Wolverhampton Safeguarding Adults Board (WSAB) Learning Lessons Briefing – Adult A

The Review

This Learning Lessons briefing is created as the result of a Safeguarding Adults Review Committee (SARC) review into the maternal death of Adult A and her newborn child in September 2016.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- **Can I make changes to my own practice?**
- **Do I need to seek further support, supervision or training?**

Background Summary

Police found Adult A and her newborn baby both deceased on a mattress on the floor, in their home during a safe and well check in September 2016. The baby was approximately 7 months gestation.

Adult A was 43 years old and lived alone. She had two older children, both living with their respective fathers.

Adult A had originally decided to terminate her pregnancy but then changed her mind and booked late at 19 weeks at the end of June 2016. She requested that her 'booking visit' take place at her friend's house as she had only just secured her new address and was not due to move in for a week or so. During this visit she told the Community Midwife that that she had a previous history of drug misuse and depression and neither of her previous children were residing with her. She also advised that she was no longer in a relationship with the baby's father who was reported to have alcohol misuse issues and to be an in-patient in a Mental Health Hospital.

After this visit Adult A disengaged from maternity services and did not attend all further appointments. The Community Midwife repeatedly attempted to engage Adult A and when unsuccessful submitted a Multi- Agency Referral Form (MARF) to Wolverhampton's Multi-Agency Safeguarding Hub (MASH).

MASH checks identified that Adult A has previous offences/convictions for possession of Class A; was known in 4 other Police Force areas; had a history of depression and low mood and was on licence to Probation. A decision was taken to initiate a Pre-Birth Assessment. A Strategy Dicussion was held and an Initial Child Protection Conference (ICPC) booked.

Adult A and her unborn child were found deceased at home on the day that the Initial Child Protection Conference was due to take place.

Key learning themes arising from the review

Theme 1
Communication

Effective communication[1] across the health economy is key when working with pregnant women, particularly where there are concerns.

The Review found that in this instance the Community Midwife ensured that there was timely and proportionate information sharing with all key services across the health economy. This resulted in GP, Acute and Community services working in a co-ordinated way to engage Adult A . Sadly, she deliberately avoided appointments and attempts to engage her.

Theme 2
Identification of Risk and Harm

The timely identification of potential risk and harm[2] is key to safeguarding unborn children.

The Review found that the Community Midwife appropriately identified a range of risk factors; triangulated these with other services across the health economy; appropriately consulted with the Safeguarding Lead; and initiated a timely referral (MARF) to Children's Social Care.

Upon receipt of the referall the MASH shared information in timely way and an appropriate management decision was taken to initiate a pre-birth assessment.

Theme 3
Social Work Assessment

Social Work assessments should be informed by contributions from all relevant agencies, both parents and extended family. They should always address all of the issues/concerns raised within the original referral plus any change in circumstances.[3]

[1] Reference Para. 1.3 WSCB Inter-Agency Protocol for Unborn Children and Young Babies
[2] Reference Page 3 Outcome 3 - WSCB Inter-Agency Protocol for Unborn Children and Youny Babies
[3] Reference Section 1.18 Pre-Birth Procedures - West Midlands Region Safeguarding Children Procedures

The Review found that the social work assessment in this case was based upon one office visit and one home visit; was not informed by contributions from Father or key professionals; and did not consider all of the issues/concerns raised within the original referral.

However, the assessment did appropriately conclude that there was reasonable cause to suspect that the unborn was at risk of significant harm and therefore a Strategy Meeting was required to initiate an enquiry under Section 47 and there was sufficient evidence to substantiate the requirement for an Initial Child Protection Conference.

Theme 4
Strategy Discussions/Meetings and Enquiries Under Section 47

A Strategy Meeting should be held within 3 working days of the identification of reasonable cause to suspect significant harm[4]. For unborn children the strategy meeting/discussion should, ideally, take place at the hospital where the birth is planned or expected, or where the responsible midwifery service would be if the parents have not booked for service provision[5]. In all circumstances the Strategy Meeting must outline the actions to be taken under Section 47 and agree immediate actions to safeguard the child[6]. For unborn children there must be a plan for safeguarding at the time of birth[7]. This should include the completion of the Pre-Birth Checklist.

All enquiries under Section 47 must be informed by contributions from relevant agencies[8]. Furthermore Lord Laming concluded in his review that no enquiry under Section 47 should close without: the child being seen; the parents spoken to, unless in doing so would lead to a risk of further significant harm to the child; and the accommodation where the child usually resides visited[9].

The Review found that these standards were not met in this case.

Has Practice Changed?

Significant work has taken place within the MASH to review how effectively unborn children are supported by assessment; as a result managers and frontline practitioners have received additional training and refresher training regarding involvement of others in the assessment process.

Assessments must include visits to homes to ensure the circumstances wherein the adult and unborn child live are appropriate.

[4] Reference Section 1.8 Strategy Discussions - West Midlands Region Safeguarding Children Procedures
[5] Reference Section 1.18 Pre-Birth Procedures - West Midlands Region Safeguarding Children Procedures
[6] Reference Section 1.8 Strategy Discussions - West Midlands Region Safeguarding Children Procedures
[7] Reference Para 3.2 - WSCB Inter-Agency Protocol for Unborn Children and Youny Babies
[8] Reference Section 1.9 Enquiries Under Section 47 - West Midlands Region Safeguarding Children Procedures
[9] Recommendation 40 - The Victoria Climbié Inquiry 2003