Independent Investigation

into the

Care and Treatment Provided to Ms. X

by the

Devon Partnership NHS Trust
Torbay Care Trust
South Devon Healthcare Trust

Commissioned by

NHS South West
Strategic Health Authority

Independent Investigation: HASCAS Health and Social Care Advisory Service

Report Author: Dr. Alison Conning

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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.

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

This has allowed the Investigation Team to reach an informed position from which we have been able to formulate conclusions and set out recommendations.

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. Investigation Methodology

7.1. Classification of Independent Investigations

Classification of Independent Investigations

Three types of Independent Investigation are commonly commissioned, these are:

- Type A – a wide-ranging investigation carried out by a team examining a single case;
- Type B – a narrowly focused investigation by a team examining a single case or a group of themed cases;
- Type C – a single investigator with a peer reviewer examining a single case.

Each of these categories has its own strengths which make it best suited to examining certain cases. This Investigation was commissioned by NHS South West (the Strategic Health Authority). The Investigation was regarded as a Type A due to the complexity of the case and the number of statutory agencies involved in the care and treatment that both Ms. X and her baby received.

7.2. Communication and Liaison

7.2.1. Communication with the Family of the Victim

The Investigation Team Chair and a HASCAS representative met with Ms. X on 30 March 2012 and again with Ms. X and her parents on 26 September 2012.

The father of Baby Y was offered the opportunity to take part in the Independent Investigation but it was understood that he did not wish to do so.

7.2.2. Communications with the Trusts

NHS South West SHA wrote to the Devon Partnership NHS Trust Chief Executive. This letter served to notify the Trust that an Independent Investigation under the auspices *of HSG (94) 27* had been commissioned to examine the care and treatment of Ms. X.

The Independent Investigation Team worked with the liaison person from Devon Partnership NHS Trust, South Devon Healthcare NHS Trust and Torbay and South Devon NHS Trust to ensure:

- that all clinical records were identified and dispatched appropriately;
- that each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished.

The liaison person from Devon Partnership NHS Trust took the lead role in liaising between the lead people from the three Trusts and in liaising with HASCAS.

On 14 December 2011 a representative from HASCAS offered to meet with the Senior Team from Devon Partnership NHS to discuss the Independent Investigation process but this offer was not taken up as the Trust were familiar with the process.

A workshop for witnesses to the Independent Investigation was held on 13 June 2012. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible.

Between 2 and 5 July 2012 interviews were held at Wonford House Hospital in Exeter and at Torbay Hospital in Torquay. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Trust Corporate Team.

On the 30 August 2012 a meeting was held between the Chair of the Independent Investigation, CEO of the HASCAS Health and Social Care Advisory Service and members of the Devon Partnership NHS Trust Corporate Team in order to discuss the findings and to invite the Trust to contribute to the development of recommendations.

On 6 November 2012 a telephone conference was held between the Chair of the Independent Investigation, a member of HASCAS, and members of Devon PCT in order to discuss the findings.

On 8 November 2012 a meeting was held between the Chair of the Independent Investigation, the Director of Nursing and Associate Director of Nursing and Midwifery, South Devon Healthcare NHS Foundation Trust.

The Chair of the Independent Investigation offered the Chair of the Torbay Safeguarding Children Board and the Director of Children's Services the opportunity to discuss the findings.

7.3. Witnesses Called by the Independent Investigation

Each witness called by the Independent Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Scott and Salmon processes.

Table 1: Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
2 July 2012	• Associate Director of Nursing and Midwifery, South Devon Healthcare Trust (SDHT) • Matron, Antenatal and Community Midwifery Services/Named Midwife for Safeguarding Children, SDHT • Named Nurse for Safeguarding, Adult Mental Health, Devon Partnership NHS Trust (DPT) • Clinical Risk Manager, DPT • Care Coordinator, Recovery and Independent Living Team, DPT • Senior Mental Health Practitioner	• Investigation Team Chair/ Clinical Psychologist • Investigation Team Nurse • Investigation Team Social Worker • Investigation Team Psychiatrist • In attendance: Stenographer

	1, Mental Wellbeing and Access Team • Clinical Team Leader 1, Mental Wellbeing and Access Service • Consultant Psychiatrist 2, Assertive Outreach Team • Locum Staff Grade Psychiatrist, Recovery and Independent Living Team	
3 July 2012	• Chief Executive, DPT • Director of Operations, DPT • Medical Director, DPT • Lead Psychiatrist, Perinatal Service • Consultant Psychiatrist 1, Mental Wellbeing and Access Team	• Investigation Team Chair/ Clinical Psychologist • Investigation Team Nurse • Investigation Team Social Worker • Investigation Team Psychiatrist • In attendance: Stenographer
4 July 2012	• Midwife 1, Team Leader, Hera (Midwifery Team 1) Team • Midwife 6, Christie (Midwifery Team 2)Team • Midwife 2, Hera Team • Midwife 5, Christie Team • Maternity Care Assistant 1, Christie Team • Midwife 4, Integrated Team Midwife, Juno (Midwifery Team 3)Team • Consultant in Obstetrics and Gynaecology	• Investigation Team Chair/ Clinical Psychologist • Investigation Team Nurse • Investigation Team Social Worker • Investigation Team Psychiatrist • In attendance: Stenographer.
05 July 2012	• Head of Nursing, Torbay Care Trust/Nurse Practitioner 1 • GP 1	• Investigation Team Chair/ Clinical Psychologist • Investigation Team Nurse

	• GP 2 • Health Visitor 1 • Clinical Team Leader 2, Recovery and Independent Living Team	• Investigation Team Social Worker • Investigation Team Psychiatrist • In attendance: Stenographer

In addition the Investigation Team received a written statement from the Named Nurse for Safeguarding, TCT.

7.4. Scott and Salmon Compliant Procedures

The Investigation Team adopted Scott and Salmon compliant procedures during the course of their work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a colleague, member of a trade union, lawyer or member of a defence organisation or anyone else they wish to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be able to access copies of the clinical records both before and during their interviews to refresh their memory.

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

7.5. Independent Investigation Team Meetings and Communication

7.5.1. Initial Team Processes

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Investigation Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview the general questions that they could expect to be asked. The Clinical Records from Devon Partnership NHS Trust and the Internal Investigation archive were sent to the HASCAS Health and Social Care Advisory Service during November 2011. The notes were received from South Devon Healthcare Trust early in March 2012 and from Torbay Care Trust on 27 March 2012.

7.5.2. The Team met on the following occasions

2 May 2012. On this occasion the Team met in order to plan the interviews with the Trust senior management team and clinical witness.

25 July 2012. On this occasion the Team met to work through a root cause analysis process and to discuss the findings of the Investigation.

7.5.3 Other Meetings and Communications

Other communications were maintained, via email and telephone, in order to complete the Independent Investigation report and to develop recommendations.

7.6. Root Cause Analysis (RCA)

The ethos of RCA is to provide a robust model that focuses on underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learned to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.
RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews.
2. **Causal Factor Charting.** This is the process whereby an investigation begins to process the data that has been collected. A timeline is produced and a sequence of events is established (please see Appendix 1). From this, causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This investigation utilised the Decision Tree and the Fish Bone.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team avoids generalisations and seeks to use findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

7.7. Anonymity

All staff of the Devon Partnership NHS Trust, the Torbay Care Trust and the South Devon Healthcare Trust have been referred to in this Investigation report by reference to their role titles, to preserve their anonymity.

The individual whose care and treatment is the subject of this report has been referred to throughout as Ms. X. The victim has been referred to throughout this report as Baby Y.

8. Information and Evidence Gathered

During the course of this Investigation the following documents were actively used by the Independent Investigation to collect evidence and to formulate conclusions.

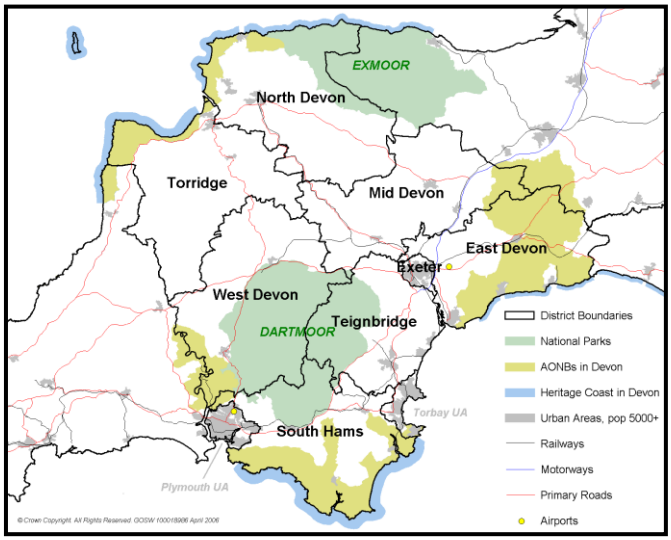
1. Ms. X's Devon Partnership NHS Trust clinical records
2. Ms. X's Torbay and South Devon Health and Care Trust clinical records
3. Ms. X's Torbay Care Trust clinical records
4. The Devon Partnership NHS Trust Internal Investigation Report.
5. The Devon Partnership NHS Trust Root Cause Analysis Investigation Report
6. The Torbay Safeguarding Children Board Serious Case Review
7. Devon Partnership NHS Trust Action Plan
8. Secondary literature review of media documentation reporting the death of Baby Y
9. Devon Partnership NHS Trust Clinical Risk Assessment and Management Policies
10. Devon Partnership NHS Trust Incident Reporting Policies
11. Devon Partnership NHS Trust *Being Open* Policy
12. Devon Partnership NHS Trust Mental Wellbeing and Access Team Operational Policies
13. Devon Partnership NHS Trust Recovery and Independent Living Team Operational Policies
14. Devon Partnership NHS Trust Depression and Anxiety Service Operational Policy
15. Devon Partnership NHS Trust Care Programme Approach Policy
16. Devon Partnership NHS Trust Wellbeing and Recovery Policy
17. Devon Partnership NHS Trust Supervision and Appraisal Policies
18. Devon Partnership NHS Trust Safeguarding Training Positions
19. Perinatal Service documents and funding bid
20. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive 2006
21. Guidelines for the NHS: National Patient Safety Agency, Safer Practice Notice, 10, *Being Open When Patients are Harmed*. September 2005

9. Profile of Mental Health Services Provided by Devon Partnership NHS Trust

Demography

In order to provide a context for the mental health services provided in Devon it is necessary to have an overview of the demography of the county as a whole.

Devon has the largest land area of any county in the South West occupying 27.5% of the region's total land area. It also has the most districts (eight) as shown on the map below and two large National Parks: Exmoor and Dartmoor.



Devon has the largest population of any county or unitary authority in the South West, and is home to 14.3% of the region's total population. However, Devon is largely rural and has the lowest population density of the region's counties and unitary authorities, and is the most sparsely populated district in the South West.[2] Devon's rural population is increasing faster than the national average, with a particular increase in people over 60. In the short term this increase in the older population adds to the social capital and volunteering resource pool of the area, but puts pressure on housing for non-economically active residents. The longer-term impacts are likely to be an increased demand for health services, care facilities and services, and public/community transport. Linked to this is the dispersed settlement pattern which currently impacts upon service delivery. Market towns, with their relatively higher population

2. ONS Mid Year Estimates 2008 (revised) /ONS Area data

density can provide a good range of key services and facilities but for the 15% of residents with no car and for those households with one car, used by the main wage earner on a daily basis, access to market towns remains a challenge.

Devon also contains two independent unitary authorities, Plymouth and Torbay.

The Devon Partnership NHS Trust

The Devon Partnership NHS Trust (DPT) was established in 2001. It serves the whole of Devon with a population of around 900,000. The Trust employs around 2,000 members of staff and has about 100 staff members assigned form Devon County Council and Torbay Unitary Authority. The Trust works in partnership with other health and social care providers.

The current Chief Executive was appointed in 2005 and the Chair of the Trust has been in post since 2009. In 2005 the Trust was reporting a large financial deficit. An external review into alleged bullying and harassment was being under taken and this revealed that there had been deficiencies in human resource management, a lack of clinical engagement and a culture of fear. The Trust was also subject to a cross-party parliamentary review due to concerns about partnership working.

The Trust embarked on a programme of financial recovery and break-even was achieved in 2006/7. At the same time a decision was taken to have one lead commissioner for mental health services.

Service Configuration Prior to 2006

Prior to 2006 the Trust was divided into localities, each with its own Director:

- North and mid Devon locality;
- Exeter and East locality;
- Torbay South locality.

Each locality delivered a range of services to the local population: adult mental health services such as inpatient services and CMHTs, Older People's mental health services, drug and alcohol services and psychological therapies. In addition there was matrix responsibility

such that a Locality Director also provided leadership across the Trust for a specialist area of service such as Older People's Services.

Transition

2006 was a time of major change for DPT.

- In 2006 the Trust reorganised its specialist services (psychological therapies, drug and alcohol services, embryonic eating disorder service) and appointed a manager and leadership team for these.
- Child and Adolescent Services ceased to be provided by DPT and were transferred to NHS Devon.
- Changes were made to the inpatient services reflecting the strategy of moving from a predominately bed-based service to a more community-focused service. The previous inpatient services were replaced by two inpatient units in Exeter, two in North Devon and two in South Devon, some of which were new commissions, providing a more even spread of inpatient units across the county.
- Learning Disability Services developed community alternatives and worked more closely with mental health services.
- Adult Mental Health began moving to a network delivery of care model with a single point of access into the service wherever that might be and rapid access to specialist mental health services.
- In 2006, NHS Devon and Torbay Care Trust delegated the management of Individual Patient Placements (IPPs) to the Trust, which assumed responsibility for funding and case-managing those people whose needs could not be met within the county. The Trust's strategic plan was to provide as many services as possible locally.
- Consultant Psychiatrists implemented a functional split so that they covered either a community or an in-patient setting, moving towards *New Ways of Working.* [3]
- 2008 Crisis Resolution and Home Treatment teams came into being.

3. New ways of working for psychiatrists: Enhancing effective, person-centred services through new ways of working in multidisciplinary and multiagency contexts 2005 DoH

Services Provided by the Trust 2010[4]

DPT have introduced networks of care that deliver a core set of health and social care services through four network areas based on the following four geographical areas:

- North Devon;
- Exeter, East and Mid Devon;
- South and West Devon;
- Torbay.

Each network area has three core network functions:

1) Mental Wellbeing and Access

Mental Wellbeing and Access teams which work closely with GPs and provide a service that aims to be easily accessible for:

- people presenting with a mental health problem for the first time who need more help than their GP can provide;
- people who have previously used special mental health services and need further help;
- people experiencing common mental health problems;
- people experiencing a potential first episode psychosis.

These teams offer specialist assessment, consultation and advice between 08.00 and 18.00 hours Monday to Friday. They link with other network function teams to ensure a response is available outside these hours.

The Specialist Teams for Early Psychosis (STEP) focus on caring for people who are experiencing symptoms of psychosis for the first time. Typically, these are younger people. The team works with each person to help him/her manage his/her symptoms and provides support to them in their daily lives.

The Liaison Service works closely with the area general hospital staff. It provides mental health assessments, and care plan advice for individuals attending the accident and emergency department, who are admitted to the hospital or who attend outpatient services. It also provides an on-call psychiatry service outside normal working hours.

4. DPT web site August 2010

These teams work in partnership with a number of other providers to deliver a range of Psychological Therapies. These aim to meet the needs of each individual. These interventions adhere to nationally agreed best practice guidelines.

2) Urgent and Inpatient Care

This service provides care and treatment at home or in hospital for people at times of crisis and acute illness. It is for people with severe mental health difficulties, in crisis or experiencing severe distress and who may require a period of stay in hospital.

The Urgent and Inpatient Care Teams include hospital wards and the Crisis Resolution and Home Treatment Teams. Together they provide a flexible 24-hours a day, seven days a week service to care for people who have an urgent need, are in a crisis, and for people who require a period of in-patient treatment.

When a hospital admission is needed the team works towards minimising the length of stay, involving carers and families to ensure arrangements are in place to support the individual when s/he is discharged.

3) Recovery and Independent Living Services

The purpose of the Recovery and Independent Living function is to support people's recovery through being holistic and promoting social inclusion, self-management and independence. This service is for people who have complex relationships with services and whose needs are unable to be met by the Mental Wellbeing and Access Team.

By being flexible and tailoring services to meet the individual's needs, this service aims to support people in living a full and satisfying life, more effectively. This includes supporting people to live where they choose, gaining access to education, training and employment and engaging in social activities and relationships outside mental health services.

The Trust specifically provides the following services in this function:

- Assertive Outreach;
- Rehabilitation and Recovery;
- Vocational Rehabilitation.

In addition, the staff in the Recovery and Independent Living Teams work closely with local providers in the public, private and voluntary sectors to address the identified needs of each individual and to support them in leading the life they choose.

The Trust began implementing clinical directorates in April 2010. There are four Clinical Directorates:

- Adult Mental Health;
- Specialist Services Directorate incorporating Drug and Alcohol, Gender reassignment, Psychological Therapy Services, including Personality Disorder Services, and Secure Services;
- Older People's Mental Health;
- Learning Disability Services in Partnership with Social Care.

In each Directorate there is a medical clinical director who works in tandem with a 'managing partner', a person whose background is in management and who may not be a clinician. This structure has been adopted to ensure that clinical services are led, predominantly, by a clinician.

Perinatal Services

In 2008 a Devon strategy for the delivery of an integrated perinatal mental health service was developed to reflect the 'gap' in the provision of services as highlighted in the Maternity Matters local benchmarking. Although a business case was identified the provision was not made at that time.[5] In 2010, after two serious case reviews related to perinatal mental health cases, Torbay's Ofsted report expressed concerns about the lack of specialist perinatal provision. The report recommended that the pathway development work should be expedited and resourced.[6] There was no perinatal mental health service available at the time of the incident under investigation.

Devon Partnership NHS Trust currently has a Perinatal Mental Health Service available to *"women in pregnancy who are concerned about their emotional or mental wellbeing"*.[7] The service is currently available to women receiving their antenatal care from the Royal Devon

5. 2011/12 Funding Bid Template Perinatal Mental Health
6. 2011/12 Funding Bid Template Perinatal Mental Health
7. Trust website

and Exeter Hospital in Exeter and Torbay Hospital in Torquay. The teams comprise perinatal mental health nurses, perinatal consultant psychiatrists and specialist midwives. Women can refer themselves or be referred by their midwife, GP or other healthcare professional. 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.

However, in Torbay (South Devon) a full perinatal care pathway has been established. The team is able to carry out assessment with women at high risk and to remain involved in the care of these women pre-conception, in pregnancy and for up to a year. In the Exeter area a full perinatal service is yet to be commissioned and there is only provision to remain involved in women's care for up to ten days postnatally.[8] [9] Commissioning is currently being sought for the development of the service in Exeter and for the development of a Perinatal Service in North Devon.[10]

Commissioning

How Services were Commissioned

Prior to October 2006 work was initiated by the CEO of Teignbridge PCT to bring together a Devon-wide commissioning arrangement to align service planning and investment decisions.

8. Witness Interview, Lead Psychiatrist, Perinatal Mental Health Service
9. Operational Policy Perinatal Team
10. 2011/12 Funding Bid Template, Perinatal Mental Health

Devon PCT was formed in October 2006 with the amalgamation of six PCTs (Torbay was not included in this amalgamation). Prior to this each of the PCTs had their own commissioning arrangements. While each of these was in line with the national service framework there were significant geographical variations in the services provided due to the different levels of investment. Strategic planning was led by the Devon and Torbay LIT (local implementation team) which brought together the Local Implementation Groups (LIGs) for each of the PCT areas, together with the statutory and voluntary sectors, users and carers.

Since 2006 Devon PCT has acted as the lead commissioner of mental health services from DPT. Torbay Care Trust (Torbay and South Devon Health and Care NHS Trust from 1 April 2012) has the status of an associate commissioner and from October 2005 had responsibility for both commissioning and providing integrated health and social care services to people in the Torbay area. From April 2011 it was also responsible for community health care services in the southern part of Devon. In April 2012 the Trust separated the commissioning and provider responsibilities and healthcare commissioning became the responsibility of the commissioning Cluster for Devon, Plymouth and Torbay.

On 1 December 2011 the PCT cluster of NHS Devon, NHS Plymouth and Torbay Care Trust was established, taking on the statutory functions of the three PCTs across Devon.

There is a functional separation between strategic commissioning and contract and performance monitoring.

Local Authority services are not commissioned as part of the NHS contract but performance monitoring arrangements do include a number of Local Authority key performance indicators.

How Services are Monitored

It is recognised that prior to 2006 monitoring and performance were not well developed and varied across the PCT areas. Since then work has been done to improve the contract performance arrangements through the introduction of monthly meetings held with the provider Trust. These meetings have been separated into two components:

1. clinical quality review;

2. contract and performance issues.

The same arrangements are in place for Torbay Care Trust.

10. Chronology of Events

10.1. This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Ms. X and on her care and treatment from mental health services and other health care professionals.

10.2. Chronology

10.2.1. Past Psychiatric History

21 June 1979 Ms. X was born.[11]

9 June 1998, 12 days before her 19th birthday, Ms. X took an overdose of 30 Coproxomol tablets, 48 Paracetamol tablets, possibly some Isotretinoin and half a bottle of spirits. She was a University student at the time and had returned home two days previously. She was found unconscious by her sister and taken to hospital where she was admitted via Casualty and remained until she was discharged on **12 June 1998**. Whilst in hospital she was assessed by a staff grade psychiatrist, who thought it likely that she was suffering from brief depressive episodes with no precipitating factor for her overdose other than a sudden dip in her mood. A plan was made for her to be reassessed by a psychiatrist in the outpatient clinic on 18 June 1998.[12] [13] [14]

On **18 June 1998** Ms. X was assessed by a psychiatric social worker and a community psychiatric nurse with a view to her being treated by the Community Mental Health Team. Ms. X informed the social worker that she had been depressed since she was 15 years old, experiencing two episodes of depression a year lasting about one week. Ms. X reported that

11. DPT notes page 1
12.DPT notes pages 204, 207, 277; SDHT notes page 566; GP notes pages 48-49
13.GP notes page 48
14.GP notes page 49-50

there was a family history of depression: her mother had suffered from depression and postnatal depression, her maternal and paternal grandmothers had both received psychiatric intervention, as had an uncle. The plan of treatment was that she should be seen by a community psychiatric nurse, that both her acne treatment and her contraception should be reviewed and that she should be prescribed Sertraline 50mg. The link between her acne treatment Isotretinoin and depression leading to suicide was noted. An appointment was made with a community psychiatric nurse for **23 June 1998**.[15]

On **11 August 1998** a community psychiatric nurse from the Dorchester Community Mental Health Team wrote to Ms. X's GP. She informed him that Ms. X had had minimal involvement with the team because she had found it too stressful. She commented that Ms. X had had a *"shaky start"* on Sertraline and that she had a *"lack of insight into her problems"* and was not ready to address them.[16]

On **29 February 2000** Ms. X consulted her GP. She had returned to University two weeks previously but felt *"unable to concentrate or cope"*.[17]

On **24 March 2000** a community psychiatric nurse (CPN) from the Dorchester Community Mental Health Team wrote to Ms. X's GP. She explained that Ms. X had attended one appointment with her and had been given a Cognitive Behaviour Therapy CBT diary which she had kept for a while, but that Ms. X had then cancelled her appointment with the CPN and had then said that she did not want any further contact with the Community Mental Health Team. [18]

On **20 September 2002** Ms. X visited her GP because she was feeling depressed again. Ms. X had come off Sertraline after taking it for two years. She was about to start training as a teacher. She was described as unable to identify a trigger for the depression. She was prescribed Sertraline 50mg. She was offered counselling but declined it.[19]

15. GP notes pages 51-2
16. GP notes page 86
17. GP notes page 28
18. GP notes page 87
19. GP notes page 26

In **November 2002** (date unreadable) she was described by her GP as *"virtually back to normal"*. She remained on Sertraline 50mg.[20]

On **7 June 2004** her GP noted that Ms. X suffered from recurrent depression which returned every three months despite her remaining on Sertraline 50mg. Her Sertraline was increased to 100mg and the GP planned to see her two weeks later after she had been seen by a Psychiatrist.[21]

On **27 July 2004** she was seen by a Psychiatrist in Plymouth. Ms. X had recently moved to Plymouth to be with her boyfriend of six years who she met at University. It was noted that she had a nine years history of anxiety and depression, that she was currently taking Sertraline 100mg and that she reported a family history of depression. Ms. X reported experiencing two episodes of anxiety and depression each year with no apparent triggers. At this time she was in her first year of teaching. The psychiatrist advised that she continue on Sertraline 100mg and *"discussed the possible usefulness of psychotherapy in the future"*. She made no plans to see Ms. X again.[22]

On **13 December 2006** Ms. X visited her GP because she was having *"difficulty with coping"*.[23] She was described as tearful and as losing weight as she felt *"not bothered"* about eating. The GP described it as a *"stress reaction"* and asked her to return *"if any problems"*.[24]

On **19 December 2006** her GP in Plymouth, wrote to the Consultant Psychiatrist asking her to review Ms. X. He noted that she had been *"relatively episode-free for the last four or five years whilst being on Sertraline 100mg"* but that she had recently relapsed after the ending of her relationship with her boyfriend.[25] She was offered an appointment with the Mental Health Services on 16 January 2007, which she declined, and another on 20 February 2007 which she also declined, informing the service that she no longer required an appointment. The referral was closed.[26]

20. GP notes page 22
21. GP notes page 23
22. GP notes pages 88-89
23. GP notes page 24
24. GP notes page 24
25. GP notes page 46
26. GP notes page 47

10.2.2. Care and Treatment by Trusts Involved in the Investigation

On **24 October 2007** Ms. X registered with the Old Mill Surgery in Torquay with GP 1.[27]

She was seen on **10 February 2007** for assessment in the Dermatology Service for treatment with Ruoaccutane for scarring acne.[28] She declined treatment.[29] She was referred again in **October 2007** and until **1 October 2008**[30] she was treated with Ruoaccutane in the Isotretinoin Monitoring Clinic for scarring acne which she had suffered from since she was 15 years old.[31] During this period of treatment she was not allowed to become pregnant and she was given a pregnancy test prior to being given each new prescription. No change in her mood was noted while on Ruoaccutane.[32] She remained on Sertraline while receiving this treatment.[33]

In **September 2009** Ms. X stopped taking Sertraline 100mg on finding that she was pregnant.[34]

On **17 September 2009** Ms. X had her 'booking' appointment with the Midwife 1. The notes record that she reported that she did not have a history of mental health problems or any family history of mental health problems and that she did not feel depressed at that time.[35] A Risk Assessment at this appointment stated that she had no risk factors.[36] At her third assessment by the midwife it was recorded that she was now feeling depressed and that she wanted help.[37]

On **1 October 2009** she was referred by GP 1 to the Obstetric Department for a scan at ten weeks and five days of pregnancy because she had experienced intermittent bleeding from the vagina the previous day.[38] No cause for the bleeding was found and it was noted that she had an on-going intrauterine pregnancy.[39]

27. GP notes page 77
28. SDHT notes page 144
29. SDHT notes page 143
30. SDHT notes page 131, 129, 142, 143
31. SDHT notes pages 144 to 151, 155, 206
32. SDHT notes page 138
33. SDHT notes pages 138, 206
34. DPT notes page 204, GP notes page 70
35. SDHT notes page 97
36. SDHT notes page 107
37. SDHT notes page 97
38. SDHT notes page 153, GP notes pages 92 and 93
39. SDHT notes page 128

At 13 weeks and three days of pregnancy she had an ultrasound scan which showed that she had a low risk screening result for Down's syndrome.[40]

In **October 2009** she was seen at 14 weeks of pregnancy by the midwifery team who noted *"all well"*.[41]

In **November 2009** Ms. X became concerned about the risk to her unborn child of catching swine flu and took a couple of weeks off sick from her teaching job to reduce the risk.[42]

On **27 November 2009** Ms. X rang the midwife asking for a second week off work because of the high rate of people absent from work with swine flu. She did not want to have the vaccination. She was advised to ring her GP.[43]

On **3 December 2009** Ms. X had an anomaly scan at 20 weeks and four days of pregnancy. The scanner was unable to see the baby's heart, face and head due to his position.[44] The scan was repeated on **11 December 2009** when there was no obvious structural foetal anomaly.[45]

On **14 January 2010** she was seen by Midwife 1 who noted *"all well"*.[46]

On **18 January 2010** Ms. X was seen at her GP surgery by the Nurse Practitioner.[47] She completed a PHQ-9 (Patient Health Questionnaire) obtaining a score of 11 (indicative of symptoms of moderate depression).[48] The Nurse Practitioner noted that Ms. X had been feeling low in mood for three weeks, with reduced appetite, but not suicidal. It was noted that there were no particular triggers for the depression. She undertook blood tests to exclude any physical causes for the symptoms. The Nurse Practitioner made an appointment for Ms. X to see GP 1 later that week, informed the GP about the consultation and the blood tests and referred Ms. X for *"guided self help for depression"*.[49]

40. SDHT notes page 104
41. SDHT notes page 111
42. DPT notes page 204
43. SDHT notes page 162
44. SDHT notes page 103
45. SDHT notes page 102
46. GP notes page 72
47. GP notes page 72
48. GP notes page 91
49. GP notes page 72

On **22 January 2010** Ms. X saw GP 1. He prescribed her Ferrous Gluconate tablets, advised her about long-acting reversible contraception, and discussed recommencing Sertraline. The plan was developed that she should *"hang on"* without taking Sertraline because of the risks in pregnancy but that she should return to see him if need be and consider taking Sertraline at a low dose.[50]

On **26 January 2010** Ms. X returned to see GP 1 feeling that her condition had worsened and she was no longer able to think straight. He discussed medication with her and they agreed that she should start taking Sertraline 50mg. He gave Ms. X a sick certificate and referred her to the Health Visitor for supportive counselling and so that they could establish a relationship prior to her postnatal care.[51] [52]

On **1 February 2010** Ms. X saw her GP again. It was noted that her condition was the same and she sought reassurance that she was not mad. It was noted that her mother experienced postnatal depression.[53] She attended the appointment with her husband.[54]

Ms. X was seen by Midwife 1 on **11 February 2010** when she was 30 weeks pregnant. It was noted that she had started feeling depressed recently and had commenced taking Sertraline and iron tablets. It was noted that she was seeing the Health Visitor the following day and that she had been offered, but refused, an appointment with the Consultant Obstetrician and Gynaecologist. It was stated that she had *"good family support"*.[55] Midwife 1 discussed Ms. X with GP 1 and Health Visitor 1 who informed her that they were seeing Ms. X and that she had good support from her family.[56] Midwife 1 recorded in the antenatal notes held by Ms. X that her antidepressants had stopped in 2009 and that she had had a few episodes of depression in the past for which she was treated with Lustral (a trade name for Sertraline). These references to her history of depression were later covered with correction fluid and it is presumed that this was done by Ms. X.[57]

50. GP notes page 71
51. GP notes page 71
52. Witness Statement
53. GP notes page 71
54. Witness Statement
55. SDHT notes pages 111, 162
56. Witness Statement
57. Witness Statement

On **12 February 2010** Ms. X saw GP 1. She remained depressed and was *"struggling"* to get out of bed and carry out her activities of daily living. GP 1 increased her dose of Sertraline to 100mg. [58]

Also on **12 February 2010** Ms. X had a planned antenatal appointment with Health Visitor 1 at Old Mill Surgery. This appointment lasted one and a half hours. Ms. X was feeling *"very down"* and concerned that she was not feeling overjoyed by her pregnancy. The plan was that she should keep a mood diary and see Health Visitor 1 again in two weeks.[59]

On **18 February 2010** Ms. X saw her GP. He noted that she remained depressed, had difficulty speaking and was visibly slowed down. Her husband commented that she felt numb, and that she was *"not part of the experience"*.[60]

On **19 February 2010** GP 1 wrote to the Mental Wellbeing and Access Team asking for an urgent assessment of Ms. X by the team and *"a medic"* because of her marked depression. He noted that she was 32 weeks pregnant and that she had met her Health Visitor.[61] GP 1 rang the secretary of the mental health service to request that Ms. X was seen within one to two weeks because he was concerned that she was in a poor state to care for a new born baby.[62] On 23 February she was offered an appointment for **25 February** to see Consultant Psychiatrist 1, and Clinical Team Leader 1 at her home.[63]

On **24 February 2010** Ms. X was seen by Health Visitor 1 at Old Mill Surgery. Ms. X's husband was present for some of this appointment. Ms. X requested that her history of depression was not discussed while her husband was present. Health Visitor 1 described her as an *"anxious mother"* and noted that she was still feeling as if she was unable to do anything. Health Visitor 1 recorded that she had been referred to the Mental Wellbeing and Access Team and made an appointment to see her in two weeks.[64] [65]

58. GP notes page 71
59. Witness Statement
60. GP notes page 71
61. GP notes page 70-71, DPT notes page 204
62. Witness Statement
63. DPT notes page 208
64. GP notes page 70
65. Witness Statement

On **25 February 2010** she was seen by Midwife 2 at 32 weeks of pregnancy who noted that Ms. X was feeling very depressed and had been seeing the Health Visitor every two weeks.[66]

Also on **25 February 2010** Ms. X met with Consultant Psychiatrist 1, and Clinical Team Leader 1 from the Mental Wellbeing and Access Team. It was noted that Ms. X had a ten-year history of depression and anxiety and a family history of depression. It was stated that Ms. X did not want people to know about her history of depression and preferred this episode to be considered to be antenatal depression. She reported that she disliked not being able to hide this episode of depression from her family. She was not thought to be suicidal at that time, although under the heading of risk her previous overdose was noted. The plan was that she should be referred immediately to the Senior Mental Health Worker at her GP surgery for support, to help her to look at things in a different way and to de-stigmatise her illness. She was also referred to the Depression and Anxiety Service for *"further work in the future"* after her child was born. It was suggested that after the birth she could be referred back to the team to see a *"medic"* to review her medication. She was given some websites to look at including a computer guided self help for depression course.[67]

On **10 March 2010** Ms. X was seen for a planned appointment with Health Visitor 1 at the GP Surgery. Her mother-in-law was present. She reported that she did not feel any better but denied any feelings or intentions of self harm or harm towards the baby. She had not yet been seen by the Mental Wellbeing and Access Team. Health Visitor 1 telephoned the Mental Wellbeing and Access Team and the urgency of assessment prior to the birth was stressed. Health Visitor 1 recalls being told that no appointment was available for eight weeks.[68] Senior Mental Health Practitioner 1 recalls that during the telephone call with Health Visitor 1 she was unable to say when an appointment would be offered as she had just returned from annual leave and had not had time to look at the referrals made to her in her absence, including that of Ms. X.[69] Health Visitor 1 discussed Ms. X with GP 1 because she was concerned that she had not been given an appointment for a mental health assessment and the possibility of private counselling in the interim was discussed. Health Visitor 1 left details of

66. SDHT notes page 111
67. DPT notes pages 206-7
68. Witness Statement
69. Witness Statement

a counselling service on the answer phone of the family. An appointment with Health Visitor 1 was offered for two weeks time, but cancelled by Ms. X.[70]

On **11 March 2010** Ms. X was seen by Midwife 1 who noted that she had accepted referral for an appointment with the Consultant Obstetrician and Gynaecologist about her depression, as an appointment with the mental health team was not available for eight to ten weeks.[71] Midwife 1 informed GP 1 and Health Visitor 1 about the referral.[72]

On **15 March 2010** Ms. X saw the Consultant Obstetrician and Gynaecologist. She was 34 weeks and two days pregnant. He noted that recommencing Sertraline had done nothing to improve her mood: she remained very low in mood with little interest in anything, but no suicidal thoughts. The Consultant Obstetrician and Gynaecologist contacted Clinical Team Leader 1 from the Mental Wellbeing and Access Team, who said that he would update the Senior Mental Health Practitioner and ensure that Ms. X was seen by her the following week.[73] The Consultant Obstetrician and Gynaecologist wrote to the Mental Wellbeing and Access Team asking for her appointment for Cognitive Behaviour Therapy to be expedited as it was so close to her due date. The letter was copied to GP 1.[74] The letter was received by the Mental Wellbeing and Access Team Office on **19 March 2010**.[75] A handwritten note was added to the letter in the SDHT notes on **31 March 2010** that her allocated worker was Senior Mental Health Practitioner 1 from the Mental Health Team.[76]

The Public Health Midwife informed Midwife 1 that she had seen Ms. X during her appointment with the Consultant Obstetrician and Gynaecologist and that she was concerned about her mental state.[77]

On **17 March 2010** Ms. X was sent a letter from Senior Mental Health Practitioner 1, Mental Wellbeing and Access Team, offering her an appointment on **26 March 2010** at the Medical Practice *"to discuss what you might find useful from a brief intervention"*. Senior Mental

70. Witness Statement
71. SDHT notes page 111
72. Witness Statement
73. SDHT notes page 124
74. DPT notes page 211, GP notes page 38
75. Witness Statement
76. SDHT notes page 127
77. Witness Statement

Health Practitioner 1 stated that she had been trying to contact Ms. X by telephone since **10 March**.[78]

On **18 March 2010** an email was sent from the secretary of Consultant Psychiatrist 1, to Consultant Psychiatrist 2, Torbay Assertive Outreach Team, asking if the Locum Staff Grade Psychiatrist could telephone him on **19 March** at 09.00 hours to discuss some patients. It was noted that his mobile telephone was not working. Consultant Psychiatrist 2 replied that this time was not convenient and he would be available to *"catch up"* in the afternoon of **19 March 2010**.[79]

On **25 March 2010** GP 1 left a telephone message for Senior Mental Health Practitioner 1 explaining that he had spoken with Ms. X's mother who said that Ms. X had caused a lot of concern to her family at the weekend when she drove to London without letting them know. He said that her mother-in-law may attend the appointment Ms. X had with Senior Mental Health Practitioner 1 the following day.[80] Also on **25 March 2010** Ms. X did not attend her midwifery appointment. Midwife 3 informed Midwife 1 of this and also of her drive to London. She also informed Midwife 1 that her mother-in-law had moved in to help her.[81]

On **26 March 2010** Senior Mental Health Practitioner 1 met with Ms. X for the first time. She noted that Ms. X only attended the appointment with the persuasion of her mother-in-law as she was reluctant to be associated with the mental health service. Senior Mental Health Practitioner 1 was concerned that Ms. X was flat in presentation, numb in mood, nihilistic, and hinting at some odd beliefs which were affecting her behaviour such as not allowing herself to wear makeup at the present time. Ms. X also *"alluded to a significantly higher number than average of predictions about a negative outcome to her pregnancy"*. On the following working day, Monday **29 March 2010** Senior Mental Health Practitioner 1 made an urgent referral to the Recovery and Independent Living Team, stating that Ms. X was now 37 weeks pregnant. The referral was made after she discussed Ms. X with Clinical Team Leader 1 and she realised that there had been a significant deterioration in Ms. X's mental state since she was assessed by Consultant Psychiatrist 1 and Clinical Team Leader 1 on 25

78.GP notes page 99, DPT notes page 209, Witness Statement
79. DPT notes page 383
80. DPT notes page 216
81. Witness Statement

February 2010.[82] It was decided that Ms. X should be referred to the Recovery and Independent Living Team because she required an enhanced level of care, and that the referral should be urgent because of her imminent delivery date.[83] Her letter was copied to GP 1.[84]

On **29 March 2010** the referral was received by the Recovery and Independent Living Team and she was immediately allocated to the Care Coordinator.[85] The Care Coordinator, attempted to make contact with Ms. X by telephone three times.[86] Between **30 March 2010** and **1 April 2010** the Care Coordinator rang three further times to try to make contact with Ms. X. After the final attempt an appointment letter was sent instead for **6 April 2010**.[87]

On **31 March 2010** the Care Coordinator, Recovery and Independent Living Team, informed the Consultant Obstetrician and Gynaecologist that she planned to see Ms. X the following Tuesday. The Consultant Obstetrician and Gynaecologist rang the Hera Midwifery team and asked them to inform the Care Coordinator, about their last appointment and to ensure that they saw her that week as she was now 36 weeks pregnant.[88]

Midwife 1 saw Ms. X at the GP surgery on **1 April 2010**. She noted that Ms. X was feeling numb, that she had seen the Consultant Obstetrician and Gynaecologist and that she had an appointment with the Care Coordinator.[89]

On **6 April 2010** the Care Coordinator saw Ms. X at Waverley House, having declined a home visit. Her mother in law waited in the waiting room. Ms. X was flat in affect and unmotivated. She denied thoughts of wanting to harm herself or 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 told the Care Coordinator she was attending the vulnerable women's antenatal clinic.[90] She was given a further appointment and according to the Care Coordinator this was for **20 April 2010**, whereas elsewhere it is recorded as for **22**

82. DPT notes pages 213 and 215
83. Witness Statement
84. GP notes pages 36-7
85.Witness Statement
86. Witness Statement
87. Witness Statement
88. SDHT notes pages 124-5
89. SDHT notes pages 110, 163
90. Witness Statement

April 2010.[91] Ms. X did not wish to be seen sooner because of the imminent birth. The Care Coordinator sent an urgent referral for a psychological therapy assessment and *"liaised with the community midwife team and planned to offer [Ms. X] an urgent medical review as soon as the baby had been born"*.[92]

On **8 April 2010** a handwritten note was entered on the midwifery notes by Midwife 1 stating that the Care Coordinator had telephoned and informed her that she had seen Ms. X the previous Tuesday and found her to be *"flat in mood and depressed, not paranoid, no danger to baby"*. She noted that Ms. X would be starting Cognitive Behaviour Therapy after the birth of the baby.[93] In her Witness Statement Midwife 1 stated that the Care Coordinator informed her that Ms. X was not paranoid and was not a threat to herself or the baby.[94] Midwife 1 forwarded an interagency communication form to the Christie Team Midwives who would be delivering postnatal care to Ms. X as she had made Midwife 1 aware that she was now living in Brixham.[95]

On **10 April 2010** Baby Y was born weighing 3490g at 11.32 hours.[96] Ms. X was in the care of Midwife 4 when she delivered Baby Y and her husband was present. Ms. X remained in hospital for half a day post delivery.[97] A new-born examination was carried out at 22.15 hours[98] and Ms. X was discharged after 23.00 hours.[99]

Ms. X and Baby Y were seen at home in the afternoon of **11 April 2010** by Midwife 5 from the Christie Team. She noted that the baby had breastfed in hospital the previous day up until 23.00 hours but had not fed overnight. He had had a five minute suckle during the day. She stated that the baby looked pink and hydrated.[100] Midwife 5 recorded that Ms. X was feeling very tired and was advised to rest during the day.[101] Midwife 5 rang Ms. X the same evening. Baby Y had fed well at 20.00 hours. It was noted that Ms. X was well supported by her

91. Witness Statements
92. Witness Statement
93. SDHT notes page 163
94. Witness Statement
95. Witness Statement
96. SDHT notes page 118
97. DPT notes page 394
98. SDHT notes page 20
99. SDHT notes page 4
100. SDHT notes page 4
101. SDHT notes page 61

family. She was advised to call the midwifery team if she was concerned about the breastfeeding.[102]

Ms. X and Baby Y were seen at home at 10.20 hours on **13 April 2010** by Maternity Care Assistant 1. Baby Y now weighed 3150g, a loss of 9.7%.[103] She assisted in feeding Baby Y who fed well for 5 minutes then fell asleep.[104] Maternity Care Assistant 1 noted that Ms. X was feeling *"well but tired"*.[105]

On **13 April 2010** GP 1 was notified of the birth of Baby Y. He rang and left a message congratulating Ms. X.[106]

On **14 April 2010** Maternity Care Assistant 1 rang Ms. X to check how the feeding was progressing. Ms. X told her that the feeding had improved during the night and she did not require a visit that day. Ms. X was told to ring the midwifery team if she had any concerns.[107]

16 April 2010 was the date recorded on the practice computer as Ms. X's registration with the Compass House Medical Centre. According to the Witness Statement of GP 2 it can take weeks to months for the notes to arrive at the GP surgery once registration with a new practice has taken place.[108]

At 09.30 hours on **16 April 2010** Ms. X was visited at home by Health Visitor 1. Her husband and mother were present. Ms. X remained flat in mood and was not observed to handle the baby. She was described as being supported 24-hours a day by the family. The plan was that she should keep her next appointment with the Mental Health team and psychiatrist on **22 April 2010** and that her care should be transferred to the Health Visitor for Compass House Surgery. According to Ms. X's parents, her mother was present when the Health Visitor visited Ms. X on **16 April 2010** and raised *"serious concerns"*.[109] At 11.30 hours Health Visitor 1 gave a face to face handover to the new health visitor stressing the mental health concerns.[110]

102. SDHT notes page 159
103. SDHT notes page 5
104. SDHT notes page 159
105. SDHT notes page 7
106. Witness Statement
107. SDHT notes page 159
108. Witness Statement
109. DPT notes page 420
110. Witness Statement

On **16 April 2010** Ms. X was seen at around mid day by Midwife 6, Christie Team. Baby Y was now waking to feed every three hours, was breastfed for 15 minutes, and was also being bottle fed. His weight had increased by 70g since **13 April 2010**.[111] Midwife 6 noted that Ms. X was tired, emotional and anxious. She recorded that prior to the birth Ms. X had been depressed, had been seen by her GP and had an appointment at Waverley House on **22 April 2010**. She wrote *"Contact HV/Christie Office if concerned/needs support. To follow-up appointment at Waverley House"*.[112] On **17 April 2010** a member of the Christie Team midwives rang Ms. X. She recorded in the notes *"all well – see tues"*.[113]

On **19 April 2010** Ms. X's mother rang Devon Doc expressing concern that Ms. X's depression was worsening. The person who took the call listened to her concerns and said that he would ask the appropriate person from the mental health service to ring her back. The Mental Wellbeing and Access Team was informed who passed the message to the Care Coordinator. Ms. X's mother was rung back by the Care Coordinator. Ms. X's mother informed the Care Coordinator that Ms. X was punching and smashing things in the house and that she was not bonding with the baby. The Care Coordinator said that she would inform the midwife, which she did by telephoning the midwifery team in Brixham. The midwifery notes state that the Care Coordinator telephoned, that Ms. X was not bonding with the baby, was smashing and punching things, that she had been seen by the GP and diagnosed with severe postnatal depression: *"will phone [Care Coordinator] so not visited today"*.[114] According to the Witness Statement of the Care Coordinator, the midwife informed her that there had been no concerns when Ms. X had been visited but that she would visit later that day to carry out a reassessment.[115]

Also on **19 April 2010**, at 12.14 hours, Ms. X saw GP 2 at the Compass House Medical Centre accompanied by her mother-in-law and Baby Y. Ms. X described herself as feeling *"empty"* or *"blank"* again. Ms. X gave permission for her mother-in-law to coordinate her appointments and the telephone number was entered into the computerised notes. Ms. X told 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.[116] GP 2 wrote *"severe postnatal depression, has felt blank*

111. SDHT notes pages 6, 159
112. SDHT notes page 72
113. SDHT notes page 60
114. DPT notes pages 188, 421
115. Witness Statement
116. Witness Statement

before baby arrived, now worse, no emotions, v blunted affect, mother-in-law with her and looking after baby, breast feeding but v exhausted, under m/w still, ref Waverley, has had councelling [sic.] there but no help, no immediate thought of self-harm but just wants to get away, no thoughts of harming baby. Sleep ok. No bonding at all with baby. Did drive away to London when pregnant, hasn't been able to work since Feb, no features psychosis".[117] She informed Ms. X that someone from the mental health team would be in touch with her. GP 2 was told that Ms. X would not be on her own with the baby as both her husband and her mother-in-law were present. After 13.30 hours GP 2 telephoned the midwifery team and was told that Ms. X *"was new to them too"*. She was told that the notes recorded that Ms. X had antenatal depression too, that the mental health team at Waverley House had been contacted and that Care Coordinator was trying to offer Ms. X an appointment for the following day at 15.00 hours but had been unable to get hold of her. GP 2 telephoned the Care Coordinator but was unable to speak to her so she left a message asking the Care Coordinator to ring her on her mobile phone.[118] GP 2 phoned the Care Coordinator back again 20 minutes later and the Care Coordinator said that she had rung Ms. X who had put the telephone down on her. GP 2 told her that Ms. X had asked for appointments to be arranged via her mother-in-law and gave the Care Coordinator the telephone number. According to the Witness Statement of GP 2, *"I told [Care Coordinator] to phone [Ms. X's mother-in-law] with the appointment as Ms. X had given permission".*[119] The Care Coordinator did not mention the family's concern that Ms. X had been punching and smashing things at home.[120] The Care Coordinator said that she would contact Ms. X's mother in law to give Ms. X an appointment for the following day[121]. GP 2 told the Care Coordinator that she thought that Ms. X needed a psychiatric assessment and psychiatric input because of her postnatal depression: *"they will see tomorrow".*[122] According to the Witness Statement of the Care Coordinator, she asked whether the appointment for the following day needed to be brought forward, but GP 2 felt that Ms. X was well supported at home, had denied thoughts of harming herself or the baby and so there was no need to visit that day.[123]

At 14.00 hours on **19 April 2010** the Care Coordinator spoke to Clinical Team Leader 2 to express her concern about Ms. X's deteriorating mental health. She had heard that Ms. X's

117. GP notes page 1
118. GP notes pages 1-2
119. Witness Statement
120. Witness Statement
121. Witness Statement
122. GP notes page 3
123. Witness Statement

mother had contacted Devon Doc with extreme concern about Ms. X's deteriorating mental health and in particular *"that apparently Ms. X was not bonding with the baby and was punching and lashing out at things in the house".*[124] On the afternoon of 19 April 2010 the Care Coordinator asked the Locum Staff Grade Psychiatrist for a review of Ms. X's medication. The Care Coordinator told the Locum Staff Grade Psychiatrist that she had spoken to Consultant Psychiatrist 2 who asked her to have a joint assessment with the Locum Staff Grade Psychiatrist. He noted that the Care Coordinator was *"Not requesting her to be seen today"* and that she informed him that *"No risk identified by GP of harm to mother and baby"*. The Locum Staff Grade Psychiatrist noted that Ms. X's mother-in-law was concerned that Ms. X was becoming more depressed and would like advice on medication and that Ms. X *"is not left alone with the baby – husband and mother-in-law with her all the time – no thoughts or intention to harm self or the baby"*. He wrote that the Care Coordinator was happy to carry out a joint assessment at 15.00 hours on **20 April 2010**.[125] The Locum Staff Grade Psychiatrist arranged to discuss Ms. X's care with Consultant Psychiatrist 2 at 16.00 hours on **20 April 2010** after he had assessed Ms. X[126]. The Care Coordinator had rung Ms. X who said that *"things were not very well and hung up the phone"* then switched the telephone off. The Care Coordinator attempted to ring Ms. X's mother-in-law but her telephone was also off.[127]

On the afternoon of **19 April 2010** Ms. X's mother-in-law rang the GP surgery to say that she wanted to share with GP 2 a discussion she had had with Ms. X's mother *"about her condition": "happy to phone am"*.[128]

Also on the afternoon of **19 April 2010** Ms. X's mother telephoned Ms. X's former GP, GP 1. He returned her call at about 18.30 hours. She expressed concern that Ms. X was frustrated, angry and making or shaking her fist. Ms. X's mother stated that she expressed concern that Ms. X might harm Baby Y and said that Ms. X was *"paranoid"* that her husband would leave her. Ms. X's mother reported that GP 1 *"was not sufficiently concerned to take any further action"*.[129] In his Witness Statement GP 1 said that he did not interpret her

124. Witness Statement
125. DPT notes page 384
126. DPT notes page 419
127. Witness Statement
128. GP notes pages 1 and 3
129. DPT notes page 419

account as showing intent to harm herself and suggested that the planned appointment with the mental health service for the next day was appropriate.[130]

At 09.15 hours on **20 April 2010** the Care Coordinator rang Ms. X's mother asking if she could bring Ms. X to see them at Waverley House. Ms. X's mother explained that Ms. X was with her mother-in-law and telephoned back with her telephone number.[131] The Care Coordinator attempted to ring both Ms. X and her mother-in-law but both telephones were switched off.[132]

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: she commenced CPR. There were no other signs of physical injury or bruising. Ms. X was arrested on suspicion of murder.[133]

On **20 April 2010** the Midwifery Matron received a telephone call from the Torbay Children and Young People's Services, informing her that Ms. X was under police arrest following admission of her baby to Accident and Emergency, and Ms. X had admitted smothering him. The Midwifery Matron rang the Accident and Emergency department and was informed that Baby Y had been pronounced dead. The Midwifery Matron rang the Christie Team Midwives and was informed that the Midwife was on her way to visit Ms. X. The Midwifery Matron contacted the Midwife and advised her not to attend. The Midwifery Matron informed the Associate Director of Nursing and Midwifery, and the Obstetrics and Gynaecology Clinical Governance Coordinator of the incident.[134]

On **20 April 2010** a member of the Health Visiting team rang GP 2 to inform the GP that Baby Y had been admitted to the Accident and Emergency Department after a cardiac arrest and where he was declared deceased. She said *"sounds like mother smothered her baby"*.[135]

130. Witness Statement
131. DPT notes page 420
132. Witness Statement
133. DPT notes page 1, SDHT notes pages 27, 28, 29
134. Witness Statement
135. GP notes page 3

At 15.30 hours on **20 April 2010** a Mental Health Act (1983 & 2007) assessment of Ms. X was carried out at Torbay Police Station by the Locum Staff Grade Psychiatrist, Consultant Psychiatrist 3, Consultant Psychiatrist 4, and an Approved Social Worker. According to the Locum Staff Grade Psychiatrist, Ms. X said that she put a pillow over Baby Y's head. Ms. X said that she had felt very happy when the baby was born but panicky afterwards. She said that the baby did not feel like hers; she said that she did not want the baby to die. Ms. X reported having heard voices around the time of having a nap, but that there was no psychotic motivation and there was no evidence of psychotic symptoms. Ms. X described having felt numb for the past few weeks, unable to think clearly, with her head not working properly. She said that she felt like she could not do anything. She reported that she had told the midwife that she had lost interest in everything and felt panicky, and that the midwife had told her to keep all her medical appointments. Ms. X admitted that she had stopped taking Sertraline before the birth of Baby Y, but was uncertain about when and how, and had not discussed this decision with anyone. The assessment concluded that she was at high risk of suicide, and that she had severe depression. After consultation with a Forensic Psychiatrist colleague 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.[136]

On **20 April 2010** the Midwifery Matron rang the midwifery office to inform them of the *"smothering"* of Baby Y and the arrest of Ms. X.[137]

136. DPT notes pages 385 to 388, 394 to 408
137. SDHT notes page 60

11. Identification of the Thematic Issues

11.1. Thematic Issues

The Independent Investigation Team identified 11 thematic issues that arose directly from analysing the care and treatment that Ms. X received from Devon Partnership NHS Trust, South Devon Healthcare NHS Foundation Trust and the Torbay and South Devon Health and Care Trust.

These thematic issues are as follows:

11.1.1 The Care Programme Approach and care coordination

11.1.2 Risk assessment and management

11.1.3 Diagnosis

11.1.4 The Mental Health Act and the Mental Capacity Act

11.1.5 Treatment: medication and psychological therapy

11.1.6 Safeguarding

11.1.7 Service user involvement in care planning

11.1.8 Family involvement

11.1.9 Communication

11.1.10 Care Pathway

11.1.11 Clinical Governance and Performance

12. Further Exploration and Identification of Causal and Contributory Factors and of Service Issues.

12.1. RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. key causal, contributory and service issue factors.

In the interests of clarity each critical issue is set out with all the factual evidence relevant to it contained within each subsection. This will necessitate some repetition but will ensure that each issue is examined critically in context. This method will also avoid the need for the reader to be constantly redirected to reference material elsewhere in the report. The terms 'key causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Key Causal Factor. The term is used in this report to describe an issue or critical juncture that the Independent Investigation Team has concluded had a direct causal relationship with the events of 20 April 2010. In the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the care and treatment that a service user received and any subsequent homicide perpetrated by them.

Contributory Factor. The term is used in this report to denote a process or a system that failed to operate successfully thereby leading the Independent Investigation Team to conclude that it made a direct contribution to the breakdown in Ms. X's mental health and/or the failure to manage it effectively.

Service Issue. The term is used in this report to identify an area of practice within the Trust that was not working in accordance with either local or national policy expectation. Identified

service issues in this report whilst having no direct bearing on the events of 20 April 2010, need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made.

12.2. The Care Programme Approach

12.2.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness.[138] Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Coordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[139]

"The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services" (Building Bridges; DoH 1995).[140] This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function

138.The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
139.Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
140.Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH 1995

is to minimise the possibility of patients losing contact with services and to maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient;
  - to monitor that the agreed programme of care remains relevant; and
  - to take immediate action if it is not;
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need. From this period service users are either designated 'CPA' or 'Non CPA'. Ms. X was designated as being 'CPA'.

Devon Partnership NHS Trust NHS Trust CPA Policy (2008 – 2010)

The Independent Investigation Team found this policy to be evidence based and fit for purpose. The Policy stated:

"CPA sits within the broader function of recovery coordination as the approach used to assess, plan, review and coordinate the range of treatment, care and support for the minority of people who have the most complex characteristics and who present with the highest risk. These complex characteristics are defined in CPA guidance but can be summarised in terms of:

- *The severity of mental health problem and degree of clinical complexity*
- *The level of current or potential risk*
- *A current or significant history of severe distress/instability or disengagement*

- *The presence of non-physical co-morbidity such as substance misuse or a learning disability*
- *A need for multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies*
- *The person is or has recently been detained under the Mental Health Act or referred to the urgent care services*
- *The person is subject to Supervised Community Treatment or Guardianship under the Mental Health Act*
- *There is a significant reliance on carer(s) or the person has their own significant caring responsibilities*

1.4 In addition to the above characteristics, certain key groups are a priority for CPA, they include people:

- *who have parenting responsibilities*
- *who have significant caring responsibilities*
- *with a dual diagnosis (substance misuse)*
- *with a history of violence or self harm*
- *who are in unsettled accommodation*

1.5 CPA is characterised by the intensity, persistence and multidisciplinary and multiagency nature of responses. The delivery of CPA will conform to the published guidance by providing:

- *A named care coordinator and consultant psychiatrist*
- *A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks*
- *An assessment of social care needs against Fair Access to Care Services (FACS)*[141] *eligibility criteria (plus Direct Payments)*
- *Comprehensive formal written care plan: including risk and contingency/crisis plan*
- *On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly*
- *Assessment of the need for advocacy*

141. Protocol for use of Fair Access to Care Services (FACS) by staff in Partner Agencies, J. Stephens. July 24th 2002

- *Information for family and other supporters about the availability and right to have a carer's assessment".*[142]

"3. Duties within the Organisation

3.1 Devon Partnership NHS Trust is the statutory provider of integrated mental health and social care services in Devon and Torbay. As such it has a duty to guarantee the effective provision of care coordination in all care settings[143] *and to implement the Care Programme Approach for those people with the greatest need of support. This duty is discharged by:*

- *Practitioners through their adherence to this policy.*
- *Clinical team leaders through regular practice supervision*
- *A regular cycle of practice audit using the Practice Quality Audit Tool*
- *Responsibility for the delivery of CPA functions rests with the Director of Care".*[144]

Table from Trust Policy[145]

People needing CPA	***People who do not need CPA***
Personal characteristics	
Complex needs; multi-agency input; higher risk.	*More straightforward needs; one agency or no problems with access to other agencies/support; lower risk*
The response that can be expected	
Support from CPA care coordinator (trained, part of job description, coordination support recognised as significant part of caseload)	*Support from professional(s) as part of clinical/ practitioner role. Lead professional identified. Service user self-directed care, with support.*
A comprehensive multi-disciplinary, multi-agency assessment covering the full range of needs and risks	*A full assessment of need for clinical care and treatment, including risk assessment*
An assessment of social care needs against FACS eligibility criteria (plus Direct Payments)	*A full assessment of need for clinical care and treatment, including risk assessment*
Comprehensive formal written care plan: including risk and safety/contingency/crisis	*Personal recovery plan shows a clear understanding of how care and treatment will*

142. Devon Partnership NHS Trust Care Programme Approach Policy: C05 pages 5-6
143. SHA/Darzi care pathway group priorities 2008/9
144. Devon Partnership NHS Trust Care Programme Approach Policy: C05 page 6
145. Devon Partnership NHS Trust Care Programme Approach Policy: C05 pages 8-9

plan	*be carried out, by whom, and when.*
On-going review, formal multi-disciplinary, multi-agency review at least once a year but likely to be needed more regularly	*On-going review as required*
At review, consideration of on-going need for CPA support	*On-going consideration of need for move to CPA if risk or circumstances change*
Increased need for advocacy support	*Self-directed care, with support*
Carers identified and informed of rights to own assessment	*Carers identified and informed of rights of own assessment*

Devon Partnership NHS Trust Torbay Adult Directorate Recovery and Independent Living Operational Policy

"The service will ..:

- *Ensure the person is allocated to a recovery coordinator and where appropriate a CPA care coordinator .*
- *Devise an interim care plan upon referral while an in depth collaborative therapeutic care plan and risk assessment is formulated.*
- *The care plan, risk assessment and contingency plan should all be formulated with the person and if they choose their carer.*
- *Ensure the individual and as appropriate any carers have a copy of the care plan or are offered a copy.*

The care plan, risk assessment and contingency plan in most cases is reviewed within a period of a maximum of 6 months. The review should take place on a needs led basis – it therefore maybe appropriate to review it within a very short period time according to the persons need". [146]

12.2.2. Findings

Care with the Mental Wellbeing and Access Team

On the 19 February 2010 Ms. X was referred to the Mental Wellbeing and Access Team with *"quite marked depression".*[147] GP 1 wrote that Ms. X had previously attempted to commit

146. Operational Policy Torbay Adult Directorate Recovery & Independent Living Team page 2
147. Vol 5 PP 204 GP record pages 70-71

suicide in 1998 for which she had been admitted to hospital and that in 2004 she had experienced a recurrence of her depression.

At the time of the referral GP 1 wrote that Ms. X was 32 weeks pregnant and that she had been depressed since January 2010. Ms. X had ceased taking Sertraline 100mg once she knew that she was pregnant. At the time of the referral she was described as having deteriorated over the past four weeks and was now finding it difficult to speak and to get out of bed. She rated her wellbeing as being '0' out of '10' when in the GP surgery earlier that day. The referral was described as requiring urgent attention.

Ms. X was seen by Clinical Team Leader 1 and Consultant Psychiatrist 1 from the Mental Wellbeing and Access Team on the 25 February 2010. On this occasion it was noted that she was expressing paranoid and negative thoughts about what people thought about her and that she was neither eating nor sleeping well. Ms. X did not want her family to know that she was depressed. It was decided that there would be an *"immediate"* referral to a Senior Mental Health Practitioner within the team, and that Cognitive Behaviour Therapy was also recommended. The plan was to work with Ms. X to *"de-stigmatise"* her understanding of depression and that a referral would be made to the Depression and Anxiety Service after the birth of her baby.[148]

Ms. X proved difficult to contact and it was not until the 26 March that Senior Mental Health Practitioner 1 from the Mental Wellbeing and Access Team met with her for the first time. As can be seen from the Chronology in Section 10 above, between the 25 February and the 26 March several Health Care Professionals had been expressing concern about Ms. X and her mental health. By the time Ms. X was seen on the 25 March it was thought that she required an enhanced level of care and that a referral to the Recovery and Independent Living Team was indicated. An urgent referral was made.[149]

Between the period from 19 February to 25 March 2010 it was known that:

1. Ms. X was in the last trimester of pregnancy;
2. GP 1, Health Visitor 1 and the Obstetrician were concerned about her mental health and had put into motion a secondary care referral and assessment;

148.Vol 5 pages 206-7, GP record pages 97-8
149. Vol 5 pages 210, 213, 215, GP record pages 36-7

3. Ms. X had a long history of depression and self-harm and there was a familial history of depression;
4. Ms. X's depression was growing worse despite being recommenced on Sertraline 50mg in January 2010, with the dose increasing to 100mg on 12 February 2010;
5. Ms. X's mental health was steadily deteriorating in that she was exhibiting the early stages of motor retardation, was not sleeping or eating well, was expressing negative and paranoid thoughts, and she was expressing *"odd beliefs"* and had expressed a fear of losing control.[150]

Care with the Recovery and Independent Living Team

On the 6 April the Care Coordinator from the Recovery and Independent Living Team met with Ms. X. This was 12 days following Senior Mental Health Practitioner 1 from the Mental Wellbeing and Access Team assessing that an urgent referral needed to be made, and nine days from the date the urgent referral was received by the Recovery and Independent Living Team and Ms. X being seen. The Care Coordinator was in receipt of a detailed referral letter.

The Trust Recovery and Independent Living Team Operational Policy requires that urgent referrals are seen within seven days of the referral being made. Clinical Witnesses to this Independent Investigation could not state what the referral criteria timeframes were for urgent referrals. The Independent Investigation Team found that this basic service delivery information was not known to either members of the treating team at the Recovery and Independent Living Service or to the individuals referring Ms. X to them. The Independent Investigation Team noted that delays were caused due to the reliance of the Care Coordinator upon telephone and written communication with Ms. X which appeared to have been unsuccessful in the first instance. The Care Coordinator reportedly tried to contact Ms. X on the 29 March, the day she received the referral, three times on the telephone but was unsuccessful. Three more attempts were made and then a letter was sent to Ms. X on the 1 April. No record of these attempts was made in the clinical record and this information was brought forward by the Care Coordinator as part of this Investigation process. At this stage the Care Coordinator knew the concerns other health care professionals had about Ms. X.

150. Vol 5 pages 210, 213, 215, GP record pages 36-7

On the 6 April Ms. X was noted by the Care Coordinator to be flat in affect and unmotivated. She denied any thoughts of wanting to harm either herself or her unborn child and said she was taking her medication. The Care Coordinator made an urgent referral for a psychological therapy assessment and planned to offer Ms. X an urgent medical review after her baby was born. She also 'liaised' with the Community Midwife. The Midwife made an entry in the clinical record that the Care Coordinator had seen Ms. X. She was flat in mood and depressed but was not deemed to be paranoid or to present a danger to her baby.[151]

On the 12 April 2010 (two days after the birth of Ms. X's baby boy) the Care Coordinator wrote a referral letter to the Clinical Psychologist with an urgent referral which subsequently led to an appointment being made with the Psychologist for the 24 April 2010.

Chronology for the 36 Hours leading to the Death of Baby Y

Ms. X had given birth to her baby boy on the 10 April 2010, a fact that the Care Coordinator was not aware of. On the 19 April 2010 Ms. X's mother telephoned the Crisis Team expressing concern over her daughter's depression and deteriorating condition. She had used the Crisis Team telephone number but had been re-routed to the 'Devon Docs' Service. In witness statements made by the family of Ms. X this call is described as a request for a crisis response. **This call was routed through to the Mental Wellbeing and Access Team, who in turn contacted the Care Coordinator at 10.30 hours**. The Care Coordinator telephoned Ms. X's mother back at 11.00 hours. The Care Coordinator listened to the mother's concerns and was apparently told that Ms. X had been punching out and smashing things. The Care Coordinator said that she could not discuss the case as Ms. X did not want her family informed about her condition.[152] The family of Ms. X gave a statement to the Independent Investigation to say that a friend, who works in the NHS, advised them to contact the Crisis Response Team. Ms. X's mother did this but the family felt the response was not supportive. Ms. X's mother spoke with two people, one from Waverley House, and in the end the *"mental health worker"* from Waverley House (presumably the Care Coordinator) only offered to *"Let the midwife know".*[153] The family did not feel that this was a suitable response as Ms. X required urgent intervention in their view.

151. SDHT page 163
152. DPT notes Vol 1 pages1-3
153. Family Statement

At around 14.00 hours the Care Coordinator went to see Clinical Team Leader 2 in order to discuss the case. On this occasion the Care Coordinator discussed the information given to her by Ms. X's mother earlier that day. The advice given was that Ms. X needed to be seen immediately and that all other healthcare professionals who were involved should be consulted with.[154]

Also on the 19 April Ms. X, accompanied by her mother-in-law, attended the GP surgery. GP 2, who was meeting Ms. X for the first time, noted that she was not bonding with her baby and had severe postnatal depression. It has to be noted that Ms. X did not give a truthful account of her mental health history to GP 2 on this occasion, and neither did GP 2 have access to any information about Ms. X as she had only registered with the surgery four days earlier. GP 2 made telephone contact with the midwifery team who informed GP 2 of the fact that Ms. X had a Care Coordinator who had been in touch with them due to concerns raised by Ms. X's mother on 'Bay Doc'. GP 2 was not informed what the nature of these concerns was. **Mid afternoon GP 2 very sensibly made a telephone call to the Care Coordinator to find out more of the background to Ms. X's mental health history.** GP 2 contacted the Care Coordinator and told her that she thought Ms. X was depressed. The Care Coordinator said that she was planning to meet with Ms. X the following day but that each time she telephoned her Ms. X hung up on her. The GP explained that the Care Coordinator should telephone Ms. X's mother-in-law as this is what Ms. X had requested in the surgery earlier that day due to feeling too tired to manage telephone calls herself. GP 2 gave the Care Coordinator the mother-in-law's telephone number and asked her to make contact. GP 2 asked the Care Coordinator if she thought Ms. X was at risk and the Care Coordinator said no. Based on this it was agreed that Ms. X would be visited the following day by the Care Coordinator. It would appear that by the time Baby Y was killed the Care Coordinator had made *no* telephone calls to arrange an appointment for the 20 April as agreed.[155]

At around 15.00 hours on the 19 April the Care Coordinator discussed Ms. X with Consultant Psychiatrist 2, from another team, for advice as to how to proceed. She had also contacted the Locum Staff Grade Psychiatrist who worked with her team (the Torbay Team had no Consultant Psychiatrist input of its own at this time). The Care Coordinator stated that GP 2 had said there were no current risks and it was agreed that a joint visit would be made the

154. Witness statement
155. Witness Statements

following day to conduct an assessment with the Locum Staff Grade Psychiatrist. There is no note in the clinical record that the Care Coordinator mentioned Ms. X was punching out and smashing things in the home.

It is evident that by the close of the day on the 19 April 2010 there was sufficient information that was either known, or should have been known, by the Care Coordinator to have instigated a same day assessment. This information was of great significance and should have prompted a clear discussion and information exchange between the disparate members of Ms. X's treating team. This did not appear to take place. The Independent Investigation Team made the finding that the Care Coordinator did not keep any contemporaneous record and that her recollection of events was potentially unreliable and misleading. She states in various witness statements that she knew directly from Ms. X's mother on the 19 April about her punching and smashing things, but does not appear to mention this information to key health care professionals with whom she consulted that day. Other clinical witnesses to this Investigation do not recollect being told about Ms. X's violent behaviour.

The following day, despite knowing that Ms. X was depressed and had recently delivered a baby, the Care Coordinator tried to arrange for her to make a visit to the Outpatient Clinic at 15.00 hours. This was inconsiderate and also not indicated clinically as a home visit would have ensured a more holistic assessment environment. The Care Coordinator telephoned Ms. X's mother at 09.15 hours on the 20 April to ask her to bring her daughter in to the Outpatient Clinic. Ms. X's mother explained that she did not live in Devon and asked her to telephone Ms. X's mother-in-law (whose telephone number GP 2 had already given to the Care Coordinator the previous day). It was evident that by the time Baby Y was killed the Care Coordinator had made no direct contact with Ms. X's mother-in-law in order to make an appointment for her to be seen. The Care Coordinator reportedly telephoned Ms. X's mother-in-law following this conversation but no one answered the telephone. By this time Baby Y was probably already dead. There are several concerns. These are as follows:

1. The Care Coordinator had been contacted about the call made by Ms. X's mother to Devon Doc at 10.30 hours in the morning on 19 April 2010. She says that she responded to this call immediately and telephoned Ms. X's mother. She was told that Ms. X was deteriorating and punching out and smashing things.[156]

156. Vol 2 pages.1-3

2. The Care Coordinator informed her Team Leader about the family's concern and sought his advice. She was advised to speak to the midwife immediately to ascertain who was the last professional to speak to Ms. X and advised that Ms. X should be assessed "as soon as possible" rather than that day.[157]
3. The Care Coordinator talked to GP 2, Consultant Psychiatrist 2 and the Team Locum Staff Grade Psychiatrist about Ms. X during the afternoon of 19 April 2010 but appears to have failed to mention the crisis call made by Ms. X's mother and the fact that Ms. X was punching out and smashing things.[158]
4. The Care Coordinator wrote in witness statements that GP 2 said Ms. X was not at risk and so a visit did not need to be conducted urgently and could wait until the following day. GP 2 stated in witness statements that the Care Coordinator was asked if Ms. X was at risk and that the Care Coordinator had said this was not the case.
5. GP 2 gave the Care Coordinator the telephone number of the mother-in-law in order for an appointment to be made with Ms. X the following day. In spite of this she telephoned Ms. X's mother, apparently in error, the following day, 20 April 2010, at 09.15 hours to make an appointment at the Outpatient Clinic. It would appear that the Care Coordinator had not made an attempt to contact Ms. X's mother-in-law the previous day as agreed with GP 2. Bearing in mind that Ms. X had recently given birth to a baby it was unrealistic to expect her to be able to travel to the Outpatient Clinic without a decent notice period being given.[159]
6. Having been told that Ms. X's mental health was deteriorating by the family and that they needed an intervention to take place, it is difficult to understand why a telephone call was not made in order to monitor the situation and to offer support and advice.
7. The Care Coordinator says she attempted to call the mother-in-law but failed to make contact on the morning of the 20 April. She left three messages. By this time Baby Y was already dead.

Quality of the Care Programme Approach and Care Coordination

The context paragraphs of this report subsection set out the expectations of the Care Programme Approach and of Care Coordination as established against both local and national policies. Ms. X should have been in receipt of an in-depth assessment process and care plan which should have included reference to her forthcoming parental responsibilities and how

157. Witness Statement
158. Witness statements and CMHT records.
159. Vol8 pages 419-422

she would cope/be supported. As can be seen from the chronology of events set out directly above, Ms. X's condition deteriorated rapidly and the absence of a coordinated approach meant that the disparate members of the treating team were neither in possession of all of the information they needed in order to ensure the wellbeing, safety and health of Ms. X and her baby, nor knew who to contact or what to do in the event of a crisis. The lack of a thorough assessment and plan to address her needs also resulted in a lack of attention to considering her parenting capacity and the needs of her unborn child as required by the local Safeguarding Children Board unborn baby protocol.[160]

On the 6 April an assessment was commenced by the Care Coordinator. The assessment highlighted several areas of concern that would require active monitoring and intervention. It was evident at this stage that Ms. X:

1. had poor eye contact, was not eating and had a slow speech rate;
2. was depressed and anxious and felt totally numb;
3. had poor memory and concentration levels;
4. had a long history of depression;
5. was due to give birth in two-weeks time (Baby Y was born four days later);
6. was assessed as having moderate risks.

The plan required the following:

1. urgent referral for cognitive behaviour therapy;
2. review with Care Coordinator in two weeks;
3. Care Coordinator to liaise with GP, midwife and health visitor;
4. ensure medical review as soon as possible after the baby's birth;
5. consider referral to the crisis team if Ms. X was to deteriorate further.

Apart from the referral to the Clinical Psychologist for Cognitive Behaviour Therapy and a brief telephone call to the Midwife, none of the actions listed in the plan were pursued. It is a fact that the assessment which should have been ongoing at this stage was halted, and that no liaison took place between any other members of Ms. X's disparate care and treatment team. There was an embryonic assessment, a plan that was not implemented, and no multi-professional crisis and contingency strategy developed. Of particular significance was the

160. Working with Mothers and their Unborn Babies where there are Concerns for the Welfare of the Unborn child, 2009

failure to assess or evaluate any safeguarding implications for Ms. X's unborn child. Neither were Ms. X's pregnancy and imminent delivery assessed as being factors of additional complexity. Once Ms. X's mental health broke down no plan was in place to ensure that a timely and effective response could be made.

It is a fact that once Ms. X's mental health started to deteriorate, following the birth of her baby, the Care Coordinator had only met her once and had not built up any kind of therapeutic relationship with her. Even so, despite being contacted twice on the same day by people who were expressing concerns about Ms. X (GP 2 and Ms. X's mother), the Care Coordinator did not consider either making an emergency home visit in order to undertake an assessment, or to state to the people she talked to that she did not know what Ms. X's mental state was. Instead the Care Coordinator discussed the case with people who either had not met Ms. X or who did not understand her in the context of her mental illness history. The Care Coordinator failed to communicate the seriousness of the family's concerns to the other health care professionals she spoke to that day. She also failed to verify them by arranging a home visit or ensuring further contact with the family by telephone.

The Role of the Care Coordinator

The Trust policy in operation at the time Ms. X received her care and treatment stated the following:

*"**CPA care coordinators will:***

- *Uphold the principles and meet the standards described in the **Policy Implementation Guide and staff handbook for recovery coordination.***
- *Coordinate all assessments and support each person to develop a Personal Recovery Plan. This will outline what should happen, when and who is responsible. Upon completion, and at any review, any financial aspect of the plan will be presented to the Clinical Team Leader who will sign off the plan on behalf of the Trust. Sign off of non financial aspects of personal recovery plan is by the registered professional agreeing the plan with the service user and is reported back via the supervisory process.*
- *Complete a contingency plan with each person which gives details of the specific and individual requirements and needs which others may need to know should a difficult situation or crisis develop.*

- *Ensure that other key people involved have an opportunity to share their views and opinions. This will include ascertaining whether a carer's assessment is required and commissioning one if indicated.*
- *Act as a reference point for other support providers, relatives, carers and advocates.*
- *Ensure the person is registered with a GP who is involved and informed as necessary.*
- *Maintain regular contact with the person and monitor their progress wherever they may be within the system. If a vulnerable person declines to take part in the CPA process, all steps should be made to continue engagement.*
- *Organise reviews at appropriate intervals and ensure that all those involved in the Personal Recovery Plan are consulted and involved directly in the review where appropriate.*
- *Explain the CPA process to the person and others involved, making them aware of rights, roles, confidentiality and the limits of confidentiality.*
- *Consider the need for advocacy and provide information about the local options for this.*
- *Remain in contact with the care, treatment and support of people who enter acute inpatient units or the prison system and prepare an appropriate Personal Recovery Plan following discharge/release.*
- *Identify unmet needs and communicate these to the Clinical Team Leader.*
- *Ensure that Fair Access to Care procedure is followed in accessing social care.*
- *Record all CPA activity on the electronic record.*
- *Arrange for someone to deputise when absent and to pass on the CPA care coordinator role to someone else if no longer able to fulfil it.*
- *Regularly update the Clinical Team Leader about their caseload, highlighting high-risk areas.*
- *Participate in regular clinical supervision appropriate to the work being undertaken".*[161]

"…*Record keeping is an essential element of treatment and care. Practitioners are professionally accountable for maintaining accurate, comprehensive and up to date records. It is the responsibility of every individual to ensure that this information is recorded accurately and shared appropriately within the confines of confidentiality protocols".*[162]

161. Devon Partnership NHS Trust Care Programme Approach Policy: C05 pages 11-12
162. Devon Partnership NHS Trust Care Programme Approach Policy: C05 pages 21

The Care Coordinator did not keep a contemporaneous record of the care and treatment inputs that she made with Ms. X. The Independent Investigation Team found this to be problematic as it was difficult to understand the train of events and the rationales deployed. Consequently there is a significant difference of opinion and recollection on the part of the clinical witnesses to this Investigation who were involved in the care and treatment of Ms. X and her baby that cannot either be ratified or understood by examining the extant clinical record.

It would appear that the Care Coordinator met with Ms. X on a single occasion. Following this meeting she made a clinical psychology referral and commenced the assessment process. An embryonic care plan was put into place which was neither developed further, communicated, nor implemented. It was evident from an examination of the record and from conducting interviews with clinical witnesses that no Care Coordination took place in keeping with either local or national policy expectation. Consequently neither Ms. X nor her baby had their health, safety and wellbeing appropriately assessed. In the absence of a monitoring and assessment period which should have continued as a matter of urgency no care plan was developed, beyond one of the most basic kind which could not address the rapid deterioration that Ms. X experienced.

Team and Organisational Factors

The Independent Investigation Team asked clinical witnesses whether there were any pressures on the Recovery and Independent Living Team which could have caused care and treatment to have been delivered in a sub-optimal manner to Ms. X. This Investigation was told that the team caseload was not overloaded and that the individuals involved directly were considered to be both experienced and competent. The Independent Investigation Team did however note that there was a paucity of senior medical input which may have influenced the quality of the clinical assessment that was undertaken and the quality of the clinical support available to the Care Coordinator.

12.2.3. Conclusions

Conclusions of the Trust Root Cause Analysis Report and Serious Care Review Pertinent to CPA issues

Serious Case Review

The Serious Case Review conducted by the Torbay Safeguarding Children Board concluded that the Care Coordinator did not take Ms. X's pregnant state into sufficient account when conducting the initial assessment. Consequently the unborn baby, and the baby once born, was not taken into consideration as required by the local child protection policies and procedures. The needs of the adult appeared to supersede those of the child.[163]

The rights of the father did not appear to be considered in regard to the safety of his child. Ms. X's *"extreme"* need for privacy was considered to have made a significant contribution to the *"obstruction"* of information that flowed between health care professionals and family members.[164]

A lack of continuity of care was also seen as being a significant problem as was the number of different NHS organisations involved in the care and treatment of Ms. X and her baby.

Trust Root Cause Analysis Report

The Trust Root Cause Analysis Report found that:

1. there was no mental health review planned for soon after the birth;
2. mental health assessment did not adequately reflect the context of the pregnancy;
3. there was no multi-agency care plan or arrangements for communication flow (NICE guidance was not followed);
4. carers had no plan or sense of what to do when Ms. X's mental health deteriorated;
5. patient confidentiality issues obstructed information flow.

The Independent Investigation Team concurs with these conclusions. In addition the Independent Investigation draws a direct link between these conclusions and failures with regard to both the Care Programme Approach and Care Coordination practice.

Conclusions of the Independent Investigation Team

It is the conclusion of the Independent Investigation that the Care Coordinator did not fulfil her duty of care in two essential regards:

1. no adequate contemporaneous clinical record was maintained;

163. Serious Care Review page 17
164.Serious Care Review page 17

2. no assessment or care coordination processes were conducted to the standard expected for a service user in receipt of CPA.

The Independent Investigation heard from clinical witnesses that as the case had been referred to the Recovery and Independent Living Team as an urgent referral it was allocated immediately and by-passed what would normally have been an allocation team meeting discussion. As a result the Care Coordinator picked the case up with immediate effect and no medical input contributed to the initial discussion held around the case.[165] The Independent Investigation recognises that this placed an additional level of responsibility upon the Care Coordinator. The Trust Care Programme Approach Policy stated that all those service users on CPA should expect the input of a named Care Coordinator and Consultant Psychiatrist. This did not happen.

The Care Coordinator did not provide an adequate level of assessment and follow up after her initial meeting with Ms. X on the 6 April 2010. Apart from a psychology referral and a brief telephone conversation with the midwifery service, no other actions took place. This ran counter to Trust policy and procedure which required an in-depth period of assessment to take place once a person had been accepted onto the Recovery and Independent Living Team caseload.

No liaison took place with the other health care professionals involved in Ms. X's care and treatment even though the care plan stated that this was an identified action. It is a fact that the Care Coordinator was not even aware that Ms. X had given birth to her baby until she spoke to her mother on 19 April. Whilst it could be stated that all healthcare professionals have a duty to communicate with each other, especially when there are children involved (born or unborn), it is the particular role and responsibility of a Care Coordinator for those service users on CPA to ensure that all communication takes place in a systematic and coordinated manner. This is an integral part of the role. Therefore this duty, once secondary care mental health services were involved and the decision to provide an enhanced care package had been reached, rested with the Care Coordinator.

165. Witness transcription

On the 19 April two separate channels of communication commenced. One was triggered by Ms. X's mother making a call to the Crisis Team; the other was triggered by Ms. X visiting GP 2. It was these two independent events that appeared to have prompted action from the Care Coordinator. On the 19 April it would appear that the Care Coordinator informed the midwifery team that Ms. X was punching out and smashing things. It would also seem that she had a similar conversation with her Team Leader when she went to him for advice. It does not appear that she had the same depth of conversation with GP 2, the Locum Staff Grade Psychiatrist or Consultant Psychiatrist 2 with whom she also discussed Ms. X's mental state. The paucity of the extant clinical record means that we have a situation where individual clinicians' memories do not concur one with the other about what was discussed. This is unfortunate.

However the Independent Investigation Team concluded the following:

1. Ms. X was not seen between the 6 April and the 20 April by any mental health practitioner. This Investigation understands that Ms. X did not want regular contact with mental health services, but secondary care services have a duty of care to intervene assertively when initial assessment indicates that further assessment is required and there is evidence of risk. This difficulty regarding engagement should have been subject to a multidisciplinary discussion and been part of the risk assessment formulation.
2. Ms. X gave birth to her baby during this period and experienced a further deterioration of her mental state.
3. The family of Ms. X grew increasingly concerned and on the morning of the 19 April 2010 put a call through to the Crisis Team which was eventually re-routed through to the Care Coordinator. The family were requesting an urgent intervention and described Ms. X as punching out and smashing things; this should have instigated a same-day home visit and assessment.
4. The Care Coordinator discussed the case with several health care professionals; it is unclear exactly what information the Care Coordinator shared, but it was established that Ms. X did not present a risk to either herself or to her child and that an appointment should be offered the following day.
5. The duty to arrange the appointment fell to the Care Coordinator who did not appear to contact the family about the appointment in a timely manner.

6. The Care Coordinator did not attempt to telephone Ms. X's mother-in-law to monitor the situation and to offer support. This kind of action was most definitely indicated in the circumstances.

Summary

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. It is unclear whether she provided all of those with whom she consulted with critical information concerning Ms. X's mental state.

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.

12.2.4. Contributory Factors and Service Issues

- ***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.***

12.3 Risk Assessment and Management

12.3.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety and that of others who may be affected by them. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service users' past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed".*[166]

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation in order to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and/or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which includes where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

In his forward to *Best Practice in Managing Risk (2007*) Louis Appleby commented:
"Safety is at the centre of all good healthcare. This is particularly important in mental health but it is also more sensitive and challenging. Patient autonomy has to be considered alongside public safety. A good therapeutic relationship must include both sympathetic support and objective assessment of risk".[167]

The guidance goes on to list 16 principles which should characterise the assessment and management of risk. These are listed below:

"Best practice

1. *Best practice involves making decisions based on knowledge of the research evidence, knowledge of the individual service user and their social context, knowledge of the service user's own experience and clinical judgement.*

166.Best Practice in Managing Risk; DoH; 2007
167. DoH (2007), *Best Practice in Managing Risk*

Fundamentals

2. *Positive risk management as part of a carefully constructed plan is a required competence for all mental health practitioners.*

3. *Risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.*

4. *Risk management must be built on recognition of the service user's strengths and should emphasise recovery.*

5. *Risk management requires an organisational strategy as well as efforts by the individual practitioner.*

Basic ideas in risk management

6. *Risk management involves developing flexible strategies aimed at preventing any negative event from occurring or, if this is not possible, minimising the harm caused.*

7. *Risk management should take into account that risk can be both general and specific, and that good management can reduce and prevent harm.*

8. *Knowledge and understanding of mental health legislation is an important component of risk management.*

9. *The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.*

10. *Where suitable tools are available, risk management should be based on assessment using the structured clinical judgement approach.*

11. *Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user.*

Working with service users and carers

12. *All staff involved in risk management must be capable of demonstrating sensitivity and competence in relation to diversity in race, faith, age, gender, disability and sexual orientation.*

13. *Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and recognition that each service user requires a consistent and individualised approach.*

Individual practice and team working

14. *Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.*

15. *All staff involved in risk management should receive relevant training, which should be updated at least every three years.*

16. *A risk management plan is only as good as the time and effort put into communicating its findings to others".*[168]

Devon Partnership NHS Trust Policy

The Independent Investigation Team found that the Trust policy was evidence based and fit for purpose. It stated the following:

1.1 "Risk management should aim to improve a person's quality of life and their plans for recovery, whilst being mindful of the safety needs of the person, those in their immediate social network and the wider population. The Trust endorses positive risk management and will support any risk-related decision if it is:

- ***Considered*** *– carefully, collaboratively, based upon the best information available and conforming with relevant guidelines/best evidence*
- ***Documented*** *– in accordance with the tool/structured prompt and documentation in place <u>and</u> that identified risks are reflected in overall treatment/care plans*
- ***Communicated*** *– the relevant people are involved/informed in a timely way".*[169]

Trust risk assessment processes supported the use of both a 'Level 1' and a 'Level 2' risk assessment process. The first level was indicated in simple cases where risks were deemed to be low. The second level was indicated for those service users who were deemed to be exhibiting problematic risk behaviours or whose cases were deemed to be complex by virtue of their health and social care circumstances.

12.3.2. Findings

Care with the Mental Wellbeing and Access Team

GP 1 requested an urgent referral to the Mental Wellbeing and Access Team for Ms. X. A combined nursing and medical review was held with Ms. X on the 25 February 2010. On this occasion Ms. X's ten-year history of depression was noted but no risks to either self or others were identified. The decision was made to refer her to a Senior Mental Health Practitioner to offer continued support.

168. DoH (2007), *Best Practice in Managing Risk* pages 5-6
169. Clinical Risk Assessment and Management Policy : R04 page 4

Senior Mental Health Practitioner 1 met with Ms. X on the 26 March 2010, having sent the appointment letter on 17 March 2010. Prior to this meeting Ms. X's Obstetrician (19 March 2010) had requested that her mental health input was expedited as her mood was low and she was rapidly reaching her delivery date. On the 25 March GP 1 left a telephone message with the Mental Wellbeing and Access Team for Senior Mental Health Practitioner 1 saying that Ms. X had caused the family concern by driving impulsively to London at the weekend without letting anyone know. Senior Mental Health Practitioner 1 noted that Ms. X had been reluctant to attend the appointment with her and that she was flat in presentation, numb in mood, nihilistic, and hinting at some odd beliefs which were affecting her behaviour such as not allowing herself to wear makeup at the present time. Ms. X also *"alluded to a significantly higher number than average of predictions about a negative outcome to her pregnancy".* On 29 March 2010 Senior Mental Health Practitioner 1 made an urgent referral to the Recovery and Independent Living Team, stating that Ms. X was now 37 weeks pregnant. The referral was made after she discussed Ms. X with her Clinical Team Leader 1 and she realised that there had been a significant deterioration in Ms. X's mental state since she was assessed by the team on the 25 February 2010.[170] It was decided that Ms. X should be referred to the Recovery and Independent Living Team because she required an enhanced level of care, and that the referral should be treated as urgent because of her imminent delivery date.[171] No formal risk assessment process was completed.

Care with the Recovery and Independent Living Team

On the 6 April 2010 Ms. X was assessed by the Duty Worker who became her allocated Care Coordinator with the Recovery and Independent Living Team. A letter had been sent from the Mental Wellbeing and Access Team outlining Ms. X's history and presentation.

On the 15 April 2010 a 'Risk Assessment and Management Level 1' form was completed by the Care Coordinator. The Independent Investigation Team was given only the first page of this two-page document and it is unclear whether or not the complete Level 1 screen was ever completed. The assessment date was given as being the 6 April 2010. Ms. X was not considered to be a risk to either herself or to others. There was no reference made to either Ms. X's pregnancy or unborn baby. It was noted that Ms. X had a long history of depression and that she had made a previous self-harm attempt at the age of 18 years. It was recorded

170. DPT notes PP 213 and 215
171. Witness Statement

that Ms. X had been reluctant to engage with mental health services and that this may present a challenge in the future. Her family were noted to be encouraging Ms. X to eat and attend to her personal care needs. Overall Ms. X was considered to be a low risk. It was not considered necessary for the assessor to proceed to a 'Level 2' assessment.

On the 19 April a second 'Risk Assessment and Management Level 1' form was completed by the Care Coordinator, presumably as a response to the communication via the Crisis Team made earlier in the day. The only change made to the assessment documentation was an entry that said under the 'risk to children' section *"... [Ms. X] denies any thoughts of harm to her baby".* It is unclear how the Care Coordinator had obtained this information as she not had assessed Ms. X since her first meeting with her on the 6 April two weeks earlier.

By the time the Care Coordinator had completed the second 'Level 1' assessment form on the 19 April 2010 she presumably had already spoken to Ms. X's mother and knew that Ms. X was becoming aggressive, was punching out and smashing things. This information was not entered onto the risk assessment documentation. Once again the Independent Investigation Team was given only the first page of this two-page document and it is unclear whether or not the complete Level 1 screen was ever completed. Once again it was not considered necessary for the assessor to proceed to a 'Level 2' assessment.

It is evident that the Care Coordinator discussed Ms. X with the Midwife, GP 2, Clinical Team Leader 2, the team Locum Staff Grade Psychiatrist and Consultant Psychiatrist 2 from another team. The Independent Investigation Team was told by clinical witnesses that these discussions all featured Ms. X's risk profile, even though all information relevant to risk had not been shared by the Care Coordinator, and what actions needed to be made in the short term. These discussions were not recorded in the clinical record other than by the Locum Staff Grade Psychiatrist. These discussions did not appear to inform the risk assessment documentation.

12.3.3. Conclusions

Conclusions of the Trust Root Cause Analysis Report and Serious Care Review

Specific issues regarding the quality of holistic clinical risk assessment and clinical decision making *were not* explicitly examined as part of the Serious Case Review or Trust Root Cause

Analysis Investigation, particularly with regard to the final 24 hours prior to the killing of Baby Y.

Conclusions of the Independent Investigation Team

The word 'urgent' appears with great regularity in Ms. X's clinical record. However, key members of the disparate treating team involved with the care and treatment that Ms. X received did not demonstrate an understanding of the urgency that Ms. X's care required.

Care with the Mental Wellbeing and Access Team

Prior to the referral made to the Recovery and Independent Living Team on the 29 March 2010 it would appear that most of the healthcare professionals who were involved with Ms. X were concerned about her mental health and the possible impact that this would have upon both Ms. X and her unborn baby. It had also been noted that the family of Ms. X were becoming concerned.

Had a formal risk assessment been conducted by the Mental Wellbeing and Access Team at this stage it may have supported the urgency with which the referral was made to the Recovery and Independent Living Team and could have served to underline the concerns that were building amongst the disparate members of Ms. X's treating team and her family. The Independent Investigation Team has been made aware that formal risk assessments were not routinely carried out by the Mental Wellbeing and Access Team at that time.

Care with the Recovery and Independent Living Team

Following Ms. X being allocated to a Care Coordinator with the Recovery and Independent Living Team the expectation would have been that a comprehensive risk assessment should have been conducted. Ms. X met the criteria for CPA and was therefore considered to be a service user who required an in-depth assessment and monitoring period. It was also known that she had a history of depression, had a mental state that was deteriorating and that the birth of her baby was imminent. The first risk assessment was of the most basic kind and did not appear to have addressed even in the most minimalistic manner the fact that Ms. X was about to give birth. Several issues of significance were raised during this initial assessment meeting. It was evident that Ms. X was ambivalent about being engaged with mental health services. Her presentation was problematic, and she did not want her family informed about her condition. None of these factors were considered as part of the risk formulation and no

further assessment or exploration appears to have been considered. The Care Coordinator appears to have taken the information at face value, recorded it and then considered no further action to be necessary.

On the 19 April two separate and parallel events occurred which brought Ms. X back to the attention of the Care Coordinator. The first event being Ms. X going to see her new GP, GP 2, and the second event being the call made by Ms. X's mother to the Crisis Team. It was evident by the afternoon of the 19 April that Ms. X had been violent and aggressive at her home, and that her depression was being noted as severe by the GP. It is often the case that a service user can present one way to one person and another way to a second person. The information that the Care Coordinator received on the 19 April appeared to have been fairly disparate in that the GP did not know about Ms. X's aggression and had not picked up upon this aspect when she came to the surgery earlier that day. However the nature of the information given to the Care Coordinator was of great significance and required further assessment, corroboration and examination.

It would appear that the Care Coordinator did discuss Ms. X on the afternoon of the 19 April, however as had already been examined above it would appear that not all of the risk information was shared with all of the parties involved. At this stage an in-depth 'Risk Assessment and Management Level 2' process was indicated in order to be able to draw together everything that was known in a systematic manner. If this had been done it would have become evident that not enough information was available in the absence of an up-to-date mental health assessment by the Care Coordinator and that a medical opinion was required in order to understand Ms. X's mental state better and any subsequent risks that she may have presented.

The decisions made on the 19 April did not appear to have been based upon everything that was either known, or should have been known, about Ms. X. The decisions reached did not appear to have been made in a multidisciplinary and systematic manner and neither were these decisions communicated and recorded appropriately. The family of Ms. X were not considered as being an important part of the risk assessment process and they were not involved in either the collection of information on the 19 April or the communication processes about the appointment which had been planned for the following day.

Summary

The Department of Health guidance states that *"any risk related decision is likely to be acceptable if:*

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed"*.[172]

As long as a decision is based upon the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time. 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 assessing adults of working age without the back up of a Consultant Psychiatrist. 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 factors, in addition to the lack of sharing of critical information, 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

172.Best Practice in Managing Risk; DoH; 2007

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.

12.3.4. Contributory Factors and Service Issues

- ***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.***

12.4. Diagnosis

12.4.1. Context

An often critical element in the planning of an individual's care is the diagnostic process. There is an on-going debate in the academic literature about the reliability and utility of categorical diagnostic schemas and what is sometimes, imprecisely, referred to as the medical model. What is not in debate, however, is that if an individual is to receive effective and efficient treatment there has to be a clear formulation of his/her difficulties, which informs a plan determining how the individual might be helped to achieve identified goals. This formulation should be based on a robust and comprehensive assessment and best practice suggests that the formulations should be multidisciplinary with all members of the treating team being guided by a common understanding of the individual's problems. Information should be gathered from a number of sources: a thorough history from the service user, collateral information from carers/family/GP/interested or involved others, mental state examination and observation.

Psychiatry currently uses the diagnostic system defined in The International Statistical Classification of Diseases and Related Health Problems as determined by the World Health Organisation. This is in its tenth revision and is commonly known as ICD10.[173]

The diagnosis noted in the case of Ms. X was that of Depression. ICD10 defines the diagnostic criteria for depression in its chapter on Mood (Affective) Disorders, F30 - F39. Depression can be defined as a single episode or recurrent disorder. It can be graded mild, moderate or severe and it may have associated somatic and/or psychotic symptoms. The ICD10 defines a depressive episode (F32) as follows:

"In typical depressive episodes of all three varieties described below (mild, moderate and severe), the individual usually suffers from depressed mood, loss of interest and enjoyment and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness only after slight effort is common. Other common symptoms are:

a) Reduced concentration and attention

173. World Health Organisation, 1992, The International Statistical Classification of diseases and Related Health Problems – Tenth Edition

b) Reduced self esteem and self confidence
c) Ideas of guilt and unworthiness (even in a mild type of episode)
d) Bleak and pessimistic views of the future
e) Ideas or acts of self harm or suicide
f) Disturbed sleep
g) Diminished appetite

The lowered mood varies little from day to day and is often unresponsive to certain circumstances, yet may show characteristic diurnal variation as the day goes on...

Some of the above symptoms may be marked and develop characteristics features that are wildly regarded has having special clinical significance. The most typical examples of these "somatic" symptoms are: loss of interest and pleasure in activities that are normally enjoyable, lack of emotional reactivity to normally pleasurable surroundings and events, waking in the morning, two hours or more before the usual time, depression worse in the morning, objective evidence of definite psychomotor retardation or agitation (remarked on or reported by other people), marked loss of appetite, weight loss (is often defined as 5% or more of body weight in the past month), marked loss of libido. Usually this somatic syndrome is not regarded as present, unless about four of these symptoms are definitely present.

...Differentiation between mild, moderate and severe depressive episodes rests upon a complicated clinical judgement that involves the number type and severity of symptoms present. The extent of ordinary social and work activity is often a useful general guide to the likely degree of severity of the episode".

It should be noted that ICD10 does not have a separate category for perinatal mental health presentations, although a depressive episode in the context of the perinatal period is categorised.

The National Institute for Health and Clinical Excellence has issued guidelines on the clinical management of antenatal and postnatal mental health.[174] It offers guidance for the prediction

174. NICE Clinical Guideline 45, 2007, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.

and detection of perinatal mental health problems by all healthcare professionals involved in the care of the pregnant woman:

"At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about:

- *Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression*
- *Previous treatment by a psychiatrist/specialist mental health team including inpatient care*
- *A family history of perinatal mental illness.*

At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

- *During the past month, have you often been bothered by feeling down, depressed or hopeless?*
- *During the past month, have you often been bothered by having little interest or pleasure in doing things?*

A third question should be considered if the woman answers 'yes' to either of the initial questions.

- *Is this something you feel you need or want help with"?*[175]

The guidance goes on to say:

"Women with an existing mental disorder who are pregnant or planning a pregnancy, and women who develop a mental disorder during pregnancy or the postnatal period, should be given culturally sensitive information at each stage of assessment, diagnosis, course and treatment about the impact of the disorder and its treatment on their health and the health of their fetus or child. This information should cover the proper use and likely side-effects of medication".[176]

175. Ibid page 8
176. NICE Clinical Guideline 45, 2007, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance. Page 10

After the initial detection of a pregnant woman with a mental health problem the guidance goes on to suggest how the assessment of her mental health problem should progress:

"After identifying a possible mental disorder in a woman during pregnancy or the postnatal period, further assessment should be considered, in consultation with colleagues if necessary.

- *If the healthcare professional or the woman has significant concerns, the woman should normally be referred for further assessment to her GP.*

- *If the woman has, or is suspected to have, a severe mental illness (for example, bipolar disorder or schizophrenia), she should be referred to a specialist mental health service, including, if appropriate, a specialist perinatal mental health service. This should be discussed with the woman and preferably with her GP.*

- *The woman's GP should be informed in all cases in which a possible current mental disorder or a history of significant mental disorder is detected, even if no further assessment or referral is made".*[177]

12.4.2. Findings

Findings of the Internal Investigation/SCR

The Individual Management Review for Devon Partnership NHS Trust made the following analysis of her initial assessment with the mental health services of DPT:

"They explored her overdose in 1998 but there had been no further attempts on her life and she had no current thoughts of self-harm or suicide. Throughout the session she did not want people to know her history of depression but attributed her current illness to antenatal depression as she was worried about people judging her. They have recorded her husband's name at this assessment but have not explored his role in her life and whether this is a supportive one. There were other family members involved in her life but again their role or influence has not been explored. There is no mention of how the depression might affect her unborn baby but there is mention of a referral to the Depression and Anxiety Service. There are no process notes from this assessment but the letter to the GP acts as a written record of the assessment".[178]

177. Ibid page 14
178. Individual Management Review, DPT, page 9

The Devon Partnership NHS Trust Root Cause Analysis Investigation Report found Influencing Factors to be:
"Assessment by mental health services which did not adequately reflect the context of pregnancy." and "*An underestimation of the level of depression by mental health services".*[179]

The Serious Case Review Overview Report stated:
"Had there been a formal referral from the GP to the midwifery service, either in writing or by face to face contact it is more likely that information about the mother's mental health would have been shared. This was a missed opportunity for information sharing".[180]

Findings of the Independent Investigation

Ms. X had experienced symptoms of mental ill health since her teenage years and first received a diagnosis of depression in 1998 after she took a significant overdose resulting in admission to hospital. Her family history of depression was noted at this early stage[181] as was her reluctance to engage with the local mental health service.[182]

Over the next few years she continued to be treated by her GP with antidepressant medication (Sertraline). She relapsed after coming off her medication in September 2002 and quickly improved after Sertraline 50mg was recommenced.[183]

On **7 June 2004** her GP at that time noted the diagnosis of recurrent depression and noted that her symptoms returned every three months despite her remaining on Sertraline 50mg.[184]

On **27 July 2004** she was seen by a Psychiatrist who noted that she had a nine-year history of anxiety and depression, and that she reported a family history of depression.

In **September 2009** Ms. X stopped taking antidepressant medication on finding that she was pregnant.[185]

179. DPT Root Cause Analysis Investigation Report page 2
180. Serious Case Review Overview Report, paragraph 4.8
181. GP notes pages 51-52
182. GP notes page 26
183. GP notes page 26
184. GP notes page 23
185. DPT notes page 204, GP notes page 70

Ms. X's symptoms of depression re-emerged during her pregnancy, after she stopped taking her antidepressant medication. She was seen by a range of health professionals and mental health professionals during her pregnancy who were in agreement that she was suffering from depression. On **26 January 2010** Ms. X was prescribed antidepressant medication again.[186] [187] On **12 February 2010** this was increased as her symptoms were worsening.[188] On **19 February 2010** GP 1 described her depression as *"marked"* when referring her to the Mental Wellbeing and Access Team for an urgent assessment. He was concerned that she was in a poor state to care for a new born baby.[189] Her mental state continued to deteriorate throughout her pregnancy. For example, on **26 March 2010,** Senior Mental Health Practitioner 1 realised that there had been a significant deterioration in Ms. X's mental state since she was assessed by Consultant Psychiatrist 1 and Clinical Team Leader 1 on 25 February 2010.[190]

During her pregnancy Ms. X requested that her history of depression was not made known to her family preferring it be thought of as antenatal depression.

On **24 February 2010** Ms. X was seen by Health Visitor 1 and requested that her history of depression was not discussed while her husband was present.[191] [192]

On **25 February 2010** Ms. X met with Consultant Psychiatrist 1, and Clinical Team Leader 1 from the Mental Wellbeing and Access Team. It was noted that although Ms. X had a ten-year history of depression and anxiety she did not want people to know about her history of depression and preferred this episode to be considered to be antenatal depression. She reported that she disliked not being able to hide this episode of depression from her family.[193]

On **6 April 2010** Ms. X told the Care Coordinator that she did not want her family involved in her care or for information to be shared with her family.[194]

On **19 April 2010**, Ms. X told 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.[195]

186. GP notes page 71
187. Witness Statement
188. GP notes page 71
189. Witness Statement
190. DPT notes pages 213 and 215
191. GP notes page 70
192. Witness Statement
193.DPT notes pages 206-7
194. Witness Statement

Despite a brief period of elation after Baby Y was born on **10 April 2010**, Ms. X's symptoms of depression continued postnatally and worsened. For example, on **16 April 2010** her mother raised *"serious concerns"* with Health Visitor 1 about Ms. X's mental state.[196]

On **19 April 2010** Ms. X's mother informed the Care Coordinator that Ms. X was punching and smashing things in the house and that she was not bonding with the baby.[197] On the same day Ms. X reported to GP 2 that her symptoms had worsened since the arrival of the baby.

A Mental Health Act assessment of Ms. X was carried out after the death of Baby Y on **20 April 2010.** Ms. X said that she had felt very happy when the baby was born but panicky afterwards. She said that the baby did not feel like hers; she said that she did not want the baby to die. Ms. X reported having heard voices around the time of having a nap, but that there was no psychotic motivation and there was no evidence of psychotic symptoms. Ms. X described having felt numb for the past few weeks, unable to think clearly, with her head not working properly. She said that she felt like she could not do anything. Ms. X admitted that she had stopped taking Sertraline before the birth of Baby Y, but was uncertain about when and how, and had not discussed this decision with anyone. The assessment concluded that she was at high risk of suicide, and that she had severe depression.[198]

Prior to her pregnancy, Ms. X had been diagnosed with depression, depression and anxiety and recurrent depression. Her symptoms of depression re-emerged during her pregnancy after she stopped taking her antidepressant medication. After the birth of Baby Y her new GP, GP 2, diagnosed her with severe postnatal depression, but her history of depression prior to pregnancy was not known to GP 2. On the day that Baby Y died Ms. X was assessed as suffering from severe depression. The Independent Investigation was informed by the Psychiatrist caring for Ms. X after the death of Baby Y that at the time she met the criteria for a diagnosis of puerperal psychosis.

The following symptoms were noted by the professionals involved in her care prior to and during her pregnancy:

- low mood;

195. Witness Statement
196. DPT notes page 420
197. Witness Statement
198. DPT notes pages 385 to 388, 394 to 408

- flat or numb affect;
- being slowed down;
- reduced appetite;
- little interest in things;
- difficulty in carrying out activities of daily living;
- anxiety;
- nihilistic thinking;
- higher than average prediction of a negative outcome to her pregnancy;
- hinting at odd beliefs;
- inability to think straight;
- difficulty in getting out of bed;
- history of one overdose of medication.

After the birth of Baby Y, when her mental state deteriorated further, she was also noted to be:

- punching and smashing things in the house;
- not bonding with the baby;
- frustrated;
- angry;
- 'paranoid' that her husband would leave her.

On the day of the death of Baby Y it was noted that she was experiencing the additional symptoms of:

- feeling that the baby was not hers;
- having heard voices around the time of a nap.

12.4.3. Conclusions

It is not the role of an Independent Investigation to adjudicate on the 'true' diagnosis but rather to identify whether good practice was followed in the assessment of an individual's mental health problems and the subsequent diagnosis and formulation of his or her difficulties.

Diagnosis is not an end in itself but rather an element in understanding an individual's problems and needs. This understanding should lead to focused, evidence based, effective interventions. This drawing together of disparate phenomena into a common framework is commonly known as a formulation. It is this common understanding that needs to be shared by all those providing care and treatment so that interventions are coherent and have the maximum chance of being effective.

The Independent Investigation concurs with the diagnosis of Recurrent Depressive Disorder, which is consistent with her symptoms and history.

The Independent Investigation noted that her symptoms of depression worsened during her pregnancy and particularly in the last trimester of her pregnancy. After one day of feeling elated postpartum, her symptoms of depression returned and deteriorated further. As her mental state deteriorated there were some suggestions of psychotic symptoms and the Independent Investigation understands that although these were not evident to a degree consistent with a diagnosis of a psychotic disorder on the day of the death of Baby Y, further deterioration after that time led to her symptoms meeting the criteria for Postpartum Psychosis.

Whilst the professionals involved in the care and treatment of Ms. X were, in the main, aware of her history of depression prior to pregnancy and, over time, increasingly concerned about the deterioration of her mental state, the Independent Investigation found that the likely impact of her deteriorating mental health on her ability to care for her baby, and the impact of the birth of her baby on her mental health, were not given priority.

The Independent Investigation is in agreement with the conclusion of the Individual Management Review for Devon Partnership NHS Trust regarding Ms. X's initial assessment with the mental health services of DPT:
"There is no mention of how the depression might affect her unborn baby but there is mention of a referral to the Depression and Anxiety Service".[199]

199. Individual Management Review, DPT, page 9

The Independent Investigation is in agreement with the Devon Partnership NHS Trust Root Cause Analysis Investigation Report which found Influencing Factors to be:
"Assessment by mental health services which did not adequately reflect the context of pregnancy." and "*An underestimation of the level of depression by mental health services".*[200]

At the time of her referral to the mental health services, GP 1 expressed concern that her mental state would have an impact on her ability to care for her baby once born. However, this did not lead to the mental health service staff developing a robust multi-agency plan for the care of Ms. X and Baby Y in the perinatal period.

If the context of her pregnancy had been given emphasis when Ms. X's deteriorating symptoms of depression were assessed by the mental health service, this might have led to the consideration of the likely course of her depression after delivery and its possible impact on the wellbeing of Baby Y. This in turn may have prompted mental health professionals to consider the potential risks to Baby Y and to develop a robust multi-agency plan for the care of Ms. X and her baby at the time of the birth and postpartum. The Independent Investigation considers the lack of emphasis placed on the context of Ms. X's pregnancy in the consideration of her mental state to have contributed to the death of Baby Y.

The Independent Investigation found that prior to the birth of her baby Ms. X was reluctant for her family to be made aware of her diagnosis of recurrent depression, preferring her symptoms to be considered those of antenatal depression. She was initially reluctant for the midwifery service to be made aware of her history of depression but this appeared to change once her mental state deteriorated. A clinical witness informed us that she disclosed her history of depression to the midwife initially caring for her during labour and asked for this not to be discussed, presumably because her husband and mother-in-law were present.[201] There appears to have been an interpretation of her resistance to engage as being driven by shame and embarrassment, without acknowledging the impact of depression on her thinking, that is to say, an increasingly negative outlook and negative interpretation of the world and events around her. Although it cannot be concluded that the family's knowledge of Ms. X's diagnosis would have prevented the death of Baby Y, there is no evidence that the

200. DPT Root Cause Analysis Investigation Report page 2
201. Witness Statement

professionals involved in her care considered whether her husband had the right to know her diagnosis given its potential impact on the well being of his child or discussed with Ms. X the sharing of this information with her husband.

The NICE guidelines recommend that at her booking visit with the antenatal services a woman's history of mental health problems and any current symptoms should be discussed. The midwife caring for Ms. X asked these questions at the booking appointment but was informed by Ms. X that she did not have a diagnosis or history of mental health problems or any current symptoms. The midwife was at this stage reliant upon Ms. X's account of her history and did not have any collaborating information. The Internal Investigation is in agreement with the Serious Case Review that had there been a formal referral from the GP to the midwifery service it is more likely that information about the mother's mental health would have been shared. Although it cannot be concluded that this would have prevented the death of Baby Y, it was a missed opportunity for information sharing between professionals which may have alerted the midwifery service from an early stage to the potential vulnerability of this mother.

The NICE guidelines state that the impact or potential impact of a mother's mental health problems and their treatment on the unborn or neonatal child should be discussed with the mother at each stage. GP 1 discussed the use of Sertraline during pregnancy with Ms. X on 22 January 2010 and again when it was recommenced on 26 January 2010. There is no evidence that there was further discussion about the potential impact of her mental health problems and their treatment on the wellbeing of her child, even when she was apparently not responding to the medication she said she was taking, or when she was breastfeeding.

12.4.4. Service Issues and Contributory Factors

- ***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.***

12. 5. The Mental Health Act (1983 & 2007) and the Mental Capacity Act (2005)

12.5.1. Context

The Department of Health summarises the Mental Health Act as follows:
"1. The main purpose of the Mental Health Act 1983 is to allow compulsory action to be taken, where necessary, to make sure that people with mental disorders get the care and treatment they need for their own health or safety, or for the protection of other people. It sets out the criteria that must be met before compulsory measures can be taken, along with protections and safeguards for patients.

2. Part 2 of the Act sets out the civil procedures under which people can be detained in hospital for assessment or treatment of mental disorder. Detention under these procedures normally requires a formal application by either an Approved Mental Health Professional (AMHP) [Formerly an Approved Social Worker, ASW] or the patient's nearest relative, as described in the Act. An application is founded on two medical recommendations made by two qualified medical practitioners, one of whom must be approved for the purpose under the Act. Different procedures apply in the case of emergencies….

Part 3 of the Act concerns the criminal justice system. It provides powers for Crown or Magistrates' Courts to remand an accused person to hospital either for treatment or a report on their mental disorder. It also provides powers for a Court to make a hospital order…for the detention in hospital of a person convicted of an offence who requires treatment and care".

The goal of the Act then is to ensure that people with a "mental disorder" receive assessment and treatment.

Applications to detain a person in hospital to assess or treat their mental disorder are normally made under Section 2 (often referred to as an assessment section) or Section 3 (often referred to as a treatment section) of the Act. Remand and sentenced prisoners may also be detained and transferred to hospital under Part 3 of the Act.

The Mental Health Act was substantially amended in 2007 changing the way 'Mental Disorder' is defined, making it mandatory that if a patient is detained then "appropriate treatment" must be available and a hospital bed must be identified. The amendments also introduced new legal frameworks including Supervised Community Treatment.

The Mental Capacity Act (2005)[202] provides the legal framework for acting and making decisions on behalf of individuals who lack the mental capacity to make particular decisions for themselves. It assumes that adults, defined as aged 16 years or older, have full legal capacity to make decisions for themselves unless it can be shown that they lack capacity to make a decision for themselves at the time the decision needs to be made.

The Mental Capacity Act (2005) defines a two-stage test of capacity:

1) Does the person have an impairment of the mind or brain, or is there some sort of disturbance affecting the way their mind or brain works?
2) If so, does the impairment or disturbance mean that the person is unable to make the decision in question at the time it needs to be made?

The ability to make a decision is assessed in the following way:

- Does the person have a general understanding of what decision they need to make and why they need to make it?
- Does the person have a general understanding of the likely consequences of making, or not making, this decision?
- Is the person able to understand, retain, use and weigh up the information relevant to this decision?

202. Mental Capacity Act 2005 Code of Practice, 2007, London: TSO

- Can the person communicate their decision? Would the services of a professional be helpful?

12.5.2. Findings

Findings of the Internal Investigation/SCR

The Serious Case Review made the following comment:

"Equally, at no time during the period of review, was there consideration by practitioners that the mother's mental capacity was sufficiently impaired to override her wishes. The Mental Capacity Act 2005 has as its first principle that capacity is presumed and use of the Act would normally only apply in more extreme circumstances than pertain in this case. However the best interests of the unborn baby were not given consideration, had they been, there may possibly have been indications for an assessment of the mother's capacity, especially when her depression became more severe. However as the practitioners did not consider that the primary and first-line 'safeguarding' threshold for information sharing without consent had been reached and then did not assertively pursue with the mother the need to share information with family members or other practitioners, it is unlikely that they would have considered the more extreme and intrusive course of action implied by use of the Mental Capacity Act to address the issue." (5.3.5.)

Findings of the Independent Investigation

There is no indication that during the period of care and treatment under investigation that the Mental Health Act or Mental Capacity Act were considered to be relevant until Ms. X was assessed in Police custody after the death of Baby Y.

On **20 April 2010** a Mental Health Act assessment of Ms. X was carried out at Torbay Police Station. The assessment concluded that she was at high risk of suicide, and that she had severe depression. She therefore fulfilled the eligibility criteria for detention under the Mental Health Act, that is, she had a mental disorder (depression) and she was a risk to herself and others. The next issue to be considered was the availability of appropriate treatment and a hospital bed. The decision was made not to detain her under the Mental Health Act. On the advice of a forensic psychiatry colleague a decision was taken that she should remain in the Criminal Justice system so that she could be detained under Section 48 of the Mental Health Act (which allows for the transfer to hospital of a remanded prisoner who is suffering from a mental disorder) and diverted to a secure women's facility where she could access the

appropriate care.[203] No efforts appear to have been made to contact commissioners regarding the possibility of finding such a bed immediately. It should be noted that secure women's services will take women who are detained under civil sections, such as Section 3 of the Mental Health Act, and detention under a civil section does not necessarily interfere with the criminal justice process.

12.5.3. Conclusions

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 had a history of a serious suicide attempt. 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 Senior Mental Health Practitioner Care Coordinator on 19 April 2010 after saying that *"things were not very well"*.

The Independent Investigation is in agreement with the Serious Case Review that, 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

203. DPT notes pages 385 to 388, 394 to 408

treatment facility. This decision was taken on the advice of a colleague who worked in forensic psychiatry. This meant that Ms. X then appeared at Torbay Magistrate Court on 21 April 2010, was remanded to the hospital wing of Eastwood Park Prison until she was assessed for admission to a medium secure unit on 26 April 2010 and transferred there on 28 April 2010 on Section 48/49 having spent a week on remand in prison. Section 48/49 allows a prisoner with a serious mental health problem who is waiting to be tried to be transferred to a hospital for treatment with the restriction that he or she cannot be discharged from hospital without the permission of the secretary of state.

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.

12.5.4. Service Issues or Contributory Factors

- ***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.***

12. 6. Treatment: Medication and Psychological Therapy

12.6.1. Context

The treatment of any major mental health problem is normally multi-facetted employing a combination of treatments: psychological (for example cognitive behaviour therapy,

supportive counselling, and family therapy), psychosocial (problem solving, mental health awareness, psycho education, social skills training, family interventions), pharmacological (medication), community support, vocational rehabilitation and inpatient care. The treatment of any individual should be based on a sound assessment leading to an understanding of his/her problems and needs. Treatment should be delivered as part of a unique care/treatment plan drawn up in collaboration with the service user.

12.6.2. Medication

12.6.2.1. Context

Psychotropic medications (medication capable of affecting the mind, emotions and behaviour) fall into a number of broad groups: antidepressants, antipsychotics, anxiolytics (antianxiety medication) and mood stabilisers. Treatment of a depressive disorder with an antidepressant medication is regarded as appropriate. Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and/or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders. In prescribing medication there are a number of factors that the doctor must bear in mind, including consent to treatment, risk, compliance, previous response to medication, monitoring and side effects.

Wherever practicable, consent for treatment should be obtained from the patient. Consent is defined as "*the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent".*[204] However, in some situations the patient may be incapable of giving informed consent because of the nature of their psychiatric disorder.

In addition to the issue of informed consent, the patient's ability to comply with recommended medications can be influenced by a number of factors such as his or her level of insight, his or her commitment to treatment and his or her level of personal organisation that is to say do they remember to take their tablets at the prescribed time. All medication prescribed and administered should be monitored for effectiveness and also side effects. Side

204. Department of Health (2008) Code of Practice, Mental Health Act (1983)

effects can be managed by changing dosage, changing to a different type of antidepressant medication or by prescribing specific medication to address the side effects.

When treating a depressive episode the clinician will also take into account the level of risk posed to the individual by the medication. One of the presenting features of an individual's symptoms of depression may be the risk to the individual's life through suicide and/or self harm. A number of antidepressants, whilst clinically effective if taken for an appropriate period of time at an appropriate dose, can pose a significant risk to life if taken in overdose. If the risk to life is judged present, clinicians may be more inclined to prescribe medications which are less toxic in overdose, and/or make arrangements to ensure that the medication is managed by someone other than the patient themselves. In Ms. X's case, the antidepressant Sertraline was prescribed. This is a type of antidepressant known as a Selective Serotonin Re-uptake Inhibitor (SSRI). SSRIs are sometimes referred to as the newer generation of antidepressants and are considered to be relatively safe in overdose.

The National Institute for Health and Clinical Excellence (NICE) offers guidance for the treatment of women suffering from depression while they are pregnant or breastfeeding. NICE Clinical Guidance 45 was issued in February 2007 and reissued in April 2007 and so was available during the period of care and treatment of Ms. X under investigation.[205] It makes the following recommendations regarding medication:

"When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that:

- *tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants*
- *most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs)*
- *fluoxetine is the SSRI with the lowest known risk during pregnancy*
- *imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels*
- *citalopram and fluoxetine are present in breast milk at relatively high levels*

205. NICE Clinical Guidance 45, 2007, Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance

- *SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate*
- *paroxetine taken in the first trimester may be associated with foetal heart defects*
- *venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal*
- *all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting."* (Page 8)

The guidance also makes it clear that the decision about medication should be made collaboratively with the woman and be part of a written care plan, which covers the pregnancy, delivery and postnatal period.

12.6.2.2. Findings of the Internal Investigation/SCR

The Individual Management Review carried out by Devon Partnership NHS Trust in October 2010 noted that GP 1 did not refer Ms. X to the mental health service until 19 February 2010 when she was 32 weeks pregnant and appeared not to be responding to Sertraline which she had recommenced on 26 January 2010, and which had been increased on 12 February 2010. It was concluded that GP 1 should have referred Ms. X to the mental health services when her pregnancy was first known to him in order that the mental health service could monitor her mental state and review her medication in the context of her pregnancy and the potential risks to both the mother and the child.

The Root Cause Analysis completed by Devon Partnership NHS Trust in November 2010 came to the following conclusions regarding the medication of Ms. X.

"If psychotropic medication is discontinued, or reduced, as the result of pregnancy, proactive arrangements for monitoring should be put in place which should include communication with other health professionals involved and contingency planning".[206]

and

"Medication prescribed often does not correlate with medication taken, particularly in relation to psychotropic medication, clinicians should be mindful of this, avoid closed questions and use exploratory approaches when discussing concordance with medication prescribed".[207]

206. DPT Root Cause Analysis Investigation Report, page 2
207. Root Cause Analysis Investigation Report, page 2

The Serious Case Review noted:
"It appears that there was no detailed discussion at the time that the pregnancy was diagnosed with the GP about the continuation or otherwise of the medication; the mother pre-empted this decision by stopping the medication herself. The mother had been treated with antidepressant medication for several years and her mental health had apparently been stable. The discontinuation of the medication may have had, and in hindsight did have, a detrimental effect on the mother's mental health which deteriorated during the course of the pregnancy. A more measured approach to the decision, with more clinical involvement would have been preferable. If a clinical network and pathway for the management of perinatal mental health had been in place there would have been the opportunity for a more planned and systematic approach to the mother's care".

12.6.2.3. Findings of the Independent Investigation

Ms. X was first prescribed psychotropic medication, in the form of Sertraline, in June 1998. She responded well to this medication, requiring it to be increased at times of stress, and relapsing when she came off her medication in 2002.

On 2 September 2009 she was seen at her GP surgery because she was pregnant. The GP, who was not her usual GP, carried out a urine pregnancy test, referred her to the midwife and noted *"will wean off Sertraline"*. [208] She was seen by her usual GP, GP 1 on 30 September 2009 who noted that she had stopped taking Sertraline when she became pregnant. She saw GP 1 again on 22 January 2010 with a recurrence of her depressive symptoms. They had a discussion about restarting her Sertraline, the GP gave her some information leaflets, developed the plan that she should *"hang on"* without taking Sertraline because of the risks in pregnancy but that she should return to see him if need be and consider taking Sertraline at a low dose. On 26 January 2010 Ms. X consulted GP 1 again with worsening symptoms and the decision was made to restart the Sertraline at 50mg. This was increased to 100mg (the dose she had been maintained on prior to becoming pregnant) on the 12 February 2010.

On 19 February 2010 GP 1 referred Ms. X to the Mental Wellbeing and Access Team for urgent help because of her marked depression. GP 1 noted that in the past she had responded well to Sertraline, but that this was not currently the case. On 25 February 2010 Ms. X told

208. GP notes, page 73

Midwife 2 that she did not feel that her medication was effective yet. On 15 March 2010 the Consultant Obstetrician and Gynaecologist noted that Sertraline had not helped her mood. When assessed in custody on 20 April 2010 Ms. X said that she had stopped taking Sertraline prior to the birth of Baby Y and had not discussed this decision with anyone.

12.6.2.4. Conclusions

The Independent Investigation agrees that the treatment with an antidepressant medication was appropriate for Ms. X's Recurrent Depressive Disorder. The Independent Investigation concluded that Sertraline, an SSRI, was an appropriate choice of medication, given that Ms. X had a history of overdose, and that she had responded well to this medication in the past.

The Independent Investigation agrees that it was appropriate to consider whether Ms. X should continue to take Sertraline when she found that she was pregnant, given the possible risks to the unborn child from the medication. Unfortunately the colleague of GP 1, who saw her on 2 September 2009 did not record any discussion which may or may not have taken place about the possibility of relapse if she came off Sertraline, the 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. Neither is there any record that such a discussion took place when she was seen by GP 1 on 30 September 2009 and her repeat prescription was deleted. This would have been an appropriate point in time to hold such a discussion, while Ms. X's mental state was good, whilst she was in an early stage of pregnancy, and whilst there was time to consider an appropriate plan of action should her mental state deteriorate, and to put in place a plan for monitoring her mental state, such as by regular appointments with the GP or through collaboration with the midwife.

It is documented that GP 1 did hold a discussion with Ms. X about the pros and cons of medication on 22 January 2010 and 26 January 2010 when her mental state had deteriorated. Her medication was not re-started on 22 January 2010, but was on 26 January 2010, presumably when Ms. X had had time to consider the potential risks to her child from the medication and the risks of remaining without medication. The Independent Investigation considers that this was an example of a positive collaboration between GP 1 and Ms. X and is in agreement that the decision to recommence Sertraline at this point was appropriate. Her medication was started at a dose of 50mg, which is usual practice. It was increased to 100 mg on 12 February 2010, the dose which was previously effective for Ms. X, because there was

further deterioration of her mental state. She was seen again by GP 1 on 18 February 2010 when there had been further deterioration to her mental state and it was agreed between GP 1, Ms. X and her husband that she should be referred to the mental health service.

It is unclear why Ms. X did not respond to her usual dose of Sertraline. Ms. X admitted that she stopped taking the Sertraline at some point prior to the birth of Baby Y. Given that her medication was only recommenced when she was about 28 weeks pregnant, it is unlikely that she took the medication for long before stopping. It seems likely that she stopped taking the Sertraline because she was concerned about its effects upon her unborn child. One might speculate that, prior to stopping, she was not taking the medication consistently, if indeed she was taking it at all, and that this was the reason why she did not respond as she had in the past.

The NICE guidance states that there are some risks to the unborn child if the mother takes antidepressant medication in general and Sertraline in particular:
"SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate".
and
"all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting".[209]

Although GP 1 had some discussion with Ms. X about the use of Sertraline in pregnancy when her mental state had deteriorated, there is no other evidence that the pros and cons of taking medication during pregnancy were discussed with Ms. X by the professionals involved in her care and treatment during the course of her pregnancy. Neither is there any evidence that there were discussions about the impact of Sertraline on breastfeeding either during her pregnancy or after the birth of Baby Y, other than in a visit made by Health Visitor 1 on 16 April 2010.[210] The NICE guidelines state that *"imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels"* and indicate that discussion should be held with the mother about levels of medication which are compatible with breastfeeding as well as consideration of other forms of feeding.[211]

209. NICE clinical guidelines 45 page 8
210. Witness Statement
211. NICE clinical guideline 45 page 20

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.

The lack of ongoing discussion with Ms. X about the management of her medication from the outset of her pregnancy and after the birth of her child, and the lack of a coordinated plan about the management of her medication during this period including the monitoring of her mental state and the response that should be made to any deterioration of the same, meant that there was a considerable deterioration in her mental state before medication was recommenced in February 2010, and that the professionals involved in her care were unaware that she had stopped taking the medication at the end of her pregnancy. It seems likely that this lack of open and on-going discussion about the appropriate treatment for her during this time period, and the lack of a coordinated plan concerning the management of her medication, contributed to Ms. X's secrecy about her decision to stop taking the medication prior to the birth of Baby Y.

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.

12.6.2.5. Service Issues and 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.***

12.6.3. Psychological Therapy

12.6.3.1. Context.

The NICE Clinical Guidelines on the treatment of depression comments:

"A range of psychological and psychosocial interventions for depression have been shown to relieve the symptoms of the condition and there is growing evidence that psychosocial and psychological therapies can help people recover from depression in the longer-term (NICE, 2004a)…People with depression typically prefer psychological and psychosocial treatments to medication (Prins et al., 2008) and value outcomes beyond symptom reduction that include positive mental health and a return to usual functioning (Zimmerman et al., 2006)".[212]

The guidance recommends:

"8.11.3.2. For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT)

212. NICE (2009) *Depression; Treatment and management of depression in adults, including adults with chronic pain.* CG 90 page 157

8.11.3.3. The choice of intervention should be influenced by the:

- *duration of the episode of depression and the trajectory of symptoms;*
- *previous course of depression and response to treatment;*
- *likelihood of adherence to treatment and any potential adverse effects;*
- *person's treatment preference and priorities."*[213]

NICE Clinical Guideline 45 offers guidance on the treatment of pregnant women with depression. In general it comments:

"The risks associated with antidepressant treatment during pregnancy and breastfeeding lower the threshold for psychological treatments. In addition, risks are better established in older drugs and a cautious approach would be to avoid newer drugs".[214]

Where a woman has a history of depression and is being treated for depression prior to becoming pregnant it states:

"1.4.8.1. If a woman being treated for mild depression is taking an antidepressant, the medication should be withdrawn gradually and monitoring ('watchful waiting') considered. If intervention is then needed the following should be considered:

- *self-help approaches (guided self-help, computerised CBT [C-CBT], exercise)*

or

- *brief psychological treatments (including counselling, CBT and IPT).*

1.4.8.2. If a woman is taking an antidepressant and her latest presentation was a moderate depressive episode, the following options should be discussed with the woman, taking into account previous response to treatment, her preference, and risk:

- *switching to psychological therapy (CBT or IPT)*
- *switching to an antidepressant with lower risk.*

1.4.8.3. If a woman is taking an antidepressant and her latest presentation was a severe depressive episode, the following options should be discussed with the woman, taking into account previous response to treatment, her preference, and risk:

213. Ibid page 298
214. NICE clinical guideline 45 page 27

- *combining drug treatment with psychological treatment, but switching to an antidepressant with lower risk*
- *switching to psychological treatment (CBT or IPT)".*[215]

12.6.3.2. Finding of the Internal Investigation/SCR

No specific comments or recommendations were made by the either the Root Cause Analysis or the Serious Case Review concerning Psychological Therapy.

12.6.3.3. Findings of the Independent Investigation

Prior to the period of care and treatment under current investigation, Ms. X had not engaged with opportunities for psychological treatment of her depression.

On 24 March 2000 a Community Psychiatric Nurse (CPN) from the Dorchester Community Mental Health Team wrote to Ms. X's GP. She explained that Ms. X had attended one appointment with her and had been given a Cognitive Behaviour Therapy (CBT) diary which she had kept for a while, but that Ms. X had then cancelled her appointment with the CPN and had then said that she did not want any further contact with the Community Mental Health Team.[216]

On 20 September 2002 Ms. X visited her GP because she was feeling depressed again after coming off Sertraline. She was prescribed Sertraline 50mg and was offered counselling which she declined.[217]

During the period of care and treatment under investigation the following references to psychological treatment are found.

On 18 January 2010 Ms. X was seen at her GP surgery by the Nurse Practitioner.[218] The Nurse Practitioner made an appointment for Ms. X to see GP 1 later that same week and referred her for *"guided self help for depression".*[219]

On 26 January 2010 Ms. X returned to see GP 1 feeling that her condition had worsened and she was no longer able to think straight. They agreed that she should start taking Sertraline

215. NICE clinical guideline 45 pages 27-28
216. GP notes page 87
217. GP notes page 26
218. GP notes page 72
219. GP notes page 72

50mg. GP 1 also referred her to the Health Visitor for supportive counselling and so that they could establish a relationship prior to her postnatal care.[220] [221] She saw Health Visitor 1 on three occasions prior to the birth of Baby Y (on 12 February 2010, 24 February 2010 and 10 March 2010) and on one occasion after his birth on 16 April 2010 prior to the handover to another team.

On 25 February 2010 Ms. X met with Consultant Psychiatrist 1, and Clinical Team Leader 1 from the Mental Wellbeing and Access Team. The treatment plan was developed that included immediate referral to the Senior Mental Health Worker at her GP surgery for support, to help her to look at things in a different way and to de-stigmatise her illness. She was also referred to the Depression and Anxiety Service for *"further work in the future"* after her child was born. She was given some websites to look at including a computer guided self help for depression course.[222]

On 10 March 2010 Ms. X was seen for a planned appointment with Health Visitor 1 at the GP Surgery. She had not yet been seen by the Mental Wellbeing and Access Team. Health Visitor 1 phoned Senior Mental Health Practitioner 1 and the urgency of assessment prior to the birth was stressed.[223] Health Visitor 1 discussed Ms. X with GP 1 because she was concerned that she had not been given an appointment for a mental health assessment and the possibility of private counselling in the interim was discussed. Health Visitor 1 left details of a counselling service on the answer phone of the family. An appointment with Health Visitor 1 was offered for two weeks time, but cancelled by Ms. X.[224]

On 26 March 2010 Senior Mental Health Practitioner 1 from the Mental Wellbeing and Access Team, met with Ms. X for the first and only time. She noted that Ms. X was reluctant to be associated with the mental health service. On 29 March 2010 Senior Mental Health Practitioner 1 made an urgent referral to the Recovery and Independent Living Team, stating that Ms. X was now 37 weeks pregnant. It was decided that Ms. X should be referred to the Recovery and Independent Living Team because she required an enhanced level of care, and that the referral should be urgent because of her imminent delivery date.[225]

220. GP notes page 71
221.Witness Statement
222. DPT notes pages 206-7
223.Witness Statement
224. Witness Statement
225. Witness Statement

On 29 March 2010 the referral was received by the Recovery and Independent Living Team and she was allocated to the Care Coordinator.[226]

On 6 April 2010 the Care Coordinator saw Ms. X at Waverley House, as Ms. X declined a home visit.[227] She was given a further appointment for 20 April 2010. Ms. X did not wish to be seen sooner because of the imminent birth. The Care Coordinator sent an urgent referral for a psychological therapy assessment and *"liaised with the community midwife team and planned to offer Ms. X an urgent medical review as soon as the baby had been born"*.[228] 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.[229]

12.6.3.4. Conclusions

Prior to her pregnancy, Ms. X had proved difficult to engage in any services or treatment of her depression other than medication prescribed by her GP.

When her mental health began to deteriorate during her pregnancy in January 2010, she was referred for *"guided self help for depression"* by the Nurse Practitioner. Later in January 2010, after further deterioration in her mental health she was referred by GP 1 for supportive counselling from Health Visitor 1.

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. Where the previous episode was mild, and medication was withdrawn in pregnancy, then the woman's mental state should be monitored and she should be offered guided self-help or brief psychological therapy where necessary. Where the previous episode of depression has been moderate then at the outset she should be offered the option of switching from medication to psychological therapy or switching to an antidepressant with a lower risk to the unborn child. Where the previous episode had been severe, then at the outset of pregnancy the woman should be offered medication in addition to psychological therapy.

226. Witness Statement
227. Witness Statement
228. Witness Statement
229. Root Cause Analysis Investigation Report, 19 November 2010, page 20

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. It is of course possible, given her history of poor engagement with mental health services, that she would not have agreed to participate in such therapy, but it is also possible that, as a pregnant woman, she might have considered this a safe alternative to medication at the outset of her pregnancy and as able to make a contribution to reducing her known risk of relapse when off Sertraline. Patients can be referred directly to the Depression and Anxiety Service by the GP.[230] This was a missed opportunity.

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. In January 2010 GP 1 offered Ms. X supportive counselling from Health Visitor 1 at the same time as recommencing Sertraline. Whilst early engagement with the Health Visitor was good practice, Ms. X's history of depression indicated that cognitive behaviour therapy from an experienced Clinical Psychologist would have been the treatment of choice, rather than supportive counselling. Whilst it is possible that Ms. X would not have engaged with psychological therapy at this point, and that she was willing to see the Health Visitor because this was related to her pregnancy rather than her depression, this was a missed opportunity to engage her in a therapy which might have contributed to her mental wellbeing.

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. In the meantime she was given some websites to look at including a computer guided self help for depression course.[231] Whilst Ms. X may have been reluctant to

230. Operational Policy, Depression and Anxiety Service, DPT
231. DPT notes pages 206-7

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.[232]

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.[233] 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.

With regard to the establishment of therapeutic relationships in general with the staff involved in her care and treatment, the Independent Investigation concluded that this opportunity was largely lacking.

After referral to the mental health services, Ms. X was seen once for an assessment by the Mental Wellbeing and Access Team, seen once by Senior Mental Health Practitioner 1 of the Mental Wellbeing and Access Team, and seen once by the Care Coordinator from the Recovery and Independent Living Team over a period of about two months. She did not have the opportunity to establish a therapeutic relationship with any individual from the mental health service, who provided little other than a series of assessments of her mental state. Although she was referred to the Depression and Anxiety Service, she was not seen by them. Partly as a result of her move from one GP practice to another soon after the birth of her baby, Ms. X was seen by three different midwives prior to delivery, by further staff unfamiliar to her whilst in hospital, and by three further midwifery team members after the birth compounding the fact that no member of staff saw her consistently throughout her pregnancy and after the delivery of her baby.

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

232. Operational Policy, Depression and Anxiety Service, DPT
233. Root Cause Analysis Investigation Report, 19 November 2010, page 20

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 provided to her.

12.6.3.5. Service Issues and 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.***

12.7. Safeguarding

12.7.1. Context

National Context

The primary legislation relating to child protection is set out in the Children Act 1989. This requires that children should be protected from significant harm or the likelihood of significant harm. The responsibilities of local agencies – including all NHS agencies – in relation to the protection of children is further clarified in Section 11 of the Children Act 2004 which imposes a duty to safeguard on key agencies. The Children Act (2004) stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place. *Working Together to Safeguard Children* further sets out the national policy and procedural requirements for safeguarding and for child protection.[234]

All Local Authorities are required to have a Local Safeguarding Children Board (LSCB) the prime objective of which is to coordinate and ensure the effectiveness of their member agencies in safeguarding and promoting the welfare of children. The Devon Partnership NHS Trust is a core member of the LSCB. The Trust has the responsibility to assist the local authority in its work, to identify any children who are considered to be at risk of significant harm or likelihood of suffering significant harm and to work together with partner agencies to promote the safety and welfare of such children.

The national background to safeguarding has, since 2003, comprised the following documents and initiatives:

- Lord Laming's report (2003, Climbié Report) provided safeguarding recommendations and influenced the subsequent developments in safeguarding guidance and policy;
- *Every Child Matters* (2003), the Government's response to the Laming Report, outlined five key improvement outcomes – be healthy, stay safe, enjoy and achieve, make a positive contribution and achieve economic wellbeing;
- *National Service Framework for Children* (2004) included a recommendation for Care Programme Approach meetings to take account of children's needs and any risks of harm to them;

234. Every Child Matters, 2003; Children Act 2004 Section 11

- *Children Act* (2004) stated that all organisations have a responsibility to prioritise safeguarding and to ensure that effective arrangements are in place;
- *Working Together* (2006) and its revised version of 2010 established national policies and procedures for all organisations in relation to safeguarding arrangements.
- The *NPSA Rapid Response Report* (2009) alerted mental health organisations to the risk of harm to children by parents with mental health needs.[235]

The 2010 *Working Together* guidance requires that:[236]
"1.11. Effective measures to safeguard children are those that also promote their welfare. They should not be seen in isolation from the wider range of support and services already provided and available to meet the needs of children and families".

The 2006 *Working Together* guidance, which was in force when Ms. X was under the care of the Trust, comments:
"1.6. Shortcomings when working to safeguard and promote children's welfare were brought into the spotlight once again with the death of Victoria Climbié and the subsequent inquiry. The inquiry revealed themes identified by past inquiries that resulted in a failure to intervene early enough. These included:
poor coordination; a failure to share information; the absence of anyone with a strong sense of accountability; and frontline workers trying to cope with staff vacancies, poor management and a lack of effective training (Cm 5860, p.5)".

In addressing this problem the guidance emphasises the importance of shared responsibility and joint working:
"1.14. Safeguarding and promoting the welfare of children – and in particular protecting them from significant harm – depends on effective joint working between agencies and professionals that have different roles and expertise…".

"2.1. An awareness and appreciation of the role of others is essential for effective collaboration between organisations and their practitioners…".

235. National Patient Safety Authority, NPSA/2009/RRR003 Preventing harm to children from parents with mental health needs.
236. HM Government, Department for Children, Schools, and Families (2006 and 2010) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*

"2.2. …it is important to emphasise that we all share a responsibility for safeguarding and promoting the welfare of children and young people. All members of the community can help to safeguard and promote the welfare of children and young people, if they are mindful of children's needs and are willing and able to act if they have concerns about a child's welfare…".

The 2010 guidance elaborates on this:
"2.62. …Other health professionals who come into contact with children, parents and carers in the course of their work also need to be fully informed about their responsibility to safeguard and promote the welfare of children and young people. This is important as even though a health professional may not be working directly with a child, they may be seeing their parent, carer or other significant adult and have knowledge which is relevant to a child's safety and welfare...".

With respect to the responsibilities of mental health services and mental health practitioners the 2006 guidance states:
"2.92. Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area. Consultation, supervision and training resources should be available and accessible in each service…".

"2.94. Close collaboration and liaison between adult mental health services and children's social services are essential in the interests of children. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm".

The Laming Form
Following the Climbié Report NHS Mental Health Trusts were required to record whether

users of mental health services had regular contact with children. The requirement applied to:

- people on enhanced Care Programme Approach (CPA);
- people on standard CPA where assessment indicates a significant risk;
- anyone who is admitted to an inpatient unit;
- if a patient is regarded as a potential risk.

The form covers a wide range of potential triggers including:

- drug/alcohol abuse;
- domestic violence;
- forensic history;
- past history of severe mental illness;
- past history of sexual/physical abuse;
- serious self harm attempts;
- a child with a severe physical illness or learning disability in the family;
- unsettled family circumstances;
- any other circumstances where the assessing health or social care professional is concerned about the welfare of children in the family.

In May 2009 the National Patient Safety Agency issued advice to all NHS agencies and set out clear expectations for the assessment of people with mental health problems who were parents or parents-to-be:

"Referral should be made to children's social care services under local safeguarding procedures as soon as problems, suspicion or concern about a child becomes apparent, or if the child's own needs are not being met. A referral must be made:

a) If service users express delusional beliefs involving their child and/or

b) If service users might harm their child as part of a suicide plan".[237]

In order to realise the goals of promoting the wellbeing and safety of children and young people the Children Act 2004 places specific responsibilities on the Local Authority

"Section 10 [of the Children Act] requires each local authority to make arrangements to promote co-operation between the authority, each of the authority's relevant partners…and such other persons or bodies working with children in the local authority's area as the

237. National Patient Safety Agency, NPSA/2009/RRR003 Preventing harm to children from parents with mental health needs.

authority considers appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section of the Children Act 2004 is the legislative basis for children's trust arrangements".[238]

"Section 11 of the Children Act 2004, section 175 of the Education Act 2002 and section 55 of the Borders, Citizens and Immigration Act 2009 places duties on organisations and individuals to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children".

"The Children Act 1989 places a duty on local authorities to promote and safeguard the welfare of children in need in their area. Section 17(1) of the Children Act 1989 states that: It shall be the general duty of every local authority:

- *to safeguard and promote the welfare of children within their area who are in need; and*
- *so far as is consistent with that duty, to promote the upbringing of such children by their families, by providing a range and level of services appropriate to those children's needs.*

Section 17(10) states that a child shall be taken to be in need if:
a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Section 47(1) of the Children Act 1989 states that:
Where a local authority:
a. are informed that a child who lives, or is found, in their area (i) is the subject of an emergency protection order, or (ii) is in police protection, or (iii) has contravened a ban

238. HM Government, Dept for Children, Schools and Families (2006) *Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*

imposed by a curfew notice imposed within the meaning of Chapter I of Part I of the Crime and Disorder Act 1998; or

b. have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm:

The authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare…".[239]

Local Context

The NHS Devon Child Protection Policy, which came into force in February 2011, states:

"5.6 Staff should recognise the impact that parental ill health, for example, mental ill health, parental substance misuse, has on the welfare of children".

And

"All health professionals must always act in the best interests of the child whose welfare is of paramount importance. If you have concerns about the safety or welfare of a child, even if there is no firm evidence to substantiate child abuse or risk of significant harm, you must always do something even if that is sharing your concerns with a colleague who has greater knowledge and experience in relation to child protection".[240]

The Local Safeguarding Children Board's protocol *Working with Mothers and their Unborn Babies Where There are Concerns for the Welfare of the Unborn Child* in force from 2009 echoed the national guidance. It states:[241]

"All professionals working with families need to be alert to the factors that may indicate a potential risk to the child either before or after birth. It is vital that assessments are started early and that information is shared so that the child and family have the necessary support and best start to family life thereby minimising the need for child protection intervention".

It further states:

"Any professional who has concerns for the welfare of the unborn child must ensure that the midwifery service is aware of the concerns and that any relevant information is passed on in writing".

And

239. HM Government, Dept for Children, Schools and Families (2006) *Working Together to safeguard Children: A guide to interagency working to safeguard and promote the welfare of children*

240. NHS Devon Child Protection Policy Version V 2-2 paragraph 5.2

241. Working with Mothers and their Unborn Babies Where There are Concerns for the Welfare of the Unborn Child policy, 2009, pages 3 and 5

"If necessary a child protection conference will be held or a children in need plan must be in place as soon as possible but no later than by week 28 of pregnancy, unless there is a late referral when plans must be agreed as soon as possible following identification of concerns. Any assessment must include details of the mother's partner, wider social and family history and environmental factors (as can be found in the Common Assessment Framework) as well as the obstetric history".

12.7.2. Findings

Findings of the Internal Investigation/SCR

The Serious Case Review found:

"5.6.1.Throughout the review there is indication that there was little focus on the child by any of the practitioners involved. This is made more difficult when the child is unborn and practitioners are working directly with an individual with particular needs and demands".

and

"5.6.2. Had practitioners put the child at the centre of their thinking when making decisions about information sharing and inter-agency working they would have been more likely to have both shared information and to have planned interventions in a more systematic way. A greater focus on the needs of the child, rather than the mother, may have tipped the balance in favour of information sharing when practitioners were faced with the professional dilemma of breaching confidentiality. Practitioners would also have been more likely to use the available planning mechanisms, for example the NICE guidance and the SWCPP Unborn Baby Protocol, to support them in their provision of care to the mother. They would also have been more likely to have involved family members, in particular the father, who without doubt had a right to be more involved in decisions relating to his child".[242]

Findings of the Independent Investigation

During the pregnancy of Ms. X there were a number of Trusts involved in providing her care: Devon Partnership NHS Trust; the South Devon Healthcare Trust and Torbay Care Trust. Within these three Trusts, her care involved a range of teams: two GP practices; two community midwifery teams; the hospital midwifery and obstetric team; two mental health teams; and two health visiting teams. During the course of her pregnancy and the postnatal period Ms. X saw two GPs, at least seven different midwives/maternity care assistants, a

242. Working with Mothers and their Unborn Babies Where There are Concerns for the Welfare of the Unborn Child, 2009

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.

Despite the number and range of professionals involved in her care there is little evidence that her mental health problems and her treatment were considered in the context of her pregnancy, or in the context of her being a new, first-time and breast feeding mother.

None of the professionals involved in her care sought the advice of the Named Nurse for Safeguarding nor appeared to focus on the wellbeing of Baby Y. With the exception of GP 1 at the point of referral to the Mental Wellbeing and Access Team, there was little consideration given to the potential risks to Baby Y caused by his mother's deteriorating mental health prior to his birth.

When Ms. X was assessed by the Care Coordinator a few days before Baby Y was born, Ms. X was not considered to be a risk to herself or to the baby although it is unclear how this was assessed.[243] [244]

Some, but not sufficient, consideration was given to the well being of Baby Y after his birth: On **19 April 2010**, GP 2 saw Ms. X and came to the conclusion *"no immediate thought of self-harm but just wants to get away, no thoughts of harming baby. Sleep ok. No bonding at all with baby"*.[245]

12.7.3. Conclusions

The aim of safeguarding 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.[246] The 2006 and 2010 *Working Together to Safeguard Children* guidance identified a number of factors which inhibit child protection:

- 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;

243. SDHT notes page 163
244. Witness Statement
245. GP notes page 1
246. Every Child Matters, 2003; Section 11 of the Children Act 2004

- a lack of effective training.

These system failings have been echoed in recent studies of serious case reviews.[247]

A Failure to Share Information

During the pregnancy of Ms. X there were a number of Trusts involved in providing her care: Devon Partnership NHS Trust; the South Devon Healthcare Trust and Torbay Care Trust. Within these three Trusts, her care involved a range of teams: two GP practices; two community midwifery teams; the hospital midwifery and obstetric team; two mental health teams; and two health visiting teams. During the course of her pregnancy and the postnatal period Ms. X saw 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. The number of teams and individual members of staff involved in her care increased the necessity for good sharing of information between teams and between individual members of staff.

During the period of Ms. X's care and treatment there are some examples of individual members of staff communicating well with other people involved in her care prompted by their concern about the mental state of Ms. X:

- on 10 March 2010 Health Visitor 1 phoned the Mental Wellbeing and Access Service to stress the urgency of the referral and discussed her concerns with GP 1;
- on 16 April 2010 Health Visitor 1 handed over Ms. X's care to the health visitor from the new team in person, stressing her mental health concerns;
- on 11 February 2010 Midwife 1 spoke to GP 1 and Health Visitor 1 about her concerns;
- on 11 March 2010 Midwife 1 informed GP 1 and Health Visitor 1 about Ms. X's appointment with the Consultant Obstetrician and Gynaecologist;
- on 8 April 2010 Midwife 1 forwarded an interagency communication form to the Christie Team midwives who were to provide the postnatal care;
- on 19 February 2010 GP 1 wrote to and rang the Mental Wellbeing and Access Team stressing the urgency of the referral;

247. Brandon M et al, 2012, Research Report DFE-RR226, New learning from serious case reviews: a two year report for 2009-2011

- on 25 March 2010 GP 1 left a telephone message for Senior Mental Health Practitioner 1 to inform her about the telephone call from Ms. X's mother;
- on 15 March 2010 the Consultant Obstetrician and Gynaecologist wrote to and phoned the Mental Wellbeing and Access Team, copying the letter to GP 1;
- on 19 April 2010 GP 2 phoned the postnatal midwifery team and the Care Coordinator.

However, there are also examples where communication between individuals or teams was absent or poor.

- When Ms. X was first seen by the midwifery service, although information about her history was potentially available in the GP notes, the midwife was reliant upon the information given to her by Ms. X and was consequently unaware that she had a history of mental health problems. This information was not flagged up by the GP.
- When Ms. X's mental state began to deteriorate in January 2010 this was known to GP 1 and the Nurse Practitioner 1 but there is no evidence of any specific communication with the midwifery service about the deterioration of her mental health.
- When discussion about re-commencing Sertraline was held between GP 1 and Ms. X in January 2010 there is no evidence that this was communicated to the midwifery service.
- When Ms. X's mental state deteriorated further in February 2010 and the Sertraline was increased this information was not communicated to the midwifery service.
- When GP 1 referred Ms. X to the Mental Wellbeing and Access Team he was concerned about her ability to care for her child once born but did not consider the instigation of a multi-professional/multi-agency meeting to plan assessment and intervention.
- On 25 March 2010 GP 1 communicated his concern about a telephone call received from Ms. X's mother to the Mental Wellbeing and Access Team. Senior Mental Health Practitioner 1 did not ring him back. On the same day the midwifery service were aware that Ms. X had missed a midwifery appointment, but this was not communicated to the GP or the mental health service.
- The hospital midwifery team and ward staff had no information available to them other than the notes carried by Ms. X and the information she gave them orally.

- GP 2 had no background information about Ms. X when she saw her on 19 April 2010 and was reliant upon information from Ms. X and from the Care Coordinator.
- The Care Coordinator was aware of the crisis telephone call from Ms. X's mother on 19 April 2010 but did not see this as a trigger to instigate the safeguarding children procedure.

It would appear that during the period of Ms. X's care and treatment there was no point at which all the individuals involved in her care were aware of all of the information available about her history and her current care and treatment. Whilst some individual members of staff attempted to communicate well with other individuals in other services, at no point in time did all the agencies, teams or staff members involved meet together to share information and develop a coordinated plan of action.

Whilst there was concern about the deterioration of Ms. X's mental state, both before and after delivery, and an escalation of referrals as her pregnancy progressed and her mental state deteriorated, no real consideration to the health and safety of Baby Y was given and therefore the safeguarding children procedure was not triggered. There were a number of junctures in the care pathway of Ms. X where this would have been appropriate.

When Ms. X was first referred to the midwifery service, had GP 1 made a formal written referral outlining her history of mental health problems and her known risk of deterioration when not taking Sertraline, it may have instigated the primary care team and the midwifery service to consider together the likely prognosis for Ms. X and her possible risk of developing perinatal mental health problems. This may have provided an opportunity for the development of an agreed plan for the monitoring and management of her mental health and of any potential risks to Baby Y.

When GP 1 referred Ms. X to the mental health services in February 2010 she was 32 weeks pregnant and her mental state had been deteriorating for at least two months despite recommencing Sertraline. GP 1 was concerned about her ability to care for her baby once born because of her mental state. At this point GP 1 should have considered whether multi-agency involvement was required in order to increase the sharing of information between individuals involved in the care and treatment of Ms. X and in order to assess the potential

risk to Baby Y in accordance with the Local Safeguarding Children Board's Unborn Baby Protocol.

On 25 February 2010 Ms. X was assessed by Consultant Psychiatrist 1 and Clinical Team Leader 1 from the Mental Wellbeing and Access Team. On 15 March 2010 Ms. X saw the Consultant Obstetrician and Gynaecologist, who was concerned about her mental state. She was 34 weeks and two days pregnant. On 26 March 2010 she was seen by Senior Mental Health Practitioner 1 who was concerned about the further deterioration of her mental state.

Despite the involvement of these professionals and their obvious concern for the mental state of Ms. X at this late stage of pregnancy, little consideration seems to have been given to the potential risks to Baby Y and how they might be managed. None of the professionals sought the advice of the Named Nurse for Safeguarding from their Trust, nor considered referral to children's social care in line with the local Unborn Baby Protocol.

When Ms. X delivered Baby Y the hospital staff were largely unaware of her history of mental health problems and therefore the likely course of her depression in the postnatal period. Had the hospital staff been aware of her history of mental health problems and her recent deterioration, and a clear plan been in place for the care and treatment of Ms. X and Baby Y in the postnatal period, their stay in hospital might have provided an opportunity for an extended period of assessment, increased support prior to discharge, discussion around breast feeding and psychiatric medication and the development of a clear and coordinated plan for the care and treatment of Ms. X and Baby Y with all the teams and agencies involved in their care. This was a missed opportunity.

Once Ms. X and Baby Y went home they were cared for by a midwifery team to whom Ms. X was previously unknown, and she was visited by three different members of the team ensuring that there was little continuity of care. She was seen by GP 2 who had not seen her before and who did not have access to her history. She had been seen once by her Care Coordinator prior to delivery, but there was uncertainty about how the Care Coordinator would be informed of the birth. At this crucial stage, when any new mother is very vulnerable, and particularly so when the mother has a history of mental health problems, no coordinated plan was in place for the care of Ms. X and Baby Y, and she was seen by staff

who were largely unfamiliar to her and who did not know her or the extent of her mental health problems.

Despite the lack of a coordinated plan of care post delivery, there was one more opportunity for ensuring an appropriate plan for the care and treatment of Ms. X and the safeguarding of Baby Y was in place. This was missed.

On 19 April 2010 Ms. X's mother rang the Devon Docs service expressing concerns about the further deterioration of Ms. X's mental state. The Care Coordinator rang Ms. X's mother back. It was reported that Ms. X was *"punching and smashing things"* in the house and not bonding with the baby. The Care Coordinator said she would inform the midwife. This level of concern from the family should have prompted an immediate home visit by the Care Coordinator and either consultation with the Named Nurse for Safeguarding about whether a referral should be made to Children's Social Care to ensure that the safety of Baby Y was assessed or a sharing of the concerns with Social Care in the absence of consultation with the Named Nurse.

On the same day as the crisis telephone call from Ms. X's mother, Ms. X and her mother-in-law went to see GP 2, who, without knowledge of her history, concluded that she had severe postnatal depression. GP 2 liaised with the midwifery service, but discovered that Ms. X was unknown to them too, and spoke to the Care Coordinator, when the plan was made that Ms. X should be seen the next day by the Care Coordinator and the Locum Staff Grade Psychiatrist from the Recovery and Independent Living Team. During the same day the family continued to be very concerned: Ms. X's mother and mother-in-law spoke to each other, Ms. X's mother spoke to GP 1 during which conversation she expressed concern that Ms. X might harm Baby Y, and Ms. X's mother-in-law tried unsuccessfully to speak to GP 2.

Despite this obvious concern of the family about Ms. X's mental state and the welfare of Baby Y, none of the professionals involved saw fit to consult with the Named Nurse for Safeguarding about whether a referral should be made to Children's Social Care to ensure that the safety of Baby Y was assessed. It was unfortunate that Ms. X was unknown to GP 2 however, had there been a clear and coordinated inter-agency and inter-professional plan in place for the management of Ms. X's care and treatment and the management of the risk to Baby Y, GP 2's lack of familiarity with Ms. X would not have carried the same importance.

It seems likely that GP 2 relied upon the judgement of the Care Coordinator as the mental health professional when agreeing to the appropriate plan of action, whilst the Care Coordinator felt secure in the knowledge that GP 2 had seen Ms. X that day. However, either professional, in the knowledge that Ms. X's family were increasingly concerned, could have instigated an assessment by a psychiatrist that day or considered a conversation with the Named Nurse for Safeguarding or made a direct referral to Children's Social Care.

In 2009 the National Patient Safety Agency (NPSA) reported that 37% of parent or step-parents who killed their children had a mental disorder including depressive illness or bipolar affective disorder, personality disorder, schizophrenia and substance or alcohol dependence.[248] The NPSA required mental health organisations to, amongst other recommendations, give staff clear guidance on making referrals to children's social care services when concern is apparent, and to involve a consultant psychiatrist in all clinical decision-making for service users who may pose a risk to children. The requirement for all staff *"to consider the child's needs and the potential for physical and/or psychological harm as an integral part of the processes of assessment and review"* was set out in a Safety Briefing issued to DPT staff in January 2010.

The Independent Investigation is in agreement with the Serious Case Review in that:
"5.6.1.Throughout the review there is indication that there was little focus on the child by any of the practitioners involved. This is made more difficult when the child is unborn and practitioners are working directly with an individual with particular needs and demands".
and
"5.6.2. Had practitioners put the child at the centre of their thinking when making decisions about information sharing and inter-agency working they would have been more likely to have both shared information and to have planned interventions in a more systematic way...".

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

248. Preventing Harm to Children from Parents with Mental Health Needs, National Patient Safety Agency , May 2009, NSPA/2009/RRR003

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 Child 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.

The Absence of Anyone with a Strong Sense of Accountability

Working Together to Safeguard Children (2006) states:

"2.92. Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child at risk of harm. This may be as a result of a service's direct work with those who may be mentally ill, a parent, a parent-to-be, or a non-related abuser, or in response to a request for the assessment of an adult perceived to represent a potential or actual risk to a child or young person. These staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse. They should follow the child protection procedures laid down for their services within their area".

There is no evidence that during the period of care of 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. The midwives and GPs may have felt that the mental health team should take the lead because of her mental health issues, the mental health professionals may have felt that the midwives had the greatest role because of Ms. X's pregnancy. This contributed to no one professional considering his or her responsibility towards the safeguarding of Baby Y.

Poor 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 the opportunity for her care to be coordinated arose. 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. This meant that there was no coordinated management and treatment plan in place at the time of Baby Y's birth, which was further compounded by the change of midwifery team, GP and health visiting team. During the postnatal period Ms. X was visited by a number of different staff members who were unfamiliar to and with her, and it is not clear that the Care Coordinator knew about Baby Y's birth until she received a message following Ms. X's mother's call to 'Devon Docs'. Effectively there was no coordination of her care during the postnatal period and assessment of her mental health was dependent upon the midwifery staff, the health visitor and her family until she was seen by GP 2.

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, the post of Consultant Psychiatrist to the Recovery and Independent Living Team was vacant, medical cover being given by a Locum Staff Grade Psychiatrist. The Independent Investigation Team understood that the specialism of this psychiatrist was in Old Age Psychiatry. Consultant cover was provided from 12 April 2010 by Consultant Psychiatrist 2 from the Torbay Assertive Outreach Team, based in Waverley House.

On 19 April 2012 the Care Coordinator asked Consultant Psychiatrist 2 if she could arrange a medical review of Ms. X. He asked her to request this from the Locum Staff Grade Psychiatrist in the first instance. According to the Witness Statement of Consultant

Psychiatrist 2, later in the day he asked the Care Coordinator if she had spoken to the Locum Staff Grade Psychiatrist and was told that an arrangement had been made for the Locum Staff Grade Psychiatrist and the Care Coordinator to assess Ms. X the following afternoon. According to the Witness Statement of Consultant Psychiatrist 2 he told the Care Coordinator that the risk of self-harm to Ms. X and the risk of harm to Baby Y should be considered and he was advised by the Care Coordinator that GP 2 had seen Ms. X that day, that Ms. X had denied thoughts of harming herself or the baby and that Ms. X was with her husband and her mother-in-law. The Independent Investigation Team understood that Consultant Psychiatrist 2 and the Locum Staff Grade Psychiatrist made an arrangement to speak to each other after Ms. X had been seen. These conversations are not documented in the clinical notes.

It would appear that the decision to leave the assessment of Ms. X until the following day, despite the escalation of concern from her family about her mental state and about the safety of Baby Y, resulted from the Locum Staff Grade Psychiatrist's dependence upon information from and the judgement of the Care Coordinator, who in turn felt that she was dependent upon the judgement of GP 2, who had met Ms. X on one occasion only without full knowledge of her history and who in turn may have felt that she was dependent upon the judgement of the Care Coordinator, who was the mental health expert and the coordinator of Ms. X's care.

As noted above, the National Patient Safety Agency in 2009 required mental health organisations to involve a consultant psychiatrist in all clinical decision-making for service users who may pose a risk to children. The covering Consultant Psychiatrist, Consultant Psychiatrist 2, was aware of the potential risk to Ms. X and Baby Y, as outlined in his Witness Statement, delegated responsibility for the assessment to a Locum Staff Grade Psychiatrist with a background in old age psychiatry and arranged to speak with him after the assessment. Consultant Psychiatrist 2, despite his apparent awareness of the potential risk to Baby Y, did not suggest that the Named Nurse for Safeguarding was consulted nor raise this as something to be considered after the assessment had taken place. This was a missed opportunity.

A Lack of Effective Training

The Independent Investigation Team was informed by clinical witnesses that all clinical members of DPT staff are required to complete Safeguarding Children and Young People

training at levels 1 and 2 and that staff of Band 6 and above are required to complete training at level 3. We were informed that training at levels 1 and 2 is by e-learning and training at level 3 is face-to-face, inter-agency training. The DPT Safeguarding Training position in February 2010 was that 1937 members of staff had completed 'CLU Child Protection' training, 3 members of staff had completed 'Child Protection Level 1 Awareness' training and 29 members of staff had completed 'Safeguarding Children Training Level 3'. Unfortunately these figures are not expressed as a percentage of staff. By June 2011 94.6% of 2089 relevant DPT clinical staff had completed Level 1 Child Protection training (1975 staff members), 7.6% of 1136 relevant DPT clinical staff had completed Level 2 Child Protection training (83 staff members), and 12.7% of 647 relevant DPT clinical staff had completed Level 3 training (77 staff members). It would appear that the majority but not all of DPT clinical staff have now completed the basic safeguarding training which is a one hour e-learning package, but in 2010 and 2011 very few had completed further training, despite it being a requirement. Although the Independent Investigation Team has not been made aware of the level of safeguarding training undertaken by individual members of staff at the time that Ms. X was receiving care and treatment, it would appear that it is possible that some members of staff had not undertaken even the most basic of training, and that despite their seniority, the majority of members of staff had no training beyond that level.

Although there is evidence that DPT mental health staff had been advised of how to manage concerns about harm or potential risk to children through the Safety Briefing given in February 2010, it appears that the majority of members of 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. Level 1 and 2 training are e-learning packages. Level 3 face-to-face training is only required of senior staff. It is possible that the provision of face-to-face training at levels other than Level 3 may be more effective in allowing staff to build inter-agency networks relevant to safeguarding and in ensuring that theoretical training leads to the appropriate identification and management of clients where the safeguarding procedures are relevant. However, a first task might be to ensure that staff undertake the currently available training required of them.

The Independent Investigation Team was informed by clinical witnesses that the post of Named Nurse for Safeguarding within DPT was a 20 hour a week post, and that the position of Named Nurse for Safeguarding Children within South Devon Healthcare NHS Trust was 0.8 of a whole time equivalent. The Independent Investigation Team has formed the opinion that the number of hours allocated to this role within the two Trusts may not be sufficient within such large organisations.

12.7.4. 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.***

12.8. Service User Involvement in Care Planning

12.8.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:
"the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes".

The National Service Framework for Mental Health (DoH 1999) stated, in its guiding principles, that *"people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that Mental Health services would *"offer choices which promote independence".*

NICE clinical guideline 45 (2007) states "*Treatment and care should take into account the woman's individual needs and preferences. Women with mental disorders during pregnancy or the postnatal period should have the opportunity to make informed decisions about their care and treatment in partnership with their healthcare professionals".*[249]

Local Context

The Trust's Care Programme Approach Policy C05 in operation at the time Ms. X was receiving her care and treatment emphases the partnership between the client and the care coordinator and notes that:
"A Personal Recovery Plan (RC3) will be drawn up ***with each person****, who will sign the plan and be offered a copy".*

249. NICE clinical guidelines 45 page 5

12.8.2. Findings

Findings of the Internal Investigation/SCR

The Root Cause Analysis Investigation did not state any findings or recommendations directly related to the involvement of Ms. X in her care planning.

The Serious Case Review noted under Lessons to be Learned
"If parents fail or refuse to co-operate with assessments, are hostile, non-compliant or display disguised compliance and there are concerns that the needs of a child, including unborn, are not being met practitioners must be assertive and authoritative in their approach to ensure that children's needs are not subsumed by the needs and wishes of the parent(s)".

Findings of the Independent Investigation Team

It would appear that Ms. X was involved in the decision to come off Sertraline at the beginning of her pregnancy in September 2009, to delay restarting it when she consulted her GP on 22 January 2010, and to restart it on 26 January 2010. The extent of the discussion around the implications of stopping or starting her medication for herself and for her baby is not documented. According to Ms. X's parents, the initial plan was that she should stop taking the medication during the early months of pregnancy and then the situation would be reviewed.[250]

There is some documented evidence that Ms. X was involved in the development of informal plans for her care when she was seen by the mental health services.

When Ms. X was assessed by Consultant Psychiatrist 1 and Clinical Team Leader 1 from the Mental Wellbeing and Access Team they reported that she was involved in the development of the informal plan for her care. The letter written to GP 1 by Clinical Team Leader 1 stated, *"Having discussed intervention options with [Ms. X] and [Consultant Psychiatrist 1] we feel that the best approach for right now will be a referral to the Senior Mental Health Worker at Old Mill Surgery for further follow-up and this will be around supporting [Ms. X] through the here and now and helping [Ms. X] look at things in a different way, but also working on de-stigmatising her understanding of her depression as being open about this experience will*

250. Statement of Ms. X's parents and Ms. X

only bring her greater benefits. I will also be referring [Ms. X] to the Depression and Anxiety Service for further work in the future following the birth of her child.

Finally, if [Ms. X] wishes she can be referred back after the birth of her child to a Medic for a thorough review of her medication as there is definite room for improvement. However, at this time leading up to the birth we do not wish to add any elements of instability".[251]

Having been seen by Senior Mental Health Practitioner 1, Ms. X was not involved in the decision to refer her to the Recovery and Independent Living Team as this decision was made after her initial appointment with Senior Mental Health Practitioner 1 when she realised the extent to which Ms. X's mental state had deteriorated since her assessment on 25 February 2010.[252] Senior Mental Health Practitioner 1 informed Ms. X of the referral on the same day that it had been accepted by the Care Coordinator.[253]

As noted in the Chronology above, when Ms. X met with the Care Coordinator on 6 April 2010 it was noted that she did not want her family informed or involved, and that she did not want a further appointment until after the birth of her baby. No formal care programme was developed or documented.

12.8.3. Conclusions

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.

251. DPT notes page 207
252. DPT notes page 215
253. Witness Statement

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 because of the concerns of Senior Mental Health Practitioner 1 after discussion with Clinical Team Leader 1, and she was in the last few weeks of pregnancy. The Independent Investigation Team 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, as suggested by the Serious Case Review, 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.

12.8.4. Contributory Factors and Service Issues

- ***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.***

12.9. Family Involvement

12.9.1. Context

The National Context

It has long been accepted as good practice that the family and carers of service users should be involved in the assessment and planning of care of those they care for.

In its most recent guidance on the CPA the Department of Health notes:
"To make sure that service users and their carers are partners in the planning, development and delivery of their care, they need to be fully involved in the process from the start. Processes should be transparent, consistent and flexible enough to meet expectations of service users and carers, without over promising or under delivering. Service users will only be engaged if the care planning process is meaningful to them, and their input is genuinely recognised, so that their choices are respected".[254]

Later in the same document it is noted that:
"Trust and honesty should underpin the engagement process to allow for an equitable partnership between services users, carers and providers of services." [255]

The guidance points out that the family and carers should be involved in the assessment and care planning process because they provide a privileged source of information and the implementation of the care plans often requires their co-operations. It continues:

"Mental illness can have a major impact on carers, families and friends as well as on the person with the illness. It may cause social and financial disruption and restrict educational and employment opportunities for both the carer and the person being supported. The demands of caring can also affect the physical and emotional health of the carer…Their needs can be overlooked by adult services.

Carers…should be identified at the service user's assessment and information provided to them about their right to request an assessment of their own needs. Services should ensure coordination of users' and carers' assessments, care and support plans and the exchange of information where agreement has been received to do this. A service user's own caring responsibilities should also be explored and appropriate support, contingency and crisis plans put in place for the service user as a carer and for the person they care for".[256]

254. DH (2008) Refocusing the Care Programme Approach page 8
255. Ibid page 18
256. DoH (2008) Refocusing the Care Programme Approach page 25

However a review by the King's Fund and The Sainsbury Centre for Mental Health into how well the guidance had been implemented concluded:[257]

"Carers were frustrated and disillusioned with the care their loved ones are given. They felt that professionals did not listen to them and gave little information. They felt that they were not regarded as part of the service users' care; rather they were treated like part of the problem. Their main support came from voluntary organisations". [258]

With specific regard to women with mental health problems in the perinatal period, the NICE guidance on antenatal and postnatal care again stresses the importance of involving carers and families in the care and treatment of the women, and of providing information and support for the family members:

"Good communication between healthcare professionals and women, and their partners, families and carers, is essential. It should be supported by evidence-based written information tailored to the woman's needs".

and

"*Carers and relatives should have the opportunity to be involved in decisions about the woman's care and treatment, unless the woman specifically excludes them.*

Carers and relatives should also be given the information and support they need".[259]

Local Context

In line with national policy, the DPT Care Programme Approach Policy C05, in place during the period of Ms. X's care and treatment with the Trust, states:

- *"Those with significant caring responsibilities for the person using services should be identified either at the referral stage or during assessment and their details logged in the first 'significant contacts' fields.*
- *A carer's assessment takes place either at the request of the carer or at the instigation of the CPA care coordinator. Following an assessment and an identification of need, a Carer's Action Plan (RC8) should be completed and held on the record of the person using the service. The carer's assessment is not formally part of the CPA process.*

257. Warner, L., Mariathasan, J., Lawton-Smith, S., Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health.
258. Warner, L., Mariathasan, J., Lawton-Smith, S, Samele, C. (2006) *Choice Literature Review.* King's and & The Sainsbury Centre for Mental Health page 80
259. NICE clinical guidance 45

- *The carer should routinely be given a copy of the carer's action plan".*[260]

With regard to situations in which an unborn baby is deemed to be at risk, the Local Safeguarding Childrens Board's Unborn Baby Protocol notes:

"Although this protocol does not explicitly mention fathers and extended family members it is implicit that they must be included as appropriate in the casework with the mother and the unborn child".[261]

12.9.2. Findings

Findings of the Internal Investigation/SCR

The Root Cause Analysis Investigation noted:

"There was a lack of clarity for those caring for [Ms. X], both professionals and family, as to what to do in the event of a change or deterioration".[262]

and states that this would not have been the case had the NICE guidance been followed.

It concluded that one of the lessons learned was:

"If permission is not given to share information with families, or those who are involved in supporting a person, consideration should be given to how this will compromise their ability to support the person and contribute to the maintenance of safety. Discussion should move away from a position of not to share information, to one of what information should be shared and with whom".[263]

It was recommended that "*Multiagency information sharing, review, care and contingency planning in accordance with NICE guidance needs to be established"* which includes a written care plan *"developed in collaboration with the woman and her partner, family and carers, and relevant healthcare professions".*[264]

The Root Cause Analysis identified as one causal factor in the death of Baby Y:

"The lack of information sharing with relatives; in the absence of consent".[265]

260. DPT Care Programme Approach Policy C05 page 23
261. Working with Mothers and their Unborn Babies where there are Concerns for the Welfare of the Unborn Child, 2009, page 6
262. DPT Root Cause Analysis Investigation Report, 2010, page 21
263. Root Cause Analysis Investigation Report pages 24
264. Root Cause Analysis Investigation Report pages 23 and 24
265.Root Cause Analysis Investigation Report pages 23

The Serious Case Review noted the absence of any involvement of Ms. X's family in the planning of her care, the limited response to the concerns raised by Ms. X's mother, and the lack of any consideration of the role the father played in the family and assessment of his future parenting role.

The Serious Case Review recommended:
"To ensure that there is planned, coordinated and comprehensive child and family focussed intervention Torbay SCB should, by working with partner agencies, holding them to account and having strategic oversight, ensure that there is a clear multiagency pathway for working with families where there may be concerns about the mental health of parents and carers. This should be embedded in practice guidance and training available for practitioners across all agencies".[266]

Findings of the Independent Investigation Team

The Independent Investigation heard that despite her history of depression since her teenage years, the family of Ms. X were unaware that she had been suffering from, and treated for, depression since that time. The parents of Ms. X reported that her overdose as a teenager *"should be understood as an allergy to alcohol".*[267]

The Independent Investigation found that during the period of care and treatment under investigation, Ms. X remained reluctant for her family and her husband's family to be made aware of her history of mental health problems prior to pregnancy.

Ms. X was seen by Midwife 1 on **11 February 2010** when she was 30 weeks pregnant. It was noted that she had started feeling depressed recently and had commenced taking Sertraline and iron tablets.[268] Midwife 1 recorded in Ms. X's patient-held antenatal notes that her antidepressants had stopped in 2009 and that she had had a few episodes of depression in the past for which she was treated with Sertraline. These references to her history of depression were later covered with correction fluid and it is presumed that this was done by Ms. X.[269] It seems likely that she did this so that her family could not read the references to her history of mental health problems in her notes which were kept at home.

266. Serious Case Review: Overview Report page 32
267. Interview with the family
268. Witness Statement
269. Witness Statement

On **24 February 2010** Ms. X was seen by Health Visitor 1 at Old Mill Surgery. Ms. X's husband was present for some of this appointment. Ms. X requested that her history of depression was not discussed while her husband was present.[270] [271]

Also on **25 February 2010** Ms. X met with Consultant Psychiatrist 1, and Clinical Team Leader 1 from the Mental Wellbeing and Access Team. It was noted that Ms. X had a ten year history of depression and anxiety and a family history of depression. It was stated that Ms. X did not want people to know about her history of depression and preferred this episode to be considered to be antenatal depression. She reported that she disliked not being able to hide this episode of depression from her family.[272]

Despite her reluctance for her family to be made aware of her history of mental health problems, she was supported in some of her appointments with health and mental health professionals by her husband or her mother-in-law who were well aware of the current mental health problems she was experiencing.

On **1 February 2010** Ms. X saw GP 1 accompanied by her husband. It was noted that her condition was the same and she sought reassurance that she was not mad. It was noted that her mother experienced post natal depression.[273] [274]

On **18 February 2010** Ms. X saw GP 1 again accompanied by her husband. GP 1 noted that she remained depressed, had difficulty speaking and was visibly slowed down. Her husband commented that she felt numb, and that she was *"not part of experience"*.[275]

On **24 February 2010** Ms. X was seen by Health Visitor 1 at the GP Surgery. Ms. X's husband was present for some of this appointment.[276] [277]

On **10 March 2010** Ms. X was seen for a planned appointment with Health Visitor 1 at the GP Surgery. Her mother-in-law was present.[278]

270.GP notes page 70
271. Witness Statement
272. DPT notes pages 206-7
273. GP notes page 71
274. Witness Statement
275. GP notes page 71
276. GP notes page 70
277. Witness Statement
278. Witness Statement

On **26 March 2010** Senior Mental Health Practitioner 1 from the Mental Health Wellbeing and Access Team met with Ms. X for the first time. She noted that Ms. X only attended the appointment with the persuasion of her mother-in-law as she was reluctant to be associated with the mental health service.

On **6 April 2010** The Care Coordinator saw Ms. X at Waverley House, Ms. X having declined a home visit. Her mother in law waited in the waiting room.[279]

On **10 April 2010** Baby Y was born weighing 3490g at 11.32 hours.[280] Ms. X was in the care of Midwife 4 when she delivered Baby Y and her husband was present.[281]

On **16 April 2010** Ms. X was visited at home by Health Visitor 1. Her husband and mother were present.

On **19 April 2010** at 12.14 hours, Ms. X saw GP 2 at the Compass House Medical Centre accompanied by her mother-in-law and Baby Y.

There are references to her family being very supportive of Ms. X as her mental state deteriorated and after the birth of Baby Y.

On **25 March 2010** Midwife 3 informed Midwife 1 that Ms. X's mother-in-law had moved in to help her.[282]

Ms. X and Baby Y were seen at home in the afternoon of **11 April 2010** by Midwife 5 from the Christie Team. It was noted that Ms. X was well supported by her family.[283]

At 09.30 hours on **16 April 2010** Ms. X was visited at home by Health Visitor 1. She was described as supported 24 hours a day by the family.

On **19 April 2010** Ms. X gave permission to GP 2 for her mother-in-law to coordinate her appointments and the telephone number was entered into the computerised notes.[284] GP 2

279. Witness Statement
280. SDHT notes page 118
281. DPT notes page 394
282. Witness Statement
283. SDHT notes page 159

wrote *"mother-in-law with her and looking after baby"*. GP 2 was told that Ms. X would not be on her own with the baby as both her husband and her mother-in-law were present.

The family of Ms. X were instrumental in raising concern about Ms. X with the health and mental health professionals and in trying to obtain the appropriate help for her:

On **25 March 2010** GP 1 left a telephone message for Senior Mental Health Practitioner 1, explaining that he had spoken with Ms. X's mother who said that Ms. X had caused a lot of concern to her family at the weekend when she drove to London without letting them know.[285]

At 09.30 hours on **16 April 2010** Ms. X was visited at home by Health Visitor 1. Her husband and mother were present. According to Ms. X's parents, her mother raised *"serious concerns"* with the Health Visitor.[286]

On **19 April 2010** Ms. X's mother rang Devon Docs expressing concern that Ms. X's depression was worsening. The person who took the call listened to her concerns and said that he would ask the appropriate person from the mental health service to ring her back. The Mental Wellbeing and Access Team was informed and passed the message to the Care Coordinator. Ms. X's mother was rung back by the Care Coordinator. Ms. X's mother informed the Care Coordinator that Ms. X was punching and smashing things in the house and that she was not bonding with the baby. The Care Coordinator said that she would inform the midwife, which she did by telephoning the midwifery team in Brixham.[287] According to the Witness Statement of the Care Coordinator, the midwife informed her that there had been no concerns when Ms. X had been visited but that she would visit later that day to carry out a reassessment.[288]

On the afternoon of **19 April 2010** the Care Coordinator asked the Locum Staff Grade Psychiatrist for a review of Ms. X's medication. He noted that the Care Coordinator reported that Ms. X's mother-in-law was concerned that Ms. X was becoming more depressed and would like advice on medication and that Ms. X *"is not left alone with the baby – husband*

284. Witness Statement
285. DPT notes page 216
286. DPT notes page 420
287. DPT notes pages 188, 421
288. Witness Statement

and mother-in-law with her all the time – no thoughts or intention to harm self or the baby".[289] The Care Coordinator rang Ms. X who said that *"things were not very well and hung up the phone"* then switched the telephone off. The Care Coordinator attempted to ring the mother-in-law but her telephone was also off.[290]

Also on **19 April 2010** Ms. X's mother-in-law rang the GP surgery to say that she wanted to share with GP 2 a discussion she had had with Ms. X's mother *"about her condition": "happy to phone am"*.[291]

On **19 April 2010** Ms. X's mother phoned Ms. X's former GP, GP 1. He returned her call at 18.30 hours. She expressed concern that Ms. X was frustrated, angry and making or shaking her fist. Ms. X's mother stated that she expressed concern that Ms. X might harm Baby Y and said that Ms. X was *"paranoid"* that her husband would leave her. Ms. X's mother reported that GP 1 "was not sufficiently concerned to take any further action".[292] In his Witness Statement GP 1 said that he did not interpret her account as showing intent to harm herself and suggested that the planned appointment with the mental health service for the next day was appropriate.[293]

At 09.15 hours on **20 April 2010** the Care Coordinator rang Ms. X's mother asking if she could bring Ms. X to see them at Waverley House. Ms. X's mother explained that Ms. X was with her mother-in-law and phoned back with her telephone number.[294] The Care Coordinator attempted to ring both Ms. X and her mother-in-law but both phones were switched off.[295]

12.9.3. Conclusions

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.

On 25 March 2010 GP 1 left a telephone message for Senior Mental Health Practitioner 1 informing her that Ms. X's mother was very concerned that the previous weekend, in an advanced stage of pregnancy, she had driven to London on her own and without telling

289. DPT notes page 384
290. Witness Statement
291. GP notes pages 1 and 3
292. DPT notes page 419
293. Witness Statement
294. DPT notes page 420
295. Witness Statement

anybody what she was doing. Senior Mental Health Practitioner 1 saw the message the following day. GP 1 felt that this information was of significance, hence his contact with the mental health team. There is no evidence that this was followed up by a discussion with Ms. X's mother, although the family appeared to see this as an important indication of her mental state as the incident was mentioned again by Ms. X's mother-in-law when she was seen in the initial meeting with GP 2. This incident formed a critical juncture in Ms. X's care and could have provided the mental health staff an opportunity to make contact with Ms. X's family, to listen to their concerns and to develop a care plan with both Ms. X and her family in line with the NICE guidance, *"Carers and relatives should have the opportunity to be involved in decisions about the woman's care and treatment, unless the woman specifically excludes them"*. There is no evidence that Ms. X had specifically excluded her family from being involved in her care – she had taken her husband to her appointments with GP 1 and the following day went to her appointment with Senior Mental Health Practitioner 1 accompanied by her mother-in-law.

When Ms. X was seen postnatally by Health Visitor 1 on 16 April 2010 Ms. X's husband and mother were present and the latter was said to have raised "serious concerns" about Ms. X. According to her Witness Statement, Health Visitor 1 listened to their concerns and ascertained that Ms. X was *"fully supported 24 hrs a day by husband and Paternal and Maternal Grandmothers"*.[296] Health Visitor 1 understood that Ms. X was to see her Care Coordinator and a Psychiatrist from the Recovery and Independent Living Team on 22 April 2010. She was due to hand over the health visiting care to another team that day and so took no further action.

On 19 April 2010 there was a significant escalation in the family's concern about Ms. X and their attempts to obtain help. Ms. X's mother rang Devon Docs and was rung back by the Care Coordinator. She gave the Care Coordinator the information that Ms. X was punching and smashing things in the house and was not bonding with the baby. The Care Coordinator's response was that she would inform the midwives. She was also given this information by GP 2 in addition to the information that Ms. X had given permission for her mother-in-law to be contacted in order to arrange any appointments. The Care Coordinator later made an

296. Witness Statement

arrangement for Ms. X to be assessed the following day by herself and the Locum Staff Grade Psychiatrist.

On the same day Ms. X's mother-in-law attempted to speak with GP 2 about a discussion she had had with Ms. X's mother and Ms. X's mother spoke to GP 1 about her concerns, including her concern that Ms. X might harm Baby Y.

Unfortunately none of the health or mental health practitioners involved considered the escalating concern of the family to indicate that Ms. X required an urgent assessment, that day, of her mental state or as indicating that there might be risks to Baby Y. Had the family being 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 safety and 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 safety and 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.

12.9.4. Contributory Factors and Service issues

- ***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.***

12.10. Clinical Documentation and Professional Communication

12.10.1. Context

"Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion".[297]

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours cannot be met by one agency alone[298]. The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticises agencies for not sharing information and not liaising effectively.[299] In 1996 the Department of Health set out the

297. Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) Page 121
298. Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999). Page 144.
299. Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required, in its guidance *Building Bridges* (1996).

Within Mental Health Services the Care Programme Approach plays a central role in ensuring that service users receive a coordinated service, with all those having in-put into the individual's care sharing an understanding of his/her problems and working to a common set of goals. Communication is key to the CPA and to effective and efficient multidisciplinary and inter-agency team working in general. While good communication is not a guarantor of good clinical care, without good communication between those caring for an individual it is difficult, if not impossible, to achieve efficient and effective clinical care.

Local Context

The DPT Care Programme Approach Policy C05, in place during the period of Ms. X's care and treatment with the Trust, emphasises the importance of good communication and states that the role of the Clinical Team Leader is to:

"Ensure the team has effective communication systems with related teams and network partners for the transfer of information routinely and in crisis situation".[300]

It goes on to define the role of the Care Coordinator, which includes good communication with the client and with others involved in his or her care:

- *"Ensure that other key people involved have an opportunity to share views and opinions; this will include ascertaining whether a carer's assessment is required and commissioning one if indicated.*
- *Act as a reference point for other support providers, relatives, carers and advocates".*[301]

The issue of communication is specifically addressed where risk had been identified:

- *"There may be occasions when information about risk to others needs to be conveyed within the team and to outside agencies in spite of objections by the person involved. Sharing of information will conform to CPA standards and agreements on confidentiality. Information disclosed in these circumstances should only consist of factual information held by Devon Partnership Trust".*[302]

300. DPT Care Programme Approach Policy C05 page 11
301. DPT Care Programme Approach Policy C05 page 12
302. DPT Care Programme Approach Policy C05 page 14

With regard to written communication in the client's records, DPT's current policy notes that client records should:

- be written only in black ink;
- be written in such a way as to comply with individual codes of professional practice;
- be factual, consistent and accurate;
- be written clearly, legibly and in such a manner that they cannot be erased;
- be in chronological order;
- include the person's name and NHS number on every page;
- be accurately dated, timed (24 hour clock) and signed, with the signature being printed alongside the first entry;
- be contemporaneous;
- be written, wherever possible, with the involvement of the person using Trust services or carer and in terms that they can understand;
- abbreviations should not be used unless it is previously explained in that entry;
- be consecutive;
- be relevant and useful;
- be bound and stored so that loss of documents is minimised;
- identify problems that have arisen and the action taken to rectify them;
- provide evidence of the care planned, the decisions made, the care delivered and information shared including evidence of actions agreed with the client (including consent to treatment and/or consent to share);
- document all facts and pertinent information related to an event, or course of treatment.[303]

12.10.2. Findings

Findings of the Internal Investigation/SCR

The Root Cause Analysis Investigation concluded that causal factors included the lack of information sharing with relatives and the lack of multi-agency information sharing, review, care and contingency planning in accordance with the NICE guidelines and recommended that multi-agency information sharing, review, care and contingency planning in accordance with NICE guidance was established.

303. DPT Records Keeping and Management Standards Policy GV06

The Serious Case Review concluded, with regard to South Devon Healthcare NHS Trust that they should update the departmental policy with regard to communication between professionals and especially communication with GPs following the first contact in pregnancy to identify any undisclosed risk and concerning the handover of care between midwifery teams.

The Serious Case Review concluded, with regard to Torbay Care Trust, that practitioners need to be aware of the Record Keeping Standard and adhere to it at all times, and that in particular records should reflect all conversations with other professionals, including *"corridor conversations"*.

Findings of the Independent Investigation Team

The issue of communication, both written and otherwise, has been addressed in a number of sections of this report.

In Section 12.1. Care Programme Approach, it was concluded by the Independent Investigation that the Care Coordinator did not maintain adequate contemporaneous clinical records and that no liaison took place by the Care Coordinator with the other health care professionals involved in Ms. X's care and treatment even though the care plan stated that this was an identified action.

In Section 12.6. Safeguarding, it was noted that during the pregnancy of Ms. X there were a number of Trusts involved in providing her care – Devon Partnership NHS Trust, the South Devon Healthcare Trust and Torbay Care Trust. Within these three Trusts, her care involved a range of teams – two GP practices, two community midwifery teams, the hospital midwifery and obstetric team, two mental health teams, and two health visiting teams. During the course of her pregnancy and the postnatal period Ms. X saw 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. The number and range of staff involved in the care of Ms. X meant that good communication was crucial if she was to be provided with a coordinated and effective package of care. In this section it was stated that during the period of Ms. X's care and treatment there was no point at which all the individuals involved in her care were aware of all of the information available about her history and her current care and

treatment. Whilst some individual members of staff attempted to communicate well with other individuals in other services, at no point in time did all the agencies, teams or staff members involved meet together to share information and develop a coordinated plan of action.

In Section 12.9. Family Involvement, it was noted that counter to the NICE guidance and CPA guidance, and despite Ms. X coming to appointments with various members of her family including her husband, her mother and her mother-in-law, her family were not involved in the planning of her care and were not given sufficient information to allow them to make appropriate decisions about the management of her care or to inform them about the potential risk to the wellbeing of Baby Y.

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. GP 1 did not directly communicate with Midwife 1 at the beginning of Ms. X's antenatal care, which meant that Midwife 1 was unaware of her mental health problems from the outset. GP 1 did not have the opportunity to ensure that GP 2 was aware of the significant deterioration of Ms. X's mental health and her history of mental health problems when her care was transferred from one practice to another. GP 1, who was no longer the GP for Ms. X at that point, did not inform the individuals caring for Ms. X about the telephone call from Ms. X's mother on 19 April 2010. The Care Coordinator did not inform other mental health professionals about the significant deterioration in Ms. X's mental health causing her to behave in a manner which concerned her family, as conveyed in her conversation with Ms. X's mother following the latter's telephone call to the Crisis Service.

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. As outlined in Section 12.1., the Care Coordinator did not document many of the conversations she held with other health professionals on 19 April 2010 and she did not document her attempts to contact Ms. X by telephone. GP 1 did not record his telephone conversation with Ms. X's mother held on 19 April 2010 until 21 April 2010. Whilst handwritten entries were signed and dated, the Independent Investigation found that, particularly in the case of the notes from SDHT, even when the individual clinician's name

was printed alongside the signature, often it was not possible to read the signature or the printed name.

12.10.3. Conclusions

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.

Whilst GP 1 went beyond the call of duty by listening to the concerns of Ms. X's mother on 19 April 2010, continuing involvement in the care of an individual after he or she has been discharged from the care of a particularly professional is not good practice because it can falsely indicate that appropriate intervention is going to be taken and it may deprive those currently involved in the individual's care of vital information.

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.

12.10.4. Contributory Factors and Service Issues

- ***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 multi-agency 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.***

12.11. Care Pathway

12.11.1. Context

National Context

Care pathways are described variously as integrated care pathways, clinical pathways, critical pathways, care maps or anticipated recovery pathways.[304] They are structured multidisciplinary care plans which define the expected course of events, within a specified time limit, in the care of patients with a specific clinical problem. A pathway is divided into

304. Royal College of Nursing

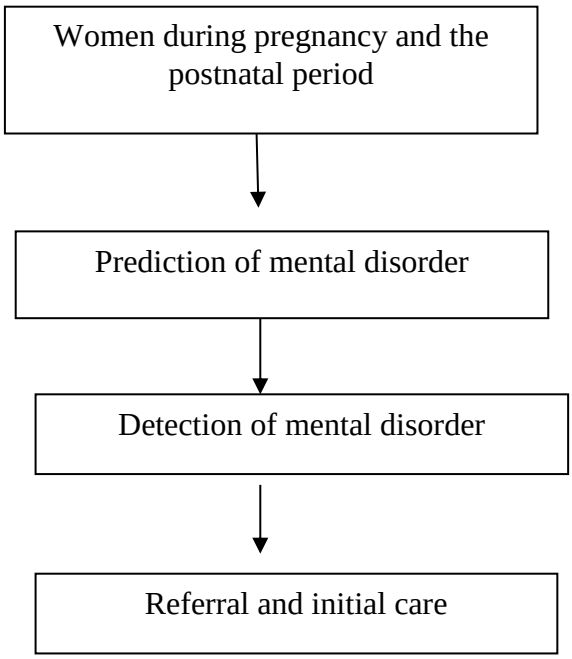
time intervals during which specific goals and expected progress are defined, together with appropriate investigations and treatment. They have been proposed as a way of encouraging the translation of evidence and national guidelines into local protocols and their subsequent application in clinical practice. They are also a means of improving systematic collection and abstraction of clinical data for audit and of promoting change in practice.[305] [306] They have been found to reduce variation in care received by individuals with the same clinical problem.[307]

The Welsh National Leadership and Innovation Agency for Healthcare guide to integrated care pathways (2005) has suggested that care pathways should include the following standards or show evidence that they are working towards meeting these standards:

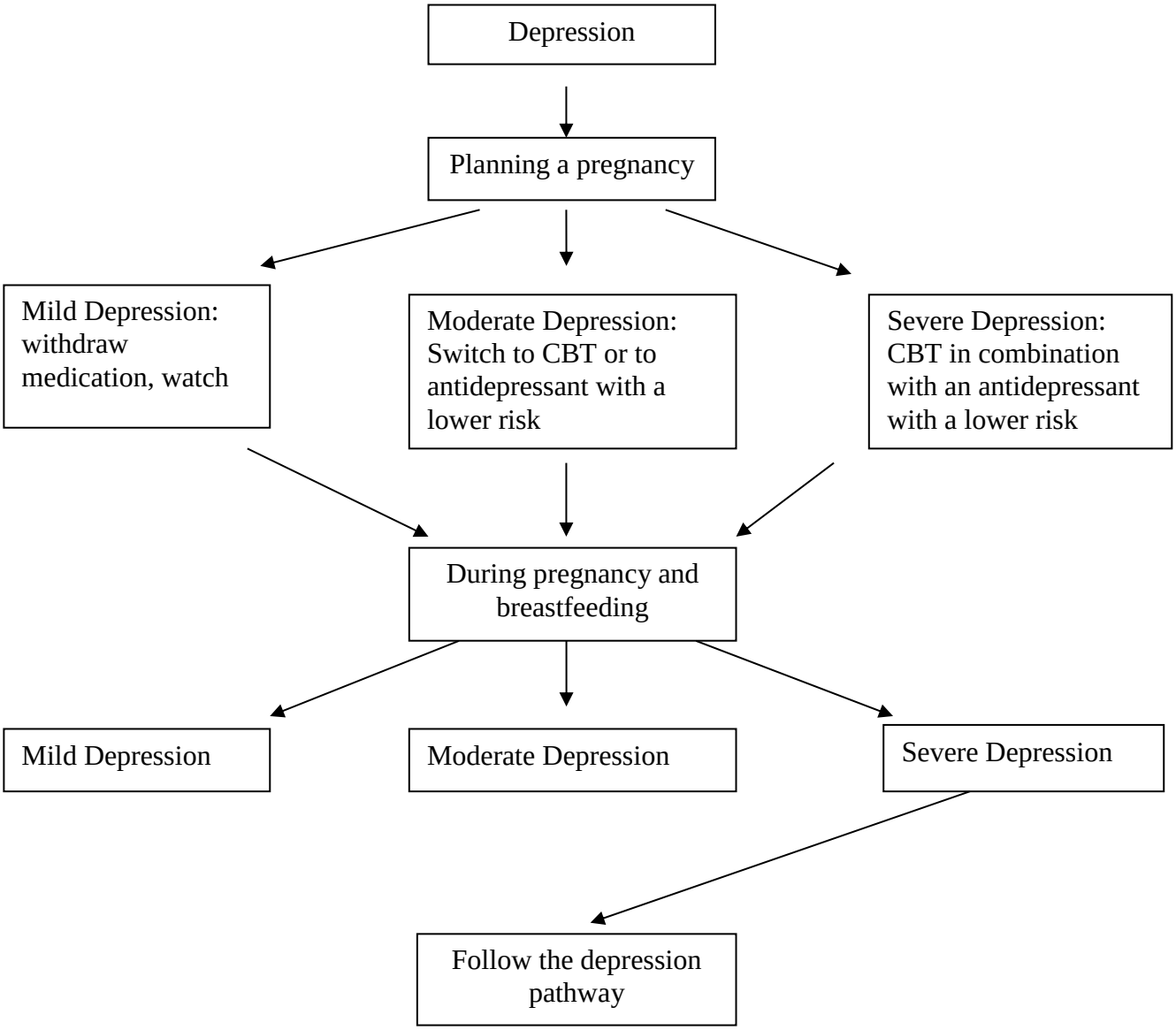
- multi-disciplinary;
- single documentation;
- use exception reporting;
- variance analysis;
- patient/user involvement;
- monitoring of utilisation;
- cross boundaries;
- standard format;
- outcome orientated;
- built in audit;
- evidence-based.[308]

The National Institute for Health and Clinical Excellence provides pathways which represent the NICE guidance for the care of an individual with a specific clinical or health problem. It suggests the following pathway for women with antenatal and postnatal mental health problems.

305.Campbell H, Horchkiss R, Bradshaw N and Porteous M, 1998, Integrated care pathways. British Medical Journal, 316, 133
306. Kitchener D, Davidson C and Bundred P, 1996, Integrated Care Pathways: effective tools for continuous evaluation of clinical practice. Journal of Evaluation in Clinical Practice, 2 (1), 65-69
307. Team la M, Marchisio S and Di Stanislao, F, 2003, Reducing clinical variations with clinical pathways: do pathways work? Int J Qual Health Care, 15 (6), 509-521
308. National Leadership and Innovation Agency for Healthcare, 2005, page 8



The prediction of mental disorder should include all health care professional involved in the care of the woman asking at the point of first contact about past or present severe mental illness, about previous treatment for mental illness, and about family history of mental illness. The step of detection of mental disorder should include all health care professionals asking specific questions to detect symptoms of depression or using screening tools to detect such symptoms. The stage of referral and initial care should include referral to the GP for assessment, and, preferably in the first trimester, the development of a written care plan with the woman, her partner, her family and with the relevant healthcare professionals. It may also include where appropriate increased contact with specialist mental health services or perinatal services. Where it is known that a woman is suffering from or has a history of depression, the following care pathway is recommended.


Depression
Planning a pregnancy
Mild Depression: withdraw medication, watch
Moderate Depression: Switch to CBT or to antidepressant with a lower risk
Severe Depression: CBT in combination with an antidepressant with a lower risk
During pregnancy and breastfeeding
Mild Depression
Moderate Depression
Severe Depression
Follow the depression pathway

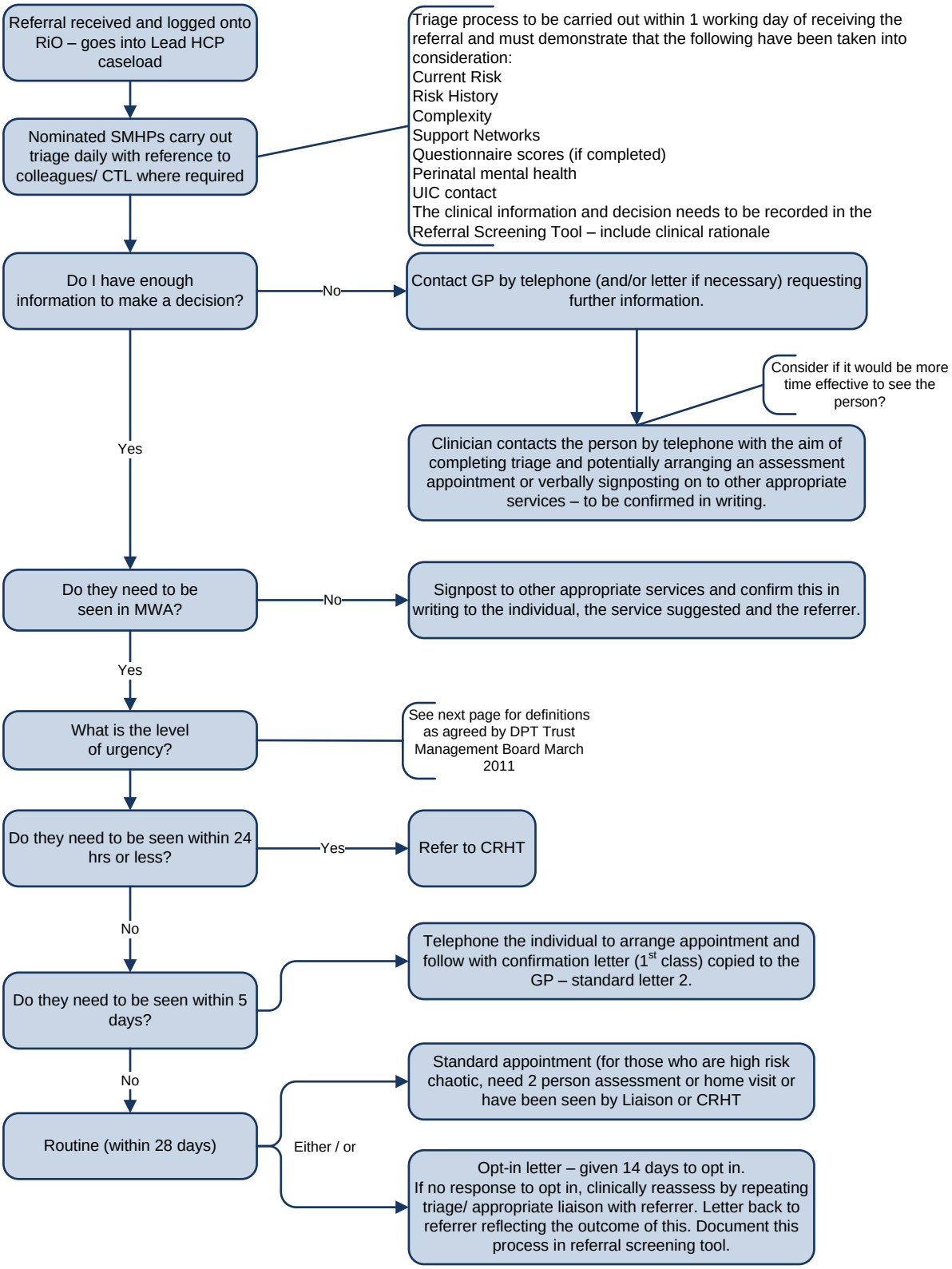
The care pathway for depression is given in the NICE Clinical Guidelines Section 90 and offers a stepped care model: [309]

Focus of the Intervention	**Nature of the Intervention**
Step 1: All known and suspected presentations of depression	Assessment, support, psychoeducation, active monitoring and referral for further assessment and interventions
Step 2: Persistent sub-threshold depressive symptoms: mild to moderate depression	Low-intensity psychological and psychosocial interventions, medication and referral for further assessment and interventions
Step 3: Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	Medication, high intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step 4: Severe and complex depression; risk to life; severe self-neglect	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care.

Local Context

The Devon Partnership NHS Trust operational policies refer to care pathways. The Torbay Mental Wellbeing and Access Team Operation Policy provides the following flow-diagram to illustrate the care pathway:

309. NICE clinical guideline 90 (2009) Depression: The treatment and management of depression in adults


Referral received and logged onto RiO – goes into Lead HCP caseload
Nominated SMHPs carry out triage daily with reference to colleagues/ CTL where required
Triage process to be carried out within 1 working day of receiving the referral and must demonstrate that the following have been taken into consideration:
Current Risk
Risk History
Complexity
Support Networks
Questionnaire scores (if completed)
Perinatal mental health
UIC contact
The clinical information and decision needs to be recorded in the Referral Screening Tool – include clinical rationale
Do I have enough information to make a decision?
No
Contact GP by telephone (and/or letter if necessary) requesting further information.
Consider if it would be more time effective to see the person?
Yes
Clinician contacts the person by telephone with the aim of completing triage and potentially arranging an assessment appointment or verbally signposting on to other appropriate services – to be confirmed in writing.
Do they need to be seen in MWA?
No
Signpost to other appropriate services and confirm this in writing to the individual, the service suggested and the referrer.
Yes
What is the level of urgency?
See next page for definitions as agreed by DPT Trust Management Board March 2011
Do they need to be seen within 24 hrs or less?
Yes
Refer to CRHT
No
Do they need to be seen within 5 days?
Telephone the individual to arrange appointment and follow with confirmation letter (1st class) copied to the GP – standard letter 2.
No
Routine (within 28 days)
Either / or
Standard appointment (for those who are high risk chaotic, need 2 person assessment or home visit or have been seen by Liaison or CRHT
Opt-in letter – given 14 days to opt in.
If no response to opt in, clinically reassess by repeating triage/ appropriate liaison with referrer. Letter back to referrer reflecting the outcome of this. Document this process in referral screening tool.

The Torbay Recovery and Independent Living Team Operational Policy offers the following under the section entitled Care Pathway:

"Care Pathway

Recovery care plans and safety plans

Each person will have an individual care plan which has been formulated between the person using the service and the care coordinator. These plans will be ambitious, realistic and sustainable, based on strengths, aspirations and needs.

Full risk assessment and management plan to reduce crisis and self/other harm. Issues of 'safety' will underpin the work of practitioners and the service will operate formal mechanism to ensure the safety of its staff. These mechanisms will include regular 'reporting in' arrangements and maintaining contact with base. Each member of staff will have access to a mobile phone. Lone worker devices are also available to staff.

Active involvement of service users and with consent their carers in the development of care plans and the choices and options which are available to people to support a return to wellness. This active engagement is seen as a cornerstone of service delivery. It is hoped this will help people to stay involved in their journey to wellness and support them in subsequent relapse prevention.

Users and carers will have access to information on existing support groups and carer networks and provide any additional input or support as required. Information leaflets, booklets and videos will be available

Use of safe and effective drugs with low side effect profiles to improve people's lives and engagement with the service.

Use of effective psycho-social interventions and programmes The service will help to meet social needs such as finding housing, claiming welfare benefits, finding work opportunities, accessing physical health care, education and training.

Access to psychological therapies as assessed as appropriate.

Close liaison and coordination with other areas of service both statutory and voluntary.

Interventions provided and links to clustering (PbR) and NICE

Work in progress

The service will work closely with GPs and practice staff. Team members will communicate regularly with individual GPs and practitioners, attend meetings and will respond to and give feedback on the service. The service will also provide information about the interventions available, referral protocols etc. That are available to practice staff, patients and carers.

Discharge processes

Discharges are conducted in accordance with directorate administrative procedures and the Trust Discharge Policy".

The Depression and Anxiety Service has the following section on its Care Pathway:

"***Referral sources***

GPs and primary care teams are the main source of referral. Individuals may self-refer. Primary care facilitated self-referral is being initiated from October 2011 and will become the norm. Referrals are also accepted from Mental Wellbeing and Access which may forward primary care referrals following triage or may refer after assessment. Other DPT services may refer (including Recovery and Independent Living; Learning Disability services; Older People's services and Addiction services). It is anticipated that in the longer term prospective patients will be able to access self referral leaflets from community settings such as libraries and supermarkets.

Response time, prioritisation and triage

Written referrals: Referrals may be checked to detect people who clearly do not meet referral criteria. A letter is sent inviting the person to contact the service within 10 days to book a first appointment and an appointment booked on contact. If no response a reminder letter is sent and if still no response 7 days later, the referrer is informed of failure to engage

Self referrals: People will have a service information leaflet given to them by their GP. When they call they are screened for current involvement with other mental health services (if so, the person delivering their care should be asked to refer), key information gathered and an appointment arranged.

Prioritisation: the service prioritises women in the perinatal period and veterans.

The standard for response time from referral to first therapy contact is 28 days.

Assessment of referrals

Assessments are undertaken using the Devon DAS assessment which collects information to determine the suitability of the service for the individual. DAS is a primary care mental health service and provides a comprehensive assessment for people with Anxiety and Depression. It does not offer a full mental health assessment. Dealt with at step three.

Care planning and risk management

Care planning: the outcome of the assessment is agree collaboratively with the person and focuses on their problems and goals, and the next action to be taken, which may include step 2 therapy, signposting to other resources, stepping up to step 3 and onward referral (see appendix for a description of stepped care). This initial care plan is reviewed on completion of each step 2 intervention, at stepping up to step 3 and at planned reviews during step 3 therapy. The majority of people will receive a Step 2 intervention

Risk management: the identification of risk is a core function of the service. However, the service is not set up or resourced to be able to manage significant or active risk, other than through routine provision of evidence-based psychological therapy.

- *Management of risk identified at referral. Risk is identified from information from the referrer / self referral and, if necessary, discussion with the referrer. If the risk at referral is at a level not manageable within DAS, the clinician will refer to the appropriate specialist mental health service team and inform the GP.*
- *Identification and management of risk at assessment. If the risk at assessment is at a level not manageable within DAS, or if further specialist mental health assessment is required to determine the nature and level of risk, the clinician will refer to the appropriate specialist mental health service team, ensuring a safe hand-over of care, and inform the GP.*
- *Identification and management of increased risk during therapy. Changes in risk are identified and recorded by means both of the scores on PHQ9 gathered in each session, and by reviewing with the patient in every session the personal significance of their scores on PHQ9 (including item 9 - thoughts of suicide or self harm) and*

other assessments. If the risk increases to a level not manageable within the DAS team, the clinician will involve the crisis team or refer on to a specialist mental health service team as appropriate, ensuring continuity and a safe hand-over of care. They will either discharge the person to the care of the other team, or keep them open on their caseload and pick up therapy again once the risk has returned to a level manageable within DAS.

Interventions provided and links to NICE and clustering

DAS provides evidence based psychological therapies for the treatment of depression and anxiety, as outlined in NICE guideline CG123 (Common Mental Health Disorders) at steps 2 and 3 of the stepped care model outlined in that guidance.

The main therapy is Cognitive Behaviour Therapy and guided self-help based on CBT principles and methods which is recommended for all common mental health problems. Eye Movement Desensitisation and Reprocessing is offered as an alternative to CBT for Post Traumatic Stress Disorder, and Applied Relaxation as an alternative to CBT for Generalised Anxiety Disorder. Counselling for Depression may be offered to people with depression who do not wish to have CBT.

While IAPT services have not yet been integrated with mental health care clusters, it is likely that DAS will be serving people whose needs fall in clusters 1 – 4.

GP practice links

DAS receives the bulk of its referrals from GPs and many therapy sessions are run in GP practices. The service maintains good links at a day-to-day level with GPs and primary care practitioners over the management of care of individual patients. Team clinical leads also attend practice meetings on occasions to share information about the service and general interface issues.

DAS keeps all GPs informed about the assessment and care of their patients through sending letters informing the GP of the progress of care.

Discharge

All patients are reviewed at each stage of their journey through the DAS care pathway. Discharge is planned with the patient at the end of therapy and the patient informed. A discharge summary is sent to the GP and or the referrer.

Some patients will be referred on for additional interventions with other services dependent of their need. The GP/referrer will be informed of this".

12.11.2. Findings

Findings of the Internal Investigation/SCR

The Root Cause Analysis Investigation concluded that a causal factor in the death of Baby Y was the absence of specialist perinatal mental health care pathways and provision and limitations in access to knowledge, understanding and skills in perinatal mental health within the services accessed by Ms. X.

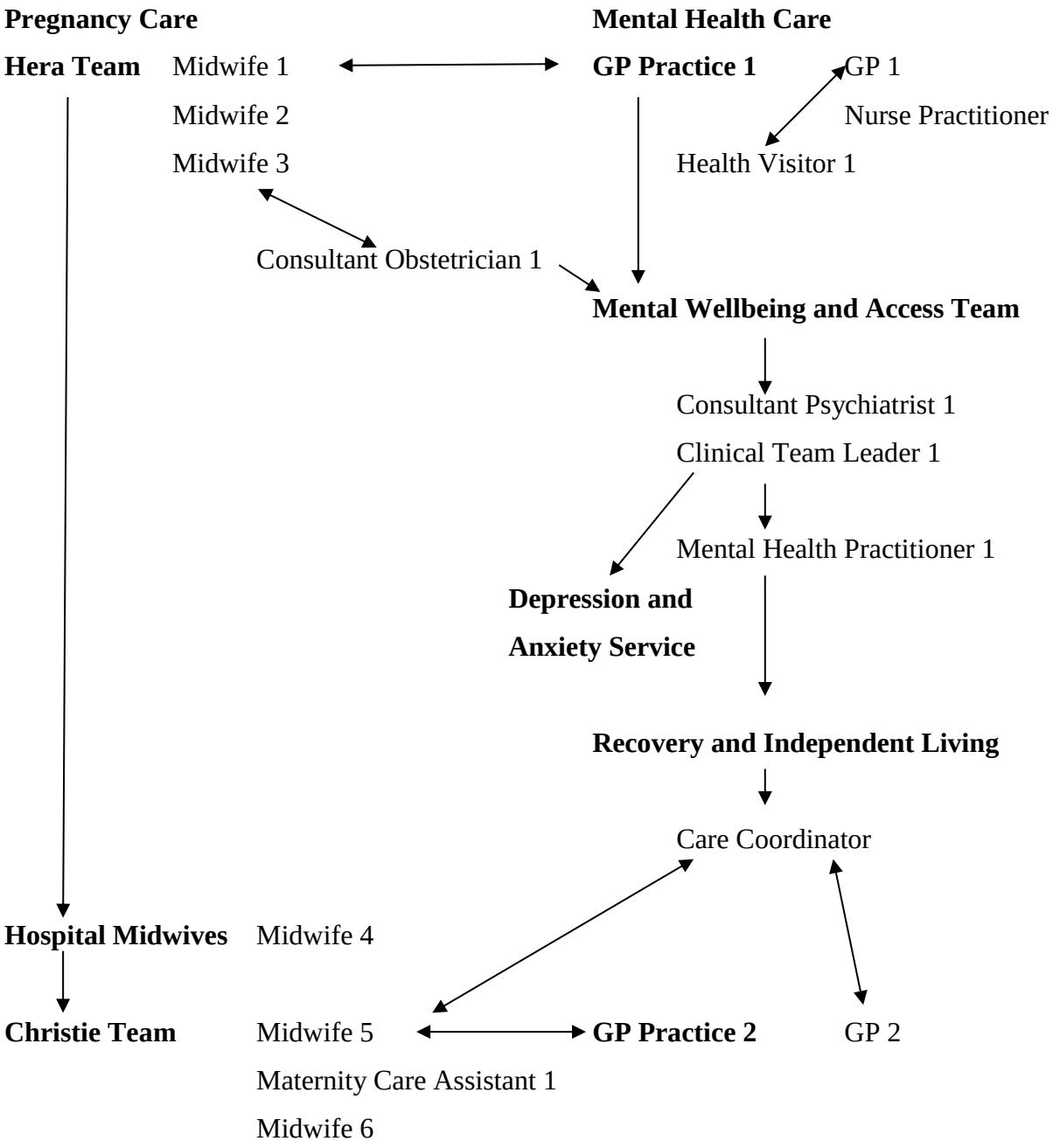
The Serious Case Review recommended:

"To promote improved and coordinated services to pregnant women with mental health concerns and thereby safeguard their babies Torbay SCB should ensure, by holding partner agencies to account, that work currently underway in health organisations to develop a care pathway and network with respect to perinatal mental health is completed and implemented and fully takes account of other legislation, multi-agency procedures and guidance, especially those contained within the South West Child Protection procedures and specifically the Unborn Baby Protocol".[310]

Findings of the Independent Investigation Team

During Ms. X's pregnancy her care followed two pathways which did not converge until the final weeks of her pregnancy: the pathway of care for her pregnancy and the pathway of care for her mental health problems.

310. Torbay Safeguarding children Board Serious Case Review Overview Report page 32



GP 1 did not refer Ms. X to the mental health service until she was in her third trimester of pregnancy in February 2010 by which time there had been a significant deterioration in her mental health and she was not responding to Sertraline. As her history of mental health problems was known to the GP, it would have been appropriate to consider referral for support from the mental health services when it first became apparent that her mental health was deteriorating in January 2010, or even when she stopped taking Sertraline at the beginning of her pregnancy as she had a known risk of relapsing when off medication.

Once referred to the mental health service by GP 1, Ms. X's treatment was delayed by the process of referral from one service to another, and the inevitable wait for assessment and treatment. This was not appropriate for someone who was in the latter stages of pregnancy with obviously deteriorating mental health. The referral from GP 1 to the Mental Wellbeing and Access Team was an urgent referral and was made on 19 February 2010 by fax.[311] Ms. X was seen on 25 February 2010, one day outside the team's standard for urgent referrals, which is five days.[312] She was then sent for 'immediate referral'[313] to Senior Mental Health Practitioner 1 and to the Depression and Anxiety Service. Senior Mental Health Practitioner 1 did not see Ms. X until 26 March 2010. She was on annual leave from 24 February 2010 returning to work on 10 March 2010. She tried to make telephone contact with Ms. X from that date with no response, resulting in her sending a letter on 17 March offering an appointment date of 26 March 2010.[314] After seeing Ms. X and discussing her presentation with the Clinical Team Leader, Senior Mental Health Practitioner 1 made an urgent referral the following working day (Monday) to the Recovery and Independent Living Team, which they received the same day and allocated her care to the Care Coordinator. Although not documented in the clinical notes, Senior Mental Health Practitioner 1 reported that she telephoned Ms. X that day and told her that her care had been transferred to the Care Coordinator of the Recovery and Independent Living Team and explained that she would be able to offer a greater degree of support and flexibility, including home visits.[315] The Care Coordinator attempted to make telephone contact with Ms. X that day without success and made further attempts at telephone calls over the next few days, again without success. She then sent a letter offering an appointment for 6 April 2010.[316] The Recovery and Independent Living Team Operational Policy states that it gives priority to women in the perinatal period. The Care Coordinator did not document her failed attempts to contact Ms. X by telephone, but these calls reported in her clinical witness statement represent a timely response within the standard set in the Operational Policy. The appropriateness of a more assertive approach to offering Ms. X care was discussed in Section 12.1 Care Programme Approach above.

Ms. X was referred to the Depression and Anxiety Service by Clinical Team Leader 1 of the Mental Wellbeing and Access Team after his assessment of her with Consultant Psychiatrist

311. GP notes page 71
312. DPT Mental Wellbeing and Access Team Operational Policy
313. DPT notes pages 206-7
314. Witness Statement
315. Witness Statement
316. Witness Statement,

1 on 25 February 2010. The plan was that this should be for therapeutic work after the birth of her child and after she had seen Senior Mental Health Practitioner 1 for work on *"de-stigmatising her understanding of depression"*.[317] Consultant Psychiatrist 1 and Clinical Team Leader 1 appeared to be of the view that considering it was late in her pregnancy there should be minimal intervention prior to the birth of her baby, with further intervention after his birth, including cognitive behaviour therapy for which she was thought to be a *"prime candidate"*[318] and a review of her medication *"as there is definite room for improvement"*.[319] Had referral been made at this point to the Recovery and Independent Living Team for care coordination there would have been more time for intervention prior to the birth of Baby Y.

The Independent Investigation heard from clinical witnesses that potential referrers to the mental health service were unsure about the appropriate means of accessing entry into the mental health services for a particular client. Each had found a tried and tested route or routes, making a distinction between referring to a team and referring directly to a psychiatric colleague, which did not necessarily accord with the route understood by members of Devon Partnership NHS Trust. This did not, however, prove a difficulty in the referral of Ms. X.

Midwife 1 referred Ms. X to the Consultant Obstetrician and Gynaecologist when she was concerned about her mental state. The Independent Investigation Team heard that this Consultant Obstetrician and Gynaecologist has a special interest in vulnerable women including those with mental health problems. He informed the Independent Investigation Team that, prior to the development of the perinatal service, if he felt that access to a psychiatrist was necessary for a client, he would have referred to a particular psychiatrist, rather than to the appropriate mental health team. This did not, however, prove a difficulty in the care of Ms. X as he was aware of her referral to the Mental Wellbeing and Access Service and contacted them to chase her appointment with Senior Mental Health Practitioner 1. The Independent Investigation noted that there was no communication directly from the mental health service to the Consultant Obstetrician and Gynaecologist, despite his involvement in Ms. X's care.

317. DPT notes pages 206-7
318. DPT notes pages 206-7
319. DPT notes pages 206-7

The Independent Investigation Team discussed care pathways for particular mental health problems with a number of clinical witnesses. The Independent Investigation Team found that on the whole clinical witnesses from the Mental Wellbeing and Access Team and the Recovery and Independent Living Team were unfamiliar with the term 'care pathway' and unable to describe a particular care pathway, despite this term being contained in their operational policies.

The Independent Investigation Team heard that at the time of the care and treatment of Ms. X no perinatal mental health service was available in Torbay.

12.11.3. Conclusions

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 for one occasion only, and delayed her access to care coordination.

The Independent Investigation Team is in agreement with the Root Cause Analysis Investigation that the absence of 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 Independent Investigation Team is in agreement with the Serious Case Review that "*work currently underway in health organisations to develop a care pathway and network with respect to perinatal mental health is completed and implemented".*

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.

12.11.4. 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.

12.12. Clinical Governance and Performance

12.12.1. Context

"Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish".[320]

NHS Trusts' clinical governance systems aim to ensure that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

The Care Quality Commission (CQC) is the health and social care regulator for England. The vision of the Care Quality Commission is to *"... make sure better care is provided for everyone, whether that's in hospital, in care homes, in people's own homes, or elsewhere".*

According to Devon Partnership NHS Trust Quality Account 2009/10, at the time of Ms. X's care and treatment with Devon Partnership NHS Trust, the Trust had *registration "conditional upon improvements being made in the field of staff supervision and appraisal".*[321]

320. Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114
321. Devon Partnership NHS Trust Quality Account 2009/10 page 3

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the death of Baby Y. However, those relevant to the care and treatment of Ms. X will be discussed.

12.12.2. Findings

Clinical Governance Systems and Performance

Devon Partnership NHS Trust has a Clinical Governance structure in place for reporting and monitoring standards of quality and safety across the Trust.

According to Devon Partnership NHS Trust Quality Account 2009/10, the Trust identified three priorities as quality improvement indicators for 2010/11:

1. improving care planning;
2. reducing slips, trips and falls;
3. improving the patient experience.

With regard to Improving Care Planning the Trust aimed to:

- Practice Standards: introduce a framework of practice standards to support staff in delivering consistent clinical standards across the Trust;
- Electronic Records: introduce a new records system, the RiO care records system and to train staff in the new system;
- Recovery coordination: embed principles of personal recovery into the framework of the organisation.

At the time of the care and treatment of Ms. X the RiO system had begun to be introduced and was being implemented across the Trust, but paper records were still in place. Practice Standards were referred to in the Operational Policies of the Mental Wellbeing and Access Team and the Recovery and Independent Living Team. The Independent Investigation Team was shown the Recovery and Wellbeing Coordination Policy C05 which was implemented from August 2012. The Trust also developed Recovery Coordination master classes and offered some staff the opportunity to undertake a degree module ‘Understanding Recovery Principles and their Application to Practice’ at the University of Plymouth. The ‘How Well is

Life Working Out for You?' practice tool helps support the principle of care being led by the person.[322]

With regard to improving the patient experience, the Trust aimed to:

- provide same sex accommodation;
- talk and listen to people who use the Trust's services, their families and the wider community;
- improve infection prevention and control;
- improve the quality of services to people detained under the Mental Health Act.

Devon Partnership NHS Trust Quality Account 2010/11

In March 2011 the CQC, following a review of the services, gave the Trust a 'clean bill of health', lifted the condition placed upon registration and acknowledged the significant improvements made in staff supervision and appraisal.

Adherence to Local and National Policy and Procedure

Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients"*.[323] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility. Policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance.

322. DPT Quality Account 2009/10
323. Callaghan and Waldock, *Oxford handbook of Mental Health Nursing,* (2006) page 328

Team Responsibility. Clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. They also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility. All registered health and social care professionals have a duty to implement all Trust clinical policies and procedures fully wherever possible, and to report any issues regarding the effectiveness of the policies or procedures and to raise any implementation issues as they arise with immediate effect.

12.12.3. Conclusions

Quality of Local Policies and Procedures

Devon Partnership NHS Trust has an appropriate set of clinical policies and strategic documents which are informed by both best practice guidance and national guidelines. It is also noteworthy that the Trust's clinical policies are informed by the learning accrued from previous events and investigations.

The Independent Investigation Team found that some of the clinical witnesses interviewed from Devon Partnership NHS Trust were unfamiliar with the concept of care pathways despite this being included in the Operational Policy for their team.

The Independent Investigation Team found that Operational Policies were not always adhered to by the clinical staff of Devon Partnership NHS Trust who were involved in the care and treatment of Ms. X. This has been discussed in the relevant sections above.

12.12.4. Contributory Factors and 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.

13. Summary of Findings and Conclusions

13.1. 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.

13.2. 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.

13.3. Findings

The main findings of the Independent Investigation are reported below.

13.3.1 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.**

13.3.2. 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.**

13.3.3. 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.**

13.3.4. 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.**

13.3.5. Treatment

13.3.5.1. 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 or 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.**

13.3.5.2. 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.[324]

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.[325] 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.**

324. Operational Policy, Depression and Anxiety Service, DPT
325. 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.**

13.3.6 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.[326] 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.

326. 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.**

13.3.7. 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.**

13.3.8. 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.**

13.3.9. 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.**

13.3.10. 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.**

13.3.11. 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.

14. Response of the Devon Partnership NHS Trust to the Incident and the Internal Investigation

The following section sets out the response of Devon Partnership NHS Trust to the events of 20 April 2010.

14.1. The Trust Serious Untoward Incident Process

At the time of the incident the Trust had in place a clear policy for the Investigation and Analysis of Incidents, Complaints and Claims including Serious Untoward Incidents. This set out the actions to be taken following a serious incident, who should be involved, the time scales, the methodologies to be employed and also provided guidance on contacting and supporting families. The policy required an Initial Management Review to be completed by the Locality Manager/Speciality Manager within 72 hours. A template for completing this report was provided. The report of this review would then be considered by the Serious Untoward Incident Review Group who will initiate any further actions required and determine the need for, and level of, any further investigation of this incident. For Serious Incidents that required further investigation, National Patient Safety Agency (NPSA) guidance was to be followed.

The policy stated that if a Root Cause Analysis Investigation was to take place, then the RCA investigator, once allocated, should make contact with families four-five days post allocation, or within two weeks post incident.

A DPT Incident Report form was completed by Team Leader, Recovery and Independent Living Team, on 23 April 2010. This was required by the Risk Manager within five working days of the incident.[327]

A DPT Serious Untoward Incident Initial Management Report was completed on 23 April 2010 by Team Leader, Recovery and Independent Living Team. This was required within three working days of the incident.

327. DPT notes pages 1-5

14.2. Root Cause Analysis Investigation

A multi-agency Root Cause Analysis Investigation was carried out, lead by Devon Partnership NHS Trust. It was agreed that this should take place alongside the Serious Case Review commissioned by the Torbay Safeguarding Children Board.

The Root Cause Analysis Investigation Report notes *"There was agreement between the health agencies involved that a multiagency review should occur, using root cause analysis methodology, to understand what happened and why and to reduce the likelihood of recurrence, and it was recognised that this review would have to 'dovetail' with the police investigation and Serious Case Review process. It was agreed with the Strategic Health Authority that Devon Partnership NHS Trust would lead this process in order that the statutory requirements placed upon mental health services in relation to the review of the care, treatment and support in place when a person in contact with mental health services commits a homicide could be met through this process".*[328]

It is recorded that *"DPT are very keen to provide a full and detailed investigation report as it may negate the need for an Independent Homicide Investigation at a late stage which can prove to be a very expensive exercise. They have achieved this for another case through providing a thorough report".*[329]

It was planned that the RCA should take place in the first week of August 2010 when the agencies involved had completed their Individual Management Reviews required for the Serious Case Review.[330]

14.2.1. Terms of Reference for the Root Cause Analysis Investigation

The terms of reference for the Root Cause Analysis Investigation were as follows:

"1. To apply the structure and process of a full root cause analysis at Level 2 as set out in the National Patient Safety Agency guidance.

2. To complete a detailed chronology of the events from the first point of contact with mental health services to the time of the alleged homicide to assist in the identification of care and service delivery problems.

328. Root Cause Analysis Investigation Report page 7
329. DPT notes page 52
330. DPT notes page 52

3. To examine the extent and adequacy of the collaboration and communication between agencies involved in the provision of services to [Ms. X].

4. To examine the adequacy of the assessments undertaken and review whether the actions consequent to the assessments were appropriate in relation to the best practice and local and national guidelines.

5. To examine the appropriateness of the training, development and supervision of those involved in the care of [Ms. X].

6. To prepare a report on the findings, with recommendations in accordance with National Patient Safety Agency guidance.

7. To bring to the attention of the Executive Nurse/Medical Director, of the relevant health providers, any practice issues that need to be addressed immediately.

8. The investigation will also seek to examine the extent to which [Ms. X's] prescribed treatment and care plans were:

a. Documented

b. Agreed with her

c. Communicated with and between relevant agencies and her family

d. Carried out, and

e. Complied with by her

9. The quality and scope of her health, social care and risk assessments

10. The appropriateness of her treatment, care and supervision in respect of any of the following that is relevant:

a. Assessed health and social care needs

b. Assessed risk of potential harm to herself/others, and the associated risk management planning arrangements

c. Any previous psychiatric history, including drugs and alcohol abuse

d. Statutory obligations, national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, and the discharge guidance HSG(94)27 and local operational policies for the provision of Mental Health Services)

e. Assessed risk and application of safeguarding children procedures.

11. Documentation review should include where relevant:

a. All chronologies developed by health agencies for the purpose of informing the Serious Case Review

b. Medical records relating to [Ms. X]; including all hospital records whether as an inpatient or outpatient, GP records, other records prepared by any other doctor, nurse or professional involved in her care

12. The review report will be shared, for comment/verification with those involved in the process of review. The final report will be shared with all those involved in the process of review; including the provider agencies, commissioners and NHS South West".[331]

14.2.2. Investigation Team

The Root Cause Analysis Investigation was led by:

- Clinical Risk Manager, Devon Partnership NHS Trust;
- Mental Wellbeing and Access Function Lead (North Devon), Devon Partnership NHS Trust.

14.2.3. Methodology

Torbay Care Trust required the RCA to be completed by 15 July 2010 in order to meet the SHA guidelines which allowed 60 days for an incident investigation.[332] The RCA meeting was planned for 26 August 2010.[333]

On 6 August 2010 the Clinical Risk Manager of DPT wrote to Ms. X's husband to invite him to comment of the terms of reference of the review and to hear about the outcomes.

A review meeting was held on 26 August 2010 with representatives from all agencies involved. Those present were:

- Clinical Risk Manager, DPT;
- Associate Director of Commissioning, TCT;
- Consultant Paediatrician/Designated Doctor Child Protection, TCT;
- Interim Lead for Recovery and Independent Living for South and West Devon, DPT;
- GP 1;
- Designated Nurse for Child Protection for Devon and Torbay;
- Matron and Named Midwife for Safeguarding Children, SDHCT;

331. Root Cause Analysis Investigation Report pages 6-7
332. DPT notes page 51
333. DPT notes page 55

- Consultant Psychiatrist, CAMHS, and Named Doctor for Devon Partnership NHS Trust;
- Consultant Psychiatrist and Clinical Director for Specialist Services, DPT;
- Mental Wellbeing and Access Function Lead (North Devon), DPT;
- Assistant Director Quality and Patient Safety Improvement, NHS South West;
- Patient Safety and Quality Manager (Commissioning), NHS Devon.

Invited but unable to attend were:

- GP 2;
- Associate Director of Nursing and Midwifery, SCHCT;
- Named Nurse for Child Protection for Devon and Torbay, NHS Devon;
- Consultant Paediatrician and Named Doctor for South Devon Healthcare NHS Foundation Trust.

A combined chronology was constructed and reviewed. A Five Whys Technique was used to analyse the care delivery and service delivery problems identified at the meeting.

Following the meeting on 26 August 2010 it was agreed with the Assistant Director for Quality and Patient Safety Improvement, South West Strategic Health Authority, that the final report should be submitted to the Homicide Review Group by 17 September 2010. A draft report was sent out, using the NPSA RCA Template, to those involved in the meeting for comment on 14 September 2010.[334]

14.2.4. Findings of the Internal Investigation

The Root Cause Analysis Investigation reported the following findings.

Influencing Factors:

- the absence of communication with other professionals involved, and lack of proactive arrangements for monitoring and contingency planning in relation to the discontinuation of antidepressants;
- assessment by mental health services which did not adequately reflect the context of pregnancy;

334. DPT notes page 200

- an underestimation of the level of depression by the mental health services;
- key professionals changed one day prior to the incident due to registering with a different GP, so there was no continuation of history and there was a loss of multiple therapeutic relationships: GP, midwife and health visitor.

Causal Factors:

- the lack of information sharing with relatives: in the absence of consent;
- variable and at times absence of information sharing between health agencies;
- no multiagency review, care and contingency planning;
- the absence of specialist perinatal health care pathways and provision;
- limitations in access to knowledge, understanding and skills in perinatal mental health within those services accessed by Ms. X;
- limitations in response by mental health services to depression in the perinatal context;
- NICE clinical guidance 45 – Antenatal and postnatal mental health was not effectively implemented across Trust services.

Root Causes:

- multiagency information sharing, review, care and contingency planning in accordance with NICE guidance would have addressed/ameliorated all of the areas of concern/limitations in service responses identified as contributory factors in this review. The absence of multiagency information sharing, review, care and contingency planning is therefore considered to be the root cause of this incident;
- lack of multi-agency protocols;
- lack of commissioned specialist expertise in perinatal mental health;
- insufficient skills, knowledge and understanding of perinatal women with mental health problems in general mental health services.

14.2.5. Recommendations of the Internal Investigation

The Root Cause Analysis Investigation made the following recommendations:[335]

335. Root Cause Analysis Investigation Report pages 24-25

1. The requirements and processes for the recording of clinical information when there is a joint assessment made by a doctor and a practitioner from another profession will be clarified and standardised by Devon Partnership NHS Trust.
2. An Implementation Plan for Devon Partnership NHS Trust will be developed for NICE clinical guidance 45 – Antenatal and postnatal mental health.
3. Multiagency information sharing, review, care and contingency planning in accordance with NICE guidance needs to be established to ensure an appropriate level of service response, timely interventions and coordinated response across agencies and professionals, to include 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. It 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 women's notes (her own records and maternity, primary care and mental health notes) and communicated to the women and all relevant health care professionals;
    - this will apply for all those in contact with secondary mental health services who are pregnant.
4. Devon Partnership NHS Trust to highlight to commissioners the need for specialist perinatal mental health care pathways and service provision to be commissioned and established across Devon and Torbay.
5. Devon Partnership NHS Trust's policy for the identification of relevant NICE guidance, its dissemination and implementation was revised in August 2010. This covers the undertaking of a self assessed organisational gap analysis, action planning to achieve compliance where appropriate, the highlighting of any risks that arise out of the self assessment and the system in place to monitor the above processes. The implementation of this policy requires monitoring and audit.
6. A safety brief will be disseminated to all clinical staff within Devon Partnership NHS Trust highlighting the key learning arising from this review; including assessment, care and contingency planning, medicines management issues, escalation of response, multi-professional and multiagency working and information sharing with families. This learning to be considered further at the Medical Advisory Committee. The report

will be shared with partner agencies to enable the learning arising from this review to be shared; particularly in relation to multiagency working and the discontinuation of psychotropic medication during pregnancy.

14.3. Serious Case Review

Torbay's Safeguarding Children Board commissioned a Serious Case Review. DPT were informed of this on 2 June 2010 by the Chair of the Safeguarding Children Board.

They were asked to identify an appropriate manager to undertake an Internal Review.

The aim of the Serious Case Review, as described in Working Together to Safeguard Children 2010, was to:

- *"Establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children*
- *Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result, and*
- *Improve intra and inter-agency working and better safeguarding and promote the welfare of children."*[336]

The SCR Team composition was:

- Independent SCR Chair;
- Representative of the Devon and Cornwall Probation Trust;
- Detective Chief Inspector for Force Public Protection, Devon and Cornwall Constabulary;
- Torbay Primary Schools Representative;
- Safeguarding Children Manager, Torbay Children's Services;
- Designated Nurse, NHS Devon and Torbay Care Trust.

Individual Management Reviews were requested from:

- Torbay Primary Care Trust – 2 GPs;

336. DPT notes page 34

- South Devon Healthcare Trust – Midwifery Services;
- Torbay Care Trust – Public Health Nursing Service;
- Devon Partnership Trust.

The first meeting of the Team was 24 June 2010.[337]

The Individual Management Review on behalf of DPT was completed on 14 October 2010 by the Named Nurse for Safeguarding, DPT, using the Serious Case Review Individual Management Review Template. The Named Nurse for Safeguarding, DPT, is an accredited IMR writer for the Torbay Safeguarding Children Board. In addition to a review of the clinical notes, this IMR included a telephone interview with the Consultant Psychiatrist for the Mental Wellbeing and Access Service and a written response from Consultant Psychiatrist 2. The Team Leader for the Recovery and Independent Living Team and the Senior Mental Health Practitioner, Recovery and Independent Living Team were not interviewed as they were off sick at the time.

The Recommendations of the Internal Management Review for DPT

Recommendation	**Action Required**	**Timescale**
The development of a multi-agency Perinatal mental health service should be completed across Devon and Torbay that has a clear pathway for pregnant mental health users that is informed by the NICE guidance.	DPT will work in collaboration with partner agencies and commissioners to identify service requirements through the commissioning process.	By end March 2011
'Think Family' is incorporated in the DPT Safeguarding Children Implementation groups current work plan and the group will prescribe how it is to be implemented in current practice.	The DPT Safeguarding Children Implementation group will add this to its current work plan.	By end March 2011
Where there are significant or complex risks identified in	The DPT Safeguarding Children Implementation	By end March 2011

337. DPT notes page 51

an assessment the DPT clinical Risk Assessment and Management Policy must be followed. All significant alterations and amendments made to documents within the service users records must be identified to enable them to be tracked.	group will add this to its current work plan. The RiO (electronic record system) Team will be informed of the issue raised by this review regarding the amendment of a key document and be asked by the DPT Safeguarding Children Implementation group for evidence that RiO can track and highlight changes.	By end December 2010

The Serious Case Review was published on 15 November 2010 and a feedback seminar was held on 1 April 2011.

The Serious Case Review Recommendations Concerning Devon Partnership NHS Trust

Recommendation	**Timescale**
A multi-agency Perinatal mental health service should be developed across Devon and Torbay that has a clear care pathway for pregnant mental health users informed by the NICE guidance.	March 2011
'Think Family' is incorporated in the DPT Safeguarding Children Implementation group's current work plan and the group will prescribe how it is to be implemented in current practice.	March 2011
Where there are significant or complex risks identified in an assessment the Devon Partnership NHS Trust Clinical Risk Assessment and Management Policy must be followed.	March 2011
All significant alterations and amendments made to documents within the service users records must be identified to enable them to be tracked.	December 2010

14.4. The Trust's Response to the Investigations' Recommendations

In response to the incident of 20 April 2010, DPT reviewed its *Safeguarding Improvement and Work Plan – Children* in August 2010.

A Safety Brief had been written by the Clinical Risk Manager on 10 July 2009 urging staff in the adult mental health services who were caring for a parent to consider the potential risks to the child as part of the CPA and Risk Assessment processes. It highlighted that *"Concerns about patient confidentiality should never delay acting as soon as suspicion, concern or problem about children arises"*.[338] A Safety Briefing was sent out urging staff to follow the recommendations of the National Patient Safety Agency in relation to preventing harm to children from parents with mental health needs. The date of this is not recorded.[339]

DPT developed action plans in response to the recommendations of the Root Cause Analysis Investigation and Serious Case Review. These action plans were incorporated into a whole-system improvement plan which was completed in June 2012. This was done because there were themes in common between the RCA and SCR and the findings of inquiries into four homicides committed by people in contact with DPT services in 2006/7 (particularly in the areas of CPA and clinical risk assessment). HASCAS have since carried out a verification of the improvements made.

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 development of the perinatal service has been in close collaboration with South Devon Healthcare Trust and midwifery staff work closely with the staff from the perinatal service.

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.

338. DPT notes page 184
339. DPT notes pages 186-7

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 remain 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 development of a Perinatal Service in North Devon and DPT is currently developing these services.

14.5. Notable Practice Identified by the Investigations

The Root Cause Analysis Investigation Report stated the following as areas of notable practice:

"Notwithstanding the issues outlined below, and the contributory factors identified, there were many examples of thoughtful practice where responses from health agencies and professionals were timely, proactive, informed and helpful.

The health agencies and professionals involved in this review have been open, honest and reflective and demonstrated a commitment to the process in order to improve the quality and safety of the care system as a whole". [340]

340. Root Cause Analysis Investigation Report page 17

The Individual Management Review of DPT highlighted the following as areas of good practice:

- That the Mental Wellbeing and Access Team responded promptly to the GP referral and referred on quickly to the Recovery and Independent Living Team when it was assessed that Ms. X required longer term support and care coordination.
- That many attempts were made to contact Ms. X by telephone despite her history of non-engagement with services, and that these telephone calls were quickly followed by appointment letters when no contact was made with her by telephone.
- That Ms. X did attend her appointments despite her reluctance to engage with the mental health services indicating that she felt supported by the staff she saw.
- That supervision was available from the Clinical Team Leaders and the covering Consultant Psychiatrist.

The Independent Investigation does not agree that these were all areas of good practice. Although many attempts were made to contact Ms. X by telephone despite her history of non-engagement with services, the Independent Investigation Team considered that when it is known that an individual has been assessed as requiring urgent intervention, and when significant information is available about the deterioration of the individual's mental health, a timely home visit would be more appropriate rather than continuing to attempt to make telephone contact.

Ms. X and her family reported to the Independent Investigation Team that Ms. X attended her appointments with mental health staff, and was encouraged to do so by her family, not because she felt supported by staff but because she was desperate to get help and hopeful that each new person she saw might be able to provide the help she required and had not previously been given.[341]

The Serious Case Review reported the following areas of good practice:

- the antenatal input by the health visitor and the visit after the birth was additional to the standard service specification;
- the input of the GP who saw the mother after the birth of the baby was thorough, painstaking and beyond the expectations of the commissioned service, especially in

341. Statement of Ms. X

light of the paucity of available information, albeit that the outcome suggests that the conclusion not to seek urgent mental health intervention may have been misjudged;

- the use by the midwifery service of the Inter-Agency Communication Form provided a systematic way of sharing information between and within services; it could helpfully have been used earlier than it was.

14.6. Dissemination and Staff Involvement

14.6.1. Root Cause Analysis Investigation

The Root Cause Analysis Investigation Report states:

"Devon Partnership NHS Trust's Serious Untoward Incident Group will consider the learning that can be taken from this report, determine the approach taken in response to the recommendations and monitor via an action plan, and ensure that learning is spread throughout the Trust via a safety brief. This group reports to the Board of Directors via the Quality and Safety Committee.

Devon Partnership NHS Trust's executive directors, clinical directors, heads of profession, managing partners and the chair of the Medical Advisory Committee will receive a full copy of this report.

The key professional involved from Devon Partnership NHS Trust will receive a full copy of this report.

The full report will be provided to NHS South West and the other agencies involved; whether as providers or commissioners, to facilitate wider learning".[342]

The Root Cause Analysis Investigation was carried out by senior staff from the three Trusts involved and did not directly involve the staff who provided care and treatment to Ms. X other than GP 1 and GP 2. The final report was distributed to senior staff from the three Trusts involved.

The Independent Investigation Team heard that the Root Cause Analysis Investigation Report was shared with the individuals from DPT who were involved in the care and treatment of Ms. X at a meeting held in November 2010 and with those who were unable to attend at a later date. The individuals who attended the meeting commented on the report which was amended in the light of their comments. The Independent Investigation Team heard that the

342. Root Cause Analysis Investigation Report, 2010, page 4

clinical staff who were involved in the care and treatment of Ms. X specifically were shown the report once it had been amended as a result of their comments.

The Independent Investigation Team was informed that an executive summary of the report was widely shared with professionals across DPT and that a subsequent Safety Brief was shared with all staff.

14.6.2. Serious Case Review

Clinical Witnesses informed the Independent Investigation Team that they experienced the process of producing an Internal Management Review as limited in scope. For example, of eight clinical staff from DPT who were identified as directly or indirectly involved in the care and treatment of Ms. X, one was interviewed on the telephone, one gave a written statement, while the others were not interviewed. The Independent Investigation Team was informed that some clinical witnesses who were interviewed found the inflexible structure of the questions asked inhibited them in expressing what they wanted to say.

14.7. Staff Support

14.7.1. Context

Devon Partnership NHS Trust's policy Guidance on the Support of Staff Affected by Incidents, Complaints or Claims (R13) recognises that members of staff can be detrimentally affected by adverse incidents:

"Adverse events, including incidents, complaints and claims, often have an adverse effect on the staff involved. The Trust is committed to supporting staff who are involved in traumatic or stressful occurrences, or who are adversely affected by any experience encountered at work".[343]

The policy goes on to state that staff support is a key responsibility of line managers, that the Clinical Risk and Complaints Manager has the responsibility to support line managers, and that the Director of Workforce and Organisational Development has a responsibility to support Directorates in ensuring support options are in place and that facilitators can be identified to conduct formal debriefing. The policy goes on the state:

343. DPT Policy, R13 Guidance on the Support of Staff Affected by Incidents, Complaints or Claims, 2010, page 2

"Managers and clinicians have a responsibility to ensure that initial supportive debriefing occurs..."

and that

"There is a range of support services, made available by the Trust, which may be helpful for staff affected by a traumatic or stressful event:

- *Trained Staff Support Advisors and Mediators*
- *Counselling provision through Occupational Health*
- *Staff support function of Chaplaincy*
- *Individual support role of Staff Side representatives*
- *Management and individual support functions of HR Business Partners/Managers*
- *Management of individual staff support function of Organisational Consultant and Associate Director of organisational Development*
- *Chief Executive's Confidential Hotline".*

The policy goes on to state that *"Formal debriefing should be arranged, for those involved in or affected by, any event which is likely to be experienced as traumatic or stressful. Formal debriefing aims to help the emotional processing of traumatic events through the expression of feelings and normalisation of reactions; aiding adjustment and increasing resilience to future traumatic experiences. However, there is some evidence that debriefing can be experienced as re-traumatising rather than a helpful process; consequently whilst formal debriefing arrangements should be put in place and staff's attendance facilitated, involvement is a matter of personal choice for the individual".*[344]

14.7.2. Findings

The Root Cause Analysis Investigation Report noted that:

- staff of DPT were initially supported by the Team Leader of the Mental Wellbeing and Access Team and the Interim Lead for Recovery and Independent Living;
- on 21 April 2010 the Chief Executive visited the teams involved;
- the Torbay Network Manager and the Interim Lead for Recovery and Independent Living held a supportive meeting with members of the teams involved;
- on 27 April 2010 the Organisational Consultant/Psychotherapist facilitated a debrief meeting for staff involved;

344. R13 Guidance for the Support of Staff Affected by Incidents, Complaints or Claims, DPT policy

- individual support as needed was provided by the Organisational Consultant/Psychotherapist and the Interim Lead for Recovery and Independent Living.

The Independent Investigation Team learned that a number of staff from DPT who were directly or indirectly involved in the care and treatment of Ms. X had moved to new roles in the Trust. The Independent Investigation Team also learned that some members of staff who were directly or indirectly involved in the care and treatment of Ms. X had required time off sick as a result of the incident.

14.7.3. Staff Support during the Independent Investigation

The three Trusts worked with the Independent Investigation Team to support staff in practical ways to ensure that:

- information was sent, and received, to advise each witness what was expected of them;
- information was sent, and received, regarding the purpose of the investigation;
- support was given if required in the writing of a witness statement;
- witnesses received support during the day of their interviews and had the offer of a debriefing session afterwards;
- witnesses received the opportunity to comment on the factual accuracy of the report.

14.8. Conclusions

The Serious Case Review and the Root Cause Analysis Investigation were carried out at the same time. The Independent Investigation Team learned that the Individual Management Reviews fed both processes but that there was some tension between the two processes.

Whilst the Serious Case Review required the three Trusts involved to provide Individual Management Reviews (IMRs) which informed the review, the three Trusts worked in parallel to prepare these IMRs. The Root Cause Analysis Investigation methodology allowed representatives from the three Trusts to work together to analyse what went wrong in the care and treatment of Ms. X and to learn together from what happened.

The Independent Investigation Team concluded that whilst the process used in the Root Cause Analysis Investigation was robust, the process of the dissemination of the report left some of the clinical staff who were directly or indirectly involved in the care and treatment of Ms. X feeling that the process had been unsatisfactory for them as individuals and that the dissemination of the findings was inadequate.

15. Being Open

15.1. Context

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006.[131] The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who have been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done[132].

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers the guidance is entirely transferable when considering any harm that may have occurred to members of the public, in particular the families of the victims, resulting from a potential healthcare failure.

15.2. Findings

Devon Partnership NHS Trust had in place a *Being Open* policy which reflected the national guidance.[345]

Devon Partnership NHS Trust made telephone and written contact with Ms. X's parents and her mother-in-law soon after the incident and offered them condolences and support.[346]

345. DPT Guidance on 'Being Open', Policy: GV11, 2010
346. DPT notes pages 223-225

DPT Trust kept an incident record in accordance with their *Being Open* policy and this was made available to the Independent Investigation.

15.3. Conclusions

Devon Partnership NHS Trust had in place a *Being Open* policy and acted in accordance with the policy.

16. Commissioning

16.1. Structure of commissioning

At the time of the care and treatment of Ms. X the mental health care provided by Devon Partnership Trust was commissioned by Torbay Care Trust, who also commissioned the health visiting and GP services. From 1 April 2012 Torbay Care Trust became the Torbay and Southern Devon Health and Care NHS Trust. Torbay Care Trust had had both a provider and a commissioning role, but Torbay and Southern Devon Health and Care NHS Trust has a provider role only. Commissioning went to the Commissioning Cluster of NHS Devon, Plymouth and Torbay.

The midwifery services are provided by South Devon Healthcare NHS Foundation Trust. They were also commissioned by Torbay Care Trust at the time of the care and treatment of Ms. X. They are now commissioned by the Commissioning Cluster of NHS Devon, Plymouth and Torbay.

16.2. Governance

Commissioners are responsible for monitoring that the services which they have commissioned are delivered and for assuring the quality of those services.

Following a serious adverse incident, as part of their governance and assurance role, commissioners of services should ensure that investigations take place in a timely manner, that these are of an acceptable quality, that they result in action plans which ensure that services are safe, fit for purpose and meet identified quality standards and current best practice guidance, and they have an identified role to play in the implementation and monitoring of the action plan.

Commissioning is currently undergoing a period of transition. Nevertheless, the Independent Investigation Team has had contact with representatives of the commissioners during the investigation process.

17. 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.

18. Lessons Learned

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

18.1. 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.

18.2. 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.

18.3. 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.

19. Recommendations

19.1 The Care Programme Approach

19.1.1. 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.**

19.1.2. 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.***

19.2. Risk Assessment and Management

19.2.1. 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.**

19.2.2. 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.***

19.3. Diagnosis

19.3.1. 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.**

19.3.2. 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.***

19.4. Mental Health Act and Mental Capacity Act

19.4.1. 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.**

19.4.2. 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.

19.4.3 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.***

19.5. Treatment

19.5.1. Medication

19.5.1.1. 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.**

19.5.1.2 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.

19.5.2. Psychological Therapy

19.5.2.1. 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.**

19.5.2.2. 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.

19.5.2.3 Recommendation

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

19.6. Safeguarding

19.6.1. 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.**

19.6.2. 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.

19.6.3 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.***

19.7. Service User's Involvement in Care Planning

19.7.1. 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.***

19.7.2. 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.

19.7.3 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.***

19.8. Family Involvement

19.8.1. 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.

19.8.2. 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.

19.8.3. 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.***

19.9. Communication

19.9.1. 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.**

19.9.2. 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.

19.9.3. 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.**

19.10. Care Pathway

19.10.1. 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.**

19.10.2. 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.

19.10.3 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.***

19.11. Clinical Governance and Performance

19.11.1. 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.**

19.11.2. 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.

19.11.3 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.***

20. Glossary

Care Coordinator	This person is usually a Health or Social Care Professional who co-ordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure that assessment and care planning occur in a timely and servicer user-centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom Government established in 2009 to regulate and inspect Health and Social Care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Cognitive Behavioural Therapy (CBT)	Cognitive Behavioural Therapy (CBT) is a talking psychological therapy that aims to help people solve emotional, behavioural and cognitive problems. CBT employs behavioural and cognitive techniques. It is goal-oriented and uses a systematic, structured procedure.
Mental Capacity Act (2005)	The Mental Capacity Act (2005) provides a framework to protect and empower people who may lack capacity to make some decisions for themselves.
Mental Health Act (1983 & 2007)	The Mental Health Act 1983 covers the assessment, treatment and rights of people with a mental health condition.
NICE	The National Institute for Health and Clinical Excellence, known as NICE, is an independent organisation responsible for providing national guidance on promoting good health and

	preventing and treating ill health.
Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
Risk assessment	An assessment that systematically details a persons risk to both themselves and to others.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
Sertraline	This is an antidepressant medication. It belongs to the class of antidepressants known as selective serotonin reuptake inhibitors (SSRIs).

Ms. X Timeline
Appendix One

Date	Event
21 June 1979	Ms. X was born
9 June 1998	Ms. X took a Paracetamol overdose and spent three days in a general hospital. She took 30 Coproxomol tablets, 48 Paracetamol tablets, some Isotretinoin (acne medication) and half a bottle of spirits. She was seen by a Psychiatrist. She was thought to be depressed.
18 June 1998	Ms. X was assessed by a Psychiatric Social Worker for treatment by the Community Mental Health Team (CMHT). It was noted that she had been depressed since 15 years of age. **Plan:** a Community Psychiatric Nurse (CPN) was to work with her; prescribe Lustral 50mg (an antidepressant); review acne treatment and contraception.
11 August 1998	A letter from the CPN, CMHT Dorchester to the GP said that Ms. X had had minimal involvement with the team as she found it stressful. She had experienced a shaky start on Lustral. She was recorded as having a *"lack of insight into her problems"* and not being ready to address them.
24 March 2000	A letter was sent from the CPN to the GP. She had given Ms. X a Cognitive Behaviour Therapy (CBT) diary. She kept it for a while then cancelled appointments and did not want further contact.
20 September 2002	Ms. X became depressed after she came off Sertraline. She declined counselling.
November 2002	Ms. X was described as being *"Virtually back to normal"* Sertraline 50mg.
16 February 2004	Ms. X was assessed as being depressed by her GP.
7 June 2004	Ms. X's Sertraline was increased to 100mg.
22 July 2004	Ms. X was assessed as having anxiety with depression.
27 July 2004	Ms. X was seen by a Psychiatrist. It was understood that Ms. X had a nine-year history of anxiety and depression. No triggers were noted. Ms. X had moved to Plymouth to be with her boyfriend. She was on Sertraline 100mg.
19 December 2006	Ms. X saw her GP presenting with anxiety and depression after separating from her boyfriend. She was referred to mental health services.
16 January 2007	Ms. X declined an appointment with mental health services. The referral was closed.

24 October 2007	Ms. X registered with a GP in Torquay.
September 2009	Ms. X stopped taking Sertraline as she was pregnant.
17 September 2009	A booking appointment with a Midwife was made. Ms. X did not report a history of mental health problems, but at the third appointment mentioned symptoms of depression and that she wanted help. A risk assessment was conducted at booking – mental health factors were ticked as *"no".*
Mid January 2010	Ms. X was seen by her GP. She was depressed. PHQ9 score 11. She was not thought to be suicidal.
18 January 2010	Ms. X was seen at the GP surgery. She was not suicidal. Low mood *"referral for guided self help for depression"* PHQ score 11 was recorded.
22 January 2010	Ms. X saw her GP. She was depressed. Discussed starting Sertraline.
26 January 2010	Ms. X saw her GP. Her conditioned had worsened, she was unable to think straight. Sertraline was restarted.
1 February 2010	Ms. X saw the GP. She was depressed. She said she was *"seeking reassurance not mad".*
11 February 2010	Ms. X saw the Midwife *"started iron due to feeling generally low and depressed".*
12 February 2010	Ms. X saw the GP. She was struggling to get out of bed. Sertraline was increased to 100mg.
19 February 2010	The GP referred Ms. X to the Wellbeing and Access Team. He asked for urgent help *"quite marked depression"*. Ms. X was noted to have been taking Sertraline 100mg until September 2009 when she stopped because she was pregnant. In the past she had suffered from depression on a number of occasions but responded well to Sertraline. There was a family history of depression on both her mother's and father's sides of the family. Ms. X had difficulty speaking and getting out of bed. She scored her wellbeing as 0 out of 10. She was 32 weeks pregnant. She had not responded to 100mg Sertraline, and had been on it since 12 February 2010.
24 February 2010	Ms. X saw the Health Visitor at the GP Surgery. She was not feeling better. She was recorded as being an anxious mother. Her husband was present for some of the appointment she requested that her history of depression was not discussed with him.
25 February	Ms. X saw a Midwife and was also seeing a Health Visitor every two weeks. It was noted that Ms. X *was "very*

2010	*depressed feels meds aren't effective yet seeing GP and HV once fortnightly. Good support from family"*. Later on the same day. Ms. X met with the Psychiatrist and Team Leader from the Wellbeing and Access Team. She described poor sleep and appetite, a history of depression, negative thoughts and wondered what people thought of her.
3 March 2010	It was recorded in the GP record PHQ9=19 *"paranoid, staying in, feels can't do anything"*.
4 March 2010	The Clinical Team Leader, Mental Wellbeing and Access Team, wrote to the GP. Ms. X had negative and paranoid thoughts about what people thought of her. She was waking at night, had poor sleep and apathy about eating. She had a ten-year history of depression. She did not want people to know her history of depression and wanted it considered to be antenatal depression. Ms. X said she hated not being able to hide her depression from her family. CBT was recommended. A section on risk noted a previous overdose. Intervention options were discussed with Ms. X and Immediate referral to a Senior Mental Health Worker for further follow-up and work on de-stigmatising her understanding of depression was agreed. A referral to the Depression and Anxiety Service was indicated for further work after the birth of her child. After the birth Ms. X could also be referred back to a *"Medic"* for review of medication. Some websites were recommended to help her.
11 March 2010	Ms. X was seen by a Midwife. Ms. X accepted a consultation with the Obstetrician regarding her depression. It was written that *"councillor not available through GP for next few weeks 8-10"*.
15 March 2010	The Consultant Obstetrician and Gynaecologist saw Ms. X then wrote to the Wellbeing and Access Team asking for CBT to be expedited because her mood was *"1/10"* and Sertraline had not helped. At 14.06 hours the same day Ms. X was seen by a Midwife. It was recorded that Ms. X felt numb. The Wellbeing and Access Team was contacted. The plan was for the Team to contact Ms. X in the next week. Ms. X's mother-in-law was looking after her. She had no suicidal thoughts.
17 March 2010	Ms. X was sent a letter from the Senior Mental Health Practitioner, Mental Wellbeing and Access Team; she was to be seen on 26 March 2010 to discuss what brief intervention she might find helpful.
25 March 2010	The GP wrote to the Senior Mental Health Practitioner, he had spoken to Ms. X who had caused concern to her family at the weekend by driving to London without letting them know.
26 March 2010	Ms. X met with the Senior Mental Health Practitioner, Mental Wellbeing and Access Team. After a discussion it was agreed that Ms. X needed to be referred to the Recovery and Independent Living Team as she needed enhanced care.
29 March 2010	The Senior Mental Health Practitioner, Mental Wellbeing and Access Team wrote an urgent referral letter to the Recovery and Independent Living Team. It was noted that Ms. X had been referred by both the GP and Obstetrics and Gynaecology Consultant. She wrote that she had met with Ms. X on 26 March 2010. Ms. X was reluctant to attend and

	was persuaded to do so by her mother-in law. It was written that Ms. X *"has some reluctance to be associated with the mental health services as this confirms to her that her thinking has always been faulty and that she is now more likely to lose control"*. Ms. X hinted at some odd beliefs, she alluded to a higher than average likelihood of a negative outcome to her pregnancy. The Senior Mental Health Practitioner asked for an urgent consideration of referral. A letter was copied to the GP.
31 March 2010	An entry in the antenatal clinic note said the Care Coordinator from the Recovery and Independent Living Team had contacted them and said she planned to see Ms. X the following Tuesday. The 'Hera Team' (Midwifery) was contacted to ask them to update the Care Coordinator regarding Ms. X's mood.
1 April 2010	Ms. X saw a Midwife at the GP surgery. She was feeling numb. She had an appointment to meet with her Care Coordinator.
6 April 2010	Ms. X met with her Care Coordinator. She declined a home visit. Her mother-in-law waited for her in the waiting room. Ms. X was flat in affect and lacked motivation. She denied thoughts of wishing to harm either herself or her unborn child. She said she was taking her medication and that she did not want her information shared with her family. She was given an appointment for the 20 April she did not wish to be seen sooner because of the impending birth. An urgent referral was sent for a Psychological Therapy assessment. It was planned that an urgent medical review would take place after the birth of the baby.
8 April 2010	A Midwifery note stated that Ms. X was flat in mood and depressed *"Not paranoid no danger to baby".*
10 April 2010	Ms. X's baby was born at 11.32 hours. She was discharged from the hospital at the midnight of the same day.
11 April 2010	Ms. X was seen at home by a Midwife. She was feeling tired and was advised to have a rest in the day. The baby was not feeding much. Ms. X was advised to *"call"* if concerned. *"Lots of support from family"* was written.
13 April 2010	Ms. X and her baby were seen at home by a Midwife. She was described as feeling *"well but tired".*
14 April 2010	A Midwife telephoned Ms. X. The baby was feeding better *"thinks she'll be OK without visit today, will ring if she needs us".*
16 April 2010	Ms. X was seen at home by the Health Visitor her mother *"raised serious concerns".* Later on the same day she was seen by a Midwife. Ms. X was tired, emotional and anxious. She was advised to contact the Health Visitor if she had concerns or needed support and to go to her planned appointment at Waverly House with the Care Coordinator.
17 April 2010	Ms. X was seen at her home all appeared to be well.
19 April 2010	Ms. X's mother telephoned 'Devon Doc' expressing concern over Ms. X's depression deteriorating. She was telephoned back by the Care Coordinator and informed her that her daughter was punching and smashing things in the house and not bonding with the baby. The Care Coordinator said she would tell the Midwife. The call from the Care Coordinator was recorded in the Midwifery notes: *"not bonding with baby, smashing and punching things, seen by GP severe postnatal depression "will phone … (CPN) so not visited today"*.

	Ms. X was seen by her new GP at a new surgery. She gave the GP permission to coordinate appointments with her mother-in-law. It was recorded *"severe postnatal depression, has felt blank before baby arrived, now worse, no emotions, v blunted affect, mother-in-law with her and looking after baby, breast feeding but v exhausted, under m/w still ref Waverley, has had councelling there but no help, no immediate thoughts of self-harm but just wants to get away, no thoughts of harming baby. Sleep ok. No bonding at all with baby. Did drive away to London when pregnant, hasn't been able to work since Feb, no features psychosis".* The GP telephoned the Midwife. She recorded *"new to them post delivery too. Notes say antenatal depression. Apparently Waverley have been contacted re her and … CPN is offering appt tomorrow at ? 3pm, but they can't get hold of her. I will try and speak to … [CPN], but couldn't find her at Waverly when I phoned so message left for … [CPN] to speak to me on mobile".* The CPN (Care Coordinator) telephoned the GP *"she will contact … [Ms. X's] mother in law to give appt tomorrow. I said I felt … [MS. X] needed psychiatric assessment/input due to PND. They will see tomorrow".* Ms. X's mother and mother-in-law contacted her former and current GPs respectively to express their concern. It was planned to communicate further the following day. The Care Coordinator discussed a medication review for Ms. X with the Team Doctor. She also spoke to a Consultant Psychiatrist, it was recorded that Ms. X did not need to be seen 'today' as the GP had assessed there to be no risk of harm to mother or child. The mother-in-law said that Ms. X was never alone with the baby and that she had not had thoughts or intentions of harm to self or baby. It was agreed that a joint assessment would take place with the Care Coordinator and the Team Doctor at 15.00 hours the next day. The Consultant Psychiatrist agreed to discuss the case at 16.00 hours on 20 April after the assessment had been carried out.
20 April 2010	At 9.15 hours the Care Coordinator telephoned Ms. X's mother asking if she could be could be brought to see her at Waverley House. Ms. X's mother explained that Ms. X was with her mother-in-law and telephoned back with her number. Ms. X's mother-in-law found the baby at the family home not breathing. The baby was taken to Torbay Hospital by ambulance, and arrived at 11.54 hours. Life was declared extinct at 12.00 hours. Ms. X was arrested on suspicion of murder. Accident & Emergency staff were informed by paramedics that the mother-in-law had found Ms. X adjacent to her baby with a pillow over his head. The mother-in-law started CPR. No other signs of physical injury or bruising were to be found on the baby. Ms. X had smothered her baby to death.