Calderdale Safeguarding Children Partnership

Serious Case Review – Child P

Author: David Mellor BA QPM

1.0 Introduction

1.1 On 7th April 2018 a three months old child, who will be referred to in this report as Child P, sustained significant injuries whilst in the care of his parents in the family home. A criminal investigation was commenced, which, at the time of writing, is ongoing.

1.2 Child P's family had been receiving substantial support from a range of agencies since early 2016 when Child P's mother became pregnant with his elder sibling, Child 1. The primary concern of the agencies providing support to the family related to the potential impact of mother's longstanding mental health problems on Child 1 and Child P.

1.3 Calderdale Safeguarding Children Board (now Calderdale Safeguarding Children Partnership) decided to conduct a serious case review (SCR). David Mellor was appointed as the lead reviewer and chair of the SCR Panel established to oversee the review. David is a retired police chief officer who has over six years experience as an independent author of SCRs and other statutory reviews. He has no connection to services in Calderdale. Membership of the SCR Panel and a description of the process by which the review was conducted is set out in Appendix A.

2.0 Terms of Reference

Scope

2.1 From 1st January 2016 (the beginning of mother's pregnancy with Child 1) until 7th April 2018 (when Child P was taken to hospital with significant injuries). Relevant historical information in respect of Child P's parents and 'significant others' will also be included within the scope of the review.

Lines of enquiry

(i) To what extent did the agencies involved share relevant information with each other in a timely manner? And was this understood?

(ii) How effective was the Early Intervention Co-ordination and planning for this family?

(iii) To what extent was the impact of Mother's mental health on her daily functioning and on her ability to provide safe care and support to her children understood by the professionals involved and acted on?

(iv) Was the role of the father and other adults in the household, the relationships between the adults, and the relationships between the adults and children understood? What might have prevented a full understanding?

(v) Was practice sufficiently child-focused?

(vi) Did the agencies involved understand what life was like for the children? What might have prevented a full understanding?

(vii) To what extent was the impact of the birth of the second child on parenting and family functioning understood?

(viii) Was the time of year when Child P was born significant in the way in which agencies worked together and planned discharge of the baby from hospital?

3.0 Glossary

Attention deficit hyperactivity disorder (ADHD) is a behavioural disorder that includes symptoms such as inattentiveness, hyperactivity and impulsiveness.

The **Care Programme Approach** (CPA) is a package of care for people with mental health problems. Service users will have a care co-ordinator (usually a nurse, social worker or occupational therapist) who will manage their care plan and review it at least once a year.

The term **Early Help** describes the process of taking action early and as soon as possible to tackle problems and issues emerging for children, young people and their families. Effective help may be needed for at any point in a child or young person's life.

The **Generalised Anxiety Disorder Assessment (GAD-7)** is an instrument used to measure or assess the severity of generalised anxiety disorder (GAD). The individual to rate the severity of his or her symptoms over a two week period.

Health visiting levels of service. The health visiting service provide four levels of service as follows (1):

- *Community*: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.
- *Universal*: health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- *Universal Plus*: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- *Universal Partnership Plus*: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or additional concerns such as safeguarding, domestic abuse and mental health problems.

Patient Health Questionnaire (PHQ-9) is used to monitor the severity of depression and response to treatment

The **perinatal period** refers to pregnancy and the first 12 months after childbirth.

Specialist community perinatal mental health teams offer specialist psychiatric and psychological assessments and care for women with complex or severe mental health problems during the perinatal period.

A person with a **Personality Disorder** thinks, feels, behaves or relates to others very differently from the average person. There are several different types of personality disorder. Symptoms vary depending on the type of personality disorder. A person with borderline personality disorder (one of the most common types) tends to have disturbed ways of thinking, impulsive behaviour and problems controlling their emotions. They may have intense but unstable relationships and worry about people abandoning them. A person with antisocial personality disorder will typically get easily frustrated and have difficulty controlling their anger. They may blame other people for problems in their life, and be aggressive and violent, upsetting others with their behaviour. Someone with a personality disorder may also have other mental health problems, such as depression and substance misuse.

Postpartum psychosis is a severe mental illness. It starts suddenly in the days, or weeks, after having a baby. Symptoms vary, and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions.

Team Around the Child (TAC) is a model of multi-agency service provision. The TAC brings together a range of different practitioners from across the children and young people's workforce to support an individual child or young person and their family. The members of the TAC develop and deliver a package of solution-focused support to meet the needs identified through assessment and multi-agency planning.

4.0 Synopsis

4.1 In late January 2016 mother informed her GP that she was pregnant with her first child. The father of the unborn child did not live with mother and was registered with a different GP practice. Over the years mother had had intermittent contact with mental health services and had been discharged by psychology in April 2015. The risks and benefits of continuing to take Mirtazapine, an antidepressant medication, were discussed with her by her GP. It was decided that mother would continue with the medication because stopping would have a significantly adverse effect on her mental health. Mother continued to be prescribed Zopiclone, a sleeping pill for serious bouts of insomnia which helps the patient fall asleep more quickly, and also helps stop the patient waking up during the night.

4.2 In late February 2016 mother saw a community midwife for maternity booking. Mother's mental health history was noted and a self-reported diagnosis of 'bipolar' was recorded. Mother was referred to the perinatal mental health lead for midwifery. (The aim of perinatal mental health services is to ensure that women have access to timely and effective mental health care during the perinatal period).
The plan was for shared care between the consultant obstetrician and midwifery due to mother's history of smoking and hypermobility (joints which can be moved beyond the normal range).

4.3 In early March 2016 the referral mentioned in the previous paragraph was received by the specialist midwife who contacted South West Yorkshire NHS Foundation Trust (SWYPFT) Single Point of Access (SPA) team and mother's GP and confirmed that mother had no diagnosis of bipolar but there was a suggestion of personality disorder and attention deficit hyperactivity disorder (ADHD). (SWYPFT provides mental health services in Calderdale and other areas. The SPA team provides, amongst other things, a referral line for service users and also offers advice to referrers.)

4.4 Also during March 2016 mother saw a community midwife and expressed some anxieties about the pregnancy and described often feeling worried. The community midwife provided reassurance.

4.5 Later in March 2016 the specialist midwife met mother to discuss her emotional wellbeing. She was assessed as having symptoms of mild depression and moderate to severe anxiety. Mother's family and upbringing were discussed and she disclosed that her mother had been dependent on alcohol and abandoned her when she was a new-born. She had been brought up by paternal grandparents and had met her father only a few times. Mother acknowledged that these experiences could impact on her own parenting skills. A plan was agreed including referral to the mental

health SPA for additional mental health support and referral to a range of sources of support. Mother declined online information as she said she did not access the internet often. Her GP was informed of the plan. It was noted that mother was experiencing increased anxiety and that practitioners may need to consider the impact of her anxiety when caring for her and to ensure she was given the opportunity to voice her concerns. It was acknowledged that additional appointments may be necessary to facilitate this.

4.6 During April 2016 mother was seen by the obstetrician. Her mood was noted to be good. She was continuing with antidepressants after it was said that she had attempted to reduce the dose which had led to a deterioration in her mental health. (There is no indication that a reduction in mother's medication had taken place, but this had been discussed with her GP (Paragraph 4.1)). It was explained to mother that the baby would need to be delivered within the hospital delivery suite and due to the medication she was taking, the baby would need to be monitored. The need to avoid breast feeding was also discussed. Advice was also provided on smoking cessation. The effects of hypermobility during pregnancy were also discussed.

4.7 In late May 2016 mother attended a mental health clinic appointment when she was said to have good insight into her mental health, no suicidal thoughts or hallucinations. Her medication was discussed and the risks to the baby in terms of withdrawal were discussed.

4.8 In early July 2016 mother's community psychiatric nurse supported her to attend an employment support allowance (ESA) appointment during which she reported suicidal ideation, but no plans to harm herself. She said she was looking forward to the arrival of her baby.

4.9 During July 2016 mother made a number of complaints about neighbour nuisance to her social housing provider. She described herself as 'furious' at the behaviour of her neighbour at one point. The housing provider arranged for mediation which appeared to resolve the conflict.

4.10 In early September 2016 the community midwife visited mother at home to discuss the birth plan. Mother reported feeling anxious about her forthcoming stay in hospital and the possibility of sharing a bay. It was said that father, who lived apart from mother, would need to stay with her in hospital as she may not wake to care for the baby due to her prescribed medication. Staff on the postnatal ward agreed that a side room would be provided if possible. It had been agreed with the breast feeding lead that it would be appropriate for mother to breast feed despite medication. However, the breast feeding lead was to seek further information regarding this. Subsequent contact with the drugs information service established

that mother could breast feed whilst in hospital when the baby could be monitored. Thereafter, following discharge from hospital, the medication mother was prescribed was not considered to be compatible with breast feeding.

4.11 Because of mother's complex needs, her case was reviewed by the named midwife, safeguarding in late September 2016. This led to a discussion with the SWYPFT safeguarding children nurse advisor which highlighted that mother's community psychiatric nurse and her community midwife had not yet been in contact with each other. It was agreed that the community midwife would contact the mental health worker to discuss mother's medication and consider whether this would impact on her ability to care for the baby (there appeared to be some concern over whether mother's medication could sedate her and prevent her waking with the baby). Additionally, it was requested that her mental health worker provide a perinatal mental health plan outlining the support for mother.

4.12 The following day mother was seen by her mental health worker. She reported waking every two hours during the night and there were said to be 'no concerns' regarding waking and feeding the baby.

4.13 The next day mother's case was reviewed by her community midwife who had a discussion with her mental health worker. The plan which was agreed noted that mother was on the perinatal mental health pathway. Following discharge from hospital after the birth, mother was to be visited by the mental health team daily for two weeks. Father was also planning to move in with mother for a month to provide support following the birth. An appointment had been arranged for the following week for review by a psychiatrist prior to the birth. Post-delivery the community midwife, the health visitor and the mental health worker would meet to plan mother and child's ongoing care. The specialist midwife, perinatal mental health would also oversee mother.

4.14 With the birth imminent, mother was referred to the SWYPFT intensive home based treatment team (IHBTT) in late September 2016. The home based treatment team intensively nurse people in their own homes as an alternative to admission to a mental health unit. They work closely with family and carers in order to provide nursing care. They see people on a daily basis while they are unwell and work to enable recovery.

4.15 Child 1 was born in hospital at the end of September 2016. No concerns were raised by maternity staff in relation to mother's care of the baby. She was supported by father. Whilst in hospital, mother had been reviewed on a daily basis by the mental health liaison team and no issues of concern noted. Mother and Child 1 were discharged in early October 2016 and the hospital discharge plan noted a risk of

postnatal depression which would be addressed by the community mental health team.

4.16 After making a number of home visits to mother and Child 1, in late October 2016 mother's community midwife transferred her care to the health visitor. The community midwife had had no concerns in relation to mother's mental health, her care of the baby or father's care of the baby. The health visitor subsequently found mother to be attentive to the needs of Child 1 who was noted to be alert, active and well fed. The health visitor service provided to mother was at the level of 'Partnership' or 'Partnership Plus'. Mother however, had expressed some anxiety to the IHBTT and had also asked them if Child 1 could sleep at father's house. There is no indication that this request was explored further. IHBTT advised mother to raise the issue with the health visitor but there is no indication that she did so. IHBTT involvement with mother also came to an end during October 2016.

4.17 During November 2016 mother twice reported hallucinations to mental health support workers and the nature and impact of the hallucinations were explored, although her mood was generally perceived to be stable.

4.18 In early December 2016 mother reported compulsively buying things on the internet and not being aware of doing this to her mental health worker. No obvious change in her mood was noted.

4.19 Also in early December 2016 mother disclosed to her mental health support worker that she had increasing debt and was signposted to support. She also shared that she continued to experience auditory hallucinations and said that father was watching her through a secret camera. (This latter concern was triggered by a camera icon on the TV screen in her bedroom which a neighbour helped her remove).

4.20 From mid-December 2016 mother began to be prescribed Quetiapine (25 mg) in addition to Mirtazapine and Zopiclone which continued. Quetiapine is an antipsychotic drug. It is assumed that mother's GP began to prescribe it on the advice of mental health services. It is unclear whether the impact of taking this drug on mother's parenting capacity was considered.

4.21 In early January 2017 the health visitor saw mother and Child 1 at home for a routine review. Appropriate bonding and attachment with Child 1 was noted. Mother reported that the baby's attachment with father was limited as father now only visited on Saturdays. Mother added that she was no longer in a relationship with father. She reported her mood to be good. She was concerned about an impending visit by bailiffs over an unpaid TV licence (Her grandmother later settled this debt for

her). Local activities which mother could access with Child 1 were discussed but mother said she would struggle to interact with other mothers. Lengthy advice was given on safe sleeping as mother reported bed sharing with Child 1.

4.22 In late January 2017 mother was seen by the community mental health team for a review of the recent change in her medication (see Paragraph 4.18). She denied any thoughts of self-harm but said she continued to experience auditory hallucinations.

4.23 In early February 2017 disclosed to her health visitor that she had been sexually abused as a child by her father from the age of 5 until 12 years which she stated had had a huge impact on her mental health. (This does not appear to be consistent with what she previously disclosed about her relationship with her father (Paragraph 4.5)). She also disclosed that she had previously been in abusive relationships but was aware of the risk abusive relationships pose to children and said she never wanted her child to be brought up in a hostile environment. Mother said that father had had greater contact with Child 1 recently. Although they were no longer in a relationship, she said she wanted to have another child with father.

4.24 During February 2017 mother and Child 1 registered with a new GP practice as she lived outside the catchment area of the GP practice she had been visiting. As a result, her former GP practice had decided to remove her from the practice list. The former GP practice has advised this SCR that mother had failed to advise them of an earlier move to live outside their catchment area. Once the GP practice belatedly became aware of her change of address, they decided to remove her from their list because many services were organised on a locality basis. Registering with a GP practice which served the area in which mother now lived would enable easier referral to locality based services.

4.25 Later in February 2017 mother's new GP was sent her medical care plan by the mental health team. Her new GP reviewed her medication and expressed concern about the long term use of Zopiclone because of the risk of addiction. When this was subsequently discussed with mother and a community psychiatric nurse by her GP, it was agreed that she would continue on Zopiclone as it helped her sleep.

4.26 In early March 2017 the health visitor advised mother about over-feeding Child 1. Mother reported a dip in her emotional wellbeing and talked of 'cutting off' from her family. Father was present and said to be 'more involved'.

4.27 During March 2017 mother saw her GP and requested to move from weekly to monthly prescriptions which had been introduced after an 'overdose 3-4 years

previously'. It was agreed that fortnightly prescriptions would be tried and she could move to monthly prescriptions if no problems were experienced.

4.28 In early April 2017 mother was seen by her health visitor and she told her that she had experienced a 'little dip' in her mental health and had visited her GP for a medication review. She said that she now felt well in herself. The health visitor referred mother to Halifax Opportunities Trust, a charity which provides a range of community services, requesting support for mother to attend children's centre groups. An assistant family outreach worker was allocated to mother.

4.29 When the assistant family outreach worker made initial telephone contact with mother in late April 2017, mother disclosed that she was pregnant, having resumed her relationship with father. The assistant family outreach worker made a home visit two days later and began an Early Intervention Single Assessment.

4.30 Also in late April 2017 mother's medication was increased (Quetiapine increased to 100mg) following a medical review by the community mental health team psychiatrist. Mother said she was experiencing low mood as a result of an ADHD assessment although the assessment had not resulted in a diagnosis.

4.31 In early May 2017 mother saw a community midwife for booking in respect of her pregnancy with Child P. This was around the sixth week of her pregnancy. Mental health issues documented included self-reported bipolar, borderline personality disorder and psychosis. She was noted to be under the care of a psychiatrist and that her mental health was 'controlled' at present. She was noted to be a smoker (4 cigarettes per day). Mother was to be allocated to the early intervention midwife supported by the perinatal mental health lead for Calderdale and Huddersfield NHS Foundation Trust (CHFT) together with shared care by a consultant obstetrician. Other practitioners involved in mother's care were documented.

4.32 Later in May 2017 the assistant family outreach worker noted difficulties in engaging with mother who had cancelled two appointments and was then going abroad on a family holiday. An extension was granted for completion of the Early Intervention Single Assessment. In the event, the assistant family outreach worker was unable to achieve another home visit until 10th July 2017.

4.33 In early June 2017 mother's obstetrician enquired if mother had, in fact, been referred to the perinatal mental health team. The perinatal mental health lead advised that mother should be on the perinatal mental health pathway. Community mental health team input was also noted. The plan was for the community midwife to liaise with mother's care co-ordinator and for a mental health care plan to be

completed between 28-32 weeks gestation of the current pregnancy. Mother's case was also to be referred to the specialist midwifes panel. The specialist midwives panel meets weekly to ensure women with complex needs are referred for the correct level of support.

4.34 Later in June 2017 the health visitor saw mother who seemed 'happy and bright.' She disclosed that her grandmother had recently died. She said she felt a certain amount of relief about this as she was her grandmother's main carer (Practitioners were unaware of mother's role as 'main carer' for her grandmother, who resided elsewhere, although she was believed to have provided some care).

4.35 At the end of June 2017 a community psychiatric nurse visited mother and found her to be struggling with anxiety and experiencing poor sleep. Mother was allocated to a mental health support worker to increase her confidence about going out in the community. Mother was said to be worried about contacting the crisis team in case this led to the removal of Child 1.

4.36 In early July 2017 the outcome of the referral to the specialised midwives panel (See Paragraph 4.31) was that mother was to be cared for by the early intervention midwife due to the complexity of the case. The midwife was to access clinical supervision from the perinatal mental health lead and access safeguarding supervision at a minimum of every three months.

4.37 In early July 2017 mother's prescription of Quetiapine was changed to Olanzapine as mother reported that the former drug was not effective. However, after taking Olanzapine for one night, mother reported feeling extremely agitated and asked to go back on Quetiapine. A month's supply of the latter was then issued.

4.38 In mid-July 2017 mother's GP received her medical care plan from mental health services. The plan stated that mother was stressed by her grandmother's death, was hearing voices and feeling anxious. She was said to deny thoughts of harm to herself or others. The plan also said that mother felt that Quetiapine was unhelpful and so this had been stopped and Olanzapine started. (This change in medication appears to contradict the previous paragraph but it is understood that at this time it was taking around 6 weeks to type up medical care plans and so the action described in this medical care plan may have already been superseded).

4.39 During a routine appointment with a community mental health team support worker later in July 2017, mother disclosed that she had been raped recently following a night out. Mother's disclosure was not shared with the police or any other agency by the practitioner. SWYPFT has advised this review that mother told the mental health practitioner that she had reported the incident to the police.

Mother had reported an earlier rape to the police in 2015 but there is no record of her reporting any subsequent rape to the police.

4.40 In early August 2017 the assistant family outreach worker visited mother who said that her GP had told her that Child 1 was not to have contact with anyone except parents and immediate family and was not to attend groups after developing a rash following his first attendance at a children's centre group. Mother's GP was contacted and confirmed that no such advice had been given. It is understood that mother was challenged on the incorrect information she had provided to the assistant family outreach worker although this was not documented.

4.41 In late August 2017 the assistant family outreach worker and mental health care co-ordinator made a joint visit. The former recorded that mother discussed hearing voices. After the care co-ordinator left, Child 1 developed a rash which the assistant family outreach worker observed. Mother attributed the rash to the care co-ordinator's perfume. Later the same day the care co-ordinator emailed the assistant family support worker to outline the level of mental health support mother was being given. Her service assessed that mother suffered from pseudo-hallucinations and did not have a serious enduring mental illness, adding that mother was one of her more stable service users and if it wasn't for the fact that she was pregnant she may have been discharged from the service, or the service would be moving to discharge her. Mental health services were said to feel that mother had a borderline personality disorder and that increased support created a dependency and made her more demanding and therefore did not actually help her in the long term. However, the care co-ordinator arranged for mother to be supported by a mental health support worker to assist with her anxiety.

4.42 Also in late August 2017 Family Support and Outreach senior supervision decided that due to the concerns related to mother's case, Team Around the Child (TAC) support was required which necessitated the identification of a more experienced family support worker to work alongside the assistant family outreach worker.

4.43 At the end of August 2017 mother's GP received a medical care plan from mental health services which stated that mother was hearing voices but denied thoughts of harm to herself or others. A diagnosis of 'Emotionally Unstable Personality Disorder' was referred to. The medical care plan appears to have been an outcome of a SWYPFT clinical review of mother which was carried out on the same date. Although the details of the medical review are very brief, there is a reference to mother self-referring to counselling. There is no indication that she did indeed self-refer.

4.44 At the beginning of September 2017 mother was seen at home by the community midwife. She said she was feeling tired and reported that she was hearing voices at night which were frightening for her. She said she had had minimal contact with her care co-ordinator. (SWYPFT has advised this review that care co-ordinator would be dependent on clinical need and that it is the role of experienced support workers to carry out visits unless the needs of the patient change). A maternity mental health assessment was completed. The community midwife recorded that mother's mental health was 'still unstable'. She also contacted the mental health team with whom it was subsequently agreed that the community midwife home visits would be co-ordinated with those of the perinatal mental health team.

4.45 In late September 2017 a pregnancy and early postnatal plan was drawn up in respect of mother. She was transferred to the community mental health team (CMHT) enhanced pathway as it was anticipated that the CMHT core pathway would not have provided her with sufficient support as her pregnancy progressed and, in all likelihood, her mental health symptoms intensified. The antenatal plan included a minimum of weekly visits by her care co-ordinator or other health practitioners, involvement of consultant perinatal psychologist, referral to the rapid assessment interface and discharge (RAID) service to monitor and support mother with her mental health whilst a patient in hospital a week prior to admission for the birth of Child P and referral to the intensive home based treatment team (HBTT) to provide daily contact immediately following discharge from hospital. The postnatal plan, which was subsequently delivered, included daily contact by care co-ordinator, HBTT, midwife or health visitor for 14 days post discharge, appointment with consultant at earliest opportunity, visits to reduce to weekly then fortnightly if mother remained well, monitoring of mother's mental state, assessing for any change and ensuring mother had access to CMHT telephone support.

4.46 In early October 2017 Child 1 was taken to ED following an apnoeic episode (temporary cessation of breathing especially during sleep). After being diagnosed with croup, the child was discharged and advice provided to mother and father.

4.47 Also in early October 2017 the community midwife and the CHFT perinatal mental health lead reviewed mother's case. The mental health team was requested to contact the community midwife to discuss the plan of care. The community midwife and the CHFT perinatal mental health lead planned to complete a joint visit at 30 weeks gestation.

4.48 In mid-October 2017 a management plan was documented by the CHFT perinatal mental health lead which confirmed that mother remained under the care of the community mental health team (CMHT). Mother's care co-ordinator was to

complete and circulate the perinatal mental health plan and liaise further with the community midwife and the CHFT perinatal mental health lead.

4.49 Later in October 2017 Child 1 was taken to hospital ED after becoming unwell whilst feeding. He was said to have stopped breathing for a short time. He was discharged the next day having suffered a febrile convulsion and a urinary tract infection.

4.50 The next day the community midwife contacted mental health services as she was concerned that mother's obsessive compulsive disorder symptoms were increasing.

4.51 In late October 2017 mother's new family support worker made a home visit during which mother said she had taken Child 1 out of nursery. Mother was advised that it was important for Child 1 to attend nursery.

4.52 In early November 2017 the health visitor made an antenatal home visit. Child 1's sleeping was said to be a concern. Mother was also worried that Child 1 'will not eat'. Mother appeared to have unrealistically high expectations including that Child 1 should be able to eat with a fork. Advice was provided by the health visitor.

4.53 In mid-November 2017 the consultant obstetrician reviewed mother who reported that she was still struggling with hallucinations. Father was noted to be working nights. A delivery by caesarean section was booked for late December 2017.

4.54 Also in mid-November 2017 mother's family outreach worker telephoned the manager of Child 1's nursery. The latter advised that Child 1 had attended only 3-4 times since September. Mother had recently informed the nursery that Child 1 would no longer be attending as doing so made him unwell. Mother was subsequently advised by the family outreach worker to continue to take Child 1 to nursery.

4.55 Later in November 2017 mother telephoned her care co-ordinator to say that she had not been doing so well and had felt suicidal the previous week but father had come over and been a lot more supportive. She said she was feeling better that day.

4.56 The next day the Early Intervention Single Assessment initiated by mother's assistant family outreach worker in late April 2017 (Paragraph 4.29) was completed and shared with the family. A TAC meeting was discussed with mother who requested that it was held at a children's centre rather than at her home address.

4.57 On 23rd November 2017 mother was seen by the consultant perinatal psychiatrist in company with her care co-ordinator. Father accompanied mother and was seen briefly at the end of the appointment. The consultant perinatal psychiatrist was concerned that mother denied having any recollection of prior disclosures she had made to multiple mental health practitioners over the years including that she had served a term of imprisonment for offences involving serious violence. (It has since been established that mother has no forensic or custodial history meaning that these, and possibly other, prior disclosures were untrue).

4.58 The consultant concluded that the many hallucinatory experiences described by mother were more of a dissociative pseudo hallucinatory experience rather than being symptoms of classic psychosis. The consultant observed that, in common with people who are impulsive, she had a high need for sedative medication to aid sleep which was a chronic problem for her. He was particularly concerned by mother's comments that 'extra meds would be good because they will stop me waking up if the baby cries'.

4.59 The consultant's main concern was the impact of mother's disordered personality upon her parenting (although father did not indicate that this had been a concern when he was spoken to), rather than the risk of a classic postnatal breakdown. During the appointment the consultant administered an AQ questionnaire to objectively measure her autistic traits on which she scored very highly despite not presenting as someone with a classic autistic spectrum condition. He was concerned that these traits may make it more difficult for mother to reciprocate emotionally with a baby. However, he considered that she may be extremely protective towards her 'own kin' and it was unlikely that she would accept professional concerns if they conflicted with hers.

4.60 Given that mother was not considered to have a true psychotic illness, the consultant did not think she needed daily contact from mental health services during the 14 days following delivery of the baby. The following plan was drawn up as a result of the appointment:

1. For the care co-ordinator to visit mother with the family outreach worker to further explore concerns and discuss if she would accept a referral to children's social care for a pre-birth assessment 'to look at further support needs'.
2. If following discussion with mother and other practitioners involved it is felt that the existing support plan would not adequately reduce the risks of the impact of parental mental health on children, then a referral to children's social care would be made.

4.61 On 27th November 2017 a multi-agency meeting took place at mother's home. Only the health visitor was unable to attend but her verbal views had been obtained. Mother and father were present. Mother was said to be hallucinating and was unhappy with her medication which she felt was contributing to her difficulties in sleeping. Mother's new care co-ordinator was to visit weekly until the birth of the new baby and would discuss coping strategies in case of any deterioration in mother's mental health with her. A TAC meeting had been arranged for 12th December 2017 which would be prior to the birth of Child P. One of the issues to be discussed at the TAC meeting was the need for support to reduce Child 1's social isolation.

4.62 On the same day the concerns raised by the consultant perinatal psychiatrist were shared with the community midwife who said she did not have any concerns about mother's parenting capacity, as the family home was presentable and Child 1 was clean and appeared well cared for and well stimulated.

4.63 On 30th November 2017 mother's care co-ordinator contacted the health visitor to discuss the consultant perinatal psychiatrist concerns about mother's parenting capacity and to check whether the health visitor had any concerns. The health visitor advised that she did not have any concerns before adding that if the consultant had safeguarding concerns he should make a referral to children's social care. On the same date mother's care co-ordinator rang her family outreach worker and said that the consultant perinatal psychiatrist wished to refer mother to Calderdale's Multi-Agency Screening Team (MAST) over his concerns about her mental health and his opinion that mother just said what professionals wanted to hear in respect of her parenting. (MAST is the first point of contact for any child protection concern). The family outreach worker said that her only concern about Child 1 was whether his social needs were being met. She also drew attention to inconsistencies in mother's behaviour in that she was very reluctant to attend nursery or the children's centre whilst having no difficulties in travelling much further afield for social events.

4.64 On 5th December 2017 mother's care co-ordinator sought advice from the SWYPFT safeguarding team. The advice provided was to explore the concerns which had arisen about mother's parenting capacity. It was noted that no concerns had been raised by other practitioners such as the midwife and health visitor. If from further discussion it was felt that current support was inadequate and that the impact of parental mental health was judged to be having a negative impact on the child, the SWYPFT safeguarding team advised that a referral to children's social care should be considered.

4.65 On the same date the care co-ordinator contacted the MAST Information and Advice line stating that mother was pregnant, had mental health issues, and there was concern that mother would not be able to cope with her second child who was due in the next 3-4 weeks. The outcome of the discussion was that the care co-ordinator would hold a multi-agency meeting with the practitioners involved in the case in order to review the care package. The MAST records state that 'if there are safeguarding concerns the worker (i.e. the care co-ordinator) is clear a referral to MAST is to be made'.

4.66 The care co-ordinator recorded the outcome of the conversation with MAST as being that a pre-birth assessment was not required due to the number of practitioners already involved and due to mother being 'under the early intervention panel'. 'Planned to go see mother, with intention early help' was also recorded by mother's care co-ordinator.

4.67 On 6th December 2017 mother's care co-ordinator and family outreach worker carried out a joint visit and mother was asked if she wanted any support from children's social care which she declined. Father had changed his working hours in order to stay with mother during the night. He also asked for the crisis team telephone numbers should mother's mental health deteriorate. The care co-ordinator was to provide these at the forthcoming TAC meeting. Mother and father agreed to try the parent and toddler group at the children's centre as Child 1 was said to be no longer suffering from rashes. The SWYPFT recording of the joint home visit also included that mother's children and father were 'protective factors'.

4.68 Two days later the GP practice agreed to mother being issued with a month's supply of her medication due to the fact that she was shortly to be admitted to hospital for a caesarean section birth. The agreement with mother's pharmacist appeared to be conditional upon a 'suicide risk assessment'. The outcome of any such assessment is not known.

4.69 The TAC meeting planned for 11th December 2017 was cancelled and was to be rescheduled for January 2018. The meeting was to have been led by family support but both the family outreach and family support workers who had detailed knowledge of the family became unavailable.

4.70 The next day mother was seen by the community midwife and reported that her mental health was deteriorating and consented to contact being made with the mental health team. A maternity mental health assessment was completed. (National guidance advises that the GAD (anxiety) and PHQ (depression) assessments should be completed at booking and at 28 weeks gestation but they

had been completed more frequently for mother in view of her mental health history).

4.71 In mid-December 2017 a review in clinic involving maternity and the anaesthetist noted that mother was aware that post-delivery she and the baby would require a 5 day stay in hospital if the baby was showing any signs of withdrawal in respect of mother's prescribed medication and that she was to be visited by the RAID mental health liaison team whilst in hospital. It was also documented that there may be a need to hold a discharge planning meeting.

4.72 In late December 2017 Child P was born.

4.73 Whilst in hospital following the birth of Child P, mother was reviewed by the RAID mental health liaison team daily as her mental health history, anxiety and poor sleep meant that she was at risk of developing post-partum psychosis. During her mental health review on the day after Child P was born, mother expressed concern that the pain relief was inadequate. The hospital pain team advised that some pain relief medication could not be given along with the medication prescribed for mother's mental health. Mother was also said to be worried about Child P not feeding well. Overall, there were no signs of a relapse in mother's mental health.

4.74 Two days after the birth of Child P, the plan for mother's sister-in-law to stay with her in hospital and help her care for Child P during the night came under strain. Sister-in-law attended the hospital ED as she felt faint and mother complained that sister-in-law was not getting up in the night to care for Child P. This was said to have left mother feeling tired, stressed and angry. Concern was expressed about this development during the review of mother's mental health which took place the same day, as sleep deprivation was regarded as a significant factor in the deterioration in mother's mental health. Mother described how the stress of the pregnancy, birth and general overall tiredness were contributing to voice and visual hallucinations. Staff on the ward cared for Child P overnight but a revised plan was developed under which father would stay in hospital overnight to support mother in caring for Child P, whilst sister-in-law would care for Child 1 overnight in mother's home. Whilst staff appeared to be aware of the plan for sister-in-law to support mother in hospital, there is no record of this plan being documented.

4.75 When mother was reviewed by the hospital mental health liaison team three days after Child P's birth, it was documented that she was fairly well mentally, having slept well and received positive support overnight from father. There were no indications of withdrawal in respect of the baby who was now feeding well. Mother was keen to be discharged and after a review by paediatricians, it was decided to discharge mother and Child P four days after his birth. A perinatal mental health

discharge plan was in place. Daily home contact by the community midwife service would take place for 14 days (including the Christmas and New Year holidays) and father would stay with mother for one month to support care of Child P. No discharge planning meeting appears to have taken place as suggested in Paragraph 4.71.

4.76 The community midwife made daily home visits. In late December 2017 mother was described as 'tired and emotional' in a telephone discussion with her care-co-ordinator who advised mother to rest. A follow up home visit by the care-co-ordinator may have been prevented or delayed by adverse weather.

4.77 At the beginning of January 2018 the intensive home based treatment team spoke to mother by telephone. She described her mood as 'rock bottom' but said that she was managing 'OK' and declined support from HBTT. However, HBTT concerns about mother's mental health were diminished by mother appearing 'chatty' throughout the call.

4.78 Also in early January 2018 the community midwife found mother to be postnatally well but feeling mentally unwell. Father was present. Mother reported an increase in hearing voices, feeling 'very chaotic' and was said to be having a very poor diet. The midwife contacted the SWYPFT single point of access (SPA) which advised her to contact the perinatal mental health team. A message was left for mother's care co-ordinator and contact was also made with the IHBTT who agreed to triage mother and update the community midwife on the outcome of this. Mother was advised that should her mental health deteriorate she must contact the crisis team. The community midwife had no concerns for mother's parenting capacity or the manner in which she was caring for Child 1 or Child P at this point.

4.79 The care co-ordinator visited mother at home later the same day. She reported being unable to sleep and feeling tired. Her OCD symptoms had apparently increased, particularly around cleaning. It was planned to monitor mother's mental health closely and manage through a Flexible Assertive Community Treatment (FACT) approach (This approach is used to manage people when they are struggling to manage their mental health and allows closer monitoring of mental health and the offer of more contact if needed).

4.80 Also in early January 2018 the health visitor made a new birth home visit. Mother reported undescended testes in respect of Child P. Father was present but mother was noted to be over protective in that she was reluctant to allow father to assist in feeding. She was seen to be affectionate towards both children during the visit. Mother said she had been hallucinating and experiencing thoughts that she would be 'better off dead'. She said she no longer wanted to live. However, mother

said that she would not be contacting the crisis team because she was worried that if she did so, children's social care would remove her children.

4.81 On the same date mother's GP received a further letter from mental health services describing their assessment of mother whilst in hospital following the birth of Child P. Her risk to herself and others had been assessed as 'low'.

4.82 Also in early January 2018 the community midwife made her final home visit to mother who was said to be feeling 'manic' with OCD. Care was transferred from the community midwife to the health visitor. The former had no concerns about mother's parenting capacity.

4.83 On the same date mother's care co-ordinator visited her with a mental health support worker. The children appeared to be well cared for and the lounge was described as 'spotless'. Mother said she had fallen from the 'top of the stairs' after losing concentration due to voices in her head. She said she had suffered 'heaving bleeding' and had been seen by her GP although she had not disclosed the fall to the GP (There is no record of any contact with GP). The care co-ordinator advised mother to visit her GP in respect of the fall. Mother reported that she was sleeping 'much better' but that her OCD had increased since the birth of Child P.

4.84 The mental health support worker visited mother in early January 2018 when she said she wanted to begin breast feeding Child P. After consulting the perinatal consultant psychiatrist, mother was advised that the medication that she was taking would not prevent her breast feeding. (This advice appeared to be inconsistent with previous advice on breastfeeding (Paragraph 4.10) although it is acknowledged that there had been changes in mother's medication).

4.85 In mid-January 2018 the initial TAC meeting was held. Neither the health visitor nor the midwife were able to attend. The care co-ordinator, family support worker, mother and father were present. Mother said that since the birth of Child P she felt that her mental health had deteriorated. She said that she had been crying for the past 2-3 weeks at night and that she did not feel she could cope as the voices 'get too much for her' and when Child 1 was crying, the voices 'get louder over Child 1'. She said she was continuously cleaning from 4am until 3pm. Mother also expressed concern that father was returning to work on night shifts. Mother's care co-ordinator said that her care plan envisaged gradually discharging her from the community mental health team (CMHT) enhanced pathway to the core pathway. This would be reviewed by the care co-ordinator in six months who, in the interim, would visit mother weekly, provide coping strategies and support mother with her mental health appointments. Family support planned to move from fortnightly to weekly visits and accompany mother to access community services once a month.

Mother was to be referred to the 'friends group' and baby massage and referring Child 1 to unspecified support was to be explored. Mother was to be provided with support to help her get Child 1 into a consistent sleep routine.

4.86 The following day the health visitor made a home visit during which mother expressed concern about Child P requiring frequent bottle feeding. The health visitor formed the view that the baby was being overfed. Mother said that she fed him when he cried. She was advised to complete a feeding chart and was also provided with advice about the cues to look out for that the baby needed feeding. Child 1's sleep had regressed and he was now back in his parent's bedroom at night. Mother described Child 1 as 'naughty' and was given advice about normal behaviours for a child of that age (fifteen months). Father had returned to work causing mother some anxiety. Mother was having some difficulty breastfeeding Child P. Mother said she had recently been told that it was safe for her to breast feed Child P (Paragraph 4.84). The inconsistency in advice on breastfeeding was not explored further.

4.87 Also in mid-January 2018 mother attended a clinic appointment with her care co-ordinator. During the appointment mother said she heard 'evil voices' talking to her all the time asking her to do things such as clean the house, which she said she did for hours to cope with the voices. She denied any thoughts or intentions of harming others. Her sleep was said to be erratic and it was decided to increase her dosage of Quetiapine from 400mg at night to 500mg.

4.88 On the same date mother's care co-ordinator visited her at home. During the visit mother expressed her frustration when Child 1 moved his toys around as she liked to see them 'in order'. It is understood that mother received ongoing advice on how to manage this frustration.

4.89 Later in January 2018 mother registered Child P with the family GP. She also requested a referral for sterilisation which her GP agreed to make.

4.90 Later in January 2018 mother was visited by her family outreach worker. Mother's caesarean section had become infected and she was taking antibiotics. She said she was "hitting rock bottom with tiredness" and had spoken to the mental health team about medication (See Paragraph 4.89). Mother was booked for a sterilisation operation.

4.91 On the same date the health visitor saw mother and the children at home. Concerns of over-feeding of Child P had diminished. Although mother had not completed the food diary as she had been unwell, Child P's weight showed a slight decrease on the centile chart. Mother expressed anxiety about the consultant perinatal psychiatrist visiting her at home as she felt he had previously wanted to

refer her to children's social care and had discussed a period of imprisonment which she said she had no knowledge of. She went on to say that father had been questioning whether he was the father of Child P as the child was of pale complexion whilst father was of mixed race heritage. This issue was causing animosity between them. Mother also said that sometimes she wished it was just her and Child 1. Although she felt she was coping, she said she did not always enjoy being the mother of two small boys. Mother was given advice to help her bond with Child P.

4.92 At the end of January 2018 the GP received mother's medical care plan from mental health services which stated that her Quetiapine dosage had increased, she was hearing voices and denied any thoughts of harm to self or others.

4.93 At the beginning of February 2018 mother was seen at home by the consultant perinatal psychiatrist and a member of the perinatal mental health team. Mother's interaction with Child P was described as 'perfectly appropriate'. However, there was concern over mother claiming that Child 1 was 'seeing the people that she sees'. It was decided that the impact on Child 1's mental health of mother describing her hallucinations to him would be considered at a future multi-agency meeting, as would the related issue of how concern about this would be communicated to mother. Mother was not considered to be suicidal or persistently depressed. However, she was noted to worry and ruminate obsessively. She was also noted to have strong traits of rigidity and control and difficulties in dealing with change. She did not see things from the point of view of others which may lead to difficulties in understanding the motives of practitioners. It was decided to reduce and then cease her Mirtazapine (which mother reported no benefits from taking) and replace this with Clomipramine which could help with the obsessional and ruminative components of her psychological issues.

4.94 In early February 2018 mother and father visited a nursery where Child 1 had been offered two half day sessions. During the visit mother disclosed that Child 1 'bit at home'. This behaviour was never subsequently noticed at nursery or brought up again by mother or father with the nursery.

4.95 On the same day mother telephoned a health visitor to say that Child P had been unsettled with stomach ache and had been crying for two days. Management of colic was discussed and mother was signposted to NHS Choices.

4.96 In early February 2018 mother was seen by her GP who began reducing her dosage of Mirtazapine after being advised to wean her off this drug following the home visit to mother by the consultant perinatal psychiatrist (Paragraph 4.93). Clomipramine was prescribed as a replacement.

4.97 In early February 2018 the health visitor made a home visit. Mother reported that Child P had been poorly with symptoms of colic and reflux. She said he had been crying whilst arching his back and tensing his body. Advice was provided. Mother was noted to handle Child P with affection but said she felt guilty that she could not stop him crying. Mother was given advice about safe sleeping as she said that Child P was sleeping in bed with her. Child 1 had started at nursery but mother said she had asked for support around behaviour management as Child 1 had 'bit someone'. She again described Child 1 as 'naughty' and the health visitor responded by advising that he was displaying typical toddler behaviour. Realistic expectations of age appropriate behaviour were discussed with mother. Mother said she became stressed at times when caring for her children and felt like she was 'doing everything' despite support from father.

4.98 During a three day period in mid-February 2018 mother made five contacts with the health visitor or her GP to seek advice about bottle feeding Child P. She appeared to be having difficulty with a newly prescribed reflux stay-down milk. When she saw her GP later in February 2018 feeding was reported to be better.

4.99 Later in February 2018 an adult who is assumed to be mother took Child 1 to see her GP with a rash but also expressed concern about 'vacant episodes' of around ten minutes duration each when she was unable to attract the child's attention. A referral was made to paediatrics. Child 1 was later seen by Ophthalmology and no abnormality was detected.

4.100 Later in February 2018 Child 1 was not taken to nursery and no explanation for his absence was provided. After some difficulty, contact was made with mother who said the child was poorly.

4.101 On the same date the care co-ordinator made a home visit to mother who was said to have immediately stated that she was not doing well, had hit rock bottom, was not sleeping, that Child P was 'allergic to milk', and that Child 1 had a fever which she found stressful. Father had taken time off work to provide support. Mother declined a referral to the intensive home based treatment team.

4.102 In late February 2018 a TAC meeting took place. Concerns were expressed that the mental health care plan had been completed in November 2017 and may therefore not reflect mother's current needs. Concern was also expressed about the coping strategies that mother had been advised to adopt, particularly the coping strategy of going out for a walk which was not considered to be realistic or safe given that mother was caring for two small children. The fact that mother asked for help was regarded as a positive factor. There were said to be 'no concerns' about

the way in which the children were cared for. The TAC plan was said to be being 'worked through'. A multi-agency meeting was due to be held at the end of February 2018 at which it was suggested that the perinatal health visitor should attend. There was mention of mental health services 'pulling out' and taking a 'positive risk'. The health visitor questioned the sustainability of the current situation, particularly if mother's mental health deteriorated.

4.103 A multi-agency meeting took place at the end of February 2018 at which the consultant perinatal psychiatrist said that he had first assessed mother in 2007. He had discharged her from mental health services after diagnosing psychopathic personality and not psychosis. She had been managed at 'core level' within CMHT and escalated to an enhanced level when pregnant. Practitioners described comments from mother such as 'thank goodness for medication as I won't have to get up in the night with the baby' which they felt indicated a preoccupation with her own needs rather than the needs of her children. The consultant perinatal psychiatrist reported that the voices mother heard were her own thoughts and were not psychotic in nature. He describes her hallucinations as hypnogogic which were related to how the brain behaves in sleep. Half the brain is sleeping whilst the other half continued to work and have awareness hence the visual images of people. When mother woke the image disappeared as the brain returned to synchrony again. The consultant went onto say that he had previously completed an autistic traits assessment in which mother scored 'very high'. He had tried to prescribe medication to help which mother had refused to take. He said that she would not accept his professional opinion. He described her as stubborn, inflexible, believing her way to be the only way, pedantic and disliking change. However, the consultant described that when mother was challenged regarding her anxieties of perceptions she would re-evaluate. Reference was also made to mother being motivated to remain within mental health services in order to retain some benefits. The implications of mother's behaviour for her children's emotional wellbeing was discussed at length. The mental health practitioners present took the view that mother did not meet the threshold for their service and that continued specialist mental health service involvement was reinforcing mother's view that she had a mental illness. The plan which emerged from the discussion was that a personalised crisis management plan would be devised for mother which she would have at home. It was said that the plan would also be available to other practitioners to reduce the potential for manipulation of different practitioners by mother. Mother was to be seen by consultant perinatal psychiatrist for a final consultation before discharging her.

4.104 During the same evening mother rang mental health services to say she felt suicidal and had been trying to contact the HBTT. Mental health services rang her back and concluded that although she felt low, she had no plans to self-harm. She

said she had good support at home from father and her sister-in-law. She was advised to call HBTT or hospital ED if necessary. Later the same evening mother telephoned HBTT to say she was having suicidal thoughts. She said that the children were being cared for by father and sister-in-law at her home address. After speaking with the HBTT for 15 minutes, she said she felt better.

4.105 At the end of February 2018 mother's GP stopped her Mirtazapine and increased Clomipramine to 75mg on the advice of the mental health team.

4.106 In early March 2018 a person recorded as 'Uncle C' rang mental health services to enquire whether mother's medication should be changed as her symptoms had 'increased'. The recent change in mother's medication (see previous paragraph) was thought to be a potential explanation for any change in her presentation. In the record of the conversation the children were again described as a 'protective factor'. (The identity of 'Uncle C' is not known).

4.107 Also in early March 2018 mother contacted the HBTT. She said she had been in touch with the crisis team with whom she had shared her childhood trauma. She said she had suicidal thoughts but no plans to act on these. She said that father was present until Monday (the next day) and would then be working night shifts.

4.108 The following day mother contacted her family outreach worker to say that she had been suicidal and hallucinating about a woman in her home. She claimed that the HBTT had said that she was a 'high risk' case yet mental health services were planning to close her case. She said she had been in touch with her MP for support.

4.109 Also in early March 2018 Child 1's nursery recorded that mother's family support worker contacted them to advise that mother had mental health issues and asked the nursery to 'keep an eye' on her relationship with Child 1 as she sometimes demonstrated a lack of empathy towards him. Halifax Opportunities Trust disagree with this interpretation of the contact between themselves and the nursery and has advised the review that the family support worker told the nursery about mother's mental health and the services involved with the family.

4.110 On the same date the care co-ordinator, family support worker and the intensive home based treatment team (HBBT) made a home visit. (HBBT had been visiting mother twice daily for two weeks but this support was due to end that day). Mother presented as anxious and remained standing during the meeting. She was stuttering when speaking. She said she had been 'really on edge' for two weeks. Mother was spoken to about the impact of how she presented upon Child 1, in particular the concern that the child could 'mimic' her behaviour. Mother said that

she would simply walk out of the room to avoid any impact on Child 1. Mother was talking about a woman she had been hallucinating about and was also scratching herself. It was noticed that when she picked up Child P, this behaviour stopped. When this was pointed out to mother, she resumed the behaviour.

4.111 Following this meeting mother's care co-ordinator contacted MAST to request 'support around the children' as services were 'mainly focussed on mother'. The mental health worker was advised to contact the EISA co-ordinator. (See Paragraph 4.114 for details of contact with EISA co-ordinator). Children's Social Care have advised the review that there is no record of this call. However, contacts which did not lead to a referral were not recorded. This practice changed in August 2018 and all contacts and referrals made to MAST, whether or not they lead to a referral, are now recorded.

4.112 In early March 2018 mother saw the consultant perinatal psychiatrist and perinatal mental health practitioner. She was accompanied by father. Mother was said to continue to have hallucinations which were stress induced and relatively fleeting whilst remaining intense, distressing experiences. These took place at times of high stress or sleep and were not typical of schizophrenia or enduring psychosis. The consultant's assessment of her neuro-development difficulties was that she demonstrated raised levels of autistic traits, impulsivity/ADHD traits and had symptoms consistent with what might well be multiple hidden impairments including dyslexia, dyscalculia and dyspraxia. The consultant also observed that mother was likely to become more stressed when there were more practitioners involved in her care who might talk at cross purposes with one another. He felt that she might do better with less people involved where mother had a clear understanding of their roles. The concern was reiterated that mother had said that Child 1 could experience the hallucinatory voices she referred to, although mother's assurance that she would not let this happen again had provided some reassurance. A key issue was stated to be to understand mother's parenting support needs and identify appropriate services to help her with this. Mother was said to have consented to the consultant liaising with 'social services' that day to communicate his and the perinatal mental health practitioner's professional anxieties to ensure mother received appropriate care to ensure there was a lower likelihood of ongoing (unintentional) emotional harm to her children. (See Paragraphs 4.112 and 4.114 for details of the possible contact between SWYPFT and MAST). Mother was prescribed Flupenthixol as a trial, with a plan to consider switching this to depot formulation if tolerated. The community mental health team (CMHT) were to draw up a self-management crisis plan after which enhanced CMHT were to withdraw.

4.113 The next day a telephone discussion took place between the perinatal team and 'early intervention' over what further support could be offered. Concerns about

the impact of mother's presentation on the children were shared but it was agreed that safeguarding children procedures were not warranted. TAC meetings were to continue. It is not clear whether the conversation with 'early intervention' was a conversation with the EISA co-ordinator or not.

4.114 In mid-March 2018 the family support worker made a home visit during which mother said she felt her mental health was much improved and that she understood herself better now. Her sister-in-law was present. Child 1 was said to be developing well.

4.115 Later in March 2018 mother took Child P to the GP and he was diagnosed with a chest infection. Amoxicillin was prescribed. No enquiry about mother's ability to cope was recorded.

4.116 In late March 2018 a TAC meeting took place at which all agencies were present including Child 1's nursery. Mother's care co-ordinator advised that she was being discharged from the CMHT enhanced pathway but would continue to be supported on the perinatal mental health pathway. Self-help and crisis plans had been completed. This decision appeared to be questioned by the health visitor on the grounds that mother was still reporting that she was struggling with her mental health and had not felt able to be alone with the children. It was also said that mother was avoiding taking her medication as she was concerned that she wouldn't be able to wake up when the children needed her. Mother, who was present, voiced the concern that all the services were 'pulling out' and leaving her without appropriate support. It was agreed that the health visitor would continue to visit monthly and that family support and perinatal mental health would be visiting fortnightly. The latter two agencies intended to co-ordinate the dates of their visits to ensure mother received a visit from one of them each week. A further TAC meeting was to take place in late April 2018. The Early Intervention Plan continued to include the risk that mother's mental health could deteriorate and impact on the children. The plan continued to state that mother would be gradually discharged to the CMHT core pathway.

4.117 A care programme approach (CPA) review of mother which took place on the same date recorded that mother was more stable and had more insight into her mental health. Mother was also said to be more positive, was to join groups and was motivated to make change.

4.118 In late March 2018 the GP received mother's medical care plan from the mental health team which stated that the consultant perinatal psychiatrist would be main contact for perinatal services, that the CMHT were drawing up a self-management crisis plan following which the enhanced CMHT were going to withdraw

(mother had been discharged on 21st March 2018) with ongoing input from family support.

4.119 At the end of March 2018 mother contacted NHS 111 to say that Child 1 had had four febrile convulsions the previous day and another convulsion on that day. He also had a high temperature. Mother was advised to attend the emergency department (ED) at Calderdale Royal Hospital. Child 1 was subsequently admitted with febrile convulsion and tonsillitis and reviewed on the paediatric assessment unit. After being prescribed antibiotics, Child 1 developed a rash and so it was decided that the child would remain in hospital for observation. Mother was said to appear anxious and shared her history with the staff. It was agreed that father could stay on the ward overnight to support mother. There is nothing documented to suggest that hospital staff had any concerns about the hospital admission or parenting capacity. It was documented that the family had a support worker 'to help with appointments'. It isn't clear whether mother's health visitor was informed of Child 1's admission. (It is understood that Child P was being cared for by mother's sister-in-law during this episode).

4.120 On the same date mother telephoned her family support worker to advise that Child 1 had been admitted to hospital. Mother said she hadn't taken her medication as she wanted to be able to drive. The family support worker advised her to take her medication as not doing so could adversely affect her mental health.

4.121 At the end of March 2018 Child 1 was discharged from hospital. It was recorded that mother felt confident to manage the seizures. On the same date mother had telephoned HBTT from the ward to say she had not been given any Diazepam and was 'going out of her mind'. Following discussion with the perinatal consultant psychiatrist, a prescription was provided.

4.122 In early April 2018 mother's mental health was recorded as 'more stable' when she attended clinic for depot medication.

4.123 Also in early April 2018 mother contacted the HBTT and said she felt agitated but offered no specific reason for this. Mother informed the HBTT that she had taken her medication and planned to collect her prescription the following day.

4.124 In early April 2018 mother's family support worker discussed her case in supervision. The notes recorded that mother had a history of when services say they will pull out she would say her mental health was worse and that she felt suicidal. It was agreed to keep mother's case open for a 'while longer' due to the concerns about her mental health. It was also recorded that the children's needs were being met to an adequate level.

4.125 During the evening of Saturday 7th April 2018 the ambulance service received a 999 call from mother to report that Child P was not breathing. The child was conveyed to the ED at Calderdale Royal Hospital. On examination Child P was found to have a subdural haematoma and multiple bruising including a bite mark to his left leg and bruising to his scrotum and the front of his neck. The ambulance service notified the police and children's social care.

5.0 Involvement of Child P's family

5.1 Mother and father were contacted to advise them of this review and offer them the opportunity to contribute. Mother expressed a wish to contribute to the review and several attempts were made to meet with mother to enable this to happen but without success.

6.0 Analysis

To what extent was the impact of Mother's mental health on her daily functioning and on her ability to provide safe care and support to her children understood by the professionals involved and acted on?

6.1 When midwifery became aware of mother's first pregnancy with Child 1, prompt contact was made with the SWYPFT single point of access (SPA) to clarify her diagnosis which at that time was recorded to be (suggested) personality disorder and ADHD. The SPA was able to confirm that mother was not bipolar as she reported herself to be. (However, it seems clear that mental health services understanding of mother's mental health needs evolved over the course of the period covered by this SCR. Mother's autistic traits only appear to have become more fully understood from November 2017 and the possibility of previously hidden impairments such as dyslexia, dyscalculia and dyspraxia were only diagnosed in March 2018).

6.2 The specialist midwife also promptly referred mother to the SPA for 'additional mental health support' after assessing mother as having symptoms of mild depression and moderate to severe anxiety. Mother had intermittent contact with the community mental health team for a number of years. Mental health services had been reorganised in January 2016 so that the majority of service users were on the CMHT core pathway (stable, less complex needs) and the more complex service users were on the CMHT enhanced pathway.

6.3 Mother was placed on the perinatal mental health pathway. Perinatal mental health pathways have been established to enable mothers to promptly access appropriate mental health services during the perinatal period. Whilst most mental health problems are just as common during the perinatal period as at any other time in a woman's life, it is important that when mental health problems occur during the perinatal period, there is prompt access to care in order to improve outcomes for the woman and to minimise negative impacts on the unborn or developing baby/child (2).

6.4 A perinatal mental health plan was drawn up, which outlined the support mother would be offered. This included referral to the intensive home based treatment team (IHBTT) shortly before the birth of Child 1, daily monitoring by the RAID hospital mental health liaison team following delivery, daily visits by the CMHT during the fortnight after discharge and an early post-hospital discharge appointment with the consultant psychiatrist (no details of this appointment have been shared with the SCR).

6.5 Thereafter, mother's ongoing care would be overseen by the specialised midwife, perinatal mental health working with the community midwife and the health visitor. The risk of postnatal depression was to be closely monitored.

6.6 During her pregnancy with Child 1, mother's mental health appeared to be fairly stable although she expressed anxiety about her stay in hospital for the birth and the possibility of sharing a bay with other mothers. She reported suicidal ideation to a mental health support worker on one occasion although she was said to have no plans to harm herself.

6.7 The impact of mother's medication on the unborn Child 1 was considered by mother's GP and her obstetrician. Mother initially attempted to reduce her dosage of anti-depressants but this led to a deterioration in her mental health. Mother was advised that Child 1 would need to be delivered in the hospital delivery suite to monitor for any withdrawal symptoms in the new born baby. The question of whether or not it would be safe for mother to breast feed Child 1, given the medication she was taking, was considered and ruled out except for the period when mother was in hospital following the birth of Child 1 when the impact of breast feeding could be carefully monitored. This question did not appear to be as carefully considered when the question of breast feeding Child P came to be considered and mother was advised that she could breast feed the child following her discharge from hospital. Breast feeding advice appeared to be inconsistent across the two births although it is accepted that changes in mother's medication could have been a factor. However, midwifery provided the advice to mother in respect of Child 1 after checking with the drug information service. In respect of Child P, the advice was given by mother's mental health worker and there is no reference to checking with the drug information service.

6.8 During the pregnancy with Child 1 mother expressed the concern that the medication she was taking might prevent her from waking to care for her baby at night. It is unclear to what extent this risk was assessed and monitored by the agencies in contact with her. However, this risk was mitigated to an extent by arrangements for father to stay with mother in hospital following the delivery of Child 1 and for father, who lived elsewhere, to stay with mother overnight for the first month following discharge from hospital. However, the latter arrangement was not permanent and mother and father's relationship appeared to come to an end for a period following the birth of Child 1. Apart from maternal self-reporting, practitioners were not in a strong position to obtain assurance that mother was able to wake during the night to care for Child 1 once father was no longer present.

6.9 It became clear that Child 1 was sleeping with mother who was given advice about safe sleeping. The same situation arose in respect of Child P. It seems

possible that mother's fears that she may not wake to care for her children during the night may have been a factor in the unsafe sleeping practices in that she may have felt that she was more likely to wake in the night of the child was sleeping with her.

6.10 Following the birth of Child P it was suggested that mother was avoiding taking her medication out of fears that the sedation would prevent her waking to care for the children (Paragraph 4.116) but there is no indication of whether mother was challenged on this point.

6.11 The period following the discharge of mother and Child 1 from hospital passed off without difficulty. Her community midwife transferred care of mother and baby to the health visitor as planned and no concerns were expressed about mother or father's care of Child 1 at this point.

6.12 Mother was reluctant to access activities for Child 1 because of her own anxiety about interacting with other parents. The health visitor referred mother and Child 1 to family support to support mother to take the child to children's centre and other groups. However, concerns that Child 1 was becoming socially isolated and therefore largely unobserved outside mother's care persisted. Practitioners noted a lack of congruence between mother's stated anxieties such as interacting with other parents and her enthusiastic engagement in social activities and holidays abroad.

6.13 Mother and Child 1's change of GP practice in February 2017 could have increased the risks to the child as the previous practice had become very familiar with mother's presentation. However, no risks materialised from the change of GP practice which may have helped her to consistently access locality based services.

6.14 Practitioners became aware of mother's second pregnancy from April 2017. Mother remained on the CMHT caseload and was again referred to the perinatal mental health pathway. A mental health care plan for mother was to be completed between 28 and 32 weeks of the pregnancy. This plan was apparently completed in November 2017 but at the second TAC meeting (Paragraph 4.102) concerns were expressed whether the plan met mother's current needs and the plan was updated for the third TAC meeting (Paragraph 4.116) although it was referred to as a 'crisis plan' in the latter TAC meeting.

6.15 Mother was also referred to the specialised midwifes panel which ensures women with complex needs are referred for the correct level of support. The outcome of this referral was that mother was to be cared for by the early intervention midwife who was to access clinical supervision from the perinatal mental health lead.

6.16 Mother's auditory hallucinations continued during the second pregnancy leading to a change in her medication which left her feeling extremely agitated which led to a further adjustment in her medication. During the period covered by this review mother's medication was changed many times, often at her request. There was sometimes quite a long delay in communicating the medical care plans, which set out the justification for the changes in medication, to mother's GP. Mother's consultant perinatal psychiatrist has contributed to this review and has advised that there was a six week delay in typing up his audio recordings of appointments with mother which formed the basis for the medical care plans sent to her GP. It is clear that changes in mother's medication sometimes had quite a significant impact upon her presentation. Whilst mental health services routinely communicated these medication changes to mother's GP, no evidence has been provided to this review that the medication changes to the non-mental health practitioners working with mother, such as midwifery, health visiting and family support, which seems likely to have undermined multi-agency working and efforts to safeguard the children. (At a late stage in the review SWYPFT has advised that medication changes would have been notified to the health visitor and midwife).

6.17 Mother's grandmother died around three months into her second pregnancy which is said to have left her stressed. The nature of mother's relationship with grandmother is not completely clear. Mother may have had some caring responsibilities for her. Grandmother appears to have cleared a debt for mother at some point which suggests she may have been a protective factor for mother to an extent.

6.18 In July 2017 mother disclosed a recent rape to a mental health practitioner but this information was not shared with any other agency. As previously stated, SWYPFT has advised this review that mother told the mental health practitioner that she had reported the incident to the police. Mother had reported an earlier rape to the police in 2015 but there is no record of her reporting any subsequent rape to the police (Paragraph 4.39).

6.19 Mother continued to resist attempts to support and encourage her to take Child 1 to groups and falsely claimed that her GP had advised her not to expose the child to contact with anyone outside immediate family because of a rash he had developed. She later removed Child 1 from nursery. These actions indicated that mother may have been placing her needs above those of her child and it is unclear from agency records how firmly she was challenged on this and other issues. There seems to be a possibility that the apparent fragility of mother's mental health may have inhibited practitioners in challenging her at times.

6.20 In September 2017 mother was transferred from the core to the enhanced CMHT pathway. Part of the justification for this was that as mother's second pregnancy progressed it was anticipated that her mental health symptoms would intensify. The antenatal plan drawn up at this time included a minimum of weekly visits by her care co-ordinator or other health practitioners, involvement of consultant perinatal psychiatrist, referral to the RAID hospital mental health liaison team a week prior to admission for birth of Child P and referral to HBTT to provide daily contact immediately following discharge from hospital.

6.21 During the months prior to the birth of Child P there were concerns that mother's OCD symptoms were increasing, unrealistically high expectations of Child 1's ability to feed himself were noted and mother reported feeling suicidal periodically. Whilst the Early Intervention Plan identified the risk of mother's mental health deteriorating which could impact upon the children, the specific impacts of her mental ill health upon the children, other than the risk of isolation, were not documented in the plan.

6.22 The appointment with the consultant perinatal psychiatrist anticipated by mother's antenatal plan took place four weeks prior to the scheduled birth of Child P. The consultant expressed concern about the impact of mother's 'disordered personality' upon her parenting. His concerns are summarised as follows:

- Mother had a high need for sedative medication to aid sleep which was a chronic problem for her. The consultant had been disturbed by mother's comments that 'extra meds would be good because they will stop me waking up if the baby cries'.

- During prior contacts with CMHT, mother had previously disclosed a term of imprisonment for offences of violence which she now denied. The consultant appeared to be concerned that mother may have been denying previous violent behaviour out of a concern that it could impact on agency views of her parenting capacity (As previously stated mother actually had no previous forensic or custodial history).

- Mother's autistic traits (which had been measured for the first time at this appointment) may have made it more difficult for her to reciprocate emotionally with a baby.

- These autistic traits may have made her extremely protective of her children and unlikely to accept professional advice if it conflicted with her preferred approach.

6.23 The consultant's concern led to the consideration of the need for a safeguarding children referral to children's social care which will be discussed later in this report. However, this appointment, just four weeks prior to the birth of Child P, appeared to be the first occasion on which the potential impact of mother's mental health on her capacity to parent Child 1 and Child P was documented reasonably fully.

6.24 In the weeks prior to the birth of Child P mother was said to continue to hallucinate, although the consultant perinatal psychiatrist concluded that her hallucinations were hypnogogic (associated with sleep) rather than psychotic. Mother also reported that her mental health was deteriorating. However, support was to be provided by father and sister-in-law over the period of the birth and post discharge from hospital.

6.25 Mother was assessed as 'fairly well' whilst in hospital following the birth of Child P and the child showed no indications of withdrawal.

6.26 Mother's mental health appeared to deteriorate to a degree following discharge home. She reported difficulties sleeping, hallucinations, an increase in OCD symptoms including many hours spent cleaning her home daily (mother's home was noted by practitioners to be 'spotless' which generally appeared to be regarded as a positive indicator when in fact it may *not* have been) and some suicidal ideation.

6.27 Concerns arose over mother over-feeding Child P and her unrealistic expectations over Child 1's behaviour who she perceived to be 'naughty' when he was in fact displaying typical toddler behaviour. She also expressed frustration when Child 1 moved his toys around as she liked to see them 'in order'. Additionally, she said that sometimes she wished it was just her and Child 1 as she did not always enjoy being the mother of two small boys. However, during the second TAC meeting in February 2018 there were said to be 'no concerns' about the way in which the children were being cared for. Additionally, there was no reference to over-feeding, unrealistic expectations or frustration at Child 1 moving his toys around in the Early Intervention Plan.

6.28 During a home visit from the consultant perinatal psychiatrist in February 2018 concerns arose that mother was describing what she saw during her hallucinations to Child 1, who mother claimed was 'seeing the people she sees'. This raised specific concerns that Child 1's mental health could be adversely affected by mother's mental health. The consultant concluded that whilst mother was not suicidal or persistently depressed she did worry and ruminate obsessively. Her rigidity and difficulties in dealing with change were again noted as was a difficulty in seeing things from the point of view of others, including her children.

6.29 There appeared to be a deterioration in mother's mental health in late February/early March 2018 although this may have been linked to medication changes. There was also a suspicion on the part of mental health services that mother tended to present with greater anxiety at times when mental health services were attempting to withdraw from, or reduce their engagement with her.

6.30 Mother's mental health was considered to be more stable in the weeks immediately prior to the significant injuries caused to Child P in April 2018 although a hospital admission after Child 1 suffered febrile convulsions, twelve days prior to the injuries to Child P, understandably generated anxiety for mother which led to contact with the HBTT.

6.31 There was a strong practitioner focus on understanding the impact of mother's mental health on her daily functioning and on her ability to provide safe care and support to her children although the impact on her children was inconsistently documented. Whilst it is important to note that most parents or carers who experience mental ill health will not abuse or neglect their children, mental health problems are frequently present in cases of child abuse or neglect. An analysis of 175 serious case reviews from 2011-14 found that 53% of cases featured parental mental health problems (3). Additionally, the risks to children are greater when parental mental health problems exist alongside domestic abuse, parental substance misuse, unemployment, financial hardship, poor housing, discrimination and a lack of social support (4). Together, these problems can make it very hard for parents to provide their children with safe and loving care (5). In mother and father's case there was little evidence of these factors although father had disclosed issues with drink and drugs to his GP and there was an insufficiently clear picture of the nature and extent of family and other social support which mother may have been receiving.

6.32 Research indicates a number of ways in which parental mental ill health can result in children in the household experiencing abuse, particularly emotional abuse and neglect (6):

- Mothers who experience mental ill health after birth may struggle to provide their babies with the sensitive, responsive care essential to their social, emotional and intellectual development.

Parents and carers may:

- experience inappropriate or intense anger or difficulties controlling their anger around their children.

- have rapid or extreme mood swings, leaving children frightened, confused and hyper-vigilant.

- be withdrawn, apathetic and emotionally unavailable to their children. They may have trouble recognising children's needs and responding to cues.

- view their children as a source of comfort and solace, which may lead to children taking on too much responsibility for their age.

- have distorted views of their children. For example, they may believe a child is to blame for their problems or a child has behavioural problems when there is no evidence for this.

- struggle with keeping to routines such as mealtimes, bedtimes and taking their children to school.

- neglect basic standards of hygiene and their own and their children's physical needs.

- fail to seek medical care for their children.

- struggle to keep their homes clean, buy food and clothes and pay essential household bills.

- struggle to set boundaries, discipline and supervise their children, which could leave them in unsafe situations.

- In rare cases of severe mental illness, parents and carers may have delusions related to their children, for example they may believe they are possessed, have special powers or are medically unwell.

6.33 In mother's case her mental health needs appear to have impacted on her children in that she sometimes had difficulty in recognising children's needs and responding to cues, particularly cues that Child 1 needed sleep and had been fed sufficiently. She also held distorted views of Child 1, characterising his typical toddler behaviour as 'naughtiness' for example. Mother may have also experienced delusions in respect of what she claimed to be Child 1's susceptibility to rashes and infections when exposed to contact with others outside the immediate family environment.

6.34 The practitioners working with mother during her pregnancies with Child 1 and Child P were faced with quite a challenging situation. They needed to continually

assess whether mother's mental health problems posed a risk to the safety and wellbeing of the children whilst also considering whether the everyday stresses of parenting were having a negative effect on mother's mental health. This required practitioners to holistically assess the children's development, the ability of mother to meet the child's needs and the impact of broader family and environmental factors. In this case the primary vehicle for assessing these factors was the early intervention single assessment completed by the assistant family outreach worker which will be discussed in greater detail later in this report.

6.35 Research indicates a number of key issues for practitioners to take into account when assessing the risks that parental mental health could present to children within the household including (7):

- The paramount importance of focussing on the child.

- A focus on the needs of each child to help identify any children who have adopted a carer's role within the family.

- The impact of a parent's mental health problems may vary according to the child's health, stage of development and relationship with other family members. It is therefore important to treat children, parents, carers and other significant relatives as individuals.

- Perinatal health teams should feel comfortable and confident asking women about their mental health and use evidence-based tools to help them detect problems and offer support during pregnancy and after the mother has given birth.

- Assessment should be informed by the parent or carer's background, medical history and current circumstances. As previously stated, attention should be paid to other risk factors alongside mental ill health such as substance misuse, domestic abuse, financial hardship or relationship problems. These difficulties may increase vulnerability and pose a greater risk to the child.

- Really listen to what parents and carers are saying. If they tell you they are not coping well with looking after their children, provide support at the earliest opportunity.

- Always take threats of suicide or threats to kill a partner or children seriously.

- Children are also at risk if the parent or carer has psychotic beliefs about them, or if their mental ill health is isolating them or making it very difficult for them to function on a day-to-day basis.

- Do not over-estimate the ability of a well parent or carer to cope with both parenting and supporting a partner with mental health problems. This impact should be properly assessed and support offered, for example in the form of a Carer's Assessment.

- It is important to include any extended family members or friends who offer support to the family in assessments.

- Assessment should be a shared task between children's social workers and adult mental health practitioners. This will ensure professionals fully understand how the situation is affecting children and help identify risks at an early stage.

- Professionals should also seek the views of colleagues from other agencies who are involved with the family, such as teachers.

- Assess factors increasing the children's risk of harm against protective factors which will increase the family's resilience.

- If a child is assessed as in need or at risk of harm, draw up a care plan or child protection plan to provide support which involves adequate supervision and checks and balances.

6.36 Applying these issues to mother's case, one becomes aware of a key difficulty which impeded the ability of practitioners to assess risk. From the discussions at the practitioner learning event organised to inform this SCR, it became apparent that mental health practitioners interpreted mother's presentation differently from the non-mental health practitioners. The former understood that mothers' hallucinations were hypnagogic rather than psychotic partly because there were no apparent physical effects of the 'hearing of voices' such as distress behaviours. Additionally, when mother reported suicidal thoughts mental health practitioners perceived this to be mother's way of expressing her anxiety. For non-mental health practitioners there appeared to be an understandable tendency to accept what mother reported about suicidal ideation and hallucinations at face value. This quite stark difference in interpreting mother's presentation, particularly comments which could be perceived as suicidal ideation, led to some difficulties in mental health and non-mental health practitioners working effectively together.

6.37 Father was twice offered a Carer's Assessment by the community mental health team, in January and March 2018 but declined on both occasions.

How effective was the Early Intervention co-ordination and planning for this family?

6.38 Calderdale Safeguarding Children Partnership has a 'continuum of need and response' policy which sets of the five levels of need as follows (8):

- Level 1 represents children with no identified additional needs. Their needs are met through accessing universal services.

- Level 2 represents children with additional needs that can be met by targeted support by a single practitioner or agency from universal services.

- Level 3 represents children with additional needs that can be met by targeted support by a multi-agency integrated support package - mainly universal services coordinating their approach.

- Level 4 represents children with significant additional needs that have not been met following a co-ordinated, multi-agency response from the Early Intervention Panel and for whom significant concerns remain. This is when Children's Social Care may become involved.

- Level 5 represents children with complex needs at the highest level of vulnerability which will be met by multi-agency support from specialist services.

6.39 Where it is felt that a child, young person or family has needs that are beyond the remit of universal services alone the early intervention single assessment (EISA) should be used as a means of identifying the level of need. In this case the assistant family outreach officer commenced a single assessment on 28th April 2017 and completed it on 21st November that year. This was well outside the expected local timescales of 45 working days. Key factors in this delay were worker inexperience and inconsistent engagement in the process by mother and father. The Early Intervention Single Assessment was considered by the Halifax Opportunities Trust to be of good quality and thorough in respect of the wellbeing and needs of Child 1 and the unborn Child P which were said to warrant a tier 2 response only. However, the Early Intervention Single Assessment was said to lack analysis relating to mother's mental health and the impact on family functioning.

6.40 Although the single assessment was not completed until 21st November 2017, a senior family support worker identified the need for a team around the child (TAC) approach on 25th August 2017 due to the 'concerns and issues' present in the case. Although this decision was not fully informed by consideration of a completed single assessment, it indicates that the senior family support worker was of the opinion that the level of concern had reached, or was approaching level 3. At that point a (higher level and more experienced) family support worker was allocated to work alongside the assistant family outreach worker.

6.41 However, there was a further delay in commencing the TAC. As previously stated, the early intervention single assessment was not completed until 21st November 2017, despite the involvement of the family support worker, at which point mother and father were asked whether they consented to a TAC, which they did.

6.42 There are two Early Intervention Panels in Calderdale which provide a mechanism to ensure the delivery of efficient and effective services to families who have been identified as being most at risk of needing support from a specialist service. Where a service has specific concerns, it is a recommendation, but not a requirement, that an Early Intervention Single Assessment (EISA) be completed before a referral to the locality panel is made. It is expected that the person commencing the EISA, contact the EISA Team to check whether an assessment has already been completed and logged by another professional. This is essential to ensure that only one EISA is in existence for a child/young person or family at any one time. Completion of an EISA generates an action plan which requires a multi-agency approach to meeting the child's needs. This should help to improve the outcomes for a child or young person, especially where current intervention and support processes are not working.

6.43 In this case the early intervention single assessment was not logged with the Early Intervention Single Assessment Team until 8th March 2018 and was not referred to the EI panel. The reason for this delay is unknown. Had the EISA been centrally logged with the EISA team the completion of this would have been monitored to ensure completion of the assessment took place within the 45 days guidance. However, the effect of the lengthy delay in the completion of the EISA and the delay in establishing a lead practitioner and multi-agency coordinated response, appears to have undermined early intervention efforts in this case. The first TAC meeting was not arranged until 11th December 2017 which was eight working days prior to the scheduled birth of Child P. Unfortunately, this meeting was cancelled and the first TAC meeting did not take place until 15th January 2018. Had this case been referred to the Early Intervention Panel, the panel may have recommended an EISA and this process would have triggered a notification to the

EISA team who would have then contacted the lead practitioner, the panel could have provided advice and ensured that the most appropriate agencies were supporting the family.

6.44 Essential elements in successful early intervention and prevention are to identify key indicators of need, identify and assess any risks or protective factors, help specify desired outcomes and identify key services for the child and their family through the single assessment, leading to agreed early and effective interventions. Although there was considerable multi-agency involvement with mother, father, Child 1 and Child P, efforts to achieve co-ordinated early intervention were frustrated by the delays set out above.

6.45 The initial TAC meeting in January 2018 was attended only by mother's care co-ordinator and the family support worker who was the early intervention lead practitioner. Mother reported an apparent deterioration in her mental health and expressed concern about father's imminent return to work on night shifts. The care co-ordinator explained that mother would be gradually discharged from the enhanced to the core CMHT pathway. There was to be a continued focus on supporting mother and Child 1 to access groups within the community.

6.46 The second TAC meeting took place on 22nd February 2018 at which concerns were expressed that the crisis plan for mother required updating and that coping strategies mother had been advised to adopt may not be realistic or safe. There were said to be no concerns about the way in which the children were cared for.

6.47 The third and final TAC meeting took place on 21st March 2018 at which all agencies involved in supporting the family were present. Mother's care co-ordinator explained that mother was being discharged from the CMHT enhanced pathway but would continue to be supported on the perinatal mental health pathway. This decision appeared to be challenged by the health visitor on the grounds that mother continued to struggle with her mental health and 'had not felt able to be alone with the children'. Mother expressed concern about services 'pulling out'. The Early Intervention Plan continued to include the risk that mother's mental health could deteriorate and impact upon the children. Self-help and crisis plans had been completed for mother.

6.48 The impression gained is that the early intervention work tended to focus on mother's needs rather than the needs of the children. When the TAC meetings eventually began they appeared to continue in a similar vein to the multi-agency meetings rather than having a sharper focus on early intervention. (The multi-agency meetings took place prior to, and in parallel with, the TAC meetings. These multi-agency meetings were not part of any formal process. Whilst valuable, there

was a risk that holding multi-agency meetings and TAC meetings could lead to confusion and duplication of effort). Practitioners may have experienced difficulty in matching this case to the levels set out in the continuum of need. For level 3 to be evidenced, the health and development of the child/children is being impaired by a range of unmet needs which requires an integrated response from a number of agencies and support systems to achieve an improvement. In Child 1 and Child P's case there was *a risk* that their health and development could be impaired by a range of unmet needs arising from compromised parental capacity. As discussed later in the report, practitioners also appeared to experience difficulty in articulating specific safeguarding concerns in respect of the children.

6.49 It is important to try and tease out why early intervention appeared to have been less successful in this case as early help services have been regarded as a strength in Calderdale since at least 2015 when Ofsted concluded that the Early Intervention Panels ensured effective information sharing and timely access to services, so that children and families were offered help when needs were first identified which was said to be reducing the need for formal social work intervention (9). The 2018 Ofsted inspection confirmed early help services as a strength (10).

6.50 In this case the reasons why early help was less successful appear to be as follows:

- Family support was the lead agency in co-ordinating early help. In this complex case, in which the impact of maternal mental health on the health and development of very young children was perceived to be a central issue, family support may not have been as well placed as other agencies to lead on early help. They certainly needed strong support from partner agencies in providing early help. Although partner agencies worked conscientiously to support the family, the focus on early help was not conspicuous.

- As previously stated there were significant delays in the completion of the early help single assessment, the commencement of the TAC process and the referral/notification to the Early Intervention Panel. The inexperience of the assistant family outreach worker and inconsistent engagement by the family were factors in the delays.

- Mental health services appeared to be focussed on working with adults and appeared less confident in addressing child safeguarding issues.

To what extent was the impact of the birth of the second child on parenting and family functioning understood?

6.51 Practitioners appear to have taken confidence from the relatively trouble free pregnancy, birth and care of the new born Child 1 and appear to have initially assumed that largely replicating that level of care and support for the second pregnancy would be sufficient.

6.52 However, mother's mental health appeared to be less stable during the second pregnancy and when she was seen by the consultant perinatal psychiatrist on 23rd November 2017, a number of concerns about the impact of mother's mental health on her parenting capacity arose. These concerns prompted the consideration of a referral to children's social care for a pre-birth assessment.

6.53 However, the approach to deciding whether or not to make such a safeguarding referral may not have been in accordance with policy. Firstly, mother was asked if she would accept such a referral to children's social care for a pre-birth assessment. Consent is required if making a safeguarding referral in respect of level 4 concerns (children with significant additional needs that have not been met following a co-ordinated, multi-agency response from the Early Intervention Panel and for whom significant concerns remain) but is not required in respect of concerns at level 5 (children with complex needs at the highest level of vulnerability which will be met by multi-agency support from specialist services). Whether or not the level of need was judged to have reached level 4 or level 5 was not documented. However, giving mother the option of consenting to, or declining a referral to children's social care ran the risk of mother declining because of her previously stated fear of children's services involvement (Paragraph 4.82).

6.54 Secondly, it was decided to consult partner agencies and obtain their views of mother's parenting capacity before deciding whether to make a safeguarding referral. This was an unnecessary step which had the potential to delay any referral. When consulted, partner agencies expressed no concerns about mother's parenting of Child 1 other than the concern that the child had become socially isolated through mother's continuing strong reluctance to take him to groups. However, the health visitor responded to this consultation by saying that if the consultant had safeguarding concerns, he should make a safeguarding referral.

6.55 Eventually, mother's care co-ordinator made contact with the MAST Information and Advice service. The outcome of the discussion recorded by MAST was that the care package would be reviewed at a multi-agency meeting and if there were any safeguarding concerns a referral to MAST was to be made. Mother's care co-ordinator recorded a different outcome which was that a pre-birth assessment was not required due to the number of practitioners already involved and the fact that mother was 'under the Early Intervention Panel'. (In fact the Early Intervention Panel was unaware of this case at that time). In the event, no multi-agency meeting

was held and the initial TAC meeting planned for 11th December 2017 was cancelled. Comfort may have been taken that a well-attended multi-agency meeting had recently taken place although it is unclear whether the safeguarding concerns expressed by the consultant had been explored in that forum.

6.56 The actions taken in response to the consultant's concerns about mother's parenting capacity were unsatisfactory. Whilst no agency consulted on behalf of the consultant perinatal psychiatrist supported a referral to children's social care, there is no evidence that the potential impacts on her parenting capacity of the evolving understanding of mother's mental health needs were clearly and fully articulated and fully informed the consultation with partner agencies.

Was practice sufficiently child-focused? Did the agencies involved understand what life was like for the children? What might have prevented a full understanding?

6.57 There was insufficient focus on the potential impact of mother's mental health problems on her parenting of the children. This was a focus of practitioner attention at times but was not sustained. This was due in part to mother's reported needs tending to soak up a great deal of practitioner attention. The synopsis in section 4 of this report only provides a summary of mother's contact with agencies. The actual level of contact by mother as recorded by agencies was much more substantial. Mother appeared to have a very high level of need for advice and reassurance to help her deal with her anxieties and there is some indication that she may have attempted to manipulate services particularly when she feared that agencies were considering withdrawing support from her.

6.58 There were occasions when mother put her needs before those of the children, particularly the social isolation of Child 1 which appeared to be motivated by her fears of relating to other parents. This behaviour persisted for many months despite the efforts of family support. This demonstrated mother's resistance to professional advice when it conflicted with her own preferences but, as previously stated, there may have been a reluctance to challenge mother because of the fragility of her mental health.

6.59 Child 1's isolation meant that there was an absence of practitioner observation of the child outside the family home.

6.60 There were several occasions when mental health practitioners referred to the children as 'protective factors' in respect of mother's mental health. Previous SCRs have found that whenever practitioners perceive children as 'protective factors' in

respect of parental mental health, the unintended outcome is invariably to increase risks for the children who in this case were a toddler and a newly born baby (11).

6.61 Mother's stated reluctance to access the services of the crisis team because of fears that this would lead to the involvement of children's services should have generated greater concern than it appears to have done.

To what extent did the agencies involved share relevant information with each other in a timely manner? And was this understood?

6.62 Mother's social housing provider had fairly substantial contact with her during the period covered by this SCR but was completely unaware of the support being provided by CMHT, perinatal mental health services, midwifery, health visiting and family support. Mother's consent would have been necessary for agencies to share information with the housing provider.

6.63 At the practitioner learning event organised to inform this SCR non-mental health practitioners expressed some confusion about how mental health services were organised and delivered. One comment from a non-mental health practitioner was that she 'never felt she was speaking to the same person'. A lack of continuity in practitioner involvement with mother may also have contributed to this.

6.64 The perinatal mental health pathway appeared to be insufficiently understood by non-mental health practitioners who may have perceived it as a passport to secondary mental health services when in fact the majority of mothers on the pathway have mild to moderate mental health needs and therefore do not need secondary mental health services. So expectations may have been raised when in fact the pathway exists to ensure that any mother receives the mental health support she needs.

Was the role of the father and other adults in the household, the relationships between the adults, and the relationships between the adults and children understood? What might have prevented a full understanding?

6.65 During the period covered by the review, father had routine contact with his GP to whom he disclosed excessive alcohol intake which he planned to reduce in 2016. At that appointment he also disclosed previous cocaine and cannabis use which he said he had stopped taking two years earlier.

6.66 Father was known to agencies as the father of Child 1 and Child P. He was known to be in an on/off relationship with mother. He was perceived to be only

intermittently present during mother's first pregnancy but was regarded as 'practically living with mother' during the second pregnancy. Practitioners felt that father had effectively moved in with mother but the fact that he worked regular night shifts enabled mother to present herself as a single parent which meant that she could claim higher state benefits than if father had been declared to be living with her.

6.67 Practitioners generally perceived father to be a protective factor providing much needed support, particularly during the night in the periods following the births of Child 1 and Child P. His presence during these periods helped to mitigate the risk that mother might struggle to wake to care for the children during the night because she was sedated. However, when he was working, he appeared to regularly work night shifts. He also seems to have been regarded as a reliable source of information about mother's mental health and the impact of this on her care for the children, despite the fact that his presence in the household was intermittent.

6.68 No concerns were expressed about father's observed care of the children. Mother was concerned over father's attachment to Child 1 as his involvement with the child diminished after providing more intensive support in the immediate post-birth period. Conflict arose between mother and father after father was reported to have cast doubt on the paternity of Child P.

6.69 In general, the primary focus of practitioners supporting the family was on mother's mental health and the potential impact of this on her parenting capacity. As a result, there may have been less attention paid to father and a less than full understanding of his role within the family unit.

6.70 Support was also provided by father's sister. The extent of this support is unclear from the records shared with this review, but practitioners who attended the learning event organised to inform this SCR felt that she provided quite substantial support at times which could have helped to mask any deficiencies in parenting.

6.71 There is a reference to an 'Uncle C' contacting mental health services on mother's behalf on one occasion. No further information is currently known about 'Uncle C'. There is no indication that assessments were considered in respect of father, his sister, or any other adults providing support to mother.

6.72 Whilst father could not be described as a 'hidden male', the focus on mother's mental health and the impact of this on the children resulted in practitioners having a less than fully informed understanding of him. The issue of 'hidden males' in families is a recurrent theme in SCRs conducted when children die or suffer significant harm (12). These SCRs have frequently found that practitioners rely too

much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children. Another 'hidden male' finding is that practitioners do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in practitioners missing crucial information and failing to spot inconsistencies in the mother's account.

6.73 Good practice which has emerged from SCRs in which key males within the family have been overlooked by practitioners includes the need for practitioners to identify and carry out checks on any new adults who have significant contact with vulnerable children and the need to clarify who the members of a household are each time practitioners visit a family (13).

Was the time of year when Child P was born significant in the way in which agencies worked together and planned discharge of the baby from hospital?

6.74 The birth of Child P just prior to Christmas may have slightly accelerated his and mother's discharge from hospital and may have been a factor in no multi-agency discharge planning meeting taking place.

6.75 Daily community midwife contact with the family appears to have been maintained during the Christmas/New Year period although adverse weather conditions may have impacted upon face to face contact.

Good Practice

- The review of mother's case by the named midwife in September 2016 which highlighted the need for closer working between midwifery and mental health.

- The support provided to mother in hospital following the birth of both Child 1 and Child P including the monitoring of her mental health.

- The referral to family support by the health visitor in April 2017 to support mother and Child 1 to attend children's centre groups.

- Joint visits by family outreach and care co-ordinator.

- Appropriate challenge between practitioners (Paragraph 4.63, 4.102).

- Health visitor responsiveness to mother's anxieties about parenting the children.

7.0 Findings and Recommendations

7.1 At the time of writing, it is not known whether the injuries sustained by Child P were inflicted by mother, father or a third party.

Mother's mental health: Impact of the birth of second child.

7.2 During the period of two years and three months which preceded the injuries to Child P there was extensive multi-agency involvement with mother, father, Child 1 and Child P. The primary focus of agencies was on providing support to mother in order reduce the risks of any deterioration in her mental health during the perinatal periods in respect of Child 1 and Child P and to prevent any harm to the children which might arise from mother's mental health problems.

7.3 Mother's mental health remained relatively stable during the first pregnancy with Child 1 and in the months following his birth. Although mother's care for Child 1 was generally perceived as positive by practitioners working with the family, concerns about mother's parenting gradually emerged, specifically in respect of unsafe sleeping, social isolation and unrealistic expectations. The social isolation of Child 1 also gave rise to concerns that mother was placing her own needs ahead of those of the child. Agencies found the issue of whether mother was fully capable of meeting Child 1's needs during the night hours when sedated by her medication difficult to fully resolve.

7.4 Mother's second pregnancy began approximately six months after the birth of Child 1 and appeared to more adversely affect her mental health. However, agencies were slow to appreciate that the arrival of a second child had the potential to increase risks to both Child 1 and the unborn Child P. Whilst the need for Early Help to be provided to the family was identified, there was considerable delay in formally putting this in place. Additionally, it was not until a month prior to the birth of Child P that the option of making a referral to children's social care for a pre-birth assessment was considered. This was prompted by the consultant psychiatrist documenting the potential impact of mother's 'disordered personality' on her parenting capacity. No safeguarding referral was made at that time or subsequently.

7.5 It is understood that an earlier Serious Case Review commissioned by Calderdale Safeguarding Children Board found that the risks associated with the birth of a second child had not been fully appreciated by practitioners. It is therefore recommended that agencies are reminded to carefully consider the impact of the birth of a second or subsequent child to a family in which there are already concerns and to ensure that any support needs are identified and acted upon without delay.

Recommendation 1

That Calderdale Safeguarding Children Partnership reminds partner agencies of the need to carefully consider the potential impact of the birth of a second or subsequent child to a family about which there are prior concerns and to ensure that any support needs are identified and acted upon without delay.

Mother's mental health needs: Lack of clarity about the potential impact on the children.

7.6 Despite the considerable efforts of a range of practitioners from community mental health services, the perinatal mental health pathway, maternity, health visiting and family support, mother's mental health needs appear to have inadvertently diverted practitioner attention away from the needs of the children at times.

7.7 Throughout most of the period during which mother was pregnant with Child 1 and Child P there was a lack of clarity over precisely what the child safeguarding concerns arising from mother's mental health diagnosis were. The Early Intervention Single Assessment provided insufficient clarity in this regard and the Early Intervention Plans which were reviewed at each of the TAC meetings specified only the social isolation of the children. However, the safeguarding concerns arising from maternal mental health were much more numerous and are briefly set out below:

- Mother's ability to wake during the night to care for Child 1 and Child P whilst sedated by medication to help her sleep.
- Persistent co-sleeping.
- Over-feeding of both Child 1 and Child P.
- Unrealistic expectations of Child 1 in respect of self-feeding.
- Unrealistic expectations of Child 1's behaviour (Perceived him to be 'naughty' when he was in fact displaying typical toddler behaviour).
- Mother's frustration when Child 1 played with toys so that they were no longer 'in order'.
- The social isolation of the children, particularly Child 1.
- Mother sharing her hallucinations with Child 1.

- Mother's periodic unwillingness to accept and act upon advice from practitioners

7.8 As stated earlier, it was not until shortly before the birth of Child P that some of these safeguarding concerns were documented and the risks to the children articulated. Without clarity about what they were looking for, practitioners were ill-equipped to notice emerging concerns and there was a risk that they might misread what they noticed. For example, mother's 'spotless' home tended to be seen as a positive indicator, when in fact it could have been viewed as a concern given mother's obsessive cleaning and her desire for the children's toys to be set out in order.

7.9 In order to safeguard Child 1 and Child P, practitioners needed to fully articulate the potential impacts of mother's mental health needs upon the children and in order to do this they needed to be aware of key issues when assessing the risks that parental mental health could present to children in the household (which are set out in Paragraph 6.35). These key issues include the paramount importance of focussing on the child, really listening to what parents are saying so that support can be provided at the earliest opportunity if they say they are not coping well with looking after their children and sharing the task of assessment between the wider children's workforce and adult mental health practitioners.

7.10 Calderdale Safeguarding Children Partnership may wish to emphasise the importance of assessing the risks that parental mental health could present to children in the household and the need to clearly and fully document safeguarding concerns. In support of this, it would be useful to circulate the key issues that practitioners should take into account when assessing such risks and gain assurance that these are fully reflected in policy and practice.

Recommendation 2

That Calderdale Safeguarding Children Partnership emphasises the importance of fully assessing the risks that parental mental health could present to children in the household, including the use of tools and guidance, and obtains assurance that single and multi-agency policy, systems and training supports the assessment of such risks and the documenting of any safeguarding concerns which arise.

Early Help

7.11 Although Calderdale's Early Help Strategy is highly regarded, Early Help did not make a positive difference in this case. There were considerable delays in

completing the Early Intervention Single Assessment, initiating Team Around the Child support and notifying the Early Intervention Co-Ordinator. Family Support was the lead agency for completing the Early Intervention Single Assessment and for the assistant family outreach worker who carried out the assessment, this was her first allocated case although she was supported by supervision and, once the complexities of the case became more apparent, jointly worked the case with an experienced family support worker.

7.12 With the benefit of hindsight, family support may not have been the ideal agency to take the lead on Early Help. Their role was to support mother in attending groups, taking Child 1 to nursery etc. This was a vital role in addressing the social isolation concerns in respect of Child 1 but arguably an agency with more of a core role in supporting the family would have been better placed to lead on Early Help with support from mental health services. Additionally, the lead role played by family support may have impacted on the focus of the early intervention work. For example, the Early Intervention plan lists only 'isolation' as an impact of mother's mental health on the children.

7.13 This review has been advised that there is no formal process for identifying or reviewing the agency/practitioner to lead on Early Help. As stated above, family support was not a core agency in providing support to this family, and when concerns began to escalate in the period prior to the birth of Child P, there was a strong case for reviewing whether they should continue to lead on Early Help. Calderdale Safeguarding Children Partnership may wish to examine the issue of how the lead agency/practitioner for Early Help is decided upon and reviewed.

Recommendation 3

That Calderdale Safeguarding Children Partnership obtains assurance that the provision of Early Help is timely, addresses the needs of the child and their family and is managed robustly in order to avoid drift. The Partnership should also examine the issue of how the lead agency/practitioner for Early Help is decided upon and, where necessary, reviewed. This examination will inform any decision over whether a more formal approach to deciding which agency/practitioner leads on Early Help is required.

Mental Health services: confidence in respect of the Safeguarding Children agenda

7.14 Additionally, family support would have been better placed to lead on Early Help if they had received stronger support from partner agencies. In particular, the

Early Help Single Assessment needed to be completed in partnership with mental health services.

7.15 However, mental health services in this case did not appear to have sufficient appreciation of the importance of Early Help and the safeguarding children agenda generally. Consideration of whether to make a safeguarding children referral in November/December 2017 did not appear to be informed by the ongoing Early Help work and there was a lack of clarity about whether the proposed referral required the consent of the parents. Additionally, there were occasions when mental health practitioners recorded that Child 1 (a toddler) and Child P (a new born baby) were 'protective factors' in mother's life. The use of this term in this context should always be avoided as the child should always be the central consideration in the management of risk by all services. Furthermore, concern was expressed by some agencies that the coping strategies suggested to mother to help her address feelings of anxiety were insufficiently child-focussed (Paragraph 4.102).

7.16 Calderdale Safeguarding Children Partnership may wish to obtain assurance that mental health services, particularly those which are primarily focussed on the needs of adults, have sufficient awareness of the need to safeguard the children of adults with mental health needs and always give priority to the needs of the child in considering risk.

Recommendation 4

That Calderdale Safeguarding Children Partnership obtains assurance that mental health services, particularly those which are primarily focussed on the needs of adults, have sufficient awareness of the need to safeguard the children of adults with mental health needs and always give priority to the needs of the child when considering risk.

7.17 Calderdale Safeguarding Children Partnership may wish to widely disseminate the learning from this case. It would be particularly beneficial for mental health practitioners to be an important target audience for any learning event(s) which should provide the opportunity for both mental health and non-mental health practitioners to discuss the complementary roles they play in safeguarding children.

The perinatal mental health pathway

7.18 The perinatal mental health pathway was being implemented in Calderdale during the period on which this SCR focusses. The 2018 NHS England and NHS Improvement guidance *The Perinatal Mental Health Care Pathways* (14) highlights a number of potential long term gains arising from timely access to good quality

perinatal mental health care. One of these gains is improving outcomes for children, including reducing the risk of adverse parenting outcomes. Given the inadvertent focus on the needs of mother at the expense of the needs of Child 1 and Child P, Calderdale Safeguarding Children Partnership may wish to seek assurance that the perinatal mental health pathway has sufficient focus on parenting capacity including multi-agency review of this issue by all agencies working with the family.

Recommendation 5

That Calderdale Safeguarding Children Partnership seeks assurance that the Perinatal Mental Health Pathway includes sufficient focus on parenting capacity including multi-agency review of this issue by all agencies working with the family.

7.19 Non mental health practitioners experienced some confusion over how mental health services were organised and delivered. In particular, there was a lack of awareness and understanding of the perinatal mental health pathway.

7.20 Therefore Calderdale Safeguarding Children Partnership may wish to invite SWYPFT to further promote knowledge and awareness of the perinatal mental health pathway and how mental health services are organised and delivered generally.

Recommendation 6

That Calderdale Safeguarding Children Partnership obtains assurance that South West Yorkshire Partnership NHS Foundation Trust has appropriately promoted knowledge and awareness of the Perinatal Mental Health Pathway and how mental health services are organised and delivered generally.

Changes in mother's medication

7.21 During the period covered by this review mother's medication was changed several times and that this sometimes had quite a significant impact upon her presentation. Whilst mental health services routinely communicated these medication changes to mother's GP, there is no evidence that they communicated the medication changes to the non-mental health practitioners working with mother, such as midwifery, health visiting and family support, which may have had the unintended consequence of undermining efforts to safeguard the children.

7.22 SWYPFT have included a single agency recommendation (in the action plan they have drawn up as a result of the learning arising from this SCR) to share the details of medication changes with relevant practitioners where there are concerns

over the impact of medication changes on parental mental health or on parenting capacity. Calderdale Safeguarding Children Partnership may wish to request a report from SWYPFT when this single agency recommendation has been completed.

Advice on breastfeeding

7.23 Mother appeared to be given conflicting advice on the safety of breastfeeding her children given the medication she was taking (Paragraph 6.7). Calderdale Safeguarding Children Partnership may wish to request Calderdale and Huddersfield NHS Foundation Trust (midwifery) to reflect on the learning from this SCR and provide or update guidance to practitioners accordingly.

Recommendation 7

That Calderdale Safeguarding Children Partnership requests Calderdale and Huddersfield NHS Foundation Trust (midwifery) to reflect on the learning from this SCR and provide or update guidance to practitioners if necessary on the safety of breastfeeding whilst the mother is taking medication.

Co-Sleeping concerns

7.24 Co-sleeping was a continuing concern with this family and mother was given advice about safe sleeping in respect of both Child 1 and Child P. In this case there were additional co-sleeping risk factors in that mother took medication which helped her to sleep more heavily and she was a smoker. Co-sleeping is a recognised risk factor in sudden and unexpected deaths in infancy (SUDI). Calderdale Safeguarding Children Partnership may wish to ensure that the learning from this SCR informs continuing efforts to promote safe sleeping messages.

'Hidden male'

7.25 There was insufficient understanding of the role of father, and other adults, including father's sister, in the household (See Paragraph 6.72). This is an issue which has been highlighted frequently in earlier Serious Case Reviews but services primarily focussed on the needs of adults, such as mental health services, may be less familiar with 'hidden male' research.

7.26 Calderdale Safeguarding Children Partnership may wish to remind agencies of 'hidden male' research findings with a particular focus on adult services which may be less familiar with the issue than members of the safeguarding children workforce.

Recommendation 8

That Calderdale Safeguarding Children Partnership reminds agencies of 'hidden male' research findings with a particular focus on raising the awareness of adult services which may be less familiar with the issue than members of the safeguarding children workforce.

7.27 The 'Safe, Successful Families' framework for social work practice has been implemented in Calderdale. This approach enables staff to gain a clearer sense of family functioning in order to intervene more effectively. Social workers did not become involved with Child P's family prior to the injuries he suffered. However, the agencies which were involved with the family did not manage to obtain a sufficiently clear understanding of family functioning. Calderdale Safeguarding Children Partnership may wish to give further consideration to the question of how the "Safe, Secure Families' approach informs multi-agency safeguarding practice.

Access to Safeguarding Supervision

7.28 It was clear from the practitioner learning event organised to inform this SCR that practitioners found this complex case challenging. Whilst some practitioners appear to have had access to safeguarding supervision, this does not appear to have been the case for all. Calderdale Safeguarding Children Partnership may wish to seek assurance (through the Section 11 Audit process) that practitioners involved in complex cases are routinely able to access safeguarding supervision.

Standard of Recording

7.29 There are several examples of a lack of clarity and precision in recording in the agency chronologies shared with this SCR. In particular, the rationale for decisions could have been improved. Improving the standard of recording is included in several of the single agency action plans developed in response to the learning from this SCR.

References

(1) Retrieved from https://www.england.nhs.uk/ourwork/qual-clin-lead/hlth-vistg-prog/

(2) Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/05/perinatal-mental-health-care-pathway.pdf

(3) Retrieved from https://www.nspcc.org.uk/preventing-abuse/child-protection-system/parental-mental-health/

(4) ibid

(5) ibid

(6) ibid

(7) ibid

(8) Retrieved from http://calderdale-safeguarding.co.uk/wp-content/uploads/2018/01/Continuum-of-need-website-min.pdf

(9) Retrieved from https://files.api.ofsted.gov.uk/v1/file/50004288

(10) Retrieved from https://files.api.ofsted.gov.uk/v1/file/50045446

(11) Retrieved from https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=F01AF3CF-F58F-42AD-B89A-96A4A692DF77&searchterm=maternal%20mental%20health&Fields=%40&Media=%23&Bool=AND&SearchPrecision=20&SortOrder=Y1&Offset=10&Direction=%2E&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

(12) Retrieved from https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

(13) ibid

(14) Retrieved from https://www.england.nhs.uk/publication/the-perinatal-mental-health-care-pathways/

Appendix A

Process by which SCR conducted and membership of the SCR review group

A review group of senior managers from partner agencies was established to oversee the SCR which was chaired by the independent lead reviewer. The membership of the review group was as follows:

- Service Manager, Children's Social Care, CMBC.
- Service Manager, Safeguarding and Quality Assurance, CMBC.
- Safeguarding Nurse Advisor, South West Yorkshire Partnership NHS Foundation Trust.
- Named Nurse, Safeguarding, Calderdale and Huddersfield NHS Foundation Trust.
- Detective Inspector, West Yorkshire Police.
- Deputy Designated Nurse, Safeguarding Children, Calderdale CCG
- Service Manager, Early Intervention and Early Years.
- Family Support and Outreach Team Manager, Halifax Opportunities Trust.
- Head of Safeguarding, Locala Community Partnerships, the community provider of Calderdale Public Health Early Years' Service.
- Manager, Private Day Nursery
- Customer Experience Manager, Housing Association
- Interim Calderdale Safeguarding Children Board Business Manager
- Business Support Co-ordinator Calderdale Safeguarding Children Board.
- David Mellor Lead Reviewer and Independent Chair of the SCR Panel

It was decided to adopt a systems approach to conducting this SCR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Chronologies which described and analysed relevant contacts with Child P and his family were completed by the following agencies:

- Calderdale and Huddersfield NHS Foundation Trust

- Calderdale Children's Services
- Calderdale Clinical Commissioning Group
- Calderdale Public Health Early Years' Service
- Halifax Opportunities Trust
- Housing Association
- Private Day Nursery
- South West Yorkshire Partnership NHS Foundation Trust
- West Yorkshire Police
- Yorkshire Ambulance Service

The review group analysed the chronologies and identified issues to explore with practitioners and managers at learning events facilitated by the lead reviewer.

The lead reviewer then developed a draft report which reflect the chronologies and the contributions of practitioners and managers who had attended the learning event. With the assistance of the SCR review group, the report was further developed into a final version and presented to Calderdale Safeguarding Children Board.

As previously stated efforts to engage mother and father in contributing to the SCR proved unsuccessful.