NEWCASTLE SAFEGUARDING CHILDREN PARTNERSHIP
PROPORTIONATE SERIOUS CASE REVIEW
BABY D
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Independent Report Author

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CONTENTS **PAGE**

Key:

Baby D	Child subject to review
M1	Mother
A1	Aunt
MGP	Maternal Grandparents

Professional involvements:	
D1	Doctor 1
D2	Doctor 2
D3	Doctor 3
MW1	Delivery Suite Midwife
MW2	Delivery Suite Midwife
SM1	Senior Midwife
NTW1	Manager Newcastle and Gateshead crisis resolution and home-based treatment team

1. SERIOUS CASE REVIEWS AND DECISION MAKING

1.1 The decision to undertake this review was made under Working Together 2015 guidance and associated regulations[1], which was revised in July 2018 to replace Serious Case Reviews (SCRs) with local child safeguarding practice reviews. This review therefore has been commissioned and managed as a SCR in accordance with Working Together (2015) as part of agreed transitional arrangements.

The purpose of a serious case review is set out as follows:

"The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policy- makers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents".

1.2 The Case Review Committee (CRC) met on five occasions to consider the case.

At the 2 October 2018 Case Review Committee (CRC) meeting the recommendation was that the criteria for a national or local review was not met given the limited learning available. The NHS Trust also agreed to share their single agency learning and actions (root cause analysis) with the CRC.

In the CRC Rapid Review report, 11 October 2018, partners agreed unanimously that other than the learning already identified by the NHS Trust and there were no other identified areas of learning to be explored. However, if additional information did emerge as part of the ongoing criminal investigation to suggest abuse had occurred the case would be re-considered. The recommendation from the Case Review Committee therefore was that neither a serious case review nor any other learning review was thought to be necessary or required and that the circumstances of the death would be reviewed by the Child Death Overview Panel under the child death review process.

[1] *Working Together to Safeguard Children (2015) HMSO,*

1.3 In subsequent discussions with the Chair of the national panel, a decision was later taken to commission a serious case review.

1.4 Between January 2018 and September 2019, a series of conversations took place between the Chairs of the Case Review Committee, NSCB and the Child Safeguarding Practice Review Panel (the National Panel) deliberating as new information emerged as to whether the criteria were met for SCR; it was finally agreed that a proportionate SCR would be undertaken.

1.5 A Review Team of senior professionals was established whose role was to provide a source of high-level strategic information about their own agency involvement with Baby D and mother. Members of the Review Team also identified practitioners who knew or had been involved with Baby D to be interviewed by the Independent Reviewer.

1.6 The review has considered information from the first antenatal appointment with mother,14.12.17, until the mother's contact with the Police in July 2018, including any other relevant information that emerged during the review process.

1.7 The Review Team agreed the content and publication of the final report on behalf of the Newcastle Safeguarding Children Partnership, who ratified the decision on the 12th February 2020, pending the outcome of the decision by the Crown Prosecution Service.

2. THE CIRCUMSTANCES WHICH LED TO THE REVIEW

2.1 As set out in the minutes of the Rapid Review meeting (18.01.18) M1 attended an appointment at the British Pregnancy Advisory Service (BPAS) on 14 December 2017. Following a scan and an advanced pregnancy being confirmed she was referred on to The NHS Trust for follow up the same day.

2.2 M1 was then seen for a medical review. M1 stated that she suffered from polycystic ovaries which caused her to have irregular periods. Maternity staff explained that the pregnancy was too advanced for a termination. She was noted to be in a degree of shock about the news of an advanced pregnancy. A further appointment was given for 2 January 2018 and she was advised to contact her GP for midwife support.

2.3 It is important to note that at some point M1 may have been considered as a concealed pregnancy, although staff believed she thought she was 12 weeks pregnant. She was examined by D1 and information subsequently

shared by the Police noted that D1 discussed the option of adoption and that D1 had no concerns for M1's immediate welfare.

2.4 M1 did not attend her appointment on 2 January 2018. The consultant reviewed the notes and left instructions for the hospital midwives to contact the community midwife, however this did not happen. An appointment for 9 January was automatically generated.

2.5 M1 did not attend her appointment on 9 January 2018.

2.6 On the 10 January 2018 these two failed appointments triggered a search for M1 to ascertain whether she had attended anywhere else for her care. M1 had given incorrect GP practice information and a check with another GP practice revealed M1 was registered but with a different address. Following these enquiries, the safeguarding midwife was contacted.

2.7 On the 11 January 2018 after further failed attempts to locate M1 by community midwives the police were contacted. They contacted M1, and she told them that she had given birth to a girl whilst visiting with her parents overseas. She stated that she had flown home on 2 January 2018, leaving Baby D with her parents with the intention of returning to live overseas. M1 confirmed to the police that she had not disclosed her pregnancy to anyone.

2.8 The officers were concerned for her welfare and took her to a friend's address to stay overnight whist the information provided was checked.

2.9 Further police enquiries confirmed that M1 had not in fact left the country and on further interview on 12 January 2018 M1 confirmed the sequence of events relating to her pregnancy and Baby D.

2.10 M1 was distressed whilst giving the account and stated that she had given birth, at home alone, to a still born baby girl in the early hours of the 5 January 2018, although was noted to share the three-bedroom flat with two other people. The Rapid Review Meeting minutes noted the explanation given by M1 to police officers.

2.11 Police officer noted from the search of the property that M1 had cleaned up any signs of the birth. M1 had cut the cord and had put the placenta in a bin in the yard.

2.12 A post-mortem was arranged and, following a mental health assessment, M1 was arrested for concealment of birth of a child. M1 was interviewed then released into the care of her Aunt (A1).

3. THE APPROACH USED

3.1 The approach used in this serious case review aimed to utilise the principles of the systems methodology recommended by the Munro review. In particular its ambition to identify the 'deeper', underlying issues that are influencing practice and exploring, the local understanding of those involved. The meeting with those Health professionals involved, as a group, focused on reflective practice and learning through dialogue and the consideration of multiple perspectives.

4. THE INDEPENDENT REVIEWER

4.1 An independent reviewer was commissioned by the Newcastle Safeguarding Children Board.

4.2 The Independent Reviewer, Russell Pilling, has a professional background of over 25 years in the statutory social work sector including senior management of children's safeguarding services in several different local authorities.

4.3 As an independent social work consultant, he has authored several case and service reviews and chaired a number of Domestic Homicide Reviews. He has also led improvement work for a range of local authorities, recently including development of a regional adoption agency and approaches to early permanence planning for a group of local authorities in the North East.

5. PARENTAL INVOLVEMENT

5.1 M1 was offered the opportunity to contribute to the review but did not take this up.

5.2 Given the unusual circumstances of this case in terms of M1 not being previously known to any agencies it has not adversely affected the analysis undertaken. This has also been mitigated by a detailed discussion with the crisis resolution and home-based treatment team regarding M1's history and presentation.

6. PARALLELL PROCEEDINGS

6.1 In July 2020 the Crown Prosecution Service recommended that M1 receive a Conditional Caution for the offence of concealing birth; there was insufficient evidence of any other offence being committed.

7. WHAT WAS KNOWN TO AGENCIES?

7.1 The case is unusual in that M1 appears to have been unknown to any agencies prior to the death of Baby D, other than maternity services at her late presentation to them.

8. WHAT HAS BECOME KNOW SINCE THE CHILD'S DEATH?

8.1 In interview D1 stated that she was asked to review M1 on 14.12.17. M1 presented at 36 weeks pregnant, well dressed, with nothing striking about appearance or particularly nervous. D1 stated that she felt that M1's presentation was genuine. M1 talked about her work in a bar and D1 recalled that she mentioned that her family lived at a distance in the UK. M1 complied with taking of bloods and the making of a further appointment. M1 appeared genuinely shocked regarding the pregnancy. She took part in a discussion with D1 regarding options and indicated that she would be putting the baby up for adoption. D1 stated that she was not concerned regarding M1's presentation and did not have any concerns about any potential action M1 might take and did not feel there was a need for any further support.

D1 discussed the case with the Consultant on call, D3. A further appointment was made and M1 was advised to contact her Community Midwife.

D1 is clear that there was no suggestion of any mental health issues or other vulnerabilities. D1 stated that from M1's perspective it presented as mistaken gestation. D1 felt that this was genuine and that the case did not meet the criteria for a 'concealed pregnancy'.

8.2 In interview D2 stated that in terms of M1's presentation on 12.01.18 it would be hard to have guessed that she had recently given birth. M1 claimed to have irregular periods and stated she initially thought she was at an earlier stage in her pregnancy than she actually was when she presented at BPAS. All staff on duty on the 12 January 2018 had access to notes from 14.12.17. It was, they stated in interview, an unusual case. The notes from the 14.12.17 stated that M1 was clearly shocked.

When MW1 saw M1 on the 12.01.18 she was told that M1 was under arrest. M1 seemed calm, clean and appropriately behaved. M1 stated that she had had the baby 10 days previously. MW1 asked about the baby and delivery of the placenta. She stated in interview that it was quickly apparent that these were unusual circumstances and MW1 consulted with D2. MW1 also spoke to the police regarding the timeline as she was trying to make

decisions regarding clinical support for M1, but this was difficult because the date of delivery was not clear.
MW1 stated that M1 presented as a little detached, articulate but difficult to "read". MW1 stated that she could not decide if M1 was in shock or not.
In terms of the age of the placenta D2, MW1 and MW2 could not comment as they did not see it.

As on 14.12.17, on 12.01.18 D2 did not feel that M1 needed an acute psychiatric assessment. M1 was discharged from the service on 12.01.18.

8.3 The only other account from M1 was given to the police where, during her initial interview, M1 stated that neither her boyfriend nor her flatmates knew of the pregnancy. Further that she had interpreted her symptoms as related to her polycystic ovaries. She explained that she had left work, feeling unwell on 4 January 2018 and returned to work the following day following the birth of Baby D.

8.4 M1 was reviewed in custody for a mental health screening. She stated she was in shock when she discovered that she was pregnant. She reported that she had no thoughts or plans to harm herself. Good levels of engagement were noted, her mood appeared low which was felt to be realistic response to the situation. The conclusion was that there was no evidence of psychosis or thought disorder. Screening was handed over to the police and following liaison with the perinatal mental health team a mental health assessment was arranged for the 22 January 2018.

8.5 A strategy meeting was held at the MASH on 12.01.18. The basic chronology was shared between professionals, and Children's Social Care confirmed that they held no records regarding the family, however, a possible South Tyneside connection was noted. This was later clarified and discounted.

The police also advised that M1 had an alias. No further information was shared regarding the purpose of the alias or any relation to current events.

The recorded, but undated, manager's decision noted that Children's Social Care were not invited to the Rapid Response Meeting and that the contact and strategy discussion were to be closed.

A further contact was made by the Hospital by SM1 on 12.01.18. This is recorded in a contact record that has the same information as set out in the strategy meeting.

8.6 Further contact was made with the Emergency Duty Team (EDT) on 13.01.18. The request focused on the issue of potential support needs for

M1, including accommodation, and noted that there were no concerns about M1's capacity and that she did not want any family members to know about recent events in relation to the pregnancy. The response details that advice was given regarding accommodation and potential contact with the Housing Homelessness Officer. The recorded decision was to send to Social Care Direct[2].

8.7 The Rapid Review Meeting took place on 18.01.18. Information was presented by the Consultant Pathologist and summarised the condition of Baby D and the signs that a potential live birth was indicated.

8.8 At this meeting a referral to the coroner was noted as was the ongoing police investigation and a number of initial issues were raised:

- Clarification with the Obstetric team regarding communication between hospital and community midwives (see paragraph 2.5)
- Concern about the response social care regarding support for M1 (it was noted that the police sought out her A1 who was very supportive)
- Case met the criteria for referral to Case Review Committee for further consideration for a serious case review
- Final case discussion to be held once post-mortem results available

8.9 On the 22 January 2018 M1 was seen by the Consultant Psychiatrist. M1 was still staying with A1. M1 gave a history consistent with what was known to that point, adding that when Baby D was born "dead at birth" she didn't know what to do and did not tell anyone.

8.10 A Maternity Root Cause Analysis meeting took place on 27th February 2018. This made three recommendations and this review has had access to the revised guidelines put in place as a result.

8.11 The Case Review Committee met on 03.04.18 and noted previous information relating to a potential live birth and that further results were awaited from the post-mortem. The meeting agreed to wait for further information to consider whether an SCR was required but anticipated a possible learning review being undertaken.

8.12 The report[3] for the Case Review Committee 02.10.18, stated that there was little to indicate past or current psychosis or that M1 posed a risk to herself or others. It also noted M1's interest in engaging in counselling and that an appropriate referral had been made.

[2] *Adult Social Care*

[3] *Case for Consideration by the Chair of Newcastle Safeguarding Children Board for a Serious Case Review*

8.13 In interview NTW1 added that M1 had further contact with mental health services when on 10.07.18 she was referred from Police Custody by the criminal justice liaison team (nurse team based at the station). M1 was presenting as a vulnerable person and the police, during an interview, were concerned for her mental health. The criminal justice liaison team undertook a full assessment on 11.07.18 and referred M1 to the crisis resolution and home-based treatment team.

The assessment concluded that M1 had not been previously known to mental health services and was not considered a risk to herself or others. The case was allocated for home-based treatment and closed.

In a further review discussion with a psychiatrist it was noted that M1 presented appropriately regarding her emotional state and once again was not a risk to herself or others

The psychiatrist also noted that it was not clear how much M1 suspected that she was pregnant. M1 had stated, for example, that she had continued her periods, had completed some negative pregnancy tests and had continued to use contraception. Antidepressants were prescribed and following this M1 was discharged and referred onto a therapist at 'Talking Helps'.

8.14 This report (see 8.12) is the first that mentions the Police examination of M1's phone records. These indicated that M1 had been looking at ways to abort the baby using tablets, stabbing herself in the stomach or falling downstairs (Police information 28.08.18).

8.15 At the Case Review Committee meeting on 02.10.18 it was noted that on-line searches around 'how to cause a termination' commenced from 14.12.17. Other searches took place on the night of the birth, for example, 'what causes pain in thighs.

At this meeting the police also shared that M1 had stated that Baby D had not made any noise following birth and prior to her wrapping her in a towel. M1 also said to police that she felt scared, sad and confused and felt calling 999 would not change anything. However, it was noted that the post-mortem had concluded that the baby was born alive. The police stated that they were still pulling together the case file to submit to the CPS.

9. ANALYSIS OF PRACTICE

9.1 Analysis of practice in this serious case review largely focuses on the small window of opportunity presented to professionals following M1's initial presentation on 14 December 2017.

Prior to this date M1 was not known to any agencies. Furthermore, no recent, relevant, information is available to this review from the GP or any family members regarding M1's history or any precipitating factors. The history gained by mental health professionals during 2018 referred to in section 8 of this report does not provide any additional information that could be considered a contributory factor to the death of Baby D.

9.2 The relevant definition set out in NSCB guidance applicable at the time regarding 'concealed pregnancy' is as follows;

"A concealed pregnancy is when a woman knows she is pregnant but does not tell any health professional; ***or*** *when she tells another professional but conceals the fact that they are not accessing antenatal care;* ***or*** *when a pregnant woman tells another person/s and they conceal the fact from all health agencies.*

A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases, a woman may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children (Spinelli, 2005)."

In the same guidance, where suspicion arises it states:

"5.2 Professionals must balance the need to conserve confidentiality and the potential concern for the unborn child and the mother's health and well-being. Where any professional has concerns about concealment or denial of pregnancy then they should contact other agencies known to have involvement with the woman so that a fuller assessment of the available information and observations can be made.

5.3 Where there is a strong suspicion there is a concealed or denied pregnancy then it is necessary to share this irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child will override the mother's right to confidentiality. A referral should be made to Children's Social Care, Initial Response Service

(IRS) team about the unborn child. If the woman is aged less than 18 years, then consideration will be given to whether she is a child in need. If she is less than 16 years, then a criminal offence may have been committed and needs to be investigated.

5.4 The reason for the concealment or denial of pregnancy will be a key factor in determining the risk to the unborn child or new-born baby. The reasons will not be known until there has been a systematic multi-agency assessment. If there is a denial of pregnancy, then consideration must be given at the earliest opportunity to a referral which will enable the woman to access appropriate mental health services for an assessment. Advice can be sought from the designated or named professional or from IRS at Newcastle Children's Social Care services."

9.3 There is a fundamental issue in terms of how M1 was seen and understood by practitioners when she presented on 14.12.17. In interview D1 did not consider her vulnerable. D1 stated that there was no suggestion of any mental health issues and that from M1's perspective it presented as mistaken gestation. M1 was noted to be in a degree of shock about the news of an advanced pregnancy. D1 felt that this was genuine, and that the case did not meet the criteria for a 'concealed pregnancy' given that she had presented to BPAS and attended the RVI. Neither D2 nor the midwifes who saw M1 later 12.01.18 disputed the previous notes. In discussion with the independent reviewer D2's opinion was that M1 was very plausible and she could understand why staff anticipated M1 would follow the advice given to her regarding follow up. Although MW1 stated that M1 presented as a little detached, articulate but difficult to "read".

If M1 had presented as a concealed pregnancy, then the Directorate of Women's Services Safeguarding guidelines at the time and the later revised version, recommend referral to children's social care services. This was not done, because at the time this was not how M1 situation was understood or labelled. M1 was not seen as vulnerable and there was no identified need for mental health screening. D1 consulted appropriately with a senior colleague and M1 was offered a further appointment.
As a result of the root cause analysis meeting the Trust identified that on reflection the late booking at 36-week should have generated a safeguarding notification to the safeguarding team at the Trust and have also acted regarding the communication with community midwifes and the sharing of internal safeguarding alerts. Although a safeguarding notification was sent later when attempts to locate M1 got underway. This review would endorse these as reasonable and positive improvements to the guidelines. The strengthened guidelines also clarify the issue of practice when a mother's plan is for adoption.

However, it is also clear that the medical staff were unaware of the NSCB guidance document. The Trust and NSCB guidance could therefore more clearly reflect and support practitioners in making the key distinction between 'mistaken gestation' and 'concealed pregnancy'.

9.4 Whilst M1 gave initially conflicting information and her registration with a GP practice remains confused, her account of the birth of Baby D is as set out in this report. M1 was screened for any mental health vulnerabilities whilst in custody and none were identified. M1 identified a family member (A1) as her support and she was quickly involved by the police.

The findings of the post-mortem discussed at multi agency meetings clearly were central to the criminal investigation. For the purposes of this review it remains unclear regarding the cause of death but that the missed appointment of the 02.1.18 would have been an opportunity to provide a level of care to M1 and that may have improved the outcomes for Baby D. In fact, the Case Review Committee (02.10.18) acknowledged that there would have been no reason to suppose that Baby D would not have survived if delivered in a healthcare setting.

9.5 The automatic generation of a further appointment for the 02.01.18 would have been at 39 weeks and the second appointment for 09.01.18 was beyond the expected date of delivery. Neither was attended by M1; however, the automated system was clearly not useful and mitigated against proper care for M1. Again, it is positive that this has been addressed in the revised Directorate of Women's Services Safeguarding guidelines.

9.6 A strategy meeting was held at the MASH on 12.01.18, as set out in the procedures, and the case closed in view of the death of Baby D and the multi-agency meetings taking place regarding the circumstances, for example, the Rapid Response Meeting/CDOP Initial Information Sharing meeting. In light of this the recorded, but undated, managers decision was for the strategy discussion to be closed.

10. SUMMARY OF LEARNING

10.1 There could be greater awareness across the agencies involved in this case of the multi-agency procedures in place to guide practice as well as the single agency procedures available.

10.2 The issue of whether this was in fact a concealed pregnancy has been subject to some confusion. The practitioners who saw M1 did not regard it as such, even though it was referred to in this way at a later discussion. All guidance in relation to 'concealed pregnancy' should address the issue of categorisation and the distinction to be made with 'mistaken gestation'.

10.3 In terms of CDOP action (4) D2 felt it was not clear what had led to the request for the hospital midwife to contact the community midwife not been actioned. She felt that it was likely human error in a busy clinic. This represents learning for The Trust and in revised 'Directorate of Women's Services safeguarding guidance' issued in August 2018 the section 'Referrals from BPAS Women attending BPAS who due to gestation are not eligible for termination of pregnancy states:

"Identify Community Midwife: inform Community Midwife verbally and obtain date and time for antenatal appointment."

10.4 Further internal Trust learning was highlighted in relation to GP information. The process now is for the Hospital Midwife to directly contact the GP to notify of pregnancy. In addition, safeguarding alerts are saved electronically in the designated folder that Band 7 midwives have access to on the shared drive. Furthermore, for local alerts hard copies are sent to all maternity wards and departments within the RVI.

10.5 Given the traumatic circumstances experienced by M1 the lack of further potential contact with M1 and assessment of her support needs as requested by the Police was not in her best interests. Although screening regarding her mental health had taken place at the police station there was a potential role for more holistic engagement with M1 to support her at this time.

10.6 Children's Social Care were not invited to attend the child death review initial information sharing meeting and although they had no information to share, subsequent events and learning, for example, the support offered to M1 described above (10.5), may have been more effectively dealt with had they been present. Children's Social Care are such a central service in circumstances such as these that there is a case for them being core members of all child death review initial information sharing meetings.

11. RECOMMENDATIONS

	Recommendation	Responsibility
11.1	NSCP guidance to be reviewed and if necessary revised to reflect the issues of 'concealment' and 'mistaken gestation' more clearly. The NSCP should ensure that this guidance is clearly additional to or consistent with the Trust's Directorate Women's Services safeguarding guidance. This guidance to shared with all relevant staff to ensure that awareness is comprehensive across the NSCP system.	NSCP
11.2	NSCP to review the response to the Police request for support to M1 and to consider whether there is a need to review procedures guiding the partnership's response in these circumstances.	NSCP
11.3	Consideration should be given to Children's Social Care attending all child death review initial information sharing meetings as a core member. Even when information sharing is minimal this would support responsiveness and learning across the whole system.	NSCP

12. REFERENCES

HM Government (2015), Working Together to Safeguard Children
HM Government (2018), Working Together to Safeguard Children
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