Independent Investigation

into the

Care and Treatment Provided to Ms. X

by the

Devon Partnership NHS Trust
Torbay Care Trust
South Devon Healthcare Trust

Executive Summary

Commissioned by

NHS South West
Strategic Health Authority

Independent Investigation: HASCAS Health and Social Care Advisory Service

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1. Preface to the Independent Investigation Report

The Independent Investigation into the care and treatment of Ms. X was commissioned by NHS South West (the SHA) pursuant to HSG (94)27.[1] The Investigation was asked to examine the circumstances associated with the death of Baby Y. Ms. X received care and treatment for her mental health condition from Devon Partnership NHS Trust (the Trust) between 25 February 2010 and 20 April 2010. During this time she was also in receipt of care and treatment from the South Devon Healthcare Trust and the Torbay Care Trust. It is the care and treatment that Ms. X received from these organisations that is the subject of this Investigation.

Investigations of this sort aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of this Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations.

We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's senior management who have granted access to facilities and to individuals throughout this process. The Trust Senior Management Team has acted at all times in a professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this Investigation.

The Independent Investigation Team is grateful to Ms. X and her parents who met with the Independent Investigation Team and shared their reflections on the care and treatment received by Ms. X. This has allowed the Investigation Team to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

[1]. Health Services Guidance (94) 27: Guidance on the discharge of mentally disordered people and their continuing care in the community. Department of Health

2. Condolences to the Family of Baby Y

The Independent Investigation Team would like to extend its condolences to Ms. X, Mr. X, and their families.

3. Incident Description and Consequences

On 20 April 2010 Ms. X's mother-in-law found Baby Y at the family home not breathing. An ambulance and the Police were called and Baby Y was taken to Torbay Hospital, arriving at 11.54 hours. Life was declared extinct at 12.00 hours. The ambulance staff informed the Accident and Emergency Department staff that Ms. X's mother-in-law found Ms. X adjacent to Baby Y with a pillow over his head: the mother-in-law commenced Cardio Pulmonary Resuscitation (CPR). There were no other signs of physical injury or bruising. Ms. X was arrested on suspicion of murder.

A Mental Health Act (1983 & 2007) assessment of Ms. X was carried out at Torbay Police Station. Ms. X reportedly said that she put a pillow over Baby Y's head. The assessment concluded that she was at high risk of suicide, and that she had severe depression. The decision was made not to detain her under the Mental Health Act (1983 & 2007) and for her to remain in the Criminal Justice system so that she could be detained under Section 48 and diverted to a secure women's facility where she could access the appropriate care. She pleaded guilty to smothering a child less than 12 months of age with a cushion while the balance of her mind was disturbed and was detained under a Section 37 Hospital Order of the Mental Health Act (1983 & 2007).

Ms. X was detained in a secure facility under the care of the West of England Forensic Mental Health Service.

4. Background and Context to the Investigation

The HASCAS Health and Social Care Advisory Service was commissioned by NHS South West, the Strategic Health Authority (SHA, now NHS South of England) to conduct this Investigation under the auspices of Department of Health Guidance *HSG (94)27, LASSL(94) 27*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:
"…in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".

This guidance, and its subsequent 2005 amendments, includes the following criteria for an Independent Investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced Care Programme Approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient, in order to establish the lessons to be learnt, to minimize the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what would have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been fully investigated by an impartial and Independent Investigation Team.

5. Terms of Reference for the Independent Investigation

The Terms of Reference for the Independent Investigation were set by NHS South West (the SHA, now NHS South of England) and are set out below.

"To review:

1. *The quality of health care provided by the Trust, to include whether it complied with statutory guidance, statutory obligations, relevant Department of Health guidance and Trust policies.*
2. *The appropriateness and delivery of treatment and medication compliance.*
3. *Inter agency information sharing/communication/coordination.*
4. *Communication with the family to include support to them as well as information that was available from them. To consider confidentiality issues with regard to communication with the family given the clearly expressed wishes of Ms. X and having regard to the interests of the baby.*
5. *Assessments of risk, to include upon safeguarding, the recording and responses to such.*
6. *Documentation, including recording of clear plans and risk/safeguarding assessments, decisions on frequency of contact and visits, actions taken of all services.*
7. *The internal investigation, its definitions and findings, methodology, recommendations.*
8. *To identify learning points for improving systems of services, with practical recommendations for implementation.*
9. *To report findings and recommendations to NHS Southwest".*

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Devon Partnership NHS Trust, the South Devon Healthcare Trust and the Torbay and South Devon Health and Care Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Investigation Team Leader and Chair

Dr. Alison Conning	Chair of the Independent Investigation Clinical Psychologist Member of the Team

Investigation Team Members

Dr. Androulla Johnstone	Chief Executive Officer, HASCAS Health and Social Care Advisory Service. Nurse Member
Dr. Elizabeth Gethins	Consultant Forensic Psychiatrist. Psychiatrist Member
Ms. Amy Weir	Consultant Social Worker. Social Work Member

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, HASCAS Health and Social Care Advisory Service
Fiona Shipley Transcriptions Ltd	Stenography Services
Independent Legal Advice	Capstick's Solicitors

7. Summary of Findings and Conclusions

7.1. Summary of Case

Ms. X had a history of mental health problems since her teenage years. This first became apparent in 1998 when she made a serious suicide attempt at the age of 19 years by taking an overdose of tablets in combination with alcohol. At that time she was diagnosed with a brief depressive episode. She was subsequently referred to a Community Mental Health Team but was reluctant to engage with them. She was prescribed the antidepressant medication Sertraline.

After that date she consulted her GP with symptoms of depression in 2000, 2002, 2004 and 2006. In 2002 this was associated with stopping her Sertraline. In 2000 she attended one appointment with a Community Psychiatric Nurse from a Community Mental Health Team in Dorchester but then declined further appointments. In 2004 she was referred to a psychiatrist who saw her once and recommended that she remain on a higher dose of Sertraline. In 2006 she was referred to the mental health service and offered appointments in January and February 2007 which she declined.

Ms. X registered with GP 1 in Torquay in October 2007.

In September 2009 Ms. X discovered that she was pregnant and stopped taking Sertraline. She had a booking appointment with the midwifery service and informed the midwife that she did not have any current mental health problems or a history of mental health problems.
In January 2010 she consulted her GP surgery because she had been experiencing low mood for three weeks. On discussion with her GP it was decided that she should delay commencing Sertraline, but her symptoms declined further and she was prescribed the medication towards the end of January 2010. She was referred to the Health Visitor for supportive counselling. In February 2010 her symptoms declined further. Her midwife offered her an appointment with the Consultant Obstetrician and Gynaecologist with a special interest in perinatal mental health problems. Ms. X declined the appointment. She consulted her GP who increased the Sertraline. He also referred her to the Mental Wellbeing and Access team for an urgent

assessment because she was experiencing "marked depression" and because she was 32 weeks pregnant.

On 25 February 2010 Ms. X was assessed by the Psychiatrist and Team Leader from the Mental Wellbeing and Access Team. It was noted that despite her history of depression Ms. X preferred her current symptoms to be considered to be perinatal depression. She was referred to Senior Mental Health Practitioner 1 from the Mental Wellbeing and Access Team, and also to the Depression and Anxiety Service with a view to having appointments after the birth of her baby.

On 10 March 2010 she was seen by the Health Visitor who was concerned that she had not yet been seen by the Senior Mental Health Worker and who considered referral for private counselling. On 11 March 2010 she was seen by the Midwife and accepted a referral to the Consultant Obstetrician with a special interest in perinatal mental health problems who saw her on 15 March 2010, was concerned about her mental state and contacted the Mental Wellbeing and Access Team with a view to speeding up her appointment with the Senior Mental Health Practitioner.

On 25 March 2010 the mother of Ms. X contacted GP 1 with concerns about Ms. X's behaviour. He left a telephone message with Senior Mental Health Practitioner 1 of the Mental Wellbeing and Access Team.

On 26 March 2010 Ms. X attended an appointment with Senior Mental Health Practitioner 1 of the Mental Wellbeing and Access Team who was concerned about Ms. X's deterioration since her assessment one month previously. On 29 March 2010 Senior Mental Health Practitioner 1 made an urgent referral to the Recovery and Independent Living Team, because she required an enhanced level of care and her delivery date was imminent. She was allocated to the Care Coordinator of the Recovery and Independent Living Team.

On 6 April 2010 the Care Coordinator saw Ms. X. She was flat in affect and unmotivated. She denied thoughts of wanting to harm herself and her child. She said that she was taking her prescribed medication and did not want her family involved in her care or for information to be shared with her family. She was given a further appointment for 20 April 2010. The Care Coordinator sent an urgent referral for a psychological therapy assessment. The Care

Coordinator spoke to the midwifery service on 8 April 2010. The Midwife forwarded an interagency communication form to the Christie Team Midwives who would be giving postnatal care to Ms. X as she had made the Midwife aware that she was living in Brixham.
On 10 April 2010 Baby Y was born. Mother and baby were discharged after 23.00 hours on the same day.

On 11 April 2010 Ms. X and Baby Y were seen for the first time by a Midwife from the Christie Team to whom their care had been transferred. There were some concerns about breast feeding. The Midwife rang the same evening to monitor the feeding.

On 13 April 2010 Ms. X and Baby Y were visited by a Maternity Care Assistant. Ms. X was described as *"well but tired".* Also on that day GP 1 was informed of the birth.

On 14 April 2010 the Maternity Care Assistant rang to monitor the baby's feeding which had improved.

On 16 April 2010 Ms. X and Baby Y were registered with GP 2. Also on that day they were visited by the Health Visitor who then gave an oral handover to the new Health Visitor from the team where Ms. X was living, stressing the concerns about her mental health. Also on this day Ms. X and Baby Y were seen by a further Midwife from the Christie Team, who found Ms. X to be tired, emotional and anxious. It was noted that she had an appointment with the Recovery and Independent Living Team for 22 April 2010.

On 17 April 2010 Ms. X was rung by a member of the Christie midwifery team who noted *"all well – see Tues".*

On 19 April 2010 Ms. X's mother rang Devon Docs expressing concern about Ms. X's deteriorating mental state. The Mental Wellbeing and Access Team was informed and passed the message to the Care Coordinator from the Recovery and Independent Living Team. The Care Coordinator rang Ms. X's mother and was informed that she was punching and smashing things in the house and that she was not bonding with the baby. The Care Coordinator informed the midwifery service.

Also on 19 April 2010, Ms. X saw her new GP, GP 2 at the surgery accompanied by her mother-in-law and Baby Y. GP 2 did not have any information about her history. Ms. X informed GP 2 that she had been depressed since the middle of her pregnancy but that she did not have a history of depression before that. GP 2 concluded that she was suffering from severe postnatal depression. GP 2 telephoned the midwifery team and was told that the Care Coordinator was trying to offer Ms. X an appointment for the following day at 15.00 hours. GP 2 telephoned The Care Coordinator and informed her that Ms. X had given permission for appointments to be made *via* her mother-in-law. GP 2 informed the Care Coordinator that Ms. X needed a psychiatric assessment and psychiatric input. She was informed that Ms. X would be seen by the Recovery and Independent Living Team the following day.

On 20 April 2010 the Care Coordinator attempted to make the appointment with Ms. X.

On 20 April 2010 Ms. X's mother-in-law found Baby Y at the family home not breathing. An ambulance and the police were called and Baby Y was taken to Torbay Hospital, arriving at 11.54 hours. Life was declared extinct at 12.00 hours. Ms. X had been found adjacent to Baby Y with a pillow over his head. Ms. X was arrested on suspicion of murder.

Later on 20 April 2010 a Mental Health Act assessment of Ms. X was carried out at Torbay Police Station. Ms. X said that she put a pillow over Baby Y's head. No evidence of psychotic symptoms was found. Ms. X admitted that she had stopped taking Sertraline before the birth of Baby Y. The assessment concluded that she was at high risk of suicide, and that she had severe depression. The decision was made not to detain her under the Mental Health Act and for her to remain in the Criminal Justice system so that she could be detained under Section 48 and diverted to a secure women's facility where she could access the appropriate care.

7.2. Causal Factors

The Independent Investigation identified two direct causal factors connecting the care and treatment of Ms. X by Devon Partnership NHS Trust, and South Devon Healthcare Trust and Torbay Care Trust and the events of 20 April 2010.

- **Causal Factor 1: The lack of assertive and timely intervention for Ms. X's depression caused her mental state to deteriorate to the point of killing Baby Y.**

- **Causal Factor 2: The failure of mental health and other health professionals to identify the potential risk to Baby Y from his mother's deteriorating mental state and therefore to trigger, in a timely manner, the safeguarding children procedure was causal in the death of Baby Y as no inter-agency management plan was put in place to manage the risk to him.**

7.3. Findings

The main findings of the Independent Investigation are reported below.

7.3.1 Care Programme Approach

When referred to the Recovery and Independent Living Team Ms. X was allocated to a Care Coordinator and became subject to the CPA process. Had Ms. X received an ongoing and in-depth assessment, as was clinically indicated, whilst receiving care and treatment from the Recovery and Independent Living Team, it is probable that the deterioration in her mental state would have been detected and that a multi-professional/multi-agency care plan would have been in place to maintain her health, safety and wellbeing and that of her baby. This did not occur which meant that Ms. X's mental state deteriorated to the point where she reached a stage of crisis which her family did not know how to manage.

It is always good practice for mental health professionals to act upon an urgent request made by family members to intervene when a service user's mental health deteriorates. Ms. X had recently given birth and in the absence of any recent mental health assessment having been made then a same day visit was indicated. It is unclear why the Care Coordinator did not instigate this action of her own volition as was within her gift to do. Instead she consulted with four other people (three of whom had never met Ms. X and one who had only met her once and did not have her full history) before making a decision to meet with Ms. X in the Outpatient Clinic the following day.

Once this decision had been taken it would appear that no timely attempt was made to arrange the appointment. The Care Coordinator did not telephone on the 19 April to do this and made three attempts on the morning of the 20 April after making a call to Ms. X's mother in error. It would have been sensible practice to have made a telephone call to Ms. X's mother-in-law as instructed by the GP on the 19 April at least to have checked on the situation before consulting her colleagues.

The case of Ms. X illustrates well the importance of the Care Programme Approach and Care Coordination. It is essential that secondary healthcare workers get to know their patients in order to work with them and their families and to ensure their continued health, safety and wellbeing, especially when they are experiencing significant mental illness combined with equally significant life events. The role of the Care Coordinator is of vital importance. The function of Care Coordination transcends the professional background of the worker who finds themselves in the role. A Care Coordinator is not simply a 'doctor', a 'nurse' or a social worker' but is the central pivot around which a case is coordinated and managed in order to provide an essential safety net of care. This case illustrates the problems that are encountered when assessment, monitoring, care planning and communication fail. These are the things that the Care Programme Approach is designed to deliver, in the words of the Trust CPA policy, *"for the minority of people who present with the highest risk".* Ms. X had been allocated to the Recovery and Independent Living Team as an urgent referral who required CPA. She most definitely met the criteria for those service users presenting with the highest risk and level of need.

It is never a straight-forward task to make a direct causal link between an act or omission on the part of mental health care professionals and a homicide perpetrated by an independent third party. However the Care Programme Approach is an evidence-based process which is widely accepted as being an effective method of ensuring the continued health, safety and wellbeing of service users and those around them. In the case of Ms. X the most basic building blocks of the Care Programme Approach were not implemented and the Independent Investigation Team concluded that this was to the ultimate detriment of the health, safety and wellbeing of both Ms. X and her baby.

- **Causal Factor 1: The lack of assertive and timely intervention for Ms. X's depression caused her mental state to deteriorate to the point of killing Baby Y.**

- **Contributory Factor 1: The lack of a robust inter-agency care plan to manage the care of Ms. X meant that appropriate mental health care was not offered to her in a timely and planned way and the potential risk to Baby Y was not considered and managed. This contributed to the deterioration of her mental health.**

7.3.2. Risk Assessment and Management

The clinical risk assessments conducted for Ms. X were of a poor standard considering Ms. X was an urgent referral and had been deemed as requiring CPA. The Independent Investigation Team concluded that the poor quality of the risk assessment process was made more problematic in that the risks to Ms. X's unborn baby, and later new-born baby, were not taken into account. The deterioration in Ms. X's mental health, which became apparent to members of the Recovery and Independent Living Team on the 19 April 2010, was not managed in a systematic manner. In the absence of either sufficient, or current, information, instead of having discussions with individual healthcare professionals who had never met Ms. X, a home visit was indicated in order for a face-to-face assessment to be made. As a consequence the risk assessment was weak and could not inform any decisions that needed to be made or actions that needed to be taken.

The Independent Investigation Team heard that the Recovery and Independent Living Team did not have its own dedicated Consultant Psychiatrist at this time. The Locum Staff Grade Psychiatrist was from an old age psychiatry background and did not always feel comfortable when assessing adults of working age. The Independent Investigation Team also heard that the Care Coordinator had not had any risk assessment training at the time she was involved with Ms. X's care and treatment. These two factors may help to explain why both the risk assessment and clinical decision making processes utilised on the 19 April 2010 were weak. However it does not provide mitigation. All registered health and social care practitioners have a duty of care to be fit for practice when delivering care and treatment. The Independent Investigation Team concluded that the risk assessment practice utilised in the case of Ms. X was of an unacceptable standard and that team management, supervision and individual professional accountability practice was not of a sufficient standard to ensure a safe delivery of service.

The standard of clinical risk assessment fell below the standard to be expected from a secondary care specialist service and was not in keeping with local Trust policy or Department of Health guidance. This was to the ultimate detriment of the health, safety and wellbeing of Ms. X and her baby.

- **Contributory Factor 2: The standard of clinical risk assessment fell below that expected from a secondary care specialist service and was not in keeping with**

local Trust policy or Department of Health guidance. This meant that appropriate mental health care was not offered to Ms. X in a timely and planned way leading to the further deterioration of her mental state.

- **Contributory Factor 3: The standard of clinical risk assessment fell below that expected from a secondary care specialist service and was not in keeping with local Trust policy or Department of Health guidance. This meant that the potential risks to Baby Y were not recognised, a risk assessment for the baby in his own right was not considered and the potential risk to Baby Y was not managed.**

- **Contributory Factor 4: The failure of the risk assessment to identify the potential impact of Ms. X's deteriorating mental health on Baby Y, in conjunction with the lack of timely intervention, meant that the family were not alerted to the potential risks to Baby Y and so were unable to make informed decisions about his care.**

7.3.3. Diagnosis

Ms. X was diagnosed with recurrent depressive disorder. She was reluctant for the midwifery service and her family to be made aware of her history of depression, preferring her symptoms to be considered ante or postnatal depression. Although her diagnosis was appropriate to her symptoms, the likely course of her depression was not considered in the context of her pregnancy by the mental health service, nor was the potential impact of her depression on the wellbeing of her baby, with the consequence that appropriate communication between services was not established at an early stage and an inter-agency plan for her care was not drawn up prior to the birth of Baby Y.

- **Contributory Factor 5: The likely impact of Ms. X's diagnosis of recurrent depression and the deterioration of her symptoms on her unborn and neonatal child were not given sufficient consideration by the mental health service in the planning of her care during the perinatal period. Had this been given sufficient consideration it might have led to the identification of the potential risks to Baby**

Y and the development of an appropriate multi-agency plan for the care of Ms. X and Baby Y in the perinatal period.

- **Service Issue 1: where a mother has a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by a formal written referral from the GP to the midwifery service which outlines the mother's history and alerts the midwifery to the heightened need to monitor her wellbeing and its potential impact on her child. This should prompt open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

7.3.4. The Mental Health Act (1983 & 2007) and Mental Capacity Act (2005)

During the last few weeks of the period under investigation, Ms. X's mental state had deteriorated to the point at which her family were very concerned about her welfare and were asking for more help than they were receiving. She was not responding to her prescribed medication, or she had stopped taking it. She was unable to care for her baby without the help of her family. Although she appeared to be complying with intervention, she had postponed any psychological treatment until after the baby was born, she had stopped taking her medication without consultation and without informing anyone, and she had put the telephone down on the Care Coordinator on 19 April 2010 after saying that *"things were not very well"*.

As Ms. X's mental health deteriorated, it would have been appropriate to consider an assessment of the capacity of Ms. X to decide what was in the best interest of her child. Had her capacity been considered, this may have prompted clinicians to think about how information might be shared with her family and how they might take part in any decisions concerning her care and treatment which impacted on the wellbeing of Baby Y, such as by pursuing the safeguarding route or assessment under the Mental Health Act. The Independent Investigation Team is of the view that consideration of the need for safeguarding, consideration of the relevance of the Mental Capacity Act and consideration of the use of the Mental Health Act would have been more likely had there been coordination of Ms. X's care between the professionals and teams involved and had a robust care management plan been in place.

The clinicians who assessed Ms. X after her arrest made the decision not to detain her under the Mental Health Act, but to allow her to remain in the criminal justice system so that she could then be transferred under Section 48 of the Mental Health Act to a secure women's treatment facility. It is the view of the Independent Investigation that, while recognising that the decision to allow Ms. X to remain in the criminal justice system is common practice, it would have been preferable to have detained Ms. X under Part 2 of the Mental Health Act and transferred her to an appropriate hospital bed, rather than having to spend time on remand in prison when she was very ill, distressed and judged to be at high risk of suicide.

- **Service Issue 2: Ms. X's capacity to make decisions in the best interest of her child was not considered by the staff involved in her care. The Trusts may wish to consider the provision and uptake of training available to staff about the Mental Capacity Act (2005).**

- **Service Issue 3: Staff training in the Mental Capacity Act, Safeguarding and the Mental Health Act (1983 & 2007) should consider the relationship between these three processes and how they might support each other in ensuring the wellbeing of an unborn child or neonate.**

7.3.5. Treatment

7.3.5.1. Medication

Treatment with an antidepressant medication was appropriate for Ms. X's Recurrent Depressive Disorder and Sertraline, an SSRI, was an appropriate choice of medication.

It was appropriate to consider whether Ms. X should continue to take Sertraline when she found that she was pregnant. However, when she consulted the GP early in pregnancy, there is no record of any discussion about the possibility of relapse if she came off Sertraline, no development of a strategy to manage this risk, or the risks to the unborn child if she did or did not continue with the medication. No plan of action was put in place should her mental state deteriorate, nor for monitoring her mental state.

After discussion with her GP Ms. X recommenced Sertraline in January 2010 at a dose of 50mg. It was increased to 100mg on 12 February 2010, the dose which was previously effective for Ms. X, because there was further deterioration of her mental state.

It is unclear why Ms. X did not respond to her usual dose of Sertraline. It is possible that she did not take it consistently and likely that she stopped taking it prior to the birth of Baby Y.

Had there been discussion with Ms. X from the outset of her pregnancy, when her mental state was good, about the likely course of her depression if she were to stop taking Sertraline, the risks to her unborn child both from medication and from any deterioration of her mental state, and the pros and cons of breastfeeding whilst on medication, she could have made an informed decision in collaboration with the professionals involved in her care about the best course of action during pregnancy and after the birth of her child. Had there been ongoing discussion about these topics she may have felt more comfortable about taking medication and in seeking guidance prior to deciding to stop it. No overall plan concerning her medication during pregnancy and the neonatal period was in place nor any coordinated plan about the monitoring of her mental state and the appropriate response to any deterioration.

Despite the deterioration in her mental state during pregnancy and after the birth of Baby Y, the possibility that she was not taking her prescribed medication was not considered and this was not assertively investigated. Had she had an ongoing relationship with a Care Coordinator from an early point in her pregnancy it may have been possible for the Care Coordinator to assertively monitor her use of medication and agree effective methods of ensuring that she was taking it. Such a relationship with a Care Coordinator may have made it less likely that Ms. X made the decision to stop taking her medication without prior discussion with those providing her care and treatment.

- **Contributory Factor 6: Ms. X having come off her medication prior to the birth of Baby Y is likely to have contributed to the decline of her mental health and subsequent killing of Baby Y. Although she was secretive about having stopped her medication in the latter stages of pregnancy, had there been a risk assessment in place concerning her use of antidepressant medication or not during pregnancy and the neonatal period, drawn up in consultation with Ms. X, and a robust plan in place to manage this risk overseen by a Care Coordinator**

who was familiar to Ms. X, the decline in her mental health may have been prevented or at least addressed in a more timely fashion.

- **Contributory Factor 7: The lack of a coordinated plan about the management of Ms. X's medication from the outset of her pregnancy and after the birth of her child, and the lack of ongoing discussion with Ms. X about the management of her medication during this time period, may have contributed to Ms. X making the decision to stop her medication at the end of her pregnancy and therefore contributed to the deterioration in Ms. X's mental health and the death of Baby Y.**

7.3.5.2. Psychological Therapy

The NICE clinical guidance makes it clear that psychological therapy should be considered as an option for the treatment of pregnant women with a history of depression. Given Ms. X's history of a serious suicide attempt and of relapse when taken off Sertraline prior to pregnancy, it is arguable that at the point at which it was known that she was pregnant she should have been offered psychological therapy as an alternative to medication if medication was to be withdrawn, or in addition to medication. There is no documented evidence that the benefits of psychological therapy were discussed with Ms. X either when her Sertraline was withdrawn at the beginning of her pregnancy, or when her mental state deteriorated.

The next point at which psychological therapy should have been offered to Ms. X was when her mental state began to deteriorate in January 2010. This would have been in keeping with the NICE guidance and it is possible that she may have been willing to engage if it was offered as an alternative to medication at this stage and in the interest of her unborn child. This was a missed opportunity.

Ms. X's need for psychological therapy was recognised on 25 February 2010 when Consultant Psychiatrist 1 and Clinical Team Leader 1 from the Mental Wellbeing and Access Team referred her to the Depression and Anxiety Service for *"further work in the future"* after her child was born. Whilst Ms. X may have been reluctant to engage in psychological therapy at this juncture, delaying any treatment until after the birth was a further missed opportunity to engage her in a therapy prior to the birth of Baby Y which might have contributed to her mental wellbeing. The current Operational Policy for the Depression and

Anxiety Service states that the standard response time from referral to "first therapy contact" is 28 days, providing the opportunity for engagement prior to the birth of Baby Y.[2]

After the Care Coordinator saw Ms. X on 6 April 2010 she sent an urgent referral for a psychological therapy assessment. Ms. X was not seen for psychological therapy but had been offered an appointment for 28 April 2010 which was the next available appointment with a Clinical Psychologist.[3] Whilst it was appropriate for such a referral to have been made, sadly the referral was too late to be of any benefit to Ms. X.

The referral from one part of the mental health service to another meant that Ms. X did not have the opportunity to establish a therapeutic relationship with a single member of staff and she received a series of assessments rather than intervention. Once she had been allocated to the care of the Care Coordinator from the Recovery and Independent Living Team, had she been more assertive in the delivery of care to Ms. X, and more aware of the likely course of her depression following the birth, she may have established a working relationship with Ms. X more quickly, been more involved in her care after delivery, or drawn up a robust inter-agency care plan prior to the birth of Baby Y. Whilst Ms. X had previously been reluctant to engage with mental health services, and it is far from clear how far she would have cooperated in developing a therapeutic relationship, the possibility of doing so was not offered to her.

- **Contributory Factor 8: Ms. X was not offered the opportunity of psychological therapy until the third trimester of her pregnancy and did not receive an appointment for the therapy until after her due date. Had Ms. X been offered psychological therapy at the point at which her Sertraline was withdrawn, or when her mental state first began to deteriorate during her pregnancy it is possible that she may have been willing to engage and that such therapy could have contributed to her mental wellbeing. Lack of a timely referral for psychological therapy may have contributed to the deterioration of her mental state.**

[2]. Operational Policy, Depression and Anxiety Service, DPT
[3]. Root Cause Analysis Investigation Report, 19 November 2010, page 20

- **Contributory Factor 9: Ms. X was seen by a range of individuals from the midwifery service and from the mental health service. She was not offered the opportunity to establish a therapeutic relationship with a single member of staff and received only assessment rather than treatment, other than her medication. This may have contributed to the deterioration of her mental health and therefore to the death of Baby Y.**

7.3.6 Safeguarding

The aim of the Safeguarding Children Policy is to ensure that children and young people are healthy, safe, enjoy life, achieve their potential, make a positive contribution to society and are well prepared to secure their economic wellbeing in future years.[4] The 2006 Guidance identified a number of factors which inhibit the realisation of this aspiration:

- a failure to share information;
- the absence of anyone with a strong sense of accountability;
- poor coordination;
- frontline workers trying to cope with staff vacancies;
- a lack of effective training.

A Failure to Share Information

Although some individual professionals attempted to communicate with other individual professionals and other teams involved in the care of Ms. X, there were key points in her care pathway where those involved in her care were not in possession of all the necessary information, despite the information being available to others. This was compounded by the change of GP, change of midwifery team, change of mental health team and the many professionals involved briefly in her care, as well as Ms. X's reluctance for her mental health history to be made known. Nevertheless, key individuals involved in the care and treatment of Ms. X were in possession of sufficient knowledge, or had sufficient concern about her mental state, to consider consulting with the Named Nurse for Safeguarding, or to consider referral to Children's Social Care services. This did not take place resulting in poorly coordinated care, lack of a robust care plan and lack of consideration of the potential risk to Baby Y.

[4]. Every Child Matters, 2003; Section 11 of the Children Act 2004

The Absence of Anyone with a Strong Sense of Accountability

There is no evidence that during the period of care and treatment of Ms. X that any of the mental health staff involved in her assessment and care, or indeed any other professional staff involved in her care, considered themselves to be professionally accountable for their responsibility for the safeguarding of Baby Y. It is possible that each profession involved in Ms. X's care saw the other professions as taking a greater role in the provision of her care contributing to no one professional considering his or her responsibility towards the safeguarding of Baby Y.

Poor Care Coordination

During the period of care and treatment of Ms. X she was seen by two GPs, at least seven different midwives/maternity care assistants, a Consultant Obstetrician and Gynaecologist, a Health Visitor, a Nurse Practitioner and four staff from the mental health services amounting to at least 16 different members of staff. She was passed from one mental health team to another because of concern about the severity of her mental health problems. As a result, no one individual took overall responsibility for the coordination of her care. Whilst the early identification of the relevance of the safeguarding procedures may have led to the development of a coordinated inter-agency and inter-professional plan of care for Ms. X, no one professional identified the instigation of the safeguarding procedure as an appropriate line of action.

At the point of Ms. X's referral to the Recovery and Independent Living Team there was the opportunity for the situation of her uncoordinated care to be resolved. She was allocated a Care Coordinator, who had the opportunity and responsibility to liaise with all the professionals and teams involved in Ms. X's care and to draw up an appropriate management and treatment plan prior to the birth of Baby Y. This did not happen.

Frontline Workers Trying to Cope with Staff Vacancies

The Independent Investigation was not made aware that the level of staffing was in general an issue during the time period in which Ms. X was receiving care and treatment. However, from 12 April 2010 the post of Consultant Psychiatrist to the Recovery and Independent Living Team was vacant, medical cover being given by a Locum Staff Grade Psychiatrist, whose specialism was in old age psychiatry.

A lack of Effective Training

Although there is evidence that the majority of members of DPT staff may not have received more than the most basic of training in safeguarding, given that no professional involved in the care and treatment of Ms. X gave sufficient consideration to the potential risk to Baby Y, or thought to discuss Ms. X's care with the Named Nurse for Safeguarding, despite their concern about her deteriorating mental health, it seems likely that this level of training was not sufficient to alert members of staff to the presence of a situation where safeguarding was relevant or to equip them with knowledge of how to safely manage the situation.

- **Contributory Factor 10: The fact that the Safeguarding procedure was not initiated meant that the potential risk to Baby Y was not thoroughly considered prior to or after his birth and an appropriate plan to manage this risk of significant harm was not developed. This led to the lack of a clear assessment of the likelihood of harm and an over-reliance upon the family to maintain his safety and contributed to the events leading to his death.**

- **Service Issue 1: where a mother has a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by a formal written referral from the GP to the midwifery service which outlines the mother's history and alerts the midwifery to the heightened need to monitor her wellbeing and its potential impact on her child. This should prompt open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

- **Service Issue 4: Despite the availability of training in safeguarding to all members of clinical staff, the majority of DPT clinical staff have not undertaken training beyond Level 1. DPT needs to consider how this training requirement should be enforced more effectively and consider whether face-to-face and inter-agency training below Level 3 might be more effective in helping staff to identify relevant cases and to improve their awareness of how cases should be managed.**

- **Service Issue 5: the number of hours allocated to the posts of Named Nurse for Safeguarding within DPT and SDHT may be insufficient to ensure that safeguarding maintains a high profile within the Trusts.**

- **Service Issue 6: where there are serious concerns about the mental health of a pregnant woman or new mother who changes GP, consideration needs to be given to how the process of handover to the new GP might be made safer.**

7.3.7. Service User Involvement in Care Planning

Ms. X was involved in discussions with her GP about her use of medication during pregnancy. In January and February 2010 she consulted GP 1 on a frequent basis to discuss her mental state and her medication, seeing him on 22 January, 26 January, 1 February, 12 February and 18 February, as shown in the Chronology above.

On referral to the mental health services it is documented that she was involved in discussions about her care, but no formal care plans were drawn up, and once she had a Care Coordinator, no CPA documentation was completed.

When Ms. X met with her Care Coordinator for the first and only time, the Care Coordinator complied with her wishes that she was not given another appointment until after the birth of her child. It could be argued that the Care Coordinator was right to respect her wishes. However, the context of this decision was that some months previously GP 1 had been concerned about her ability to care for her baby once born because of the severity of her depression, Ms. X's mental state had deteriorated considerably from her assessment on 25 February and an urgent referral had been made to the Recovery and Independent Living Team and she was in the last few weeks of pregnancy. The Independent Investigation concluded that it is unlikely that Ms. X was in a state of mind to be able to make sensible decisions about her care and treatment at that time and that this was a situation where the Care Coordinator needed to be *"assertive and authoritative in their approach"* in order to ensure the wellbeing of Baby Y, as well as that of Ms. X. The Independent Investigation Team did not think that this was a situation in which it was appropriate to do nothing and to wait for another two weeks until seeing the client again. Although it is good practice to involve the client in decision making about his or her care, involving a client in the decision

making does not have to mean concurring entirely with the client's wishes: a skilled clinician can find acceptable ways of engaging a client. Where the wellbeing of a baby, born or unborn, is involved then the clinician has a duty to think about the safeguarding of that child when considering the treatment options for the mother, rather than complying entirely with her wishes.

- **Contributory Factor 11: The Care Coordinator's decision at her initial meeting with Ms. X to concur with Ms. X's wishes and to do nothing further until after the birth of Baby Y, contributed to the further deterioration of Ms. X's mental health and therefore to the death of Baby Y.**

7.3.8. Family Involvement

The Independent Investigation is in agreement with the Serious Case Review that the responses to the concerns raised by Ms. X's family were limited.

None of the health or mental health practitioners involved in Ms. X's care and treatment considered the escalating concern of the family to indicate that she required an urgent assessment, that day, of her mental state and the risks to Baby Y. Had the family been involved in the drawing up of a plan of care for Ms. X from an earlier stage they would have had better knowledge about who to contact in a crisis to express their escalating concerns and may have felt more confident in expressing the urgency of intervention. Had there been direct contact between Ms. X's family and her Care Coordinator it is possible that they could have discussed the expectations of the mental health staff concerning the family's ability to be present at all times and keep Baby Y safe and the reasonableness of these concerns. This was a missed opportunity to provide an adequate assessment of Ms. X's mental state and the potential risks to Baby Y, and to provide an appropriate intervention.

It could be argued that at this point in time Ms. X had agreed to her family being involved in her care through allowing them to accompany her to appointments and through allowing her mother-in-law to organise her appointments. Nevertheless, if the health or mental health practitioners were concerned about issues of confidentiality in the sharing of information with Ms. X's family, this should not have prevented practitioners from listening to the family's concerns. Consideration of the potential risks to Baby Y may have allowed the health and mental health practitioners to take into account the father's right to information that may have

significance to the wellbeing of his child. It is the view of the Independent Investigation that the father of Baby Y had the right to understand the potential impact of the deterioration of Ms. X's mental health on the wellbeing of his child and to be involved in the development of an appropriate care plan in order to minimise the risks to Baby Y. He had the right to be given sufficient information to allow him to provide appropriate care and support for his wife in order to minimise the risks to his child.

- **Contributory Factor 12: the health and mental health practitioners involved in the care and treatment of Ms. X did not give significant weight to the escalating concerns of the family of Ms. X about her deteriorating mental health and the potential risk to Baby Y. This meant that appropriate intervention was not given in a timely fashion and contributed to the death of Baby Y.**

- **Contributory Factor 13: the health and mental health practitioners involved in the care and treatment of Ms. X did not consider the right of the father of Baby Y to be given sufficient information to allow him and his family to give appropriate care and support to Ms. X and thereby reduce the potential risk to Baby Y from her deteriorating mental health. This contributed to the death of Baby Y.**

- **Contributory Factor 14: the family of Ms. X were not given the opportunity to be involved in the planning of her care and treatment, in accordance with the NICE guidelines. This contributed to the deterioration of her mental health and therefore to the death of Baby Y.**

7.3.9. Communication

The Independent Investigation is in agreement with the Root Cause Analysis Investigation that the lack of information sharing with relatives and the lack of multiagency information sharing, review, care and contingency planning in accordance with the NICE guidelines contributed to the deterioration of the mental health of Ms. X and ultimately to the death of Baby Y. The Care Coordinator did not gather information from all those involved in the care of Ms. X, nor take the lead in drawing the various health care professionals together to

develop a coordinated plan of care for Ms. X with due regard to the safety of Baby Y, as would have been appropriate to her role.

The family were not given adequate information about Ms. X's mental health problems and their management to allow them to make informed decisions about the welfare of Baby Y. When members of Ms. X's family communicated with the health and mental health professionals in crisis sufficient weight was not given to the seriousness of their concerns and they did not have sufficient information about who to contact in a crisis or about any plan for the management of Ms. X's mental health problems.

The Independent Investigation found that there were specific occasions when communication did not take place between professionals involved in Ms. X's care which meant that vital information was not shared in a timely manner.

Although the clinical notes provided by all three Trusts showed that the health professionals largely kept contemporaneous notes of a high standard there were some notable exceptions. Signatures and names were difficult to read in some instances, especially in the clinical notes from SDHT.

- **Service Issue 1: where a mother has a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by a formal written referral from the GP to the midwifery service which outlines the mother's history and alerts the midwifery staff to the heightened need to monitor her wellbeing and its potential impact on her child. This should prompt open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

- **Service Issue 7: health and mental health professionals should document all contact with an individual client, or attempted contact, and should document all clinical discussions, informal or formal, concerning the individual client.**

- **Service Issue 8: health and mental health professionals should ensure that their name is written in a legible fashion next to each signature written after a handwritten entry into the clinical notes.**

- **Contributory Factor 15: the lack of information sharing with relatives and the lack of multiagency information sharing, review, care and contingency planning in accordance with the NICE guidelines contributed to the deterioration of the mental health of Ms. X and ultimately to the death of Baby Y.**

7.3.10. Care Pathway

The Independent Investigation Team concluded that at the time that Ms. X was receiving care and treatment there was no clear perinatal care pathway for women with mental health problems within Torbay.

Despite her known history of mental health problems, NICE guidelines were not followed from the outset of her pregnancy, resulting in the lack of a written care plan being developed in the first trimester with Ms. X, her partner, her family and with the relevant healthcare professionals. It also resulted in the late referral to specialist mental health services. The early development of a care plan could have involved the mental health services from the outset or included the point at which such inclusion should be considered. By the time Ms. X was referred to the mental health services her mental state had been deteriorating for at least two months. Following the NICE care pathway for depression, she should have been offered cognitive behaviour therapy from the point of deterioration of her mental health, or even from the point at which she came off Sertraline at the outset of her pregnancy as an alternative to medication. While it cannot be assumed that Ms. X would have accepted such an intervention, there is no evidence that this was considered at this stage.

The care pathway Ms. X followed from the point of her referral to the mental health services both increased the number of professionals she saw on one occasion only, and delayed her access to care coordination.

The absence of a specialist perinatal mental health care pathway and provision and limitations in access to knowledge, understanding and skills in perinatal mental health within

the services accessed by Ms. X, contributed to the deterioration of her mental health and to the death of Baby Y.

The Court has found there to be a link between the death of Baby Y and the mental state of Ms. X at the time of the killing. Despite referral to the mental health service in the latter stages of pregnancy Ms. X's mental state continued to deteriorate up to the time of Baby Y's birth and after his birth. A number of factors contributed to her lack of effective treatment, including her care pathway, but the Independent Investigation found a causal link between:

(i) the deterioration of Ms. X's mental state and the limited care coordination she received after she entered the secondary mental health service;

(ii) the failure of professionals to trigger safeguarding and the death of Baby Y.

- **Causal Factor 1: The lack of assertive and timely intervention for Ms. X's depression caused her mental state to deteriorate to the point of killing Baby Y.**

- **Causal Factor 2: The failure of mental health and other health professionals to identify the potential risk to Baby Y from his mother's deteriorating mental state and therefore to trigger, in a timely manner, the safeguarding children procedure was causal in the death of Baby Y as no inter-agency management plan was put in place to manage the risk to him.**

- **Contributory Factor 16: Ms. X's pathway through the mental health services contributed to a delay in her obtaining treatment and the late allocation of a care coordinator with the potential to coordinate a robust inter-agency care plan. This contributed to the deterioration of her mental health and to the death of Baby Y.**

- **Contributory Factor 17: the absence of specialist perinatal mental health care pathway and provision contributed to the deterioration of Ms. X's mental health and to the death of Baby Y.**

- **Service Issue 9: some clinicians in DPT are unfamiliar with the concept of care pathways and do not know the care pathway for a particular mental health problem.**

- **Service Issue 10: the referral route for a particular mental health problem is not clear to all potential referrers into the mental health service.**

7.3.11. Clinical Governance and Performance

Service Issue 9: some clinicians in DPT are unfamiliar with the concept of care pathways and do not know the care pathway for a particular mental health problem.

Service Issue 11: some staff from the mental health teams involved in the care and treatment of Ms. X did not adhere to the operational policies relevant to their team and their role.

Conclusions to Findings

The Independent Investigation concluded that the death of Baby Y was preventable and that there were two factors in the care and treatment of Ms. X which were causal in the events leading to his death. His death occurred in the context of his mother's deteriorating mental health and the Court found that he was smothered by his mother, Ms. X, while the balance of her mind was disturbed.

The Independent Investigation concluded that causal in the deterioration of Ms. X's mental state to the point of killing Baby Y was the lack of timely and assertive intervention for her depression, despite the recognition that her mental health needs were complex and severe and the allocation of a Care Coordinator under the Care Programme Approach. This case illustrates the problems that are encountered when assessment, monitoring, care planning and communication fail: the very things which CPA is designed to prevent. The Independent Investigation found that the most basic building blocks of the Care Programme Approach were not implemented and concluded that this was to the ultimate detriment of the health, safety and wellbeing of both Ms. X and her baby.

The Independent Investigation concluded that also causal in the death of Baby Y was the failure of mental health and other health professionals to identify the potential risk to him

from his mother's deteriorating mental state and therefore to trigger, in a timely manner, the safeguarding children procedure. Implementation of the safeguarding children procedure would have led to the development of an inter-agency management plan aimed at managing the risk to him and ensuring that all health professional involved in the care of Ms. X and Baby Y, and his family, recognised this risk and were aware of the actions needed to keep Baby Y safe.

The Independent Investigation recognised that at the time of the care and treatment of Ms. X under investigation, the Trusts had not developed a specified Care Pathway for pregnant women with mental health problems to support the mental health and other health professionals in providing optimum care to such vulnerable women and their babies and to enhance communication across the professional boundaries. Since that time and in response to the findings of the Serious Case Review and Internal Investigation, DPT, in collaboration with the other Trusts and the commissioners, has developed a perinatal care pathway for pregnant women with mental health problems and perinatal services which are currently established in some areas of Devon and being developed in others. It is likely that the development of the perinatal services has significantly reduced the likelihood of such a tragic event occurring again.

8. Notable Practice

It is perhaps the nature of an Investigation that its emphasis is on things that can be improved and, in consequence, the reports of such Investigations can appear somewhat unbalanced and overly critical. Although the current report, too, focuses on what might be improved this is not to be read as indicating that good practice was not also present.

The Independent Investigation Team noted that the Trusts have responded to findings of the Serious Case Review and the Root Cause Analysis Investigation by working with their commissioners to ensure the development of specialist perinatal mental health care pathways and the provision of perinatal mental health services. The perinatal service is provided with collaboration between staff from different Trusts, such as midwifery staff and mental health staff.

In Torbay a full perinatal care pathway has been established; the team is able to work with women at high risk and to be involved in the care of these women pre-conception, in pregnancy and for up to a year following birth. In the Exeter area a full perinatal service has not been commissioned. The commissioned service allows the team to remain involved for up to ten days postnatally.

Commissioning has now been agreed for the full perinatal care pathway in Exeter and for the development of a perinatal service in North Devon. DPT is currently developing these services.

9. Lessons Learned

The following lessons are offered as generalisable lessons for national learning.

9.1. Safeguarding

Although training in safeguarding was available for all professionals involved in the care and treatment of Ms. X, none of the professionals identified this as a situation where the instigation of the safeguarding procedures was relevant. The lessons to be learned are that (i) although training might be made available to staff, the uptake of such training might be poor, so the provision of training is insufficient without a system of monitoring and enforcement, (ii) training should to focus on the translation of knowledge into practice, so that individual professionals are able to identify the relevance of knowledge acquired in training to situations they are dealing with in day to day practice.

9.2. Policy Adherence

Although Trusts may have in place Operational Policies and Care Pathways which are fit for purpose and conform to national standards, the existence of such policies and care pathways does not ensure the adherence of individual practitioners to the same. Adherence to policies by individual practitioners and by teams needs to be audited to highlight where this is not the case and work done with individuals and/or teams who are identified as noncompliant in this area.

9.3. Professional Communication

Where care is provided to an individual client by a number of different healthcare professionals, communication between the involved professionals is crucial to ensure the sharing of key information and the planning of coordinated care. This is of particular importance when care is being provided by a range of professionals who may not have an established pattern of communication, for example, by mental health professionals and by physical health care professionals. The Independent Investigation Team recognises that the establishment of the perinatal services has provided a system of communication between such professionals in the case of pregnant women with mental health needs.

Healthcare professionals of all disciplines should ensure that all contacts with clients, or failed contacts with clients, are documented and that all discussions with other professionals or family members concerning a client are documented in a timely fashion. Whereas this may be time consuming, such documentation should ensure that each professional can be clear about what they did or did not do in an individual case.

10. Recommendations

10.1 The Care Programme Approach

10.1.1. Contributory and Causal Factors

- **Contributory Factor 1: The lack of a robust inter-agency care plan to manage the care of Ms. X meant that appropriate mental health care was not offered to her in a timely and planned way and the potential risk to Baby Y was not considered and managed. This contributed to the deterioration of her mental health.**

- **Causal Factor 1: The lack of assertive and timely intervention for Ms. X's depression caused her mental state to deteriorate to the point of killing Baby Y.**

10.1.2. Service Update

DPT has used a range of approaches to improve overall standards of practice, Care Coordination and care planning and has established mechanisms whereby these are monitored.

The Trust's recovery coordination policy sets out roles, responsibilities and standards for the coordination of care and the determinants of a CPA or non-CPA approach. Practice standards, describing the practice and behaviours expected of all clinical staff, have also been developed to clarify expectations.

In 2010/11 the single electronic care record (RiO) was introduced. RiO is governed by standard operating procedures (SOPs) and RiO consistency standards. The SOPs apply to all services but the consistency standards define assessment, planning, coordination and review in different service settings.

Implementation of the recovery coordination policy and the roll out of RiO were supported by training programmes and extensive communication. However, routine monitoring, external inspection and incident and complaints investigation showed a continuing need for

improvement, particularly in the areas of personalised care planning and the assessment and management of clinical risk.

During 2011 a whole-organisation Care Quality Development Programme (CQDP) was delivered to each multidisciplinary team over the course of two days (two and a half days for inpatient units). The programme focused on standards of practice, clinical record keeping and effective team work. The content was adapted to the function of each team but included core modules on:

- mental capacity assessment and deprivation of liberty safeguards;
- clinical risk management;
- core assessment;
- personalised care planning;
- physical health and wellbeing;
- 'Think family' and safeguarding.

Anyone referred to secondary mental health services while pregnant is triaged as a priority and allocated a Care Coordinator. Multiagency information sharing, review, care and contingency planning are in place for all those in contact with secondary mental health services who are pregnant.

Practice in relation to recovery coordination, and how this is reflected in the clinical record, is monitored on an ongoing basis Trust-wide by four principle mechanisms.

- Clinical Record Self Monitoring (CRSM) is a monthly audit of approximately 500 clinical records carried out by clinical team leaders from a centrally generated sample. The results inform discussions with individual practitioners in supervision and the data informs team dashboards, can be analysed over time and can be used in comparison with teams providing similar services.
- Team level assessment and verification of compliance with the Care Quality Commission's 16 essential outcome standards for quality and safety.
- Audits against RiO consistency standards which are undertaken in respect of any area where there are concerns regarding adherence to the standards set.
- An external measure of the impact of standards of practice is the monthly survey of 1,000 people who use services. The survey questions were designed with people who

use services to measure the degree to which the desired features of practice are experienced by them.

All four of these mechanisms provide information which is routinely considered at service and team level to identify and support services and teams where further improvement is needed. The HASCAS review of November 2012 confirmed evidence from across the organisation that these mechanisms are in place.

Recommendations

- ***Recommendation 1. DPT will review its Recovery Coordination policy to ensure that it clearly describes the role and expectations of the consultant psychiatrist within the Care Programme Approach.***

- ***Recommendation 2. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.***

  This written care plan should:
  - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals***
  - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services)***
  - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes), and***
  - ***be communicated to the woman and all relevant health care professionals.***

10.2. Risk Assessment and Management

10.2.1. Contributory Factors

- **Contributory Factor 2: The standard of clinical risk assessment fell below that expected from a secondary care specialist service and was not in keeping with local Trust policy or Department of Health guidance. This meant that appropriate mental health care was not offered to Ms. X in a timely and planned way leading to the further deterioration of her mental state.**

- **Contributory Factor 3: The standard of clinical risk assessment fell below that expected from a secondary care specialist service and was not in keeping with local Trust policy or Department of Health guidance. This meant that the potential risks to Baby Y were not recognised, a risk assessment for the baby in his own right was not considered and the potential risk to Baby Y was not managed.**

- **Contributory Factor 4: The failure of the risk assessment to identify the potential impact of Ms. X's deteriorating mental health on Baby Y, in conjunction with the lack of timely intervention, meant that the family were not alerted to the potential risks to Baby Y and so were unable to make informed decisions about his care.**

10.2.2. Service Update

The implementation of RiO in 2010/11 across DPT provided the opportunity to move to a standard format for risk assessment and risk management plans. The clinical risk assessment and management policy reflects best practice guidance and outlines requirements. The RiO consistency standards further detail the timing, content and review of risk assessments and risk management plans in different service settings.

A training needs analysis for clinical risk management was completed in 2010 and a Trust-wide training plan was resourced and developed. Components of this training were incorporated into the Care Quality Development Programme delivered in 2011.

An audit tool has been developed and is used to evaluate the effect of training upon practice in relation to clinical risk. The key questions from this audit have been identified with a proposal that these are incorporated into the Clinical Record Self Monitoring Process to increase further the focus upon the coherence and comprehensiveness of clinical risk assessment, risk management and contingency planning.

Recommendations

- ***Recommendation 3. DPT will incorporate the key questions identified from the audit of clinical risk assessment into the Clinical Record Self Monitoring Process. This will improve the monitoring and performance management of this key area of practice by providing information which is then routinely considered at service and team level. This should identify and support services and teams where further improvement is needed.***

- ***Recommendation 4. DPT will review its Recovery Coordination policy to highlight the need for Care Coordinators or consultant psychiatrists to call a multi-professional meeting at short notice when concerns are raised in relation to a person's risk that are not covered by contingency plans. This review will be followed by wide dissemination of the policy and guidance to practitioners.***

10.3. Diagnosis

10.3.1. Contributory Factors and Service Issues

- **Contributory Factor 5: The likely impact of Ms. X's diagnosis of recurrent depression and the deterioration of her symptoms on her unborn and neonatal child were not given sufficient consideration by the mental health service in the planning of her care during the perinatal period. Had this been given sufficient consideration it might have led to the identification of the potential risks to Baby Y and the development of an appropriate multi-agency plan for the care of Ms. X and Baby Y in the perinatal period.**

- **Service Issue 1: where a mother has a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by a formal written referral from the GP to the midwifery service which outlines the mother's history and alerts the midwifery to the heightened need to monitor her wellbeing and its potential impact on her child. This should prompt open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

10.3.2. Service Update

DPT has worked with its commissioners to develop specialist perinatal mental health care pathways and service provision across Devon and Torbay. A perinatal mental health care pathway was developed and agreed in December 2011 and the Trust now provides services in Devon and Torbay.

The service is currently available to women receiving their antenatal care from the Royal Devon and Exeter Hospital in Exeter and Torbay Hospital in Torquay; there is currently no service in North Devon.

The provision of the Perinatal Mental Health Service is currently different in Exeter and in Torbay. Both teams offer:

- timely contact;
- assessment;
- development of a care plan;
- advice on mental health medication;
- promotion of wellbeing and prevention of relapse;
- pregnancy and birth planning for women who already have a care coordinator from the specialist mental health services;
- information about other appropriate services;
- work with the woman's partner and family members.

In Torbay a full perinatal care pathway has been established; the team is able to work with women at high risk and to be involved in the care of these women pre-conception, in pregnancy and for up to a year following birth. In the Exeter area a full perinatal service has

not been commissioned. The commissioned service allows the team to remain involved for up to ten days postnatally.

Commissioning has now been agreed for the full perinatal care pathway in Exeter and for the development of a perinatal service in North Devon. DPT is currently developing these services.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant, in accordance with NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health.

Recommendations

- ***Recommendation 5. DPT will establish perinatal services to cover all areas of Devon and Torbay in accordance with commissioner requirements.***

- ***Recommendation 6. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.***

- ***Recommendation 7. This written care plan should:***
    - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals;***
    - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services);***
    - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes); and***
    - ***be communicated to the woman and all relevant health care professionals.***

- ***Recommendation 8. Torbay Care Trust in collaboration with South Devon Healthcare Trust will consider the development of a protocol concerning (i) the mechanism of referral from the GP to the midwifery service which includes how particular areas of concern or vulnerability might be highlighted, (ii) standards for communication between the GP and the midwifery service during a woman's pregnancy and the neonatal period, and (iii) access for the midwifery service to the GP records of an individual in their care.***

10.4. Mental Health Act (1983 & 2007) and Mental Capacity Act (2005)

10.4.1. Service Issues

- **Service Issue 2: Ms. X's capacity to make decisions in the best interest of her child was not considered by the staff involved in her care. The Trusts may wish to consider the provision and uptake of training available to staff about the Mental Capacity Act (2005).**

- **Service Issue 3: Staff training in the Mental Capacity Act, Safeguarding and the Mental Health Act should consider the relationship between these three processes and how they might support each other in ensuring the wellbeing of an unborn child or neonate.**

10.4.2. Service Update

A training needs analysis has been undertaken in relation to the Mental Capacity Act (MCA) and training is provided in accordance with the needs identified. Training is provided through e-learning to all clinical staff: uptake is increasing and approaching target. Uptake of core training is monitored and routinely considered in directorate governance forums. A four-hour face-to-face training session is held monthly to consider practice in relation to undertaking MCA assessments in more detail and this level of training is provided at team level on request. This training is facilitated by DPT's Safeguarding Practice Development Lead or MCA Lead.

Training provided in the Mental Capacity Act, Safeguarding and the Mental Health Act (MHA) currently considers the relationship between these processes. MHA and Safeguarding considerations are integral to the MCA training and the linkage has been strengthened further by specifically including a consideration of the implications of the MCA in training on the MHA. Both the MCA and MHA are considered under the umbrella of safeguarding and are referred to specifically in the Level Two, mental health specific, safeguarding training.

The work streams in relation to MCA and MHA report into the DPT's overarching Safeguarding Committee.

10.4.3 Recommendations

- ***Recommendation 9. DPT will review the provision of training available to staff in relation to the Mental Capacity Act and continue to monitor and performance manage the uptake of training identified as being required.***

- ***Recommendation 10. DPT will review the training provided in the Mental Capacity Act, Safeguarding and the Mental Health Act to consider whether the relationship between these three processes could be further explored and how ensure the principle of 'paramouncy' in relation to children's safeguarding is emphasised.***

10.5. Treatment

10.5.1. Medication

10.5.1.1. Contributory Factors

- **Contributory Factor 6: Ms. X having come off her medication prior to the birth of Baby Y is likely to have contributed to the decline of her mental health and subsequent killing of Baby Y. Although she was secretive about having stopped her medication in the latter stages of pregnancy, had there been a risk assessment in place concerning her use of antidepressant medication or not during pregnancy and the neonatal period, drawn up in consultation with Ms. X, and a robust plan in place to manage this risk overseen by a care coordinator**

who was familiar to Ms. X, the decline in her mental health may have been prevented or at least addressed in a more timely fashion.

- **Contributory Factor 7: The lack of a coordinated plan about the management of Ms. X's medication from the outset of her pregnancy and after the birth of her child, and the lack of ongoing discussion with Ms. X about the management of her medication during this time period, may have contributed to Ms. X making the decision to stop her medication at the end of her pregnancy and therefore contributed to the deterioration in Ms. X's mental health and the death of Baby Y.**

10.5.1.2 Service Update

DPT now provides perinatal mental health services in Devon and Torbay which include pharmaceutical support from DPT's Medicine Management Team who provide specialist advice about prescribing in pregnancy and while breast-feeding. The post of 'Lead Clinical Pharmacist for Specialist Services Directorate' has been appointed to in order to improve the timeliness of access to advice regarding all aspects of medicine management to specialist mental health services. The Medicine Management Team works with perinatal mental health services to:

- improve information and education regarding prescribing in pregnancy and while breast-feeding to other clinicians (including GPs);
- improve information and education to individual women to support them in weighing up the risks and benefits of medication and making an informed choice about the treatment option(s) that are best for them.

A Medicine Information Helpline is now available, enabling clinicians, people who use the Trust services and their carers to access a specialist clinical pharmacist to discuss and obtain advice regarding the safe, effective and appropriate use of medication as a treatment option to support individual recovery. This includes advice and information about prescribing/taking medication during pregnancy and while breast-feeding.

DPT has a subscription to the Choice & Medication website. This enables free access to information about medication for the management of mental health conditions for clinicians, people who use the Trust services and their carers (and includes the e-mail address for DPT's

Medicine Management Team as an alternative route to contact a specialist pharmacist for advice and information about medication).

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant, in accordance with NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health. Treatment with medication (where indicated) is included as an integral part of the care-plan for an individual woman during pregnancy and/or the postnatal period.

The use of medication care plans is currently being piloted in a number of teams across DPT services with a view to staged implementation across the Trust's services when testing has been completed.

No recommendations are required.

10.5.2. Psychological Therapy

10.5.2.1. Contributory Factors

- **Contributory Factor 8: Ms. X was not offered the opportunity of psychological therapy until the third trimester of her pregnancy and did not receive an appointment for the therapy until after her due date. Had Ms. X been offered psychological therapy at the point at which her Sertraline was withdrawn, or when her mental state first began to deteriorate during her pregnancy it is possible that she may have been willing to engage and that such therapy could have contributed to her mental wellbeing. Lack of a timely referral for psychological therapy may have contributed to the deterioration of her mental state.**

- **Contributory Factor 9: Ms. X was seen by a range of individuals from the midwifery service and from the mental health service. She was not offered the opportunity to establish a therapeutic relationship with a single member of staff and received only assessment rather than treatment, other than her medication. This may have contributed to the deterioration of her mental health.**

10.5.2.2. Service Update

Access to psychological therapies has been enhanced by the implementation of Improving Access to Psychological Therapies (IAPT) in primary care. The Devon and Torbay Depression and Anxiety Service (DAS) was introduced in October 2009. The service specification for DAS requires that people are seen within 28 days of referral. The service has responded to increased demand since its introduction, where monthly referral rates have almost tripled from approximately 500 to 1,500. The increase in referrals reflects the increased awareness, understanding and appreciation of the service which can be accessed by direct referral from GPs/primary care, other health and social care professionals and through self referral.

Anyone referred to secondary mental health services who is pregnant is triaged as a priority and allocated a Care Coordinator to facilitate the establishment of a therapeutic relationship with a single member of staff. Multiagency information sharing, review, care and contingency planning are in place for all those in contact with secondary mental health services who are pregnant.

DPT has improved its response to referrals to secondary care mental health services through implementing a referral management system with Devon Access and Referral Team (DART) providing a single point of access. This service is now established across all adult mental health services provided by the Trust following a phased implementation which was completed in October 2012. All older adult services will be operational by March 2013. DART provides a single point of contact which considers all referrals to secondary mental health services. In addition the Trust has set a referral to assessment waiting time target of five working days for urgent (non crisis) referrals and ten working days for all routine referrals (this compares to the national target of 28 days) . The areas which have implemented the referral management system have exceeded their trajectories towards this target.

Referrals are triaged the same day. Urgent referrals are assessed within five days and routine referrals are assessed within ten days. Any referrals requiring a crisis response will be seen the same day. A full bio/psycho/social assessment is undertaken which results in a formulation and a decision in relation to whether a person requires allocation for further/ongoing interventions. Allocation following the initial assessment will provide the opportunity for a person to establish a therapeutic relationship with a single member of staff

without the need for further assessment and changes to different teams. The initial assessment will also ensure that anyone who is pregnant is automatically prioritised and placed on the agreed perinatal care pathway.

In conjunction with the perinatal service staff, South Devon Healthcare Trust has developed mandatory training in mental health issues for all midwives and maternity care assistants, and for medical staff involved in the care of pregnant women and new mothers. The training uses the case of Ms. X to illustrate the importance of ensuring that pregnant women and new mothers with mental health needs are provided with the appropriate treatment and care.

10.5.2.3 Recommendation

- ***Recommendation 11. DPT will audit the implementation of the perinatal pathway as described in 19.3 above.***

10.6. Safeguarding

10.6.1. Contributory Factors and Service Issues

- **Contributory Factor 10: The fact that the Safeguarding procedure was not initiated meant that the potential risk to Baby Y was not thoroughly considered prior to or after his birth and an appropriate plan to manage this risk of significant harm was not developed. This led to the lack of a clear assessment of the likelihood of harm and an over-reliance upon the family to maintain his safety and contributed to the events leading to his death.**

- **Service Issue 1: where clients have a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by the GP at the point of referral to the midwifery service promoting open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

- **Service Issue 4: Despite the availability of training in safeguarding to all members of clinical staff, the majority of DPT clinical staff have not undertaken**

training beyond Level 1. DPT needs to consider how this training requirement should be enforced more effectively and consider whether face-to-face and inter-agency training below Level 3 might be more effective in helping staff to identify relevant cases and to improve their awareness of how cases should be managed.

- **Service Issue 5: the number of hours allocated to the posts of Named Nurse for Safeguarding within DPT and SDHT may be insufficient to ensure that safeguarding maintains a high profile within the Trusts.**

- **Service Issue 6: where there are serious concerns about the mental health of a pregnant woman or new mother who changes GP, consideration needs to be given to how the process of handover to the new GP might be made safer.**

10.6.2. Service Update

DPT has worked with its commissioners to develop specialist perinatal mental health care pathways and service provision across Devon and Torbay. A perinatal mental health care pathway was developed and agreed in December 2011 and the Trust now provides services in Devon and Torbay.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant, in accordance with NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health. This provides a forum where the needs of the unborn child can be considered and where the need for initiation of safeguarding procedures can be determined if they not already in place.

A Safeguarding Hub was established in Torbay in 2010 which acts as a single point of contact for advice and referrals. Adult mental health staff from Torbay attended multiagency training when this was set up in relation to the 'child's journey' (a publication which considers referrals, thresholds and processes for children's safeguarding). Across the rest of Devon a Multiagency Safeguarding Hub (MASH) is established to act as a single point of contact for advice and referrals. DPT provides support and information to MASH and has just completed a pilot of having a DPT employee placed full-time within MASH to offer a mental health perspective and improve flow of information. DPT is looking to establish a

presence within MASH on an ongoing basis and is an advocate of MASH arrangements extending to encompass Torbay.

A training needs analysis has been undertaken in relation to Safeguarding Children and training is provided in accordance with the needs identified. Training is provided at three levels:

- Level one – e-learning for all staff;
- Level two – mental health specific e-learning for all clinical staff;
- Level three – face-to-face multiagency training.

Uptake of training is monitored and routinely considered through directorate governance structures; level one uptake is high, uptake of training at higher levels is improving though remains low.

The Safeguarding agenda within DPT is led by an Executive Director and overseen by a Safeguarding Committee, chaired by the Executive Director with membership including identified Non-Executive Director, Safeguarding Leads, Named Professionals and Functional Leads. This committee oversees a range of work-streams:

- Safeguarding Children;
- Safeguarding Adults (including Prevent);
- Domestic Violence and Abuse (including MARAC);
- Multi Agency Public Protection (MAPPA);
- Mental Capacity and Deprivation of Liberty Safeguards;
- Mental Health Act.

There are established Named Professionals for Children's Safeguarding in post and a post of Safeguarding Practice Development Lead has been appointed to in order to support best practice in relation to the above work-streams.

The Safeguarding structure within DPT is currently under review, with a view to appointing to a full-time management/leadership role to further progress and integrate practice across all the above Safeguarding work-streams.

10.6.3 Recommendations

- ***Recommendation 11. DPT will establish perinatal services to cover all areas of Devon and Torbay in accordance with commissioner requirements.***
- ***Recommendation 12. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.***

- ***Recommendation 13. This written care plan should:***
  - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals***
  - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services)***
  - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes), and***
  - ***be communicated to the woman and all relevant health care professionals.***

- ***Recommendation 14. DPT will, in conjunction with its commissioners, seek to establish a presence within MASH on an ongoing basis and will continue to advocate for the multiagency hub arrangements extending to encompass Torbay.***

- ***Recommendation 15. DPT will review its training needs analysis and training provision to consider whether face-to-face and inter-agency training below level 3 might be more effective in helping staff to identify relevant cases and improve their awareness of how cases should be managed.***

- ***Recommendation 16. DPT will continue to monitor the uptake of training identified as being required in relation to safeguarding children and strengthen its performance management in respect of uptake.***

- ***Recommendation 17. DPT will incorporate a review of the number of hours allocated to the Named Nurse post within its current review of the safeguarding governance arrangements, engaging with commissioners as required, to ensure that safeguarding maintains a high profile.***

- ***Recommendation 18. South Devon Healthcare Trust will monitor the uptake of training identified as being required in safeguarding children.***

10.7. Service User's Involvement in Care Planning

10.7.1. Contributory Factor

- ***Contributory Factor 11: The Care Coordinator's decision at her initial meeting with Ms. X to concur with Ms. X's wishes and to do nothing further until after the birth of Baby Y, contributed to the further deterioration of Ms. X's mental health and therefore to the death of Baby Y.***

10.7.2. Service Update

DPT has worked with its commissioners to develop a specialist perinatal mental health care pathway; this care pathway was developed and agreed in December 2011 and the Trust now provides perinatal mental health services in Devon and Torbay.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant in accordance with NICE guidelines; this includes information sharing and collaboration with the woman and her partner, family and carers, and relevant healthcare professionals.

10.7.3 Recommendations

- ***Recommendation 19. DPT will establish perinatal services to cover all areas of Devon and Torbay in accordance with commissioner requirements.***

- ***Recommendation 20. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 –***

Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.

- ***Recommendation 21. This written care plan should:***
    - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals;***
    - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services);***
    - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes); and***
    - ***be communicated to the woman and all relevant health care professionals.***

10.8. Family Involvement

10.8.1. Contributory Factors

- **Contributory Factor 12: the health and mental health practitioners involved in the care and treatment of Ms. X did not give significant weight to the escalating concerns of the family of Ms. X about her deteriorating mental health and the potential risk to Baby Y. This meant that appropriate intervention was not given in a timely fashion and contributed to the death of Baby Y.**

- **Contributory Factor 13: the health and mental health practitioners involved in the care and treatment of Ms. X did not consider the right of the father of Baby Y to be given sufficient information to allow him and his family to give appropriate care and support to Ms. X and thereby reduce the potential risk to Baby Y from her deteriorating mental health. This contributed to the death of Baby Y.**

- **Contributory Factor 14: the family of Ms. X were not given the opportunity to be involved in the planning of her care and treatment, in accordance with the NICE guidelines. This contributed to the deterioration of her mental health and therefore to the death of Baby Y.**

10.8.2. Service Update

The training programme for clinical risk management emphasises the need for triangulation of information from a range of sources when considering risk rather than relying on self-report and clinical presentation. A person's family or supporters are highlighted in this training as a source of information that can often be overlooked or not given sufficient weight. The audit tool developed in relation to clinical risk specifically covers whether a person's family or supporters inform the assessment of risk and whether they are informed of care plans that respond to risks identified and contingency plans.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant in accordance with NICE guidelines. This includes information sharing and collaboration with the woman and her partner, family and carers, and relevant healthcare professionals.

10.8.3. Recommendations

- ***Recommendation 22. DPT will incorporate the key questions identified from the audit of clinical risk assessment into the Clinical Record Self Monitoring Process. This will improve the monitoring and performance management of this key area of practice by providing information which is then routinely considered at service and team level. This should identify and support services and teams where further improvement is needed.***

- ***Recommendation 23. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for***

pregnant women with a current or past history of a severe mental illness, usually in the first trimester.

- ***Recommendation 24. This written care plan should:***
    - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals;***
    - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services);***
    - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes); and***
    - ***be communicated to the woman and all relevant health care professionals.***

- ***Recommendation 25. DPT will review its practice standards to ensure that they are more explicit in describing how the views of a person's family or supporters should inform assessment, formulation and recovery plans.***

10.9. Communication

10.9.1. Service Issues and Contributory Factors

- **Service Issue 1: where a mother has a history of mental health problems, or other issues of concern, these should be brought to the attention of the midwifery staff by a formal written referral from the GP to the midwifery service which outlines the mother's history and alerts the midwifery to the heightened need to monitor her wellbeing and its potential impact on her child. This should prompt open discussion with the service user about the potential impact of mental health problems and their treatment on the unborn child.**

- **Service Issue 7: health and mental health professionals should document all contact with an individual client, or attempted contact, and should document all clinical discussions, informal or formal, concerning the individual client.**

- **Service Issue 8: health and mental health professionals should ensure that their name is written in a legible fashion next to each signature written after a handwritten entry into the clinical notes.**

- **Contributory Factor 15: the lack of information sharing with relatives and the lack of multiagency information sharing, review, care and contingency planning in accordance with the NICE guidelines contributed to the deterioration of the mental health of Ms. X and ultimately to the death of Baby Y.**

10.9.2. Service Update

The introduction of RiO in 2010/11, with practice informed by standard operating procedures (SOPs) and RiO consistency standards and further supported by training has standardised and improved record keeping within DPT. Clinical Record Self Monitoring (CRSM) is a monthly audit of approximately 500 clinical records carried out by clinical team leaders from a centrally generated sample. The results inform discussions with individual practitioners in supervision and the data informs team dashboards, can be analysed over time and used in comparison with teams providing similar services. This established process provides valid ongoing monitoring of the content of the clinical record.

DPT has worked with its commissioners to develop a specialist perinatal mental health care pathway. This care pathway was developed and agreed in December 2011 and the Trust now provides perinatal mental health services in Devon and Torbay.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant, in accordance with NICE guidelines. This includes information sharing and collaboration with the woman and her partner, family and carers, and relevant healthcare professionals.

In situations where there is a transfer of care from one midwifery team to another during the care of a pregnant woman or new mother, for example because of the move of the woman from one locality to another, South Devon Healthcare Trust have put in place a policy which states that (i) the original midwifery team should continue to provide care to the woman if practically possible, such as where the move is to a location just outside the original area, or

(ii) where the provision of care from the original team is no longer practical, then the handover from one team to another should be done face-to-face so that there is no delay in the receiving team obtaining the appropriate information about the mother.

10.9.3. Recommendations

- ***Recommendation 26. DPT will develop and incorporate into the Clinical Record Self Monitoring Process question/s to check the completeness of the clinical record; that it records all contact, or attempted contact, with an individual client, and reflects all clinical discussions, informal or formal, concerning the individual client, to improve the completeness and coherence of the clinical record.***

- ***Recommendation 27. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.***

  This written care plan should:
  - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals;***
  - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services);***
  - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes); and***
  - ***be communicated to the woman and all relevant health care professionals.***

- **Recommendation 28. South Devon Healthcare Trust will monitor the implementation of the policy concerning the handover of the care of a mother from one midwifery team to another.**

10.10. Care Pathway

10.10.1. Causal and Contributory Factors and Service Issues

- **Causal Factor 1: The lack of assertive and timely intervention for Ms. X's depression caused her mental state to deteriorate to the point of killing Baby Y.**

- **Causal Factor 2: The failure of mental health and other health professionals to identify the potential risk to Baby Y from his mother's deteriorating mental state and therefore to trigger, in a timely manner, the safeguarding children procedure was causal in the death of Baby Y as no inter-agency management plan was put in place to manage the risk to him.**

- **Contributory Factor 16: Ms. X's pathway through the mental health services contributed to a delay in her obtaining treatment and the late allocation of a care coordinator with the potential to coordinate a robust inter-agency care plan. This contributed to the deterioration of her mental health and to the death of Baby Y.**

- **Contributory Factor 17: The absence of a specialist perinatal mental health care pathway and provision contributed to the deterioration of Ms. X's mental health and to the death of Baby Y.**

- **Service Issue 9: Some clinicians in DPT are unfamiliar with the concept of care pathways and do not know the care pathway for a particular mental health problem.**

- **Service Issue 10: The referral route for a particular mental health problem is not clear to all potential referrers into the mental health service.**

10.10.2. Service Update

DPT has worked with its commissioners to develop specialist perinatal mental health care pathways and service provision across Devon and Torbay. A perinatal mental health care

pathway was developed and agreed in December 2011 and the Trust now provides services in Devon and Torbay.

Multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant in accordance with NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health. This provides a forum where the needs of the unborn child can be considered and where the need for initiation of safeguarding procedures can be determined if they not already in place.

DPT has improved its response to referrals to secondary mental health services through implementing a referral management system with Devon Access and Referral Team (DART) providing a single point of access. This service is now established across all adult mental health services provided by the Trust following a phased implementation which completed in October 2012. All older adult services will be operational by March 2013. DART provides a single point of contact which considers all referrals. In addition the Trust has set a referral to assessment waiting time target of five working days for urgent (non crisis) referrals and ten working days for all routine referrals (this compares to the national target of 28 days). The areas which have implemented the referral management system have exceeded their trajectories towards this target.

Referrals are triaged the same day: urgent referrals are assessed within five days and routine referrals are assessed within ten days. Any referrals requiring a crisis response will be seen the same day. Full bio/psycho/social assessment is undertaken which results in a formulation and in a decision in relation to whether a person requires allocation for further/ongoing interventions. Allocation following the initial assessment will provide the opportunity for a person to establish a therapeutic relationship with a single member of staff without the need for further assessment and changes to different teams.

The referral management, triage and assessment process will ensure that anyone who is pregnant is automatically prioritised and placed on the agreed perinatal care pathway.

South Devon Healthcare Trust are auditing adherence of their staff to the Torbay Safeguarding Board's Unborn Baby Protocol. Each midwife has been provided with a

laminated copy of the care pathways for vulnerable women, including the perinatal care pathway.

10.10.3 Recommendations

- ***Recommendation 29. DPT will establish perinatal services to cover all areas of Devon and Torbay in accordance with commissioner requirements.***

- ***Recommendation 30. DPT will develop and implement an audit mechanism to specifically monitor practice and adherence to NICE Clinical Guideline 45 – Antenatal and Postnatal Mental Health, to ensure multiagency information sharing, review, care and contingency planning is in place for all those in contact with secondary mental health services who are pregnant. Specifically a written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of a severe mental illness, usually in the first trimester.***

- ***Recommendation 31. This written care plan should:***
  - ***be developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professionals;***
  - ***include increased contact with specialist mental health services (including, if appropriate, specialist perinatal mental health services);***
  - ***be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes); and***
  - ***be communicated to the woman and all relevant health care professionals.***

10.11. Clinical Governance and Performance

10.11.1. Service Issues

- **Service Issue 9: some clinicians in DPT are unfamiliar with the concept of care pathways and do not know the care pathway for a particular mental health problem.**

- **Service Issue 11: some staff from the mental health teams involved in the care and treatment of Ms. X did not adhere to the operational policies relevant to their team and their role.**

10.11.2. Service Update

DPT has developed operational policies at team level to clarify the purpose and function of teams and their interfaces with other services. An operational policy template was created to ensure operational policies are clear in relation to CPA policy, National Service Framework (NSF) fidelity criteria and NICE guidance, which team managers completed for their service. These were checked for completeness and consistency before ratification by Clinical Directorate governance groups. Ratified operational policies are held on the Trust performance system (ORBIT).

Operational policies are implemented in all service areas and will be revised over the coming months as services are reconfigured to reflect Payment by Results (PbR) cluster pathways. As these operational policies will shortly be developed further, the Trust has not yet introduced additional or interim monitoring of adherence to operational policies. Key aspects are monitored through existing processes:

- CPA and non-CPA care coordination is monitored through the practice standards (CRSM) and audit of RiO consistency standards;
- NSF teams are monitored in relation to fidelity criteria and national targets;
- NICE guidelines and clinical policies are audited through Directorate and Trust clinical audit programmes.

10.11.3 Recommendations

- ***Recommendation 32. DPT will complete the service redesign work in preparation for the implementation of PbR cluster pathways in 2013. This will fundamentally change the structure of services and both simplify and clarify care pathways. Implementation will include a communication plan with DPT clinicians and referring clinicians in respect of the new structures and pathways.***

- ***Recommendation 33. DPT will publish its ratified operational policies on the Trust internet and Clinical Team Leaders will be tasked with ensuring all team members***

are conversant with the operational policy for their team through induction and supervision.

- ***Recommendation 34. DPT will audit understanding of and adherence to operational policies and care pathways.***