Learning Briefing 1

Case Summary:

Mya's birth has been ascertained as a macerated stillbirth. It appears she was dead in the womb for several days prior to delivery. Mya was subject of a Child Protection Plan as an unborn baby as there was significant multi agency concern for Mya's safety and welfare. Both of her parents were drug users, neither had care of their older children and approximately three weeks prior to Mya's birth both parents went "on the run" as they were expecting to receive significant custodial sentences.

Initial enquiries within social care, the police, the drugs services and health revealed a high level of concern for Mya as an unborn baby and extensive multi-agency work was undertaken. As Mya was a stillbirth the criteria under Working Together 2013 was not met, however the decision was taken by the Board that there would be valuable learning within this case and as such, a case review was undertaken.

Areas for improvement/Concerns within the case:

There were a number of concerns about Mother's drug urine tests – that she would not provide them to midwifery; that she may have asked someone else for urine; that she presented dilute urine.
There was a strong suspicion from midwives that Mother was using above her script, this was shared by midwifery to SGDAS (South Glos Drug and Alcohol Services).
Midwives and drugs workers seeing mothers together would be beneficial.
Internal information sharing amongst professionals was not as good as it could have been. All information sharing regarding levels of drug use was not shared with all those necessary.
When Mother was missing it was reported that there was a point where she presented at a Health Centre in North Somerset after jumping out of a window and this information was not shared. However no record of this can be found.
The couple did not engage with the core group.
Mother had been referred to First Point by Probation due to concerns about risk and her pregnancy but were advised it was too early to refer.
When at Court their Barrister informed the couple they were likely to receive a substantial sentence which led them to go missing again.

Good Practice/Positives within the case:

Mother had fairly good antenatal attendance despite her late booking.
The couple continued to engage for a couple of weeks after the initial Child Protection Conference.
Mother was informed of the negative effects on pregnancy of drug use by SGDAS.
SGDAS showed sensitivity around mum's possible previous sexual abuse in terms of urine testing.
Mother was aware she was on less than a blocking dose of script.
There was good information sharing across heath, police forces and Local Authorities when the couple went missing.
Protocols and Procedures in place were thought by the Police and Judiciary to be sufficient to deal with a situation like this.
Once social care became involved, the couple received good support.
Father was engaged by agencies who took his involvement into account.
The heath visitor attended the unborn Initial Child Protection Conference.
The police allowed father to see mother following the stillbirth and their arrests.

Complicating Factors;

- Mother wanted to give birth at a hospital in Bristol (St Michaels) which is less common for South Gloucestershire residents.
- The midwifery team at the chosen birth hospital are not used to working with SGDAS.
- Drug using ante-natal cases are infrequent but not unusual events in South Gloucestershire.

Recommendations:

1. A system to be developed to invite SGDAS to St Michaels for a joint ante-natal clinic when necessary.
2. Core groups to ensure key others are fedback to and by who and when. There must be multi-agency attendance at core group meetings.
3. Where parents collect a script social care to include pharmacists in assessments.
4. Where parents are drug users, social care to establish and share whether the parent is one of the most concerning on their caseload.
5. Clear care pathways for drug using parents to be introduced.
6. Saliva testing of drug using parents to be considered.
7. Internal information sharing processes for high risk service users who go missing were not as robust as they could have been and should be reviewed.
8. The South Glos practice of reviewing unborn babies on CP plans needs to be looked at.
9. The referral from probation that was not actioned needs to be looked at – the timing of such referrals and impact of a mother's history need to be explored. Ascertain whether the health centre in North Somerset should have shared information about mother's presentation there.

The review was commissioned by South Gloucestershire Serious Case Review Sub-Group and was undertaken in September 2014.