NEWS RELEASE

BSCB Bristol Safeguarding Children Board
making safeguarding everybody's business

EMBARGOED Thursday 6 April, 3pm

Safeguarding Board publishes Serious Case Review in Charlotte Bevan and Zaani Bevan-Malbrouck case

The effective safeguarding of new mothers with mental health needs and their babies is the focus of a new Serious Case Review (SCR) published by Bristol Safeguarding Children Board today (Thursday 6 April). The Board, Charlotte's family and local agencies are marking the publication by urging anyone with mental health concerns to seek information, advice and support from their GP, NHS 111 or www.nhs.uk/mentalhealth.

The review followed the tragic deaths of Charlotte Bevan and her baby Zaani Tiana Bevan-Malbrouck on 2 December 2014, which Coroner Dr Maria Voisin noted were a result of Charlotte's 'undiagnosed psychotic relapse' as part of a narrative inquest finding in October 2015.

The review found much good practice amongst local health and safeguarding organisations, as well as things which could be improved. It does not seek to place blame, but instead intends to help agencies consider what can change and how consistent good practice can be applied within a complex multi-agency system.

Report authors Julie Pett and Sarah-Jane Leatherland make eight formal findings across a range of topics, along with extra learning from experiences on the fringes of the case and throughout the process of conducting the SCR.

Among the important issues found by the review is a strong recognition that safeguarding is everyone's business, also highlighting that 'professionals are working in increasingly pressured environments with limited resources, yet being required to deliver services with ever-higher expectations. Within this climate, both supervision and information sharing become a particular challenge and feature in a number of the Findings'.

Sally Lewis, Independent Chair of the Bristol Safeguarding Children Board said: "This was a particularly tragic case and our thoughts remain with Charlotte and Zaani's family and friends. We are very grateful for their family's involvement in the Serious Case Review, which gave the reviewers valuable insight.

"This review provides constructive learning for many agencies and professionals working in Bristol and beyond. A great deal has already changed in local professional practice since this tragic incident, some of which has been influenced by the findings of this review and has been noted by the Board in our formal response."

Rachel Fortune, Charlotte's mother, contributed to the Review. She said: "My daughter Janet and I have read the report and would like to thank everyone who contributed to it. There are eight findings and from these there is clear constructive

learning. These include how to manage the difficulty of long-term ill mental health alongside pregnancy; honest, accurate and timely communication; multi-agency working with a lead clinician; and best practice for clinic supervision. This report will now be received by many health professionals who will share the learning with their colleagues. As you can quite clearly see from the report, no single thing, action or person was to blame.

"This was a particularly difficult case to manage as long-term ill mental health and pregnancy came together. It's our hope now that any families and individuals facing such difficulties will have a multi-agency team with accountable clinicians in each service, as they now do in Bristol. Safeguarding and mental health issues often go hand in hand: both are *everyone's* business. Janet and I hope that research, education in schools and a general increased awareness of all mental health issues will go some way to preventing what happened from happening again.

"If you or someone you know are suffering from mental health problems, please don't be afraid to ask for help. There is a wide range of advice and support available and this can make all the difference."

Sally Lewis continued: "As Independent Chair of the Board I have seen evidence of improvements made by local services. These are undoubtedly meaning better support for pregnant women who are at risk of mental health issues, along with stronger recognition that the safeguarding of their new or unborn child remains in clear focus.

"We can never totally eliminate risk, but reviews like this help agencies make improvements, better recognise the potential for harm and take appropriate actions. Of course, safeguarding is everybody's business and not only a responsibility of professionals. It is important therefore that every member of our community knows that by raising concerns, even where there may be uncertainty, their contribution is valued and they can play a crucial part in safeguarding our children. If you are concerned about a child's safety call First Response on 0117 903 6444 in working hours, the police on 101 out-of-hours or, if you think there is immediate danger to someone, 999.

"If you have a concern about your own or someone else's mental health please visit www.nhs.uk/mentalhealth for information and advice, see your GP or call NHS 111."

The Serious Case Review is available now on the Bristol Safeguarding Children Board webpages at www.bristol.gov.uk/policies-plans-strategies/bscb-serious-case-reviews. Also available for download is the Board's response, which sets out progress and intentions amongst local organisations against each of the findings.

The eight key findings of the SCR are:

Finding 1
The positive strategy of long-term engagement with service users in Mental Health Services has the unintended consequence of creating difficulties when balancing the needs of a pregnant service user against the needs of the unborn child.

Finding 2
Although Bristol health professionals have access to safeguarding support and supervision; the model of support is inconsistent. This means the possible risks to an unborn child may not be recognised compared to the more immediate needs of the adult.

Finding 3
Current practice does not identify a lead clinician across services that work with vulnerable adults, including those who are pregnant. This means that case management for service users with complex needs lacks coordination.

Finding 4
Some professionals may feel intimidated by unpredictable and hostile service users, and become less confident in using their skills and expertise to challenge whilst maintaining support and engage the service user. This impact can be compounded if the service user presents as verbally assertive and challenging.

Finding 5
Professionals in Bristol are inconsistent in their ability to provide Children's Social Care First Response with a referral that articulates their concerns clearly enough to meet the threshold for a service. Children's Social Care First Response does not consistently provide feedback as to why a referral does not meet the threshold for social care, leading to inaction by referrer and First Response.

Finding 6
Common terms used professionally to describe a service user's health may have different connotations depending on the professional setting. If they are taken at face value by other professionals this will have a direct impact on practice and decision-making.

Finding 7
The practice of service users being asked to relay complex information about their treatment or condition verbally to other agencies makes it more likely that this information will be incorrectly relayed or not shared at all. This places the unborn child and service user at increased risk of vulnerability.

Finding 8
The complexity and range of individual services that work with pregnant women with mental ill health across Bristol makes it difficult to coordinate multi-organisational working.

ENDS

Notes to Editors

1. Charlotte and Zaani's family have requested that no images of Zaani Bevan-Malbrouck are used in reporting and we politely ask that you respect this request.

2. Charlotte and Zaani's family ask not to be contacted directly by reporters. No further comment will be provided by the family. Audio and video footage of Rachel Fortune's comment is available by calling 0117 922 2650 or emailing the Bristol Safeguarding Children Board c/o public.relations@bristol.gov.uk.

3. Comment from Rachel Fortune has been included at her request in order to give her own views and discourage direct media contact with her and her family. The comment is independent of Bristol Safeguarding Children Board and is in Rachel's own words.

4. Please make every effort to include in your coverage details of how readers, listeners or viewers can access support:

   Safeguarding - First Response on 0117 903 6444 in working hours, the police on 101 out-of-hours or, if you think there is immediate danger to someone, 999.

   Mental health – www.nhs.uk/mentalhealth, visit your GP or call NHS 111.

5. The Samaritans top tips on reporting suicide are attached and we politely request that these are followed in your reporting. Full guidelines can be found at http://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

6. For media enquiries please contact:

   Bristol Safeguarding Children Board
   c/o Tim Borrett, 07775 227322, tim.borrett@bristol.gov.uk
   c/o Amy Cains, 07467 335738, amy.cains@bristol.gov.uk

   Avon and Wiltshire Mental Health Partnership NHS Trust
   Lucy Robinson, 07900 494276, lucyrobinson2@nhs.net

   Bristol City Council
   John Smith, 0117 352 1258, john.smith@bristol.gov.uk

   Bristol Clinical Commissioning Group
   Kierstan Lowe, 0117 900 2549 (inc. out of hours), 07825 905801,
   Kierstan.Lowe@bristolccg.nhs.uk

   Rachel Fortune
   c/o Tim Borrett, 07775 227322, tim.borrett@bristol.gov.uk
   c/o Amy Cains, 07467 335738, amy.cains@bristol.gov.uk

   University Hospitals Bristol NHS Foundation Trust
   Fiona Reid, 0117 342 3774, fiona.reid@uhbristol.nhs.uk