LCSPR

LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

BABY ALFIE

GATESHEAD
safeguarding
children
partnership

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Contents

GLOSSARY OF ACRONYMS

MARAC	Multi-Agency Risk Assessment Conference
NPS	National Probation Service
SSO	Suspended Sentence Order
GRP	Gateshead Recovery Partnership
GHC	Gateshead Housing Company

GLOSSARY OF TERMS

Strategy Meeting	A multi-agency meeting convened by Children's Social Care to determine a child's welfare and plan rapid future action is there is reasonable cause to suspect the child is suffering or is likely to suffer significant harm.
Section 47 Enquiry	An investigation to decide whether and what type of action is required to safeguard and promote the welfare or a child who is suspected of or likely to be suffering significant harm.
Initial Child Protection Conference	A multi-agency meeting to make decisions about a child's future safety, health and development.
Family Group Conferencing	A family-led meeting in which the family and friends network come together to make a plan for a child.

STATUTORY FRAMEWORK

This Local Child Safeguarding Practice Review (LCSPR) was commenced in 2021 and undertaken in accordance with the guidance contained in Working Together to Safeguard Children 2018 which outlines that reviews should be completed in a way which:

- Reflects the child's perspective and family context
- Is proportionate to the case under review
- Focuses on potential learning
- Establishes and explains the reasons why events occurred
- Invites families to contribute
- Fully involves practitioners

Working Together 2018 encourages Local Safeguarding Partnerships to use a variety of models for undertaking LCSPRs, including the systems approach.

METHODOLOGY

Using a systems methodology reflects on multi-agency work systemically and focuses on why those involved acted in a certain way at that time. The systems approach for LCSPRs in Gateshead is described in the *LSCPR Framework & Practice Guidance*; this includes analysis and scrutiny of agencies involvement and reflective learning workshops for frontline professionals to come together to consider the circumstances surrounding the case and the reasons why actions were taken.

BACKGROUND TO THE REVIEW

i. A Rapid Review Meeting was held by Gateshead Safeguarding Children Partnership on the 22nd January 2021. This was in response to an incident where a young baby, who will be referred to in this report as Alfie, suffered significant injuries whilst in the care of his mother and her partner. The Rapid Review Meeting identified the need to undertake a learning review. The National Child Safeguarding Practice Review Panel subsequently agreed there was value in undertaking a learning review and requested that it was published as a Local Child Safeguarding Practice Review.

ii. An independent reviewer, Chris Ring, was identified in September 2021 to undertake the review. Chris Ring is a registered Social Worker with 19 years' experience working in a variety of statutory social work settings, both as a practitioner and manager. He is currently the Children and Families Principal Social Worker in a neighbouring Local Authority.

iii. A multi-agency learning review workshop was held on the 13th October 2021. A draft review report was shared with representatives from partner agencies on the 6th January 2022 and the final report was presented and agreed by the Gateshead Safeguarding Children Partnership on the 10th February 2022.

FAMILY INVOLVEMENT

i. Alfie's family have been informed that the LCSPR is taking place. Alfie's mother was offered the opportunity to contribute to the review. A number of attempts to make contact were made, both directly by lead reviewer and also via workers currently involved with Alfie, but Alfie's mother did not respond. Alfie's father is unknown. This has meant it has not been possible to reflect parental views within this report (outside of what was included in case recording and during practitioners' feedback at the reflective learning workshop).

1. INTRODUCTION

1.1 This Child Safeguarding Practice Review concerns a young baby (Alfie) who, on the 25th December 2020 when he was 6 weeks old, was admitted to hospital with significant injuries that were indicative of being shaken: Sub-dural bleeding, leading to raised intra-cranial pressure and the risk of traumatic brain injury; bruising to his left ear, with associated petechiae; " posturing" of his upper limbs; extensive retinal haemorrhaging in both eyes; repeated seizures. Alfie had been in the care of his mother and her partner in the hours leading up to sustaining these injuries. When paramedics attended the address, they observed a smell of alcohol and cannabis.

2. BACKGROUND

2.1 At the time of Alfie's birth his mother was living in her own tenancy, and it was believed that she was living alone. She had a lack of social support, and little was known about her wider family. The identify of Alfie's father was not known to agencies at the time of the incident, although there was an identified putative father who is referred to by professionals. It is now known that he is not Alfie's father.

2.2 Alfie's mother received support from Children's Social Care as a child, which centred around her relationship with her mother. As an adult Alfie's mother has been known to Adult Services and identified as vulnerable due to her being homeless and experiencing poor mental health. At that time there was a pattern of offending behaviour linked to substance misuse.

2.3 It is believed that Alfie's mother was in a relationship with an adult male at the time of the incident. No professional working with Alfie's mother at this time was aware of the relationship. Professionals now believe that he may have been living within the family home during lockdown. He has previously been discussed at a Multi-agency Risk Assessment Conference (MARAC) within Gateshead due to being assessed as posing a high risk of domestic abuse in a previous relationship.

2.4 At the time of the incident the National Probation Service (NPS) had been supervising Alfie's mother since September 2019 as part of a 24-month Suspended Sentence Order (SSO). At the beginning of the SSO Alfie's mother complied with her conditions, had reported that she had stopped using cannabis and had self-referred to the Gateshead Recovery Partnership (GRP) to complete relapse prevention work.

2.5 Alfie's mother became pregnant during the Covid-19 pandemic and there were two national lockdowns during 2020.

3. SUMMARY OF WHY RELEVANT DECISIONS BY PROFESSIONALS WERE TAKEN

3.1 When NPS began supervising Alfie's mother there was evidence of compliance with the requirement of the order and evidence of positive engagement in relation to her substance misuse. It was decided that there was not a need to make a child safeguarding referral when they were made aware of the pregnancy. In May 2020 this decision was reviewed due to Alfie's mother's reduced compliance with her order and an increased concern that there was a need to assess the impact of her emotional wellbeing and substance misuse on her pregnancy and future capacity to care for her baby.

3.2 This referral was progressed in a timely way by Children's Social Care, and at an early stage of pregnancy. An assessment was undertaken which led to a Strategy Meeting being held. The primary concerns at that time were Alfie's mother's mental health, given her history of significant self-harm

and suicidal ideation, significant financial difficulties linked to her tenancy, and sporadic engagement with services. The outcome of the Strategy Meeting was a child protection (section 47) enquiry.

3.3 The outcome of the child protection (section 47) enquiry was that whilst it was acknowledged there were a number of risk factors, support would continue to be provided on a Child In Need basis pre and post birth. This decision was in part informed by toxicology reports that were recorded as being "negative for all illegal substances", positive engagement during home visits and the fact that Alfie's mother was 22 weeks gestation at this stage.

4. CRITIQUE OF HOW AGENCIES WORKED TOGETHER AND ANY SHORTCOMINGS IN THIS

4.1 The evidence shared as part of the Rapid Review and subsequent Learning Review evidences a strong safeguarding partnership and an environment where agencies are able to work effectively together.

Assessment, investigation and intervention

4.2 In this particular case there were opportunities to strengthen the assessment work undertaken both to triangulate information being reported by Alfie's mother and to ensure that all information known by agencies at a point in time is used to inform decision making.

4.3 An audit undertaken by Children's Social Care highlights that the assessment and the child protection (section 47) enquiry could be strengthened by describing past parental behaviours in more detail both in terms of maternal mental health and substance misuse, a greater analysis of mother's own parenting experiences and how these would impact on her ability to parent, and by not placing too great an emphasis on short term engagement with services. It also identifies the need to ensure that self-reported information is triangulated.

4.4 The outcome of the child protection (section 47) enquiry was based in part on a negative toxicology test. It has been identified that there is a need to ensure that the recipients of information in relation to toxicology tests are in full knowledge of what substances that test is being used to identify, and what the caveats are to any test such as this. In this instance it is significant as cannabis use was not screened for, yet it was known that Alfie's mother used cannabis.

4.5 There was evidence within the learning review of a wide range of professionals who have invested time in building a relationship with Alfie's mother. Despite reportedly being anxious about the involvement of Children's Social Care she felt able to disclose her pregnancy to the Tenancy Support Worker and shared a significant amount of information with services that would have been unlikely without the context of these relationships.

4.6 It is not possible to identify a single piece of information, or omission of information being shared, that would in isolation have changed the outcome for Alfie but there are examples where information sharing could have been strengthened. For example, it was known by the GP practice that Alfie's mother had not engaged with talking therapies, but the GP was not contacted during the assessment or invited to the strategy meeting held in July and therefore did not share this information. The Gateshead Recovery Partnership (GRP) were unaware when they delivered their brief intervention that there had been a history of poly drug use and previous overdose.

4.7 Throughout the assessment and intervention provided by all agencies a significant amount of practical support was provided to Alfie's mother. This can and should be seen as good practice given the identified level of assessed need. However, it is also important that all agencies continue to review

the level of support provided in the context of assessing someone's ability to achieve and maintain sustainable change. During Alfie's mother's pregnancy there were six occasions where health appointments were missed however these were rescheduled and attended following prompting. It is positive that there was proactive follow-up and the appointments were attended, but it is equally important that the need to provide this support informs the ongoing assessment.

4.8 Home visits were undertaken during the assessment and intervention by Health Visitor, Social Worker, Probation Officer and Midwife. There were no signs of drug withdrawal at birth which at the time seemed to support the hypothesis that Alfie's mother was not using substances. Professionals reported being happy with the bonding between mother and baby, he was feeding well, was a good weight and noted to be thriving.

Communication and decision making

4.9 The outcome of the child protection (section 47) enquiry was communicated by Children's Social Care to partner agencies via email. Whilst this is an effective method of communication it does not create an opportunity for professionals to clarify or challenge the outcome. Working Together 2018 sets out that the action following a children protection (section 47) enquiry is the responsibility of Children's Social Care, although provides for other professionals involved challenging this outcome if they are not in agreement. In this instance there was a lack of clarity amongst some partner agencies about the rationale for deciding that there was not a need for an Initial Child Protection Conference, and it would have been helpful to create an opportunity to discuss this. Furthermore, it was identified at the learning review that only those agencies attending Strategy Meetings receive the minutes and it may be that there are occasions where it is important for agencies that have not been able to attend the strategy meeting are made aware of the outcome.

Networks

4.10 There is a limited amount known about the personal networks that Alfie's mother would have spent time with and utilised for support. In the Child In Need assessment it refers to a good relationship with a step-father and a close friend and acknowledges that the neighbours provided some practical support. A greater focus on these individuals and the wider network within the assessment by all agencies may have provided an opportunity to better understand what life was like for Alfie's mother both during and after her pregnancy. Significantly in this case it was not known that Alfie's mother had begun a relationship with an adult male who was residing in the property. Home visits had been undertaken by a number of professionals and they did not observe any evidence of another person living in the house.

4.11 The learning review acknowledged the importance of language in relation to how relationships are described and perceived by adults that we work with. There may have been an opportunity in this instance to explore what Alfie's mother understood by the concept of relationships and this may have influenced her response to professionals. It is certainly the case that there was an opportunity for greater curiosity in relation to the putative father's role in Alfie's mother's life. It is now known that he is not Alfie's father, but this was not the case during the assessment and intervention. Alfie's mother did not want him to be contacted and under the auspices of a Child in Need plan it is perhaps understandable why he was therefore not contacted. However, very little was known about any risks or protective factors within Alfie's mother's networks and the importance of this could have led to greater curiosity and challenge from all professionals to explore how to speak directly with

him. This may have been working with Alfie's mother to better understand why she did not want contact to be made. If there were risks identified, then that information in itself would have informed the ongoing assessment.

Covid-19

4.12 Visits from partner agencies continued throughout Covid-19 but the pandemic did and continues to change certain elements of practice. In this instance the Health Visiting team always phoned Alfie's mother prior to a visit to ask whether or not she was symptomatic. This is good practice from an infection control perspective, but it may have provided Alfie's mother with the opportunity to prepare for a visit or allow time for her partner to leave the property. NPS visits were conducted outside of the home, which will have inevitably impacted on their ability to observe the home environment, contribute to ongoing assessment work and discuss sensitive issues openly.

4.13 There was an occasion in early December 2020 where Alfie's mother stated that she was concerned about Alfie getting Covid and therefore didn't want any visitors to the home. Similarly, there was a missed health appointment where the reason given was that a friend was self-isolating. There is nothing tangible to suggest that the anxiety expressed was not genuine, or that a friend was not self-isolating, but it provides a context for professionals that is perhaps more difficult to challenge, and not one that was part of routine practice prior to 2020.

4.14 Thinking about the importance of networks, we know that the early part of the pandemic response meant that there was less social mixing within communities. It is not possible to identify what impact this had on this specific case, but it is important context for practitioners to consider as the pandemic continues.

5. ARE SHORTCOMINGS IDENTIFIED FEATURES OF PRACTICE IN GENERAL?

5.1 The importance of good communication during assessment and subsequent decision making is highlighted by this review and this learning will have an impact on the wider children's social care system.

6. WHAT WOULD NEED TO BE DONE DIFFERENTLY TO PREVENT HARM OCCURRING TO A CHILD IN SIMILAR CIRCUMSTANCES?

6.1 Good quality assessment work is a complex task that requires multiple sources of information and multiple perspectives to ensure it is robust. In this specific case there were a significant number of professionals involved, and a significant amount of information shared. There is a continuous need for all agencies to play their part in ensuring that information that informs assessments is detailed, provided in a timely way, is understood by the recipient and triangulated wherever possible. Creating time and space to allow discussion of emerging hypotheses and promote a cultural of critical challenge is vitally important.

6.2 Assessment should be seen as a continuous process and it is important that the learning from conversations, home visits and attendance at appointments (or lack of attendance) is routinely shared within the multi-agency team working with a family so that it can be analysed and inform the way in which interventions are delivered, or indeed inform practical considerations such as who is planning to visit and when. This is particularly important in situations such as this one where a parent feels unable to be open and honest, for whatever reason.

6.3 The importance of identifying an individual's network and exploring what role they can play in providing support should be central to everyone's practice. When done effectively, it is often those within a naturally connected network who will provide the most effective support at the time it is needed, whilst also providing invaluable information to continually inform the assessment process. Family Group Conferencing will support this work.

7. EXAMPLES OF GOOD PRACTICE

7.1 There is evidence of professionals across adult and children's services working closely together through this period of involvement. Home visits continued during Covid-19 by more than one agency and rooms were observed.

7.2 The Tenancy Support worker from The Gateshead Housing Company built a relationship with Alfie's mother, enabling her to disclose her pregnancy and continue to receive support. The NPS were proactive in making a referral to Children's Services and this was responded to in a timely way.

7.3 A Health Visitor was identified early, and Alfie's mother was booked early at approx. 8 weeks gestation. There were discussions held between Health Visitor and Midwife in relation to vulnerabilities and information shared at the GP Practice safeguarding meeting shortly after the strategy meeting in July.

7.4 ICON (Evidence-based programme which has been supported by NHSE to reduce abusive head trauma in infancy) messages were provided by both the Health Visitor and Midwifery Services.

8. WHAT NEEDS TO HAPPEN TO ENSURE THAT AGENCIES LEARN FROM THIS CASE

8.1 The following areas for action were identified by agencies at the learning review:

1. •The GSCP to co-ordinate all agencies reviewing their role in assessment work, ensure that their use of evidence-based tools is robust, and seek assurance that there is sufficient opportunity for information to be analysed on a multi-agency basis.
2. •Children's social care to review who receives details of the outcome of Strategy Meetings.
3. •Children's social care to review how the outcomes of section 47 enquiries are communicated to partner agencies and ensure that there is a well understood process to challenge this if necessary.
4. •Review how the outcomes of clinical investigations, such as a toxicology report, are shared to ensure there is clarity about their meaning.
5. •The GSCP to consider some dedicated work focusing on the importance of identifying and working with naturally connected networks.

All learning/actions identified by the LCSPR (including the rapid review) are being taken forward and overseen by the Quality, Learning and Practice group. Progress is shared with Safeguarding Partners via the GSCP.

Actions taken since the review:

- The GSCP have undertaken to review the findings from the national review *"The Myth of invisible Men" Safeguarding children under 1 from non-accidental injury caused by male carers (September 2021)* and a multi-agency gap analysis is being undertaken by the Quality, Learning and Practice group as an action from this.
- GSCP commissioned 'Hidden men' training with the aim of facilitating discussion and addressing concerns about engaging with men in safeguarding and promoting the welfare of children. This training also acknowledged values and context around issues of gender and fatherhood.