious'. Exploration at the Learning Event led to the conclusion that the level of anxiety exhibited was not disproportional or particularly unusual. The consultant confirmed he meets a lot of anxious and concerned parents. An additional appointment at the fracture clinic for six months later was given after what would typically be the seventh and final appointment. An additional x-ray was also undertaken at Mother's request and showed the fracture had healed well. The consultant confirmed during the review that this was due to the level of the parent's anxiety and not because they were fellow health professionals.

8.16 This has been identified as a key practice episode because the parents were appropriately parenting the sibling without any concerns other than the telephone call made by Mother regarding an alleged domestic abuse incident in the home. When this review was being planned questions were asked about the perceived anxiety from the parents regarding Sibling's health during this period, and this will be considered in the analysis section below.

Key Practice Episode 2: 2013 to 2014. (The period from the birth of JN15 until his death).

8.17 There is little significant information available regarding the period leading up to the birth of JN15 until his death five months later. When they met with the reviewer the parents spoke of Mother feeling increasingly anxious after the birth of JN15. She described her experience of being a new mother as quite different with the two children. With JN15 she did not want to go out, and was 'obsessed' with keeping the baby safe. She avoided taking Sibling to nursery and didn't like to attend clinics or other appointments with the children. Her memory was very poor at this time and she stated that she struggled to care for both the baby and an active toddler on occasion. This was particularly after JN15 had a urinary tract infection (UTI) at 2 weeks old, and she became even more anxious for the baby. She stated that with hindsight she can see she had post-natal depression, but was either unable or reluctant to acknowledge this at the time. Mother told the reviewer that with hindsight she believes that the psychosis which then developed was very quick and probably only occurred a day or two before JN15 died.

8.18 The health visitor spoke to the family after JN15's visit to A&E and subsequent admission to hospital for assessment and intravenous antibiotics due to the UTI and stated she felt their anxiety was appropriate. She recognised they used her to double check any health concerns, not just relying on their own knowledge. From the first visit after the birth of JN15 Mother was thought to be attentive and appeared to be very happy with the baby. He was a demanding feeder, and Mother was focused on that, but over-anxiety or low mood was not evident. Sibling had remained in full-time nursery, and was being transported to and from there by Father. Mother brought JN15 to one clinic and to the GP for two immunisation appointments and the 8-week check. Mother was invited to a parent and baby group, she did not attend but this is not unusual with a second child. The family told the reviewer that Mother did take part in family activities during this time such as swimming, however Mother did state that she stopped attending church and preferred to stay home.

8.19 All of the professionals involved can evidence they asked Mother how she was and she always stated that she was well. At the time the NICE guidance in use had trigger questions regarding low mood. The health visitor was clear at the learning event that she complies with the guidance, and the status of the parents as fellow medical professionals would not have made a difference.

8.20 JN15 was seen at the hospital regarding a routine issue identified at birth in late 2013. No concerns were identified.

8.21 On the day that JN15 died the ambulance service received a 999 call from a neighbour of the parents. An ambulance was dispatched to a 'child cardiac arrest'. Father was present when the ambulance arrived. He told the crew that Mother had been unwell for a few days and had possibly been hallucinating. A safeguarding referral was made en-route to the hospital. The child was pronounced dead shortly after arrival at the hospital.

8.22 Father repeated the history when he arrived at the hospital with JN15. He stated that Mother had been acting strangely for around 3 days including claiming that God had appeared to her. It became evident that in the days prior to JN15's death Mother had made contact with at least one family member by text message and that she had spoken to a friend who was a minister of religion in another city. She had spoken to them of her concerns, including that the world was ending.

8.23 The minister was spoken to by the Police after the death of JN15 and he confirmed that he had spoken to Father early on the day that JN15 had died and explained his concerns about Mother's health. He said that Father had confirmed he also had concerns and that he would be seeking an appointment for her with someone who could help. When visited by the reviewer, Father stated that he did not even consider that Mother was suffering from a psychosis and that her behaviour over the weekend was not of particular concern to him.

8.24 This is a key practice episode because there was limited professional contact with the family, and what contact there was did not lead to the identification of any concerns about Mother's mental health or her care of either child. This is understandable as the onset of the psychosis was allegedly very rapid. The only person in direct contact with Mother over the weekend was Father and he states her deteriorating mental health was not evident to him. The minister believed that it was evident that Mother was unwell when he spoke to her 2 days before JN15 died. He did not communicate this to Father until the morning of JN15's death however.

9 Analysis by theme

9.1 The analysis section of this report will consider the information above, all of which was gained from the Agency Reports, from the staff who had worked with the family and attended the Learning Event, and from the family themselves. At the learning event the key themes in this case were identified. This section will provide a thematic analysis.

9.2 The questions in the terms of reference were considered and answered in the majority of agency reports. The information included in those reports has been considered as part of this analysis.

9.3 The themes that emerged and will be considered are:

- Professional status and the families class and culture
- Parental anxiety

- Domestic abuse
- Maternal mental health

9.4 Viewed from a systemic perspective it is important to consider how these themes influenced and impacted on each other, and if they had an impact on the circumstances which are the reason for this review.

9.5 Professional Status and the families class and culture

9.6 At the learning event and in the agency reports, professionals including those working with the family were asked to comment on the impact of the parent's occupations on the services they received. As both parents are health care professionals the review wished to consider the impact of this on the approach taken by the agencies involved.

9.7 The parents asked for an additional x-ray to reassure them after Sibling's fracture, they also requested and were given an additional appointment with the consultant regarding the fracture. This does not appear to have been due to the parent's occupations, but because of the level of anxiety they showed. The consultant said this is not unusual.

9.8 The health visitor is an experienced practitioner who works in an area where predominantly middle class professional people live. She was clear that her work with the family was undertaken regardless of their status or professions. After Sibling had lost weight health visitors provided additional visits to support the family. This was good practice. It was not assumed that because of their jobs the parents could manage without the support.

9.9 Mother and Father knew some of the hospital and community health care professionals involved with the family in a professional capacity, however no issues were identified in regards to this.

9.10 The police officer who attended after the domestic abuse allegation made by Mother was told about the occupations of the parents, and observed their nice home and relatively affluent life-style. He followed procedures however and the status of the family did not appear to have any impact on the assessment he made.

9.11 As both parents are health care professionals who would have some responsibility for safeguarding in their job, it is probable that they would have been aware of the process that follows a domestic abuse visit from the police. In this case it has been identified that both parents were concerned about the potential stigma for both themselves and their child.

9.12 This may have also had an impact on the decision by Father not to alert services to his wife's deteriorating mental health over the weekend before and on the day that JN15 died. Father fervently denies this however.

9.13 Parental anxiety

9.14 Mother's anxiety was noted by staff on a number of occasions during their contact with the family. For example in relation to the weaning and feeding of Sibling, Mother asking the health visitor whether taking a baby to church would be harmful due to the loud singing, and the impact on Sibling of the broken arm. It is also interesting to note Mother's own admission that she became very anxious about infections after JN15's UTI at just a few weeks old.

9.15 The professionals involved were clear that while Mother was anxious, it was not exceptionally so, and they felt that this was understandable in light of her job and her

knowledge of what the potential worst-case scenarios could be. Also being a new mother with no support from her own extended family meant that Mother relied on professionals for support and advice on occasions.

9.16 The extent of Mother's anxiety regarding JN15 was not identified until after his death. She stated to the reviewer that her anxiety was heightened after the birth of JN15. She stated however that she was otherwise managing well. The family were assessed by the midwife and health visitor, including mother's mental health, and universal services were thought to be required at this time. The review was assured that had any issues been identified an additional appointment would be made and the concerns followed up.

9.17 Both parents anxiety about the reaction to the domestic abuse allegation and later to Mother's diagnosis is understandable and probably common. It is particularly significant with their chosen occupations. The impact of mental health and safeguarding concerns on their jobs is potentially significant and would have been a further cause of anxiety for them.

9.18 <u>Domestic abuse</u>

9.19 It has not been possible to access information from the previous area where the family lived regarding the one police involvement after a neighbour called the police. The lead reviewer for this SCR discussed this incident with the parents when she met them. They stated that they were having a row which was loud. They described married couples shouting at each other as their cultural norm, and said that no one was harmed and no violence took place.

9.20 The incident in Nottinghamshire in April 2013 was described in the same way by the parents. Mother stated that she had not been physically assaulted and could not account for why she had told the 999 controller that she had been, other than her being angry with Father.

9.21 In December 2011 the NSPCC, as part of their research for the '*All Babies Count*' campaign, analysed their collection of SCRs relating to children aged less than one year. Of the 130 babies in England and Wales who had been the subject of a serious case review from 2008 – 2011 domestic abuse was a factor in at least 60 of these cases, and parental mental health was an issue in at least 34 of the cases. In this case however there does not appear to be a link between the death of JN15 and the domestic abuse incidents the review is now aware of.

9.22 In a briefing paper published in November 2013 the NSPCC outlined a number of other factors which can increase the risk to children who live in families where domestic abuse is present. They include mental health problems. As Mother's mental ill health appears to be directly related to the birth of JN15 there is no evidence that the domestic abuse incident in April 2013 was related to Mother's mental health problems.

9.23 The NSPCC report also outlines the triggers for domestic abuse, which includes pregnancy, and suggests that a risk assessment is undertaken in these cases. A nationally recognised risk assessment tool was used to complete the assessment after the Police visited the family, and the result was standard risk. This means that there was no requirement for any additional work with the family after the incident. The health visitor and the GP were not informed of the incident. While this would not necessarily have made a difference in this case it might in others, so a recommendation has been made in regards to this.

Maternal mental health

9.24 There is no evidence that Mother had any mental health issue prior to the birth of JN15. She had experienced stressful situations in her life, including; moving to a new country; converting to a new religion which she was concerned would affect her relationship with her own family; and undertaking training for a demanding and stressful job. There is no evidence that she had any serious or other mental health concerns at these times. She was also well following the birth of Sibling.

9.25 It is widely recognised that the first three months after the birth of a baby 'pose the greatest lifetime risk for new mothers in developing mental health difficulties'[3]. JN15 was 5 months old at the time his mother developed postpartum psychosis, however Mother now recognises with hindsight that she had been suffering from postnatal depression before the episode. She stated that she kept this hidden from professionals and her husband at the time. "Women with mental health needs are often reluctant to seek help because of fears that they will be judged as inadequate mothers and their children will be 'taken away.' (Stanley et al 2003). Mother, as a health care professional and an experienced mother, may have been concerned about the impact on her work and her care of Sibling if she had sought help for post-natal depression.

9.26 Mother told the reviewer she was not aware at the time that she was suffering with mental health issues postnatally. She said that while she felt different after the birth of JN15 compared to after the birth of Sibling, she had no idea that she was ill. She stated that she certainly did not foresee that she would have a serious mental breakdown that could put her child's life at risk. Father also stated he had no idea that his wife was mentally ill. He said that Mother was fine for much of the weekend. She was reading the bible a lot but this was not particularly unusual. She was questioning what was written and asking his opinion, but again he described them having a number of heated religious conversations in the past, and did not feel this was unusual.

9.27 Recent NICE Guidance CG192 Published December 2014 (and therefore after the death of JN15) informs health professionals of a newly clarified expectation; 'if a woman has a sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral)'. In this case Mother was not referred to any professionals and none had contact with her within the timeframe of her sudden illness.

9.28 Mother stated that she did not have the classic symptoms of post-natal depression. She suffered with insomnia and did not want to go out, but she was not tearful and had a good appetite. Father stated he did not identify post-natal depression in Mother. The NSPCC report 'Prevention in Mind'[4] identifies that postnatal depression effect 15% of women in the antenatal period and 10-20% in the postnatal period. Post partum psychosis however affects just 2 in 1,000 new mothers. Unlike postnatal depression, postpartum psychosis is a psychiatric emergency. 'It requires urgent assessment, referral, and usually admission, ideally to a specialist mother and baby unit'[5].

---

[3] Howe D (2005) *Child Abuse and Neglect, Attachment, Development and Intervention* Palgrave McMillan New York

[4] Prevention in Mind (All Babies Count: Spotlight on Perinatal Mental Health) By Sally Hogg 2013

[5] Jones I, Shakespeare J; Postnatal depression. BMJ. 2014 Aug 14;349:g4500. doi: 10.1136/bmj.g4500.

9.29 Postpartum psychosis is different from postnatal depression. 'It is a more severe illness. There are many different ways the illness can start. Women often have symptoms of depression or mania or a mixture of these. Symptoms can change very quickly from hour to hour and from one day to the next'[6]. The Royal College of Psychiatrists state that postpartum psychosis (or puerperal psychosis) 'is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby'. In regards to Mother, the symptoms appear to have developed later than is usual, and the reviewer questioned if this may have confused Father, as on-set after the first months of a baby's life is relatively rare. Father stated that he was not confused, and that Mother did not show any signs of psychosis in the days leading up to the death of JN15.

9.30 The Royal College of Psychiatrists point out that the psychosis can 'happen to any woman'. And that it often occurs 'out of the blue' to women who have not been ill before. What is clear is that 'it can be a frightening experience for women, their partners, friends and family'. The on-set is swift and professional and specialist help should be gained within hours of the first signs emerging. This did not happen in regards to Mother. No professionals were alerted to the changes which appear to have been developing over the days before the death of JN15, as shown by the statement of the minister of religion who spoke to Mother two days before JN15 died. As is the case for Mother, 'women usually recover fully after an episode of postpartum psychosis'.

9.31 There are likely to be many factors that lead to an episode of postpartum psychosis. Genetic factors are important. A mother is more likely to have postpartum psychosis if a close relative has had it. Mother told the reviewer that there is no history in her family, to her knowledge. She did point out however that there would be a taboo about discussing mental illness in her culture. Postpartum psychosis is more common in first rather than subsequent pregnancies, and when the birth has been complicated or traumatic. Again, this was not the case with Mother.

9.32 The hospital where Mother had both her children has clear guidelines for the 'Identification and Management of Women at Risk of Serious Mental Illness.' It states that a full history must be taken and fully documented at the booking appointment. The midwife is told to enquire about previous and family history using a screening tool. There are clear actions to be followed when concerns are raised. During Mother's booking appointment it is documented that the guidance was followed and she was asked routine questions around mental health to screen for mental health issues. This mental health screening tool was completed at the booking appointments of both pregnancies. Mother said there were no issues regarding her current or previous mental health and her family's mental health.

10 Conclusions and lessons learned

10.1 The following is a summary of the learning from the review. Good practice is also identified.

10.2 There are very few lessons to be learned from this review. This is not because the agency report authors or the professionals who attended the learning event and recall day were not rigorous in their task of reviewing and analysing the work undertaken. On the whole practice was good in this case. It appears that both individually and systemically things work well in Nottinghamshire. There were no signs to suggest that Mother was struggling with post-natal depression or that she was at risk of perinatal psychosis. The baby was 5

[6] From http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postpartumpsychosis.aspx

months old and was her second child, there were no concerns about the first pregnancy and perinatal period, and there was no known mental health history for Mother or in her wider family. She would not be considered high risk for this type of mental illness.

10.3 The days and hours before the death of JN15 may have been a distressing and concerning time for the family, as well as raising concerns for the care of the baby. However there was nothing that professionals could do as they were not alerted to the deterioration in Mother's mental health on the day that JN15 died. Had they been, there is an established process of caring for the mother and child in such cases, and it is likely they would have been followed.

10.4 Father insists that there were no signs at the time that Mother was seriously ill and that he would not have left her alone with the baby had he even suspected anything was wrong. This is despite him leaving his friend feeling reassured that he would seek specialist help.

10.5 While the review acknowledges the parents assertions that they were not aware of Mother's difficulties prior to the death of JN15, the review considered that there is a wider perceived stigma of mental illness among health care staff and it was agreed that this must be acknowledged in this review. Challenging this is a priority for all organisations. Professionals who might be unwell should be encouraged and enabled to access care and support, and commit to treatment.

10.6 Good practice identified:

- The family received a good universal health service from all of the professionals involved.
- Sibling received a timely and appropriate service in regards to his weight loss and fracture.
- Additional support was offered when issues were identified, for example when Sibling was losing weight and was a difficult feeder the health visitor provided additional support.
- Despite Mother calling the police to say she no longer required them to visit regarding a report of domestic abuse in 2013, an officer went to the home and spoke to Mother. This was followed by a risk assessment.
- There was appropriate information sharing between the hospital and community health colleagues.
- All of the relevant professionals asked Mother how she was after the birth of JN15. She replied that she was well and this was clearly recorded in agency records.
- The health visitor clearly knew the family well and provided a sensitive and appropriate service to them.
- The record keeping was good across agencies.

10.7 While there are relatively few lessons to be learned, Nottinghamshire Safeguarding Children Board can reflect on the following which has been established from this review:

Lesson 1:
Nottinghamshire Police followed procedures by informing Children Social Care of a domestic abuse incident in 2013. The health professionals who were the only people having

contact with the family were not informed. It is not current policy to share police notifications with a standard risk with health visitors, school nurses or GPs. The receipt of a police domestic abuse notification could increase the input to a family from universal to targeted. A recommendation has been made in regards to this.

Lesson 2:
When pregnant a woman is more at risk of domestic abuse. The current national risk assessment tool in use includes pregnancy as a risk factor; however, on its own this does not automatically increase the level of assessed risk.

Lesson 3:
While information sharing locally was good, information regarding the call out for a domestic incident in another geographical area was not available to Nottinghamshire Police either at the time or for the purpose of this review. The NSCB may wish to inform that area LSCB of this matter.

10.8 None of these identified lessons would have made a difference when Mother became critically ill and JN15 died. JN15's death was not predictable to any of the professionals involved with the family.

11 Recommendations

11.1 Each agency report submitted to this review was asked to provide information on any changes within their agencies since the death of JN15. The following were identified, although none were specific to this case:

- The relevant NHS Foundation Trust have updated their template for recording information to ensure consistency of information gathering.
- Maternal mental health training is being delivered to all health visitors as part of the health visitor implementation plan.
- As part of the Healthy Child Programme all mothers will be visited by the Health Visitor antenatally (this was not routine at the time of JN15's birth) and postnatally.
- All midwives were trained and updated in the autumn of 2014 around domestic abuse. A flowchart was also launched outlining the pathway and emphasising that domestic abuse enquiries should be made three times during pregnancy.

11.2 All agencies were asked to make relevant recommendations that are agency specific. Only one single agency recommendation was made, and the lead reviewer accepts that in this case this is appropriate and proportional.

11.3 The agency recommendation that has been made was by the relevant Hospital and states they will '*conduct an internal audit of 'routine enquiry' during pregnancy about domestic abuse'*.

11.4 NHS England has very recently (13 May 2015) highlighted the work being undertaken recently in Devon and Torbay, where all women giving birth in hospital are asked by midwives about their mental health and referred onto perinatal heath team if required. Local hospitals in Nottinghamshire will now be considering if they can implement such an approach in the future.

11.5 This overview report makes two recommendations for the NSCB. They are:

Recommendation 1:

NSCB to share the learning from this review with staff across all partner agencies, and the other LSCB where the first reported domestic abuse incident took place.

Recommendation 2:

The NSCB should consider the feasibility of extending information sharing on police notifications of domestic abuse incidents that are graded as standard with relevant health colleagues. This is of particular importance when the incident involves a pregnant woman.