ROCHDALE BOROUGH
SAFEGUARDING CHILDREN PARTNERSHIP

Rochdale Borough Safeguarding Children Partnership
Local Child Safeguarding Practice Review –

Child E1

1.0 Introduction

1.1 Child E1 died in January 2021. The baby was almost three weeks old. Child E1 had been conveyed to hospital by ambulance after the child's mother reported that the baby was unresponsive after having difficulty breathing. The baby later died from a head injury typical of being violently shaken. Following a range of specialist examinations, the Crown Prosecution Service authorised the charging of child E1's father with the murder of the child. At his trial in November 2022, the jury were unable to reach a verdict. A retrial is scheduled to take place in April 2023.

1.2 Rochdale Borough Safeguarding Children Partnership decided to conduct a local child safeguarding practice review (CSPR) after initially conducting a Rapid Review in accordance with Chapter 4 of Working Together to Safeguard Children 2018. The Rapid Review concluded that a CSPR should be undertaken. Child E1 had been born with cleft lip and palate and so her parents received support from both universal and the specialist cleft lip and palate service. Child E1's mother, her former partner and her two elder children had recently been supported by child protection and child in need planning and by Early Help.

1.3 Melanie Hartley was appointed as the independent reviewer. However, the CSPR was suspended for a period at the request of Greater Manchester Police and when the review resumed Melanie was unavailable to continue as independent reviewer. David Mellor was appointed as the replacement independent reviewer. Melanie Hartley provided a very detailed and thorough handover document which contributed significantly to the learning subsequently derived from this CSPR. David is a retired police chief officer who has ten years' experience as an independent reviewer/author of CSPRs and other statutory reviews. He has no connection to services in Rochdale. A description of the process by which the review was conducted is set out in Appendix A.

1.4 An inquest may be held in due course.

1.5 Rochdale Borough Safeguarding Children Partnership wishes to express their heartfelt condolences to child E1's family.

2.0 Terms of reference

2.1 The time period on which the CSPR primarily focussed was from 1st February 2020 - when child protection planning came to end for child E1's older siblings - and child E1's death in January 2021. Significant events which took place prior to that date were also considered.

2.2 Purpose of the review:

a. Determine whether decisions and actions in the case comply with the policy and procedures of named services, and RBSCP.

b. Consider the impact child E1 having a cleft lip and palate, the advice and support provided to both mother and father by involved agencies in respect of this, and how these agencies worked together.

c. Establish any learning from the case about the assessment and management of mother's mental health during the timeline and also that provided by adult services prior to the timeline with a particular focus on safeguarding children work within adult services. This learning will be captured outside of review panel meetings.

d. Examine to what extent ICON[1] and Abusive Head Trauma information and advice was provided to parents, what consideration was given as to who should receive it and how this information and advice is provided to parents/carers of babies with additional needs. This line of enquiry to also include a review of materials available for the provision of such advice.

e. Understand in more detail what agencies knew about father, the impact this had on assessment and planning work and how effectively father was engaged by involved practitioners.

f. Explore the effectiveness of local safeguarding children arrangements, including information sharing and working relationships within and between agencies and decision making around safeguarding pathway thresholds and step down processes.

[1] ICON is a programme which provides information about infant crying and how to cope.

g. Explore the provision of safe sleep advice to parents in this case including what information was provided to them as parents of a new baby with a cleft lip and palate.

h. Understand Child E1's everyday life; what type of baby they were and what agencies knew about them.

i. Explore how COVID-19 may have impacted upon service delivery and the support offered particularly given Child E1's additional needs and whether it was possible to maintain a child-focused approach.

j. Explore areas of good practice.

k. Establish any learning from the case about the way in which local professionals and agencies work together to safeguard children.

l. Identify any actions required by RBSCP to promote learning to support and improve systems and practice.

3.0 Chronology of key events

3.1 The focus of this CSPR is on child E1 who tragically lived for only 20 days. If it is possible to invite family members to contribute to this CSPR, the CSPR may find out a little about how she had been developing. What is known is that she was born shortly before Christmas 2020 during a global pandemic. She was born with a cleft lip and palate which affected her feeding and may have predisposed her to colic. Her parents received support from both universal services and the specialist cleft lip and palate team and may also have benefitted from support from child E1's father's family to prepare for her arrival – which her parents were said to be 'thrilled' about. During her short life she lived with two of her older half siblings. Information in professional records indicates that her mother began to struggle to feed her and so in the last few days of her life she may have experienced some tension as her mother attempted to regain the initial confidence she had when feeding her.

3.2 In addition to a focus on child E1, this CSPR will also review agency contact with child E1's mother ('mother') and her father ('partner B') and the father ('partner A) of her mother's two older children (child 1(born in 2015) and child 2 (born in 2017)). Partner A was not the biological father of child 1 but the child related to him as their father.

3.3 Mother disclosed a serious sexual assault in 2011 (then aged 16/17). There was insufficient evidence to proceed with a prosecution. The police attended 13 incidents of domestic abuse involving mother – primarily as a victim – between 2006 and 2018. There were three separate partners involved in these incidents including partner A, who was the most recent of the three partners. Her second partner assaulted mother violently on one occasion. During her childhood mother had also been present during sometimes violent altercations between her parents and her brother who was said to have 'poor' mental health. Mother's relationship with partner A began in 2014 or 2015 when she was pregnant with child 1. It is understood that there was considerable ongoing conflict between mother's and partner A's families, which pre-dated the start of their relationship.

2018

3.4 During June 2018 the police had two contacts with mother and partner A and their children. The police attended after partner A smashed a mug in the presence of child 1 and child 2 (nearly 3 years and 13 months old respectively) after an argument between mother and himself. Later the same month the police received a third party call to the effect that child 1 had been left in the family car on a hot day although the car windows were open. The police attended and established that mother and partner A had been watching the child from their front room as they had

not wanted to wake her. They were strongly advised about the risks of leaving a child in a car on a hot day. Mother reported that she was living with depression. The police made a referral to children's social care.

3.5 On 22nd July 2018 mother (then 23 years old) attended Hospital 1 following an intentional overdose of 16 x 20mg Fluoxetine[2] capsules, where superficial cuts to both forearms were noted. She was seen by the hospital RAID (Rapid Assessment, Interface and Discharge) team which documented that her overdose was an impulsive act following an argument with partner A (then 25). The RAID team documented that she had a long history of low mood and depression, having suffered a significant amount of bullying and name-calling at school including verbal abuse about her weight - which led her to restrict her diet – and her appearance, culminating in her depression and low self-esteem. She was also noted to have been diagnosed with postnatal depression in 2015, following the birth of child 1. Mother was documented to use self-harm as a coping strategy and that her self-harming had begun in March 2017 after a dispute with partner A. She was also said to have suffered domestic abuse from an 'ex-partner'. An outcome of the assessment was that mother was to attend a follow-up appointment with the RAID self-harm clinic. The self-harm clinic offered people who had self-harmed up to three follow up appointments following their discharge from hospital, during which their presentation would be monitored. Should any concern arise that there was an ongoing severe or enduring mental illness the self-harm clinic would refer the person to secondary care services.

3.6 Just over two weeks later - on 1st August 2018 – mother was conveyed to Hospital 1 by ambulance after taking a further overdose of Codeine and Fluoxetine. She told the ambulance crew that she was in a controlling relationship with partner A who 'was creating a divide between her father and herself'. The precise details of the situation which led to mother taking this second overdose are unclear. The ambulance crew were concerned about the impact of mother's mental health - and the circumstances which appeared to have led to her overdose - on her two young children (then aged 3 and 1). Hospital 1 referred mother to the RAID team who noted that she was scheduled to attend the RAID self-harm clinic on 5th August 2018. NWAS (North West Ambulance Service) referred mother to both adult social care and children's social care.

3.7 Mother was seen in the RAID self-harm clinic on 5th August 2018 when she explained that the second overdose on 1st August had been an impulsive 'cry for help' due to stressors including the end of her relationship with partner A who had

[2] Fluoxetine (brand name Prozac) is a type of antidepressant often used to treat depression and sometimes obsessive compulsive disorder and bulimia.

'taken' their children. She said that she was receiving support from her children's health visitor and from Early Help.

3.8 Adult social care were unable to contact mother. The contact telephone number shared with them by NWAS was partner A's phone so Adult social care wrote to mother inviting her to make contact with them. Mother did not respond to this, or a subsequent letter from adult social care who then closed the case.

3.9 On 23rd August 2018 Cafcass (Children and Family Court Advisory and Support Service) received an application from partner A for a Child Arrangements Order[3] (live with) and a Prohibited Steps Order[4] to prevent mother removing child 1 and child 2 (who were living with partner A at that time) from his care or from their nursery. Cafcass noted that the local authority was involved in supporting the family as mother was experiencing mental ill health following a crisis. It is understood that mother, partner A and the children were being supported by Early Help at this time.

3.10 Cafcass spoke with both mother and partner A and filed a safeguarding letter during September 2018 which advised the Family Court that further information was needed before final orders could be made, including information about mother's mental health. During December 2018 Cafcass received a copy of the court order directing the local authority to complete a Section 7 Report[5]. The contents of the Section 7 Report and the ultimate outcome of Family Court proceedings are not known (Rochdale Children's Social Care has advised the CSPR that they have no record of the Section 7 Report – which may not have been completed by the Local Authority).

3.11 During November 2018 the police had attended an incident in which partner A reported being threatened by mother and her brother. Partner A was documented to have 'temporary residency' of child 1 and child 2 at that time. During December 2018 mother, partner A and the children were 'stepped up' from Early Help support to child in need[6] (CiN) support.

[3] A 'child arrangements order' decides where the child lives, when the child spends time with each parent and when and what other types of contact take place (phone calls, for example)

[4] A prohibited steps order is a legally binding order that prohibits someone (usually a parent) from exercising some elements of their parental responsibility.

[5] A report ordered by the court to provide information on a child's welfare and to consider the risks or concerns raised about the child, a parent or other relatives.

[6] A child in need is a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired - without the provision of services; or a child who is disabled.

2019

3.12 On 3rd April 2019 mother attended Hospital 1 following an impulsive overdose of recently prescribed venlafaxine[7] and with superficial cuts to her arms. She was referred to RAID who carried out a mental health risk assessment. She said she was experiencing feelings of hopelessness and worthlessness and the overdose had been precipitated by following an incident in which she had been distressed by the behaviour of her sister's partner which had led to tension between herself and partner A. She added that she felt overwhelmed by everything. The mental health practitioner discussed the importance of establishing adaptive, as opposed to maladaptive coping strategies. Safety planning was discussed, and mother disclosed that she was receiving support from Early Help. She denied having any suicidal thoughts at that time. Her children (now aged 3 and nearly 2), who it appeared were now living with her and partner A at this time, were documented to be 'protective factors'. RAID was aware that mother had 'consented' to a safeguarding referral by the ambulance service which had conveyed her to hospital. She was discharged from hospital to be followed up in the RAID self-harm clinic.

3.13 On 14th April 2019 mother attended the RAID self-harm clinic where she said that she had no ongoing thoughts, plans or intent to take her own life. She said that she was 'not allowed' to be with her children alone. She said that she had a good relationship with partner A and was receiving weekly support from Early Help and a 'life coach'. Mother was offered a further appointment for 23rd April 2019 which she declined because it was 'too early' and so an appointment was arranged for 12th May. RAID also contacted the local authority Emergency Duty Team to share concerns about mother's sister's partner's behaviour.

3.14 On 25th April 2019 mother attended Hospital 1 due to thoughts of suicide, having first visited her GP. She had not self-harmed or taken an overdose on this occasion. She was accompanied by two family support workers. She reported having fallen out with partner A and said she was frightened of being alone. She said that she felt unable to remain safe and a hospital admission was discussed. However, she was discharged home with advice to return to hospital ED if she felt unsafe. The family support workers planned to visit her early the following morning. Her children were staying with their paternal grandmother. Mother's forthcoming appointment at the RAID self-harm clinic was noted and she was also referred to talking therapies.

3.15 There was an unexplained delay in adult social care receiving the 3rd April 2019 NWAS referral and so they did not contact mother until 30th April 2019 when mother

[7] Venlafaxine is an antidepressant prescribed to treat depression and sometimes anxiety and panic attacks.

said that she was moving out of the family home that day because of what she described as a 'toxic' relationship with partner A. She went on to say that she was receiving support from RAID who were to refer her for CBT and was awaiting the allocation of a social worker*. She said that her medication was now being prescribed weekly. Alternatives to self-harm by cutting were discussed. Mother said that she did not require any further help from adult social care or any other support in addition to what she was receiving at that time.

*During 2019 there was a period of child in need work following escalation from Early Help as a result of concerns over mother's mental health and self-harming behaviours and a deterioration in home conditions. A child and family assessment was completed in May 2019 which identified concerns in relation to conflict between mother and father, mother's mental health and poor home conditions.

3.16 On 15th May 2019 mother attended the RAID self-harm clinic, having re-arranged the date by telephone. She said that she had attended hospital ED on 25th April 2019 because she felt that she didn't want to be here and disclosed that she had self-harmed two days later by superficially cutting her arms. She said that she had self-referred to Thinking Ahead for talking therapies and was benefitting from parenting courses where she enjoyed socialising with other parents in a similar situation and was due to start a separation course, adding that she felt that living apart from partner A may be helpful. Her next RAID appointment was arranged for 28th May 2019.

3.17 Mother did not attend the 28th May appointment and when contacted by telephone requested discharge from the service as she no longer felt she needed their support. RAID also noted that mother had not attended a planned appointment with her GP. She was discharged by RAID and her GP informed. The plan discussed with mother was to see her GP or attend hospital ED if in crisis.

3.18 Mother took a further overdose - of ibuprofen and tramadol - on 5th June 2019 and attended Hospital 1 ED but left the hospital before being seen. RAID were made aware of this overdose when Early Help contacted them on 11th June 2019. The Early Help worker said that she was concerned about mother's mood changes and being unable to contact her. RAID advised requesting the police to conduct a welfare check if concerned about mother. Mother subsequently told her GP that she took an overdose on 5th June after a difficult day and after reflecting on the fact that her children were not in her care.

3.19 Mother had no further contact with mental health services other than contact from her GP with the Access and Crisis team in August 2019 requesting advice on medication, which was changed to duloxetine.[8]

3.20 The period of child in need intervention had ended in June 2019 (precise date unknown) after the professional network concluded that risk was then 'low'.

3.21 On 3rd July 2019 mother contacted the police and children's social care to report that a few months earlier child 1 had disclosed that her paternal step great grandfather (partner A's step-grandfather) had encouraged her to masturbate him but that she had been 'sworn to secrecy' by partner A. Subsequent enquiries by children's social care established that mother made this report after becoming upset that she had largely been excluded from child 1's birthday party and partner A's subsequent reluctance to return the children to her. Enquiries established that the paternal step great grandfather had previously been charged with sexual offences against his own granddaughters but found 'not guilty' following a trial. When spoken to by the police, partner A confirmed child 1's disclosures and said that weekly contact with the paternal step great grandfather had nonetheless continued, albeit supervised by partner A. A Section 47 investigation took place, and on 23rd July 2019 both child 1 and child 2 were placed on a child protection plan under the category of sexual abuse. Children's social care were concerned about the substantial delay in reporting child 1's disclosure, during a period in which the children were being supported by child in need planning, the fact that contact with the paternal step great grandfather had been allowed to continue and that the matter was only reported in the context of a dispute between mother and partner A. Additionally, concern was also expressed in respect of mother's mental health, parental neglect (child 2's teeth were noted to be decaying and her parents were advised to reduce sugary drinks) and the conflict in mother and partner A's relationship including concerns of controlling behaviour by partner A. The children were placed with their maternal grandfather for a time.

3.22 On 15th October 2019 a review child protection conference concluded that the risk of sexual abuse had 'massively reduced' as a result of the parents and the paternal grandparents reflecting on their 'poor' decision making and that parental neglect was no longer to the fore. However, it was decided that child protection planning should continue because of the continuing risk of emotional harm to the children arising from mother and partner A's 'feuding'. The conference recommended that the family group conference service work with mother, partner A and their families to help them find solutions which enabled them to improve communication and reduce conflict.

[8] Duloxetine is a type of antidepressant prescribed to treat depression and anxiety.

2020

3.23 The second review child protection conference took place on 5th February 2020 at which it was unanimously decided that child protection planning was no longer necessary as the day to day care of the children was considered to be 'excellent' whichever parent was caring for them, but that a period of child in need support was required as family group conference support was in its infancy. Mother and partner A's relationship had ended and they were living separately and sharing the care of the children. It was noted that the family group conference facilitator had initially been reluctant to accept the case on the grounds that there appeared to be no harm to the children but this view had been successfully challenged.

3.24 On 9th February 2020 mother advised the social worker that she was in a new relationship. The following day partner A raised concerns that partner B was in mother's house when the children were staying. Children's social care were to arrange police checks and a risk assessment in respect of partner B. (The police have advised this CSPR that no police check was requested although their records contained nothing of concern about partner B at that time. Children's social care records state that the police check was requested on 18th February 2020).

3.25 A child in need plan was drawn up by 25th February 2020 which noted that family group conference meetings were underway. The plan identified six things which needed to change for the children including the parents taking responsibility for their own behaviour and ensure they did not expose the children to verbal or physical altercations, partner A to attend a perpetrator/conflict resolution programme to gain understanding of controlling behaviour and the impact on his children, the children were to be provided by safe, stable and appropriate parenting not impacted by mother's emotional wellbeing difficulties and enabling the family to make positive decisions regarding the safety and wellbeing of the children through the family group conference process.

3.26 On 27th February 2020 mother took child 1 to Hospital 1 with an accidental burn to her hand after touching the oven hob. The wound was assessed as superficial and a dressing applied. Mother advised the hospital that a child min need plan was in place. The social worker made a home visit the following day and assessed the burn as accidental.

3.27 On 2nd March 2020 the first child in need meeting took place.

3.28 On 17th March 2020 the social worker's team manager reviewed the case (the social worker was temporarily absent isolating with Covid-19 symptoms) and

documented that an assessment needed to be undertaken as no assessment had been completed since the children became subject to child protection planning. The assessment would be used to determine needs prior to the child in need plan ending.

3.29 On 23rd March 2020 the first national lockdown in response to the Covid-19 pandemic was introduced. Schools closed for most children but child 1 was offered a place by her school but this was declined by her parents. The school made daily telephone contact with mother or partner A – whichever parent the children were staying with - and provided food on several occasions. The school later repeated the offer of a place for child A which was initially accepted by the parents before being declined once again. The pandemic also affected how other agencies worked with the family. Child in need meetings were held virtually and the social worker made contact with the family by video calls. GP contact was primarily by telephone. The health visitor was redeployed to other Covid-19 related duties for a period and so the family were allocated to another health visitor during that time. Some of mother's contacts with maternity were by telephone. As stated in Paragraph 3.31 the Family Group Conference Manager was redeployed to a different role because of his Covid-19 vulnerability.

3.30 On the same date the maternal grandfather reported that child 1 had told him that she had poured water on her paternal grandfather's head whilst he was in the bath and the maternal grandfather felt that this was inappropriate. The social worker made a video call to mother and child 1 and after making enquiries, appeared to conclude that maternal grandfather's report was probably malicious and that child 1 may have been coached to support the maternal grandfather's report. There were subsequently said to be no safeguarding concerns arising from this incident.

3.31 On 26th March 2020 the Family Group Conference Manager advised the social worker that he had been unable to complete the planned work with the family due to Covid and that he was being redeployed to another role because of his Covid-19 vulnerability. He said that he had hoped to arrange a meeting attended by both the maternal and paternal families but this had not been agreed to. He had managed to meet with the maternal family and circulated the resultant plan. However, he had had to cancel the planned meeting with the paternal family due to Covid-19 restrictions. There is no indication that the Family Group Conference service had any further involvement thereafter.

3.32 On 24th April 2020 the social worker conducted a child in need visit by video. She spoke to mother and the children. Mother said that she and partner A had agreed a plan for sharing the care of the children after a period of tension between them which appeared to have been exacerbated by attempting to comply with the

Covid-19 restrictions. Mother said that she was happy with partner B and that he 'adored' child 1 and child 2. The social worker documented that mother appeared to be in a 'good place' and feels 'like she is a new person' because of the support she was receiving from partner B and his family. The risks were documented to be mother's mental health (mother said that she hadn't been taking her antidepressants because she felt well) and conflict between mother, partner A and their families. Child 1 and child 2 were described as 'happy and settled'. There is no indication that the information about mother ceasing taking her antidepressants was shared with her GP. (GP records indicate that mother's antidepressants were issued by repeat prescriptions until 18th May 2020).

3.33 On 27th April 2020 mother completed a positive home pregnancy test and contacted her GP to seek advice about continuing with Vitamin B1 injections – which were converted to oral intake as a result. There is no indication that the GP discussed the management of mother's depression – for which she continued to be prescribed antidepressants until 18th May 2020 – during her pregnancy.

3.34 On 29th April 2020 a virtual child in need meeting took place at which the school documented that the social worker advised partners that the case would be closing to children's social care and that child in need support would be ending.

3.35 On 1st May 2020 mother texted the social worker to advise that she was pregnant and also informed child 1's school during their daily telephone contact with her.

3.36 On 6th May 2020 the social worker advised the Family Group Conference manager that the case was stepping down from child in need to Early Help. The Family Group Conference manager agreed to continue to provide support once Covid restrictions eased.

3.37 On 12th May 2020 mother had her first (telephone) contact with midwifery at Rochdale Infirmary in respect of the pregnancy. She disclosed her history of depression and overdoses but said that she had been doing much better recently and had stopped taking antidepressants in February 2020. She said that her children had previously been on a child protection plan which had been stepped down to child in need but thought it had now been stepped down further. The midwife contacted children's social care and documented that the latter service told her that they were still involved with the family. Children's social care said that they would pass on the midwife's contact details to the social worker so that she could update her (the midwife) on the current situation.

3.38 On 11th June 2020 a health visitor spoke to mother who shared information with her relating to prior children's social care involvement, her mental health history and her new relationship. The health visitor contacted children's social care and was advised that her contact details would be passed to the social worker who would call her back.

3.39 On 11th June 2020 attended her booking appointment with midwifery. Mother provided details of partner B as her next of kin and disclosed her history of depression and attempts to take her own life as well as children's social care involvement with her children. The following day the midwife completed a Special Circumstances Form and marked it 'children's social care' so it was sent automatically to EHASH (early help and safeguarding hub), the GP practice and the health visitor. On the Special Circumstances form the question 'Has an offer of Early Help been considered?' was answered 'no' with the reason given as 'does not meet the threshold'. The midwife again contacted children's social care who confirmed that they were 'involved' with the family and would pass on her details to the social worker.

3.40 On 17th June 2020 the health visitor who knew the family well emailed the social worker to advise that she had returned to her normal role from Covid-19 redeployment and to ask the social worker to clarify that the child in need plan had closed.

3.41 On 22nd June 2020 the social worker emailed the health visitor to advise that the case was now closed to children's social care and that child 1's school had agreed to lead on Early Help with the headteacher fulfilling the role of lead professional. On the same date the social worker emailed professionals involved in the child in need that the case was closing to children's social care as agreed at the last child in need meeting but the social worker had been waiting for the Family Group Conference service to close the case. However, she said that the Family Group Conference service would continue to assist the family as Covid restrictions eased.

3.42 On 1st July 2020 the health visitor made video call to mother. She said her relationship with partner A was 'up and down' and that neither child 1 or child 2 were in school or nursery respectively because of the pandemic. The health visitor said that she would make arrangements to contact mother again for the antenatal contact.

3.43 On 17th July 2020 was the last day of the school year at child 1's school and so the daily telephone contact ceased over the summer holiday period.

3.44 On 22nd July 2020 Cafcass received an application from partner A for a Section 8 Specific Issues Order[9] in respect of child 1 and child 2. A Family Court Advisor (FCA) was allocated to complete enquiries and file a safeguarding letter with the court. The FCA was advised by the local authority (EHASH) that a social worker was working with the family. When she received the Cafcass documents she telephoned the social worker who provided her with advice.

3.45 On 25th July 2020 partner A contacted the local authority EDT after the children were found wandering after unlocking the door of mother's house whilst she and partner B were asleep in the morning. Following management oversight a duty social worker visited mother and provided advice about keeping her house secure and supervising the children. Mother advised the social worker that she was 18 weeks pregnant.

3.46 On 20th August 2020 mother's had an anomaly ultrasound scan which disclosed that her unborn baby had a cleft lip and palate.[10] A referral was made to the Pennine Foetal Medical Unit (PFU) and mother was later given leaflet regarding the specialist cleft lip and palate team.

3.47 On 26th August 2020 a management oversight discussion took place between the social worker and her team manager. It appears that the question of closing the family's case or continuing with the child in need plan remained under consideration. The manager noted that the record of visits to the family needed to be updated and there appears to have been a discussion about the recent incident reported to the EDT (Paragraph 3.45). There is no record of the family being further discussed by children's social care prior to the formal closure of the case on 7th October 2020. The CSPR has been advised that the team manager was about to leave the service at that time and so this may have been a factor in the issues raised by the team manager not apparently being fully addressed prior to case closure.

3.48 On 1st September 2020 Clinical Nurse Specialist (CNS) 1 from the Cleft Lip and Palate Team (CLT) made initial telephone contact with mother and partner B. Mother's primary concern was how the baby would feed. CNS 1 explained 'assisted feeding'[11] and reassured her that the CLT would support with feeding. Mother did

[9] An order giving directions for the purpose of determining a specific question which has arisen, or which may arise, in connection with any aspect of parental responsibility for a child.

[10] A cleft is a gap or split in the upper lip and/or roof of the mouth (palate). It is present from birth. The gap is there because parts of the baby's face did not join together properly during development in the womb.
A cleft lip and palate is the most common facial birth defect in the UK, affecting around 1 in every 700 babies.

[11] A baby with a cleft lip and palate may be unable to breastfeed or feed from a normal bottle because they cannot form a good seal with their mouth.

not appear particularly anxious about the diagnosis as she was aware the lip and palate can be surgically closed.

3.49 During September 2020 the Cafcass FCA spoke with partner A and mother following partner A's recent application. Mother said that she did not want to change the arrangements for sharing care of the children but partner A wanted to vary them due to his working pattern. Partner A said that he was concerned about mother's 'capacity' and her mental health as the children had recently left the house when she was asleep and she had previously suffered from post-natal depression, which he was concerned would 'resurface'. Mother said that partner B was very supportive and that their baby was due at the beginning of January 2021, adding that they had been advised that the baby had a cleft lip and palate which would require surgery. She expressed concern about partner A's ability to meet the basic needs of the children, including their hygiene needs.

3.50 On 16th September 2020 SALT wrote to mother to advise that child 2 had been discharged from the service due to no contact from her parents.

3.51 On 21st September 2020 CNS 1 made an initial home visit to discuss the diagnosis and treatment for child E1. Partner B was at work. Mother was said to be coming to terms with the cleft lip and palate diagnosis. She was provided with a cleft lip and palate information pack. She told CNS 1 that she shared the care of child 1 and child 2 with partner A, and that partner B saw his son from a previous relationship at weekends. She said that she currently had no family support as she had 'fallen out' with her father and sister but received some support from partner B's family. CNS 1 advised that she would be back in contact at 32 weeks gestation to discuss the feeding plan.

3.52 On 7th October 2020 children's social care formally closed the family's case. The case closure record summarised the support provided to the family since July 2019 and confirmed that the case had been stepped down from child in need to Early Help support. There was no mention of mother's relationship with partner B or her pregnancy with child E1.

3.53 On 26th October and 4th November 2020 mother contacted CNS 1 by WhatsApp to ask about feeding and which bottles to purchase.

3.54 On 10th November 2020 CNS 1 contacted mother and partner B by WhatsApp video to discuss the treatment pathway, feeding equipment and the parent's feelings and anxieties. Mother wished to bottle feed the baby and was advised that if the

baby has a cleft palate it is likely to need assisted feeding.[12] CNS 1 discussed and demonstrated the principles of assisted feeding using a soft bottle.[13] CNS 1 said that she would prepare a feeding plan to put in mother's antenatal notes in readiness for the baby's birth.

3.55 The Cafcass FCA filed a safeguarding letter with the Family Court and the parents on 18th November 2020, recommending that the Court may wish to see the latest information from the local authority and mother's GP to help inform the decision making. At a Court hearing on 23rd November 2020, the parents could not agree a shared way forward and the Court directed both to file a statement with a contested hearing listed for 25th March 2021 (after the death of child E1).

3.56 When mother attended hospital for ultrasound scan and doctor review on 3rd December 2020, it was documented that midwifery had received an antenatal management plan shared with midwifery by cleft lip and palate network.

3.57 On 16th December 2020 the health visitor undertook the antenatal visit by video call. Mother reported feeling well emotionally and felt prepared for the birth. The baby was due to be induced on 22nd December 2020 because of faltering growth in utero. Mother said that she was being supported by CNS 1 who had drawn up a feeding plan which included advice on the position the baby should sleep in. Mother agreed to share the plan with the health visitor. The health visitor discussed infant feeding, immunisation, safe sleeping, ICON, emotional and mental health, substance misuse, smoking, FGM (female genital mutilation), domestic abuse and safeguarding concerns in accordance with the pre-birth contact standard. The health visitor decided that the level of support the service would provide would be Universal Plus[14] because of the baby's cleft lip and palate.

3.58 Child E1 was born on 22nd December 2020. Both mother and child E1 were noted to be medically well and mother was also noted to be emotionally well. The baby was tolerating formula feed but was slow to feed. CNS 1 made telephone contact and advised that she would visit mother at feed time the following day. Child E1's birth weight was 2.60kg.

[12] In order to feed, new-born babies suck swallow and breathe in a smooth and coordinated way. Suction is important in both breast and bottle feeding. For babies born with a cleft, the gaps in the lip or palate may make it difficult to create a seal and maintain suction. To help the baby to feed, special bottles and teats may be necessary along with some adjustments in technique.

[13] The soft bottle allows the parent to give the baby milk by gently squeezing the sides as he/she suckles.

[14] Universal Plus means supporting children and families that may need additional support with health or socials needs.

3.59 On the same date health visiting sought advice from the Lullaby Trust regarding the safe sleep advice given by the cleft lip and palate team, which was to place baby on alternate sides due to the cleft palate. The Lullaby Trust responded by saying that they do not have cleft lip and palate specific advice but reiterated their general advice that all babies should be placed to sleep on their back. They also advised that the baby should be referred to their GP or a paediatrician if different safe sleeping advice was needed for medical reasons.

3.60 On 23rd December 2020 CNS 1 visited mother and child E1 in hospital and discussed, demonstrated and observed assisted feeding. She observed the baby co-ordinating suck, swallow and breathing although the feeding was stopping and starting as the baby kept falling asleep. CNS 1 advised mother to feed to a more regular pattern (approximately 3 hourly) to see if this helped the baby to stay awake. CNS 1 advised that feeding needed to be more established, and the baby needed to be taking more feed baby needed prior to discharge home. Mother was noted to be 'very weepy' as she was desperate to go home.

3.61 On 24th December 2020 CNS 2 visited mother and child E1 in hospital and documented that the baby had been feeding better since midnight. Mother said that she was squeezing the bottle when the baby was not sucking to try and stimulate her to suckle. In response CNS 2 reiterated the advice previously given that the bottle should only be squeezed when the baby is sucking. Mother and child E1 were discharged home with CNS contact details of support needed over the Christmas period.

3.62 On the date of discharge midwifery provided advice to mother on a range of issues including safe sleep and 'cot death' but not ICON. Child E1 had neonatal jaundice. [15]

3.63 On Saturday 26th December 2020 the community midwife made a home visit. Child E1 was well although still had jaundice. She weighed 2.42kg and had therefore lost 7% of her birth weight, which is at the upper end of 'normal'.

3.64 The following day (Sunday 27th December 2020) the community midwife made a second home visit to perform a routine blood test. Child E1 was well and formula feeing every three hours. Mother was documented to be 'well in mood' and well supported.

[15] Jaundice in newborn babies is common and usually harmless. It causes yellowing of the skin and the whites of the eyes.

3.65 On Tuesday 29th December 2020 heavy snow prevented a home visit by CNS 1 but she was able to observe mother feeding child E1 by video call. The baby was feeding well although assisted feeds were taking up to 45 minutes. CNS 1 demonstrated the principles of a more continuous squeeze in an effort to reduce the length of feeding times. CNS 1 left a voicemail message for the health visitor to contact her.

3.66 On Wednesday 30th December 2020 CNS 1 made another home visit and saw mother and partner B with child E1. CNS 1 demonstrated the principles of continuous squeeze and adjusted mother's technique slightly. As a result child E1 began to feed much more quickly. CNS 1 advised mother to increase the amount of feed to 90mls per feed rather than the 30-60mls she was currently feeding her.

3.67 The community midwife visited on the same date who noted that child E1 was feeding well.

3.68 The following day (Thursday 31st December 2020) the health visitor made the new birth visit (in-person) and saw mother partner B and child E1. The health visitor noted that a feeding regime was in place supported by CNS 1. Safe sleep was discussed. The health visitor discussed the Lullaby Trust advice and the specialist cleft lip and palate team advice. Mother reported feeling emotionally well and partner B said that he was 'thrilled' by the birth of child E1. The health visitor planned to return on 14th January 2021. Child 1 and child 2 were noted to be staying with Partner A on this date. It is unclear whether mother's shared care of child 1 and child 2 continued during this postnatal period.

3.69 The community midwife visited the same day and documented that mother was confident with 'baby cares and feeds'. She noted that the health visitor and CNS 1 were in contact. (There is no evidence that they made contact with each other during the postnatal period).

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3.70 On Monday 4th January 2021 schools did not re-open after the Christmas holiday as a result of Covid-19 restrictions. Child 1 did not return to school prior to child E1's death.

3.71 The community midwife visited on Tuesday 5th January 2021 to re-weigh child E1. Her weight was unchanged at 2.42kg. Mother expressed (unspecified) concerns about the teats when she was feeding and said that she would liaise with CNS 1.

3.72 Also on 5th January 2021 CNS 1 experienced difficulty in contacting mother by phone but later communicated with her via WhatsApp messages. Mother reported that child E1 had gained only an ounce since last being weighed (child E1's weight was actually unchanged) which concerned CNS 1 who advised mother that child E1 could not be feeding as well as mother reported (3 hourly feeds of 20-30 minute duration with between 2 and 3 ounces of formula and bringing 'next to nothing up') if she was not gaining weight.

3.73 On Wednesday 6th January 2021 CNS 1 again experienced difficulty in contacting mother before receiving a text from mother in which she said that child E1 'wouldn't feed' for the past couple of feeds and so partner B had taken over the feeding, which she said had 'really upset' her. CNS 1 then made a WhatsApp call to mother was appeared 'very weepy' and said that child E1 was 'too slow' with feeding, to which CNS 1 replied that it is usually not the baby who is 'too slow' but the way the parent is squeezing the bottle. Mother then disconnected the call.

3.74 Partner B then texted CNS 1 to say that she would need to let mother 'calm down a bit' as she was 'really worked up' and implied that she felt 'blamed' by what the CNS had said to her. CNS 1 replied that she had not been 'having a go' at mother but that child E1 may need to return to hospital if there was a problem with her feeding. CNS 1 also said that avoiding her would not help.

3.75 Later in the day CNS 1 received a further text from partner B in which he said that feeding difficulties had only begun recently and he didn't think it was mother, 'it's the baby, she doesn't suck or will stop after minutes and won't take any more'. He added that mother was worried about this and also being deprived of sleep in the night because of child E1 waking. He again said that he needed to help mother 'calm down' adding that this was 'really heart breaking for her and me'.

3.76 CNS 1 responded by re-iterating that she was trying to help them solve the feeding problem and prevent child E1's admission to hospital. Partner B said that they would prefer a home visit rather than a video call as video calls 'were getting them 'nowhere'.

3.77 CNS visited mother, partner B and child E1 during the afternoon feed. She noted that mother was 'very weepy'. Through conversation, she established that mother was only feeding child E1 once or twice daily and that partner B was doing the other feeds, as he appeared to have more confidently learned the technique. He was also waking for night time feeds. CNS 1 asked mother about her mood and she replied that she wasn't depressed and didn't need to see her GP.

3.78 Mother said that child E1 seemed 'a bit colicky'.[16] CNS 1 advised that unfortunately babies with cleft lip and palate can be colicky and she suggested use of Infacol[17] if needed. CNS 1 observed mother feeding child E1 but was unable to support the baby to take any milk form the bottle. She said that she was struggling with assisted feeding and squeezing the soft bottles was hurting her hand. Feed was then offered using 'Dr Brown' bottle with a different teat and mother was able to manage the feed more successfully. CNS 1 advised mother that she needed to regain her confidence with feeding child E1, and that she should feed her as many times as possible as partner B was due to return to work the following week. During the visit CNS 1 noted that partner B only spoke to her if she specifically spoke to him and was watching his phone for most of visit. CNS1 advised mother to telephone her if she continued to struggle with feeding. CNS 1 made telephone calls to the health visitor and community midwife and left voicemail messages asking them to contact her. (The health visitor attempted to ring CNS 1 twice on Thursday 7th January 2021 and spoke to one of CNS 1's colleagues on Friday 8th January 2021 who advised her that CNS 1 was not in work that day).

3.79 CNS 1 contacted mother by WhatsApp during the evening. She said that partner B was feeding child E1 as she (mother) had just sat down to eat having not eaten anything since the previous day. She said that she would manage the next feed and thanks CNS 1 for her help.

3.80 On Friday 8th January 2021 child E1 was conveyed to hospital by NWAS after a call from mother saying the baby was having difficulty breathing and was unresponsive. Child E1 died on Monday 11th January 2021 from a head injury typical of being violently shaken.

[16] Colic is when a baby cries a lot but there's no obvious cause. It is a common problem which normally gets better by around 3 or 4 months of age.

[17] Simeticone drops, such as Infacol, are designed to help release bubbles of trapped air in the baby's digestive system, although there is currently no convincing evidence that they help

4.0 Views of child E1's family

4.1 It has not yet been possible to invite any members of child E1's family to contribute to this CSPR. Father's retrial is scheduled to take place in April 2023. It may be possible to engage with family members following the trial.

5.0 Analysis and findings

5.1 Four Key Practice Episodes have been identified where professionals were directly involved in working with child E1's mother, father (partner B), partner A and child 1 and child 2 to address safeguarding concerns. For each Key Practice Episode the key lines of enquiry addressed are listed.

Key Practice Episode 1: The extent to which professionals understood mother's mental health needs, their impact upon her parenting capacity and her ability to manage the challenges of a new born baby with a disability.
Key Practice Episode 2: Decision to end children's social care involvement without considering whether a pre-birth assessment was required in respect of mother's pregnancy with child E1.
Key Practice Episode 3: Lack of consideration of an Early Help Assessment following the booking-in or when the scan subsequently disclosed that child E1 has cleft lip and palate.
Key Practice Episode 4: The extent to which postnatal support was effectively co-ordinated and consistent particularly safe sleeping advice and ICON advice to help parents cope with crying and therefore reduce the risk of abusive head trauma.

Key Practice Episode (KPE) 1
The extent to which professionals understood mother's mental health needs, their impact upon her parenting capacity and her ability to manage the challenges of a new born baby with a disability.
Key lines of enquiry (KLOE) a, c and f addressed by KPE 1.

5.2 Between July 2018 and June 2019 mother experienced a crisis in her mental health on five occasions. On four of these occasions she was taken by ambulance or presented at Hospital 1 emergency department (ED) after taking overdoses of prescribed medication. On a fifth occasion she attended the same hospital after experiencing thoughts of suicide.

5.3 She was referred to the Hospital 1 based RAID (Rapid Assessment, Intervention and Discharge) team on three of these occasions and disclosed a long history of low mood and depression, having suffered a significant amount of bullying and name-

calling at school including verbal abuse about her weight - which led her to restrict her diet – and her appearance, culminating in her depression and low self-esteem. Triggers for her overdoses were documented to be arguments with partner A, partner A's controlling behaviour, an incident involving her sister's partner and restricted access to her children.

5.4 Following referrals to the RAID team, mother was referred to the RAID self-harm clinic with which she tended to engage quite briefly. Having said that, the RAID self-harm clinic envisages no more than three follow up appointment after the person has been discharged from hospital. After her engagement with the RAID self-harm clinic, mother would then be discharged her back to the care of her GP. On one occasion RAID could have revisited their decision to discharge her after being advised by Early Help that she had attended Hospital 1 ED after taking a further overdose but had left the hospital before being seen (Paragraph 3.18). The RAID self-harm clinic had discharged her from their care less than a fortnight before this further overdose and could have considered reaching out to her again. The CSPR has been advised that when a person leaves hospital before being seen, the usual practice was for a police welfare check to be requested. The CSPR has been advised that this practice was followed in this case. However, the challenge to the RAID self-harm clinic is that after mother presented at Hospital ED after taking a further overdose but left before being seen and in all likelihood being referred to the RAID team, the RAID self-harm clinic could have considered reaching out to her again when they were made aware of this fact only two weeks after closing her case. Pennine Care – the provider of the RAID self-harm clinic – had advised this CSPR that the approach adopted now is that either the hospital or the self-harm clinic would follow up with a phone call to the patient or their next of kin, depending on the circumstances of the patient's presentation at the hospital. Such a phone call would have given the self-harm clinic the opportunity to discuss her potential re-engagement with the clinic.

5.5 Mother's GP practice knew her well and treated her for depression, prescribing antidepressant medication which she took fairly consistently until shortly before she became pregnant with child E1. Mother also had a long history of chronic hip/joint pain which, despite a referral to a rheumatologist, the cause was never ascertained. The pain arising from the hip/joint problems may have affected her sleep and could have contributed to her depression. It is not known whether, or the extent to which, this factor was considered in reviews of mother's mental health. Mother's GP attended the first practitioner learning event arranged to inform this review and questioned whether primary and secondary care had correctly diagnosed her as suffering from depression. Given mother's pattern of taking impulsive overdoses in response to adverse life events and then feeling reasonably positive within a short space of time, the GP wondered whether she may have had emotionally unstable

personality disorder[18] also referred to as borderline personality disorder (BPD). The GP went on to suggest that had she been diagnosed with BPD, mother may have been offered psychotherapy. However, the CSPR accepts that this the GP's observation based on the opportunity to reflect on mother's presentation and the care and treatment she received and is not a formal diagnosis, which would normally be given by a psychiatrist. Pennine Care NHS Foundation Trust also observed that not all personality disorders require psychotherapy.

5.6 During the eleven month period when mother experienced five mental health crises the support she received did not appear completely joined up. The links between primary care, acute care and secondary mental health care appeared to be fairly effective in that mother was referred to the RAID team by Hospital 1 and after engaging with the RAID self-harm clinic for a time she would be discharged to primary care. However, although her self-harming episodes were explored by the RAID team and in the Raid self-harm clinic – where mother consistently reported that these acts were impulsive, and a cry for help and that she had not intended to take her own life - there is no indication that her repeated overdoses over such a relatively short period led to any kind of overview of her case in order to better understand why she was so frequently presenting in crisis. As stated the triggers for mother's overdoses included arguments with partner A and partner A's controlling behaviour. This could have led to mother being offered support in respect of domestic abuse.

5.7 Several studies have confirmed that being subjected to domestic abuse can have significant consequences for mental wellbeing and the perpetration of domestic abuse is a key driver of women's mental ill health. Additionally, survivors can face a range of barriers in accessing appropriate mental health support (1) including:

- The impact of domestic abuse often includes lowered self-esteem and feelings of shame, meaning that survivors may not feel able to seek out support.

- Survivors may face 'diagnostic overshadowing' where healthcare professionals may not recognise mental health concerns as being the result of abuse.

[18] Borderline personality disorder (BPD) can cause a wide range of symptoms, which can be broadly grouped into four main areas which are emotional instability – the psychological term for this is "affective dysregulation"; disturbed patterns of thinking or perception – "cognitive distortions" or "perceptual distortions"; impulsive behaviour and intense but unstable relationships with others.

- Survivors may also fear that mental health diagnoses will be used against them in any child contact or child protection legal proceedings.

5.8 The literature also emphasises the importance of a trusting relationship between healthcare professionals and survivors for women to feel safe enough to be able to talk about domestic abuse and mental ill health (2). Mother's periods of engagement with the RAID self-harm clinic may not have been for long enough for a sufficiently trusting relationship with mother to be established. Pennine Care was asked if practitioners in the RAID self-harm clinic consider referring people who self-harm for domestic abuse support where domestic abuse is suggested to be a potential trigger for the self-harming behaviour and advised that this issue is specifically addressed in the Level 3 Safeguarding training provided to their staff.

5.9 For much of this eleven month period mother was receiving support from Early Help family support workers who accompanied her to Hospital 1 ED on one occasion and advised the RAID self-harm clinic of an overdose they (RAID) was unaware of on another occasion. Children's social care appear to have become aware of mother's mental health crisis through NWAS on two occasions and via Early Help. During 2019 mother and her children were stepped up from Early Help support to child in need planning because of concerns about mother's mental health and a child and family assessment was completed in May 2019. This short period of child in need planning ended in June 2019 when the professional network concluded that the risk was then 'low' (Paragraph 3.20). It is noted that mother had taken overdoses in May and June 2019 (Paragraphs 3.16 and 3.18 respectively) which suggests that the 'low' risk judgement may have been prematurely arrived at. Additionally, it is unclear why mother and her children had continued to be supported at the level of Early Help throughout the previous year (2018) despite similar concerns about her mental health.

5.10 NWAS also referred mother to Adult Social Care following two of the overdoses. There was an unexplained delay in the second referral reaching the duty social worker. Adult Social Care managed to engage with mother only in respect of the second referral. Reflecting on their limited involvement, Adult Social Care felt there could have been benefit in arranging an MDT to facilitate the sharing of information and potentially developing a plan.

5.11 Mother's mental health remained a concern throughout the subsequent period of child protection planning after mother and father failed to report disclosures made by child 1 that her step paternal great grandfather had encouraged her to masturbate him. The child protection plan and subsequent child in need plan highlighted mother's emotional vulnerability and the potential impact on her parenting. The child protection plan included an action to refer mother for

counselling whilst the subsequent child in need plan included an action to consider what specialist intervention mother needed to deal with her emotional fragility. Neither of these actions appear to have been achieved.

5.12 It appears that mother ceased taking antidepressants early in 2020 but when she advised her GP of her positive pregnancy test in respect of child E1 at the end of April 2020 there was no indication that the GP discussed the management of her depression during her pregnancy.

5.13 Mother shared her history of overdoses of prescribed medication with maternity at the time of her booking appointment for child E1. The health visitor for child E1 had supported mother during at least one of her previous pregnancies and appears to have been aware of her mental health issues. However the cleft lip and palate team was not made aware of mother's mental health history. This appears to have been a significant omission as Clinical Nurse Specialist (CNS) 1 observed mother's distress when she began to struggle to manage child E1's feeds and became concerned that she may be low in mood. Had CNS 1 been aware of mother's mental health history including her history of impulsive overdoses and cutting, she may have sought additional support for mother. CNS 1 may also have adopted a more sensitive, trauma informed approach to mother (Paragraph 3.73 and 3.74).

5.14 Mother disclosed postnatal depression following the birth of child 1 in 2015. If mother suffered with postnatal depression following the birth of one of her older children, there was a risk that she might experience postnatal depression following the birth of child E1.

5.15 There is no indication that there was any consideration of referring mother to perinatal services. At the second practitioner learning event arranged to inform this CSPR, the midwifery representative felt that mother was unlikely to have met the criteria for referral to the perinatal service.

Key Practice Episode (KPE) 2
Decision to end children's social care involvement without considering whether a pre-birth assessment was required in respect of mother's pregnancy with child E1.
Key lines of enquiry (KLOE) a, f, k and l addressed by KPE 2.

5.16 Mother advised the social worker of her new relationship with partner B 4 days after the second review child protection conference unanimously decided that child protection planning was no longer necessary (Paragraph 3.23 and 3.24) and advised the social worker that she was pregnant with child E1 two days after the child in

need meeting at which it was decided that child in need support would be ending (Paragraphs 3.34 and 3.35). The CSPR Panel noted that mother was aware that she was pregnant with child E1 two days prior to the child in need meeting at which it was decided that child in need support was ending but did not share this information at the meeting. Children's social care did not in fact close the family's case for a further five months (Paragraph 5.53). There is no indication that there was any consideration of whether a Pre-Birth Assessment was required in respect of mother's pregnancy with child E1.

5.17 The Greater Manchester Safeguarding Policy on Pre-Birth Assessments to which it is understood that the safeguarding children partners in Rochdale adhere, states that the below circumstances indicate an increased risk to an unborn child and a pre-birth assessment may be required:

a. A child who has previously died due to non- accidental injuries in the care of a parent/carer; - including the sudden and unexpected death of a child where any safeguarding concerns were raised (to avoid missing cases where there was no concluded injury as cause of death but could have been neglect of medical symptoms or lack of supervision).
b. Where previous children in the family have been removed because they have suffered harm;
c. Where concerns exist regarding the mother's ability to protect;
d. Where there are concerns regarding domestic violence and abuse;
e. A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children;
f. A child in the household is the subject of a Child Protection Plan;
g. A sibling has previously been removed from the household either temporarily or by court order;
h. Either parent is a Looked After Child or are known to children's social care.;
i. Any other concerns exist that the baby may be at risk of Significant Harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child;
j. A child aged under 16 and found to be pregnant;
k. Either or both parents have mental health problems;
l. Either or both parents have a learning disability;
m. Either or both parents are under 18 years;
n. Either or both parents abuse substances, alcohol or drugs;
o. If the pregnancy is denied or concealed.

5.18 Of the stated criteria which indicate an increased risk to an unborn child, concerns had existed about mother and partner A's ability to protect (criterion c) child 1 and child 2 from the risk of sexual abuse from paternal step great

grandfather but by February 2020 there were no longer any concerns in this regard. There had been concerns about domestic abuse (criterion d) although these related to partner A's controlling behaviour rather than partner B. Child 1 and child 2 had been subject to child protection planning (criterion f) but this had ended a little less than three months before mother disclosed her pregnancy in respect of child E1. Mother was known to have a mental health problem (criterion k) which had been an issue of concern in both child protection planning and subsequent child in need planning although the concerns about her mental health had diminished from the level at which they were at in 2018 and 2019.

5.19 The Greater Manchester Safeguarding Policy on Pre-Birth Assessments that in order to make the decision whether an increased risk to an unborn child necessitates a pre-birth assessment, a referral must be made to Children's Social Care/EHASH (Early Help and Safeguarding Hub) and a strategy meeting/professional meeting needs to be held. There is no indication that such a referral was made or considered or that a strategy meeting/professional meeting was held. In this case there were grounds for making such a referral - or at the very least considering a referral - to children's social care/EHASH in order that a decision was made on whether a pre-birth assessment should be undertaken on the grounds of mother's mental health problems.

5.20 Given the documented progress which had led to the ending of child protection planning and the anticipated step down from child in need planning, it seems likely that a pre-birth assessment would not have been initiated. Mother's mental health appeared to have improved although there remained concerns about her 'emotional instability'. However, her relationship with partner B was very recent and she had become pregnant very early in their relationship, which in Stage 2 ('The Commitment Whirlwind') of Jane Monckton Smith's Homicide Timeline (3) is a potential indicator of controlling behaviour on the part of partner B. (However, routine enquiry about domestic abuse was made of mother by midwifery on several occasions during her pregnancy with child E1 and mother raised no concerns about domestic abuse in her relationship with partner B). Additionally, the birth of a third child could put the improved parenting of child 1 and child 2 under strain. Furthermore, the conflict between mother and partner A, and the 'feuding' between their two families remained a concern which the involvement of Family Group Conferencing had been intended to address, but this had been interrupted by the Covid-19 restrictions and was not subsequently resumed. However, a further factor which would have counted against a pre-birth assessment was that the police check on partner B – if it was carried out (Paragraph 3.24) – would have disclosed nothing of concern and had his health records been checked they would have disclosed minimal GP attendance, although he sought help from his GP in 2015 for anxiety and panic attacks following a break up from the mother of partner B's first child.

5.21 However, considering a referral for a pre-birth assessment would have allowed some thought to be given to the support needs of mother, partner B and mother's children's further support needs ante and postnatally. The child in need plan had ended - or was in the process of ending - with a planned step-down to Early Help. This Early Help did not materialise. Formally considering the family's support needs, having decided not to undertake a pre-birth assessment, may have made the omission of the anticipated Early Help support less likely. Formally considering a pre-birth assessment would also have allowed the rationale for a decision not to undertake an assessment to be clearly recorded – as required by the Pre-Birth Policy.

5.22 It is therefore recommended that the Safeguarding Children Partnership obtains assurance from partner agencies that all relevant professionals

- are aware of the circumstances which indicate an increased risk to an unborn child and therefore may require a pre-birth assessment
- are aware of the requirement to make a referral to children's social care/EHASH if circumstances indicate an increased risk to an unborn child
- are aware of the need to fully document and decisions in respect of the consideration of pre-birth assessments
- are aware of the need to further consider the needs of the unborn child should a decision be made not to undertake a pre-birth assessment.

Recommendation 1

That Rochdale Borough Safeguarding Children Partnership obtains assurance from partner agencies that all relevant professionals

- *are aware of the circumstances which indicate an increased risk to an unborn child and therefore may require a pre-birth assessment*
- *are aware of the requirement to make a referral to children's social care/EHASH if circumstances indicate an increased risk to an unborn child*
- *are aware of the need to fully document and decisions in respect of the consideration of pre-birth assessments*
- *are aware of the need to further consider the needs of the unborn child should a decision be made not to undertake a pre-birth assessment.*

5.23 The subsequent diagnosis that child E1 would be born with cleft lip and palate changed the dynamic of the situation. This was an issue likely to increase parental anxiety during the antenatal period and present additional parenting challenges in the postnatal period around feeding and – as the CSPR has disclosed – an increased risk of colic and therefore crying.

5.24 The Pre-Birth Assessments Policy does not include disability of the baby as a criteria for considering a referral for a pre-birth assessment, nor does it advise that the criteria (a) to (o) are not necessarily exhaustive and that professional judgement may be called for, nor does it advise professionals that a decision not to undertake a pre-birth assessment can be revisited if circumstances change. A diagnosis of a disability in an unborn baby appears to be particularly relevant if there are current or recent concerns about parental mental health and/or parental capacity or there is current or recent involvement of children's social care.

5.25 It is therefore recommended that the Safeguarding Children Partnership should propose that the Greater Manchester Safeguarding Policy on Pre-Birth Assessments should be amended

- to identify a diagnosis of a disability in an unborn baby as a factor which, taken together with current or recent concerns about parental mental health and/or parental capacity or current or recent involvement of children's social care, may be an indicator of increased risk to the unborn child
- to advise that the criteria (a) to (o) are not necessarily exhaustive, and that professional judgement may be called for
- to advise professionals that a decision not to undertake a pre-birth assessment can be revisited if circumstances change.

Recommendation 2

That Rochdale Borough Safeguarding Children Partnership proposes that the Greater Manchester Safeguarding Policy on Pre-Birth Assessments is amended

- *to identify a diagnosis of a disability in an unborn baby as a factor which, taken together with current or recent concerns about parental mental health and/or parental capacity or current or recent involvement of children's social care, may be an indicator of increased risk to the unborn child*
- *to advise that the criteria (a) to (o) are not necessarily exhaustive, and that professional judgement may be called for*
- *to advise professionals that a decision not to undertake a pre-birth assessment can be revisited if circumstances change.*

5.26 The closure of the child in need plan did not proceed completely smoothly. As previously stated, the social worker advised partners that child in need planning would be ending on 29th April 2020 (Paragraph 3.34) and made arrangements for the interrupted Family Group Conference work to resume once Covid-19 restrictions eased (Paragraph 3.36). It appears to have been decided that although the involvement of the Family Group Conference was a key element of the child in need plan, the child in need plan did not need to remain open simply to ensure the completion of the Family Group Conference work. This seemed to be a reasonable

decision, although there is no evidence that the Family Group Conference work resumed when Covid-19 restrictions eased and without the child in need plan, there seemed to be no way of gaining assurance that the Family Group Conference work was completed as anticipated.

5.27 At the first practitioner learning event the headteacher of child 2's school said that she thought that the child in need plan remained open until June 2020. This viewpoint is supported by the email sent by the social worker on 22nd June 2020 to advise partners that the child in need plan had ended (Paragraph 3.41) and that child 1's school had agreed to lead on Early Help with the headteacher fulfilling the role of lead professional.

5.28 This planned Early Help did not materialise. At the learning event the headteacher said she was expecting the social worker to formally initiate the Early Help process but this didn't happen. Rochdale Children's Services Step Up/Step Down Protocol – which has applied from 1st December 2018 and was reviewed on 1st May 2021 uses the term 'step down' to describe children and their families moving from a higher level of intervention, such as a statutory children's social care intervention, to a lower level of coordinated support. The Protocol states that stepping concerns down well is important in ensuring that issues do not re-escalate. The Protocol's Step Down Flowchart states that where a child in need intervention is stepped down to early help, the social worker will chair the first team around the family (TAF) meeting and a practice manager provides advice for 12 weeks. In this case the social worker did not chair the first TAF meeting. Indeed no TAF meetings were held. The Protocol goes on to state that a TAFs operation should be based on a comprehensive up to date assessment of need and risk, which in this case would have included consideration of the impact of the unborn child E1.

5.29 The CSPR Panel questioned how realistic it is to expect the headteacher of child 1's school to lead on Early Help given the range of responsibilities held by a headteacher. Additionally, it was pointed out that whilst larger schools benefit from a family worker post to support Early Help work, child 1's school did not have such a post and so the headteacher as designated safeguarding lead would be expected to personally coordinate the multi-agency Early Help.

5.30 The anticipated step down to early help did not happen in this case. This omission happened during a period of exceptional pressure arising from the onset of the Covid-10 pandemic and the omission was mitigated to an extent by the support child 1's school provided to the family which would have been an integral part of any formal early help support. However it is recommended that the Safeguarding Children Partnership obtains assurance in respect of arrangements to step down to Early Help, in particular:

- that the Rochdale Children's Service Step Up Step Down Protocol is adhered to in all cases
- that schools which do not have a dedicated family worker post are provided with the support necessary to lead the co-ordination of Early Help
- and that professionals are encouraged to challenge any absence of step down arrangements.

Recommendation 3

That Rochdale Borough Safeguarding Children Partnership obtains assurance in respect of arrangements to step down to Early Help, in particular:

- *that the Rochdale Children's Service Step Up Step Down Protocol is adhered to in all cases*
- *that schools which do not have a dedicated family worker post are provided with the support necessary to lead the co-ordination of Early Help*
- *and that professionals are encouraged to challenge any absence of step down arrangements.*

5.31 As previously stated children's social care did not finally close the case until October 2020. It is not completely clear why there was such a long delay in closing the case but children's social care's involvement with the family continued when partner A reported child 1 and child 2 being found wandering (Paragraph 3.45) and the social worker and her team manager had a discussion on 26th August 2020 (Paragraph 3.47) in which the prospect of continued children's social care involvement appeared to be an option. It is not known whether mother's pregnancy with child E1 was a factor in the delay in closing the case. There is no documented indication that this was the case.

5.32 This case raises questions about the adequacy of case closure decision making and documentation. There was a delay of over five months in closing the case after child in need support had ended, the fact that the expected step down from child in need support to early help had not taken place was not apparently noticed and a material change in the family's circumstances – the impending birth of child E1 – was not commented upon. It is therefore recommended that the Safeguarding Children Partnership obtains assurance from Rochdale Children's Social Care that case closure is used as an opportunity to check that all relevant tasks have been completed, how any ongoing needs will be met, how any outstanding risks will be addressed and shares the rationale for case closure with relevant partner agencies.

Recommendation 4

That Rochdale Safeguarding Children Partnership obtains assurance from Rochdale Children's Social Care that case closure is used as an opportunity to check that all relevant tasks have been completed, how any ongoing needs will be met, how any outstanding risks will be addressed and shares the rationale for case closure with relevant partner agencies.

Key Practice Episode (KPE) 3
Lack of consideration of an Early Help Assessment following the booking-in or when the scan subsequently disclosed that child E1 had cleft lip and palate
Key lines of enquiry (KLOE) a, f and l addressed by KPE 3.

5.33 No Early Help Assessment (EHA) appeared to be considered at the time mother first contacted midwifery in respect of her pregnancy with child E1 (Paragraph 3.37), at the time of her booking appointment (Paragraph 3.39) or when the scan disclosed cleft lip and palate (Paragraph 3.46). The Rapid Review which preceded this CSPR was advised that had the case been brought to the attention of the specialist midwife, she would have recommended that an EHA be completed.

5.34 On the Special Circumstances form the question 'Has an offer of Early Help been considered?' was answered 'no' with the reason given as 'does not meet the threshold'. (Paragraph 3.38) Mother had disclosed her history of depression and overdoses to midwifery but said that she had been doing much better recently and had stopped taking antidepressants in February 2020. Mother also disclosed that her children had previously been on a child protection plan which had been stepped down to child in need but thought it had now been stepped down further.

5.35 Special Circumstances forms were twice completed and circulated to partners, but this process appeared to achieve little apart from prompting contact with children's social care who were documented to have confirmed that they were 'involved' with the family and that the midwife's contact details would be passed to the social worker. By this time the child in need plan had been closed or was in the process of being closed but, as stated, children's social care did not formally close the case until October 2020. It seems possible that midwifery may have taken comfort from children's social care's apparent continued involvement with the family and that this may have been a factor which dissuaded them from considering an Early Help Assessment. The Special Circumstances Forms were received by the GP practice which could have presented a further opportunity (first opportunity missed – Paragraph 3.33) for the GP to consider the impact of the pregnancy on mother's depression and the impact of stopping taking her antidepressant medication.

5.36 A multi-agency EH approach (if consented to by the parents) during the pregnancy would have supported all involved practitioners in better understanding the history and current issues/stressors faced by parents. There were many complexities in this case in addition to mother's mental health history. Her personal relationship history was complex. She had experienced domestic abuse in many of her previous intimate relationships. Relationships were also fractious between mother and her own family and as the birth of child E1 approached she appeared to have no contact with her family which reduced available support. Partner A had taken issues relating to contact with child 1 and child 2 to the Family Court and the parents had been unable to agree a way forward resulting in legal proceedings continuing. The impacts of Covid-19 restrictions may also have affected family support.

5.37 The CSPR has been advised that the lack of consideration of an Early Help Assessment was an area of learning identified in a previous CSPR (Child B1). The lack of consideration of an Early Help assessment at booking-in or when the cleft lip and palate diagnosis was made, suggests that this is an issue which may require continued focus from the Safeguarding Children Partnership. It is therefore recommended that the Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Foundation Trust that midwifery services are aware of the Early Help process and that appropriate staff have received the training and support necessary to complete Early Help Assessments and fulfil the lead professional role which co-ordinates Early Help support.

Recommendation 5

That Rochdale Borough Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Foundation Trust that midwifery services are aware of the Early Help process and that appropriate staff have received the training and support necessary to complete Early Help Assessments and fulfil the lead professional role which co-ordinates Early Help support.

Key Practice Episode (KPE) 4
The extent to which postnatal support was effectively co-ordinated and consistent particularly safe sleeping advice and ICON advice to help parents cope with crying and therefore reduce the risk of abusive head trauma.
Key lines of enquiry (KLOE) b, d, e and g addressed by KPE 4.

5.38 There was a lack of in-person, video or telephone contact between the clinical nurse specialist, the community midwife and the health visitor during the postnatal period. Unsuccessful attempts were made to make telephone contact. Contact may

have been more difficult as a result of the time of year – Christmas and New Year – and the restrictions introduced from Boxing Day to address the Delta wave of the pandemic may have added to the communication challenges. Such communication would have helped to clarify professionals understanding of child E1's weight loss for example and may also have helped to co-ordinate visits as there was a gap between 31st December 2020 and 5th January 2021 when there was no professional contact with the parents and child E1. Crucially, multi-agency communication would have provided an opportunity for midwifery and the health visitor to share information about mother's mental health history, of which the cleft lip and palate service have advised this CSPR that they were unaware.

5.39 One of the overall aims of the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network Protocol is to communicate effectively and promote mutually supportive working relationships across all specialties and geographic areas, as well as partnership working with primary care and other agencies (within the bounds of confidentiality). This aim was not achieved in this case although the aim of promoting mutually supportive working relationships across all specialities was the responsibility of all partner agencies. However, it is recommended that the Safeguarding Children Partnership share this CSPR report with the Manchester University Hospitals NHS Foundation Trust, which is the lead NHS Trust for the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network so that the Trust can consider whether the learning from this CSPR necessitates any changes to their Protocol.

Recommendation 6

That Rochdale Borough Safeguarding Children Partnership share this CSPR report with the Manchester University Hospitals NHS Foundation Trust, which is the lead NHS Trust for the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network so that the Trust can consider whether the learning from this CSPR necessitates any changes to their Protocol.

5.40 It is also recommended that the Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Trust that when referrals are made to the cleft lip and palate team, any information held in respect of parental mental health is shared with the cleft lip and palate team.

Recommendation 7

That Rochdale Borough Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Trust that when referrals are made to the cleft lip

and palate team, any information held in respect of parental mental health is shared with the cleft lip and palate team.

5.41 Contradictory safe sleeping advice was given by the health visitor who provided what is regarded as the standard advice that new born babies should sleep on their back - as recommended by the Lullaby Trust – and the clinical nurse specialist (CNS) from the cleft lip and palate team who advised the parents to place child E1 on alternate sides. At the second practitioner learning event the representative from the cleft lip and palate team said that their safe sleeping advice was informed by an ongoing research programme. The most recent paper produced by this research programme *Safe sleeping positions: practice and policy for babies with cleft palate* (2017) (4) noted that cleft palate affected the structure of the hard and/or soft palate, and is commonly associated with differences in tongue position, upper airway structure and functioning. All children affected by this condition tend to have smaller upper airways and are at greater risk of sleep-disordered breathing (SDB) and obstructive sleep apnoea (OSA). The paper noted that national guidance in the UK recommends adopting the supine position in order to reduce risk of sudden infant death and that the benefits and risks of using lateral sleep positioning for infants with conditions known to be associated with upper airway obstruction were uncertain, and the use of lateral sleep positioning for infants with cleft palate was anecdotal. The paper reviewed the advice provided for parents of infants with cleft palate about safe sleeping positions by all but one of the regional specialist cleft centres in the UK. Over half the centres used lateral positioning, but the uncertainty of evidence to support this practice was described as a matter of concern for Clinical Nurse Specialists in cleft centres. The paper observed that variation in advice indicated a lack of research evidence to guide practice and also noted that uncertainty about practice which differs from the standard advice of generalist health professionals including midwives, health visitors and general practitioners had the potential to cause anxiety for parents and risks for infants. The paper concluded that further research was needed to provide an evidence base for practice to minimise the risks of OSA as well as sudden death in infants with cleft palates. The CSPR has been advised that the further research recommended by *Safe sleeping positions: practice and policy for babies with cleft palate* was ongoing and it was anticipated that it would inform safe sleeping advice given by the cleft lip and palate service in the future.

5.42 The contradictory safe sleeping advice did not appear to be an additional source of parental anxiety in this case, but it could well have contributed to parental anxiety, given mother's mental health history and the difficulties she began to experience with assisted feeding of child E1. It is therefore recommended that the Safeguarding Children Partnership note the advice provided to this CSPR that safe

sleeping advice to parents of cleft lip and palate babies is under review and advise the National Child Safeguarding Review Panel of the current position so that the National Panel can consider what action to take in respect of the conflicting safe sleep advice currently being given to parents of cleft lip and palate babies pending the outcome of ongoing research. It is also recommended that the Greater Manchester Safeguarding Children Partnership is made aware of the possibility that conflicting safe sleep advice may be given to the parents of cleft lip and palate babies.

Recommendation 8

That Rochdale Safeguarding Children Partnership note the advice provided to this CSPR that safe sleeping advice to parents of cleft lip and palate babies is under review and advise the National Child Safeguarding Review Panel of the current position so that the National Panel can consider what action to take in respect of the conflicting safe sleep advice currently being given to parents of cleft lip and palate babies pending the outcome of ongoing research.

Recommendation 9

That Rochdale safeguarding Children Partnership notify the Greater Manchester Safeguarding Children Partnership of the possibility that conflicting safe sleep advice may be given to the parents of cleft lip and palate babies in order that Greater Manchester guidance may be provided on the action to be taken in such circumstances.

5.43 Mother and father were given ICON advice to help them cope with crying in order to reduce the risk of abusive head trauma only by the health visitor. The second practitioner learning event was advised that midwifery have now introduced ICON advice as a result of this case. The learning event was advised that the cleft lip and palate network do not currently provide advice on abusive head trauma to parents and during discussion it was agreed that this is an issue which needs to be addressed given the increase in stress and anxiety likely to arise from parenting a baby with a cleft lip and palate. Likely stressors include the challenges of becoming familiar with assisted feeding techniques and the higher likelihood that a baby with a cleft lip and palate will have colic and therefore cry.

5.44 It was agreed that the representative of the cleft lip and palate service would share materials relating to ICON with her colleagues. The issue has also been treated as 'early learning' from this CSPR and a letter has been sent to Manchester University Hospitals NHS Foundation Trust, which is the lead trust for the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network. This should

allow the Clinical Director of the Network to take urgent action to ensure that all clinical nurse specialists are supported to provide appropriate advice to parents of babies born with cleft lip and palate in order to reduce the risks of abusive head trauma. The CSPR was subsequently advised that all clinical nurse specialists in the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network received ICON training in October and November 2022 and their Protocol will be updated to include the sharing of a leaflet with parents/carers to promote a discussion of ICON advice.

5.45 It had been intended to recommend that the Safeguarding Children Partnership obtained assurance from Manchester University Hospitals NHS Foundation Trust that action had been taken to ensure that clinical nurse specialists in the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network were now being supported to provide appropriate advice to parents of babies born with cleft lip and palate in order to reduce the risks of abusive head trauma. However, given the recent update provided to the CSPR by the Cleft Lip and Palate network (see previous paragraph), this recommendation is no longer necessary.

5.46 It is recommended that the Safeguarding Children Partnership write to the National Child Safeguarding Children Panel to advise them of the previous lack of abusive head trauma prevention advice provided to parents of cleft lip and palate babies in the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network and to propose that the National Panel make enquiries of the other Cleft Lip and Palate Networks across the country to obtain assurance that appropriate abusive head trauma advice is provided to parents. The North West England, the Isle of Man and North Wales Cleft Lip and Palate Network has recently advised the CSPR that they will ensure that this issue is raised at the National ICON panel as an agenda item. This is a very welcome development but there would still be merit in writing to the National Child Safeguarding Children Panel as recommended.

Recommendation 10

That Rochdale Borough Safeguarding Children Partnership write to the National Child Safeguarding Children Panel to advise them of the previous lack of abusive head trauma prevention advice provided to parents of cleft lip and palate babies in the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network and propose that the National Panel make enquiries of the other Cleft Lip and Palate Networks across the country to obtain assurance that appropriate abusive head trauma advice is provided to parents.

Understand in more detail what agencies knew about father, the impact this had on assessment and planning work and how effectively father was engaged by involved practitioners. (KLOE e)

5.47 As previously stated partner B has been charged with the murder of child E1 and faces a retrial in April 2023 after the jury was unable to reach a verdict in his first trial.

5.48 As stated it is unclear whether children's social care requested a police check after mother disclosed her relationship with partner B (Paragraph 3.24) or conducted any risk assessment. The police have advised this CSPR that their records contained nothing of concern about partner B at that time. However, the National Child Safeguarding Panel's report *The Myth of Invisible Men* which examined cases in which babies had been killed or seriously harmed by male carers – predominantly birth fathers – found that these perpetrators had not commonly had a lot of contact with criminal justice agencies and had therefore not been flagged as presenting a significant physical threat and risk to others, including children (5).

5.49 It is noticeable that much of the information professionals received about partner B came from mother and it was uniformly positive. For example mother said that partner B 'adored' child 1 and child 2 (Paragraph 3.32), felt 'like she was a new person' because of the support she was receiving from partner B and his family (Paragraph 3.32) and stopped taking her antidepressants early in the relationship because she felt well (Paragraph 3.32). It seems possible that mother's optimism about her new relationship may have been welcomed by professionals who were well aware of how conflicted her relationship with partner A and his family had become.

5.50 There were two issues which could have led professionals to view mother's developing relationship in a less optimistic light. Firstly, mother became pregnant very early in the relationship with partner B, which as previously stated is a potential indicator of a controlling relationship (Paragraph 5.20) and partner B was staying with mother and her two older children when the children were found wandering after they unlocked the door of mother's house whilst she and partner B were asleep (Paragraph 3.45).

5.51 *The Myth of Invisible Men* stresses the importance of professionals exploring male carer's lives and experiences – including their experience of their own fathers and of being parented and a sense of what being a father is and should be (6). Unfortunately the opportunities to explore these issues with partner B did not materialise because opportunities to consider a pre-birth assessment or offer an early help assessment were missed. However, the clinical nurse specialist from the

cleft lip and palate service generally saw mother and partner B together which enabled partner B to contribute to the preparation for child E1's birth and become actively engaged in caring for and feeding the baby.

5.52 *The Myth of Invisible Men* was informed by interviews with seven male perpetrators of violence to babies and two of the men referred to a baby crying as having been a key trigger issue for them in losing control (7). This reinforces the importance of professionals taking every opportunity to provide advice to help parents cope with crying in order to reduce the risk of abusive head trauma (Paragraph 5.43). It is not known whether child E1 had been crying in the period immediately prior to the abuse. As we have seen both mother and partner B were became frustrated and stressed as a result of the difficulty mother began to experience in feeding child E1 and partner B had been doing the majority of the feeding including waking for night time feeds.

Explore how COVID-19 may have impacted upon service delivery and the support offered particularly given Child E1's additional needs and whether it was possible to maintain a child-focused approach (KLOE j)

5.53 During the first Covid-19 lockdown schools closed for most children but child 1 was offered a place by her school although this was declined by her parents. The school made daily telephone contact with mother or partner A – whichever parent the children were staying with - and provided food on several occasions. The school later repeated the offer of a place for child A which was initially accepted by the parents before being declined once again. Following the Christmas 2020 school holiday child 1's school did not re-open as a result of Covid-19 restrictions. Mother and partner B were adjusting to the needs of new born child E1 at this time and beginning to struggle with feeding. It seems possible that the fact that child 1 was not in school may have added to the pressures on mother and partner B at that time.

5.54 The pandemic also affected how other agencies worked with the family. Child in need meetings were held virtually and the social worker made contact with the family by video calls. GP contact was primarily by telephone. The health visitor who knew the family well was redeployed to other Covid-19 related duties for a period but she had returned to her usual role in time to conduct the antenatal and new birth visits in respect of child E1. Some of mother's contacts with maternity were by telephone. The Family Group Conference Manager was redeployed to a different role because of his Covid-19 vulnerability and so there was a delay in addressing the conflict between mother and partner A, and the 'feuding' between their two families – which was an issue which the child in need plan was intended to address. As

previously stated there is no evidence that the Family Group Conference work resumed when Covid-19 restrictions eased.

5.55 As stated the omission of the anticipated step down to early help occurred during the early stages of the pandemic but was mitigated to an extent by the support child 1's school provided to the family. There were other examples professionals working very effectively to maintain essential support to the family during the pandemic including the home visits made to child E1 by the community midwife on 26th and 27th December 2020 during the very challenging 'Delta' phase of the pandemic.

5.56 It is not known whether the restrictions introduced as a result of the pandemic affected mother's mental health. The most recent progress report on the England suicide prevention strategy identified two categories of individuals for whom the onset of the pandemic had exacerbated risk factors; those for whom the pandemic has exacerbated existing problems, and those for whom the pandemic has resulted in significant and specific new issues such as job loss, unmanageable or mounting debts as a result of reduced income, bereavement and loneliness or social isolation (8).

Good practice

- It was noted that school involvement with and support for the family was an area of good practice in the case, in particular during the pandemic when daily telephone contact was made and food parcels were delivered.

- Both mother and partner A had flags on their files as their children had been subject to a CP Plan and GP contributed to CP conferences appropriately. This flagging at the GP service was seen as good practice.

- Health visitor made contact with mother early on in the pregnancy (outside of expected practice) due her knowledge of the family's history.

- The health visitor liaised with CONI co-ordinator regarding advice for safe sleeping of cleft palate babies.

- The community midwife made home visits to child E1 and their parents on 26th and 27th December 2020. This is expected practice but the visits were accomplished during the 'Delta' phase of the pandemic which was an extremely challenging period in which to maintain the provision of services.

List of recommendations

Recommendation 1

That Rochdale Borough Safeguarding Children Partnership obtains assurance from partner agencies that all relevant professionals

- *are aware of the circumstances which indicate an increased risk to an unborn child and therefore may require a pre-birth assessment*
- *are aware of the requirement to make a referral to children's social care/EHASH if circumstances indicate an increased risk to an unborn child*
- *are aware of the need to fully document and decisions in respect of the consideration of pre-birth assessments*
- *are aware of the need to further consider the needs of the unborn child should a decision be made not to undertake a pre-birth assessment.*

Recommendation 2

That Rochdale Borough Safeguarding Children Partnership proposes that the Greater Manchester Safeguarding Policy on Pre-Birth Assessments is amended

- *to identify a diagnosis of a disability in an unborn baby as a factor which, taken together with current or recent concerns about parental mental health and/or parental capacity or current or recent involvement of children's social care, may be an indicator of increased risk to the unborn child*
- *to advise that the criteria (a) to (o) are not necessarily exhaustive, and that professional judgement may be called for*
- *to advise professionals that a decision not to undertake a pre-birth assessment can be revisited if circumstances change.*

Recommendation 3

That Rochdale Borough Safeguarding Children Partnership obtains assurance in respect of arrangements to step down to Early Help, in particular:

- *that the Rochdale Children's Service Step Up Step Down Protocol is adhered to in all cases*
- *that schools which do not have a dedicated family worker post are provided with the support necessary to lead the co-ordination of Early Help*
- *and that professionals are encouraged to challenge any absence of step down arrangements.*

Recommendation 4

That Rochdale Safeguarding Children Partnership obtains assurance from Rochdale Children's Social Care that case closure is used as an opportunity to check that all relevant tasks have been completed, how any ongoing needs will be met, how any outstanding risks will be addressed and shares the rationale for case closure with relevant partner agencies.

Recommendation 5

That Rochdale Borough Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Foundation Trust that midwifery services are aware of the Early Help process and that appropriate staff have received the training and support necessary to complete Early Help Assessments and fulfil the lead professional role which co-ordinates Early Help support.

Recommendation 6

That Rochdale Borough Safeguarding Children Partnership share this CSPR report with the Manchester University Hospitals NHS Foundation Trust, which is the lead NHS Trust for the North West England, the Isle of Man and North Wales Cleft Lip and Palate Network so that the Trust can consider whether the learning from this CSPR necessitates any changes to their Protocol.

Recommendation 7

That Rochdale Borough Safeguarding Children Partnership obtains assurance from the Northern Care Alliance NHS Trust that when referrals are made to the cleft lip and palate team, any information held in respect of parental mental health is shared with the cleft lip and palate team.

Recommendation 8

That Rochdale Safeguarding Children Partnership note the advice provided to this CSPR that safe sleeping advice to parents of cleft lip and palate babies is under review and advise the National Child Safeguarding Review Panel of the current position so that the National Panel can consider what action to take in respect of the conflicting safe sleep advice currently being given to parents of cleft lip and palate babies pending the outcome of ongoing research.

Recommendation 9

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may be given to the parents of cleft lip and palate babies in order that Greater Manchester guidance may be provided on the action to be taken in such circumstances.

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Appendix A

Process by which the CSPR was conducted

This LCSPR was informed by the Rapid Review which preceded it and the information provided to the Rapid Review by involved partner agencies.

Chronologies of contact with child E1 and her family from involved agencies were submitted as were key events reports in which involved agencies reflected on their key contacts with the child and family. Reports were submitted by:

- Adult Care Services
- Children's Services
- Greater Manchester Police
- Heywood, Middleton and Rochdale Integrated Care Partnership (GP practice)
- Manchester University Hospitals NHS Foundation Trust (Cleft lip and palate service)
- Pennine Care NHS Foundation trust
- Primary School
- Rochdale Care Organisation/Northern Care Alliance (Midwifery
- Rochdale Safeguarding Children Unit

A Panel of managers from the agencies involved in this case was established to oversee this review. Membership of the Panel was as follows:

Independent Reviewer (Chair)	Independent
Development Officer	Rochdale Safeguarding Children Partnership
Head of Performance Standards & Improvement	Children's Services
Head of Unit	Safeguarding Children Unit
Detective Constable	GMP Serious Case Review Unit
Designated Professional for Safeguarding Adults	Heywood, Middleton & Rochdale Integrated Care Partnership

Safeguarding Families Practitioner	Pennine Care NHS Foundation Trust
Education Safeguarding Officer	Early Help and schools
Head Teacher	Primary School
Named Nurse Safeguarding	Northern Care Alliance
Specialist Midwife Safeguarding	Northern Care Alliance

The independent reviewer analysed the reports and identified issues to explore with practitioners at two learning events facilitated by the lead reviewer.

The independent reviewer developed a draft report to reflect the agency reports and the contributions of practitioners who attended the learning event. The report was further developed with the assistance of the CSPR Panel into a final version and presented to Rochdale Borough Safeguarding Children Partnership.