Overview and Analysis Alice

Learning Lessons Review

Summary of key issues and lessons to be learnt

Bradford BSCB Safeguarding Children Board

What was the story?

- A child (known as Alice for purpose of this review). Within 2 months of her birth, she was seen to have bruising deemed to be the result of a non-accidental injury. She became a looked after child.
- The child's mother had her own vulnerabilities, including being a care leaver, having mental health and learning difficulties, at risk of Child Sexual Exploitation (CSE) and subject to domestic violence. She was also involved in criminality.

Voice of the Child?

The child's voice was not heard. Whilst accepting this was a very young baby, there were opportunities for professionals to appreciate and analyse the lived experience of the child e.g. failure to thrive, missed appointments, bruises.

What's going well?

- There was evidence of good partnership working in relation to the support provided to Alice and her mother, with a number of partner agencies involved, culminating in an intensive support plan for when Alice was born. Quote from report "The level of partnership working between agencies was good".
- GP identified bruising during a consultation for other purposes and acted swiftly. The social worker was contacted and attended the surgery immediately.

What are we worried about?

- Mum had a history of a range of vulnerabilities, known prior to the birth of her child. How realistic was it to expect her to overcome these and be able to parent a child safely? Becoming a parent brings additional stress. Was the mother's history carefully considered?
- Quality and timing of the pre-birth assessment.
- Two key services (mental health and police) were not represented. Improved engagement by Alice's mother influenced the multi-agency group into thinking she should be given the opportunity to care for her child.
- The 'Rule of Optimism' was very much in evidence. Small improvements influenced decision making and led to a 'cognitive trap' where once the decision had been made, i.e. that Alice could be cared for by her mother, professionals found it difficult to review the decision and to look at it from a different perspective to effectively minimise risk.
- Procedures not always followed effectively. Some key information was not recorded, including minutes from first pre-proceeding meeting and a strategy discussion with the police. The legal process, Public Law Outline (PLO) and links to the Initial Child Protection Conference (ICPC), timing and information sharing was problematic. The ICPC was held too late.
- The child protection medical assessment did not take place until the following day.
- There was a lack of professional challenge. Daily intensive support was provided, but this masked risks to the child and left a number of professionals feeling anxious. Despite this, the professional multi-agency challenge procedures were not used.
- Invisible males; Alice's father was known for his violence and involvement in Child Sexual Exploitation (CSE), criminality and a perpetrator of domestic abuse.
- This was recognised, but did not appear to be at the forefront of professional's minds during risk analysis.
- Overall, there was a lack of robust analysis. **The lack of information from or professional involvement with mental health services is critical to the case.** The importance of the mental health insight and omission in inviting them to pre-birth assessments/conference meant a full picture of the case was not known, which impacted greatly on the assessment of risk.

What needs to happen?

- Clear guidance for practitioners/managers on holistic and comprehensive pre-birth assessments should be available.
- Multi-agency training to be provided, focussing on challenges facing young parents experiencing a range of vulnerabilities and potential for repeat removals.
- Partners to ensure staff are aware of the impact of multiple vulnerabilities on parenting and the significance of cumulative harm whilst keeping a focus on the child.
- There should be a review of the application of legal processes, such as the PLO, so they enhance protection of a child, not detract from it.
- Children's Social Care (CSC) should always follow child protection procedures for Section 47 investigations and there should be consistent recording of strategy discussions and meetings shared with partners.
- All key professionals and agencies involved should be invited to and attend ICPCs. Attendance at these meetings is pivotal.
- All agencies should ensure professional training and development highlights risks associated with fixed thinking, the need for professional inquisitiveness and challenge.
- Professionals need to develop the skills and confidence to challenge decisions and use escalation processes if necessary.

Learning for Professionals and multi- agency practice

- Practitioners need to attend Initial Child Protection Conferences and submit timely reports.
- Practitioners need to update their understanding of the pre-birth assessment process currently under revision.
- Practitioners and their supervisors need to understand the increasing risk associated with cumulative harm and take into account the chronology for the child and their family.
- All practitioners need access to reflective supervision to assist with complex decision making.
- Everyone involved should ensure there is appropriate recording of strategy meetings and discussions.
- Everyone needs to be familiar with and make use of the Resolving Professional Disagreements and Escalation procedure

Multi-agency responses for this case

- Strategy discussion
- Pre-birth assessments/conference
- Initial Child Protection Conference process
- Threshold of Need Guidance
- Information sharing
- Resolving Professional Disagreements and Escalation
- Protocol for the Assessment of Bruising, Burns and Scalds in Non Mobile Babies

Source: West Yorkshire Consortium Procedures (Safeguarding)

Multi-agency training

- Safeguarding - A shared responsibility

Further training, guidance and resources for professionals, including policies and procedures are available on the

Bradford Safeguarding Children Board website