Child Safeguarding Practice Review (CSPR)

Child Alex

Agreed by: Somerset Safeguarding Children Partnership in May 2021

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1. Executive summary. About this review

1.1. This review has been completed following a 10-week-old child, who will be referred to as Alex, presenting at hospital in early 2020 with serious injuries. Medical examinations determined that the injuries were caused by inflicted trauma; the injuries are the subject of ongoing criminal investigation.

1.2. Alex was open to Somerset Children's Social Care as a 'child in need' following a referral from Somerset NHS Foundation Trust who were caring for Alex following a premature birth at 31 weeks gestation. Alex was also an open case to Children's Social Care in another area at the time the injuries were identified. Alex's mother had moved to Somerset whilst pregnant to live with her new partner. Alex's birth father lived in the area that Alex's mother had moved from. There were professional concerns that birth father posed a risk of harm to children.

1.3. The statutory safeguarding partners decided to conduct a Child Safeguarding Practice Review (CSPR) to identify what can be learnt from how the safeguarding system responded to the issues in this case. The review has been facilitated by an individual who is independent of agencies in Somerset and of the other local authority area. The CSPR covers the period from when the hospital made a referral to Somerset Children's Social Care, when Alex was one day old, up to the date Alex presented at hospital.

1.4. In response to the referral made by the hospital, Children's Social Care commenced an assessment, and two strategy discussions were also held. At least two of the four agencies in attendance at the first strategy discussion understood S47 enquiries would be commenced; however, the assessment continued under S17 Children Act 1989. There is a lack of consensus about the outcome of the second strategy discussion. The perspective of every agency in attendance, other than Somerset Children's Social Care, is that the outcome was that a S47 enquiry would commence. The perspective of Somerset Children's Social Care is that the chairperson of the meeting agreed to discuss next steps with their line manager. This led to the hospital using the 'Resolving Professional Differences' protocol to explore the ongoing concerns they had for Alex. The day before the second strategy discussion, mother informed Children's Social Care that she had ended her relationship with her partner and was returning to live in the local authority area she had come from. This information underpinned a decision by Children's Social Care that no further safeguarding action was

needed from them and the case should be transferred to Children's Social Care in the other local authority area. The other local authority area agreed to complete a Child and Family Assessment.

1.5. Alex was discharged from hospital to the care of mother and they lived in the other local authority area for three days before returning to Somerset to live with mother's partner. During this period, and up to the point that Alex was taken to hospital, both local authorities' Children's Social Care services were involved and initially there was consideration of a strategy discussion being held when Alex returned to Somerset. However, this did not take place as it was decided that the case would be monitored intensively for a week and then be reviewed.

1.6. The CSPR has drawn on a range of information and sought to creatively engage the views of frontline staff during the global pandemic. Family members were invited to contribute to the review and where they chose to do so, their perspective has informed the analysis and learning. The review has adopted a systems approach by going beyond identifying what happened and exploring the context in which professionals and organisations operated. This approach helps identify the factors in the safeguarding system that support good practice and those which create unsafe conditions in which poor safeguarding practice is more likely to occur. These 'system' insights are in turn used to inform the actions that can be taken to prevent or reduce the risk of recurrence of similar incidents.

1.7. Agencies have 'self-identified' a small number of learning themes to take forward on a single agency basis. However, the majority of learning arising from this case is partnership learning, i.e. it is applicable to all agencies. There are five key learning themes which are summarised below:

- Understanding and defining levels of need/statutory thresholds. Future safeguarding practice will be strengthened by practitioners defining a child's needs rather than describing these as the numerical levels referenced in the Effective Support Framework; this will promote a more shared and consistent understanding of levels of need; including children identified as 'child in need'.

- Strategy discussions. Future safeguarding practice will be strengthened by improving the effectiveness of multi-agency strategy discussions.

- Embracing and resolving professional differences. Future safeguarding practice will be strengthened by practitioners and organisations recognising that differing professional views are an asset to multi-agency working particularly given what is known from research about errors in human reasoning. Valuing differing professional views will promote and strengthen the culture of partnership working.

- Case transfer. Future safeguarding practice will be strengthened by a clear process for transferring 'child in need' cases between local authority Children's Social Care services'.

- Culture of partnership working and shared accountability. Future safeguarding practice will be strengthened by developing the culture of partnership working and individual and collective accountability for safeguarding children.

1.8. Professional knowledge of safeguarding legislation, guidance and procedures, including in relation to the threshold and decision-making processes in relation to s47 enquiries, is a common thread running through the five partnership learning themes and thus provides an overarching learning theme.

1.9. Agencies began to act on learning following the Rapid Review held after Alex sustained the injuries; an overview of the improvement actions taken to date is provided. The review concludes with an action timeline to take forward the partnership learning; progress and impact will, in accordance with statutory guidance, be publicly reported in a future Somerset Safeguarding Children Partnership (SSCP) twelve-monthly report.

2. **Story prior to the incident and around the incident**

2.1 A referral was made by the Somerset NHS Foundation Trust in respect of professional concerns about birth father following his visit to the hospital one day after Alex's birth. The referral also outlined professional concerns regarding:

I. Mother recently moving to Somerset to live with a new partner who was 'unsure about the pregnancy and birth'

II. Mother's own childhood experiences

III. Mother's emotional health and wellbeing including treatment during pregnancy for anxiety.

2.2 The case was accepted as a 'child in need' referral by Somerset Children's Social Care and a Child and Family Assessment commenced. Early on, hospital staff were advised that the case did not reach a 'safeguarding threshold' as Children's Social Care had no concerns about mother. Mother had initially been advised to use the Child Sex Offender Disclosure Scheme (CSODS) to obtain information about Alex's father. The police considered that a CSODS disclosure would not address all the risks associated with the case and as a result a strategy discussion was convened. At least two of the four agencies in attendance understood that the outcome of the discussion was that enquiries would be completed under S47 Children Act 1989. This was because mother was not consenting to an assessment. A follow up strategy discussion was to be held 14 days later because the meeting concluded that further information was needed to determine if Alex was at risk of significant harm. This suggests that not all relevant information was available to the strategy discussion. The follow up strategy discussion did not take place as planned; the allocated Social Worker then went on a period of extended annual leave which meant the case was managed via a 'duty' system. Of note, this was during the Christmas and New Year holiday period when the service was operating with reduced staffing levels.

2.3 Following the first strategy discussion, staff involved in the care of Alex at the hospital identified concerns about the parenting capacity of Alex's mother as well as concerns about her partner. The concerns centred around mother's ability to prioritise Alex's needs and indicators of controlling behaviour exhibited by her partner. Information available to the hospital also included that mother's partner had threatened to kill maternal grandparents and he was not ready for Alex to come home and wanted mother to 'give' the child away. Mother, who was then aged 20 had, during her adolescent years, been subject of a Child Protection Plan due to neglect. Her younger siblings were currently subject of a Child Protection Plan due to neglect. Furthermore, domestic abuse between mother and maternal grandmother had been reported to the relevant police force; the most recent incident took place two months prior to Alex's birth. Records indicate both parties were under the influence of alcohol at the time of the incident. Due to depression and anxiety, mother had begun receiving therapy from adult mental health services about one year before Alex's birth; mental health services formally ended their involvement when mother moved to Somerset. Mother's partner was arrested for domestic abuse related offending eight months prior to Alex's birth. The victim reported that she had experienced domestic abuse over a

three-year period. Mother's partner subsequently pleaded guilty to Assault by Beating seven months prior to Alex's birth.

2.4 There were ongoing discussions between Children's Social Care and the hospital, with the hospital requesting that the follow up strategy meeting be re-arranged. The meeting was held on New Year's Eve when the usual council offices were closed, and staff did not have access to a dedicated and private workspace for such meetings. Taking a 'systems' perspective, the conditions an employer provides/creates are a key factor that influence how staff are able to perform their duties. This, of course, does not mean that offices should not be closed during holiday periods, but it does require organisations to consider the impact of such decisions and, as required, identify solutions, e.g. co-locate staff in a building owned by a partner agency or alternatively use virtual platforms to host meetings as a way of facilitating the participation of partner agencies.

2.5 By the time of the second strategy discussion, mother had shared with professionals that she planned to leave her partner and return to her previous address which would mean Alex and mother would live with maternal grandparents. The strategy discussion included most, but not all relevant agencies; notable omissions were the GPs for both parents who could have shared information to support the ongoing assessment. There is professional disagreement about the outcome of the second strategy meeting. All attendees other than Somerset Children's Social Care report that a decision was made to commence a s47 enquiry. Somerset Children's Social Care report that the chairperson agreed to discuss next steps with their line manager. It was also agreed that due to the concerns about mother's parenting capacity that Children's Social Care would explore a mother and baby unit for Alex and mother to live after Alex's discharge from hospital. After the meeting, Children's Social Care decided "no further action" as the outcome of the strategy meeting, a decision was also made not to pursue a mother and baby placement. The rationale for these decisions was that mother was moving out of the area. By the time of the Discharge Planning meeting held a few hours later, the Children's Social Care plan for Alex was for the case to be transferred to Children's Social Care in the local authority area where Alex and mother would live.

2.6 The decision not to complete a s47 enquiry raised significant concerns for the hospital and they requested a copy of the minutes of the second strategy discussion. At the time, strategy meeting minutes were not consistently sent to agencies who were invited/ in attendance and this meant that some of the other

partners who attended the second strategy discussion were not aware that a s47 enquiry was not being completed. From the hospital's perspective, the minutes did not reflect the discussion that took place as they record the outcome as 'no further action from this process'. The hospital escalated their concerns about the decision not to conduct a s47 enquiry using the 'Resolving Professional Differences' protocol. This resulted in discussions between the hospital and Children's Social Care, it was agreed a meeting would be held and the hospital were asked to refer Alex to Children's Social Care in the area to which mother was returning to live. This referral was initially not accepted as the other Children's Social Care understood that Somerset were conducting a S47 enquiry as agreed as per their understanding of the outcome of the second strategy meeting. However, due to the concern that Alex was 'mobile' and could fall between local authorities, the other local authority subsequently agreed to accept the referral and a Social Worker was allocated to complete an assessment. Prior to the other local authority deciding to undertake an assessment, the hospital and Somerset Children's Social Care met. The hospital perspective is that this meeting was held under stage two of the Resolving Professional Differences protocol. The professional differences about the plan for Alex ultimately remained unresolved. The hospital escalated their ongoing concerns to an Operations Manager in Children's Social Care, although the matter was not escalated to Senior Leaders within the hospital. The discussions between the Operations Manager and the hospital diffused the professional differences as the hospital were advised that the local authority where Alex and mother would live upon Alex's discharge would assume case responsibility and that Somerset Children's Social Care would conduct a home visit to Alex and mother that evening following discharge.

2.7 Alex and mother returned to live with maternal grandparents for three days before returning to Somerset to live with mother's partner. The allocated Social Worker in Somerset returned to work the day prior to Alex's return to Somerset. The assessment was concluded by the social worker on the day she returned and concluded that no further work was required from statutory social work services in Somerset as mother and Alex had moved out of the area. The social work assessment records Alex's assessed level of need as 'additional' or level 2 as set out in Somerset Safeguarding Children Partnership (SSCP) Effective Support for Children and Families in Somerset framework; however, information provided to the review indicated that level 2 was selected in error. The actual level of Alex's assessed need upon completion of the assessment is unclear.

2.8 Children's Social Care in the other local authority area allocated the case so a Child and Family Assessment could commence; in response, Somerset Children's Social Care advised that they would end their involvement.

2.9 Following Alex's return to Somerset, Children's Social Care established a schedule of expectations with mother which, amongst other things, required mother not to leave Alex alone with her partner. Mother was also requested to register Alex with a GP which she did three days after her return to Somerset; prior to this Alex was not registered with a GP. Somerset Children's Social Care and Public Health Nursing (Health Visiting) liaised and initially Children's Social Care indicated the plan was to convene a strategy discussion however, the following day, a decision was made to monitor the case intensively for one week with a view to 'step down' to the Family Intervention Service.

2.10 The Somerset Social Worker and the Public Health Nurse independently visited Alex at home and the Social Worker from the other area had phone contact with mother. Somerset Children's Social Care agreed with the other local authority Children's Social Care to take case responsibility now Alex had returned to Somerset. Seven days after returning to Somerset, Alex presented at hospital with serious and unexplained injuries

3. Application of relevant research, policy and other reviews

3.1. The subject child in this case was a young baby; Somerset Local Safeguarding Children Board (LSCB) has previously conducted Serious Case Reviews (SCRs) into the death/ serious harm of a number of very young children. The learning from these and other Serious Case Reviews, as well as research in relation to the key themes arising from this CSPR, are set out below.

3.2. Babies are entirely reliant on their parents/caregivers to keep them safe; a point highlighted by Ofsted's Chief Inspector to the Association of Directors of Children's Services Annual Conference in November 2020. The Children's Commissioner[1] has also highlighted younger children living in families where there are known vulnerabilities and risk factors are at greater risk compared to older children in the family. This is because very young children are fragile, cannot speak and, unlike older children, they do not attend universal services,

[1] A Crying Shame. A report by the Office of the Children's Commissioner into vulnerable babies in England. October 2018

such as education. This means that despite their increased vulnerability, they can be invisible to professionals.

3.3. Babies are disproportionately represented in SCRs[2] and research also provides a knowledge base to inform assessment and decision making. The risk of a child being abused within the first thirteen months of life is fourteen times higher when parents have been abused themselves as children, are under 21-years-old, have a history of mental illness or depression and are living with a violent partner[3]. Weak risk assessment and poor decision making were identified as a major practice theme by the Child Safeguarding Practice Review Panel in their first annual report [4] alongside poor escalation of concerns or disagreement between Children's Social Care services and practitioners from health and education. The National Panel also report that the professionals who know the most about a child are often not those who have statutory powers to investigate and assess thus reinforcing the significance of their finding about the critical importance of comprehensive risk assessment and defensible decision making.

3.4. SCR L & J[5], published in 2017 by Somerset Safeguarding Children Board, contains learning that is pertinent to the analysis of this CSPR and which is therefore still relevant to the Somerset Safeguarding Children Partnership. Key findings from SCR L & J include strengthening guidance on strategy discussions to provide clarity about when a face-to-face meeting should be held; standardising how decisions made at a strategy meeting are recorded and shared with those who participated and those involved in the case but unable to attend. Like the National Panel's annual report, SCR L & J also identified the significance of comprehensive assessment of need/risk in relation to babies and young children, including assessing the vulnerability of young parents.

3.5. Nationally, a number of SCRs have highlighted the vulnerability of children in need when their family moves between local authority areas[6]. Statutory

[2] Sidebotham et al (2016), Triennial analysis of serious case reviews. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennia l_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

[3] Risk factors of parents abused as children: a mediational analysis of the intergenerational continuity of child maltreatment (Part 1).' Journal of Psychology and Psychiatry 46, 1, 47–57. 2005. Dixon L., Browne K.D., Hamilton-Giacritsis, C

[4] The Child Safeguarding Practice Review Panel: First Annual Report. 1 Annual Report 2018 to 2019

[5] https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/retrieve2?SetID=68074A0F-81FD-473F-A519-176D16866D41&searchterm=somerset&Fields=%40&Media=%23&Bool=AND&SearchPrecision=20&SortOrder=Y1&Offset=2&Direction=%2E&Dispfmt=F&Dispfmt_b=B27&Dispfmt_f=F13&DataSetName=LIVEDATA

[6] Johnson, Fiona and Doherty, Jane (2017) Report of the serious case review regarding Child J. Luton: Luton Safeguarding Children Board

guidance[7] requires the original authority to share all relevant information with the receiving local authority as soon as possible. The receiving authority should, based on a timely re-assessment of the child's needs, consider whether support services are still required. Support should continue to be provided by the original local authority in the intervening period.

3.6. Statutory guidance[7] requires the safeguarding partners to publish a threshold document which sets out the local criteria for action in relation to children and families. The professionals involved in this CSPR have had the opportunity to reflect on the SSCP Effective Support for Children and Families in Somerset and have identified that at Level 4 there is a stronger emphasis on 'child protection' compared to 'child in need', e.g. the framework does not include a definition of 'child in need' as set out in the Children Act 1989. In addition, the descriptors of Level 4 need are more focused on children over one year of age.

3.7. The All-Party Parliamentary Group for Children Inquiry 'Storing Up Trouble: A postcode lottery of children's social care' has a range of findings that are relevant for statutory safeguarding partners to consider in both the development and oversight of the local threshold framework including:

I. Evidence that thresholds for accessing Children's Social Care are rising alongside differing perspectives between social workers and Directors of Children's Services about whether thresholds for accessing statutory services have risen.

II. Financial concerns and availability of resources at least implicitly influence decisions to intervene to support children and families.

3.8. It is important to state that this review has neither considered, nor identified, budget pressures as impacting on professional practice however, there is feedback from the practitioner survey, as well as those who contributed directly to the review, that:

a) Partner agencies consider that thresholds for accessing Children's Social Care have risen and this issue is an area of frequent professional debate and at times disagreement.

[7] Department for Education (DfE) (2018) Working together to safeguard children: a guide to inter-agency working to safeguard and promote the welfare of children (PDF). [London]: Department for Education (DfE).

b) Volume of work in the relevant Children's Social Care team was experienced as high during the period when Alex was discharged from hospital. Staff absence over the holiday period will also have been a factor as cases needed to be managed via a duty system.

3.9. Research and learning on thresholds can therefore highlight system conditions that can helpfully be explored at a local level to understand the context in which professionals are operating including how decision making may be influenced by these factors.

3.10. Research into patterns in human judgement/reasoning draws attention to the psychological limitations of human beings and how these can negatively affect thinking and reasoning. Given the assessment of safeguarding needs is reliant on the exercise of professional judgement, the findings from this research reinforce the value and importance of supervision and multi-agency working as tools that can be used to appraise the accuracy of an individual's thinking or, in the words of Professor Munro[8], 'good reasoning is the responsibility of the whole agency and not the individual'. Common errors in human reasoning include tunnel vision[9] which is the tendency of people under pressure to narrow down their focus as a means of making the task manageable. This has the benefit of allowing professionals to stay focused on one part of a case but has the weakness of making them slow to notice issues arising outside that narrow focus. In this case, it has been identified that the focus of the first strategy discussion was on the risks posed by birth father as opposed to a wider assessment of Alex's needs. This 'tunnel vision' impacted on subsequent decision making in that an assessment of mother's parenting capacity had not been completed prior to Alex's discharge from hospital or case transfer.

4. Single agency learning and conclusions.

4.1. The organisations that contributed to this CSPR are set out overleaf in Table 1 alongside a summary of the key learning identified for their organisation based on their reflections of this case. Agencies also identified learning in relation to inter-agency working. There was a high level of congruity in the learning themes

[8] E.Munro 2008 "improving reasoning in supervision" Social Work Now, Issue 40, August 2008, pp3-10.

[9] S.Dekker (2002), The Re-invention of Human Error Technical Report 2002 -01, Ljungbyhed, Sweden: Lund University, School of Aviation.

that partners identified that need to be taken forward across the partnership. These are set out at Section 5.

Table 1

Agency	Key learning	What needs to happen	Evidence the organisation will use to test that learning has been embedded
Somerset Children's Social Care	Consistency of social worker to co-ordinate holistic and purposeful assessment of parenting capacity. Robust supervision and management oversight to support social workers to reflect on progress of assessment and consider likelihood and severity of risks as well as strengths and protective factors.	Clear management oversight upon allocation and review of this at any key points such as worker absence or change in family circumstances. Provide high quality reflective supervision training for all supervisors – this is mandatory for those who have not had recent supervision training. Systemic training is also available to managers to support the quality of analysis and reflection within supervision. Motivational interviewing training to be rolled out to support staff and managers to work in a strengths-based way.	Bi-monthly Practice Evaluations (case file audits) will consider the quality of assessments, management oversight and consistency of social work intervention. Outcome of audit of supervision in April 2021.
Avon and Somerset Police	Police Officers, like other professionals, should escalate their concerns about the action or inaction of another agency where	Through the launch of the new process for Police Protection Powers, review the use of, and publicise, the Resolving Professional	Audit use/application of Resolving Professional Differences Policy/ Procedures as part of the evaluation of

	they consider that a child remains at risk of significant harm.	Differences policy/ procedures across the Avon and Somerset region.	wider Police Protection Powers process.
Other Local Authority	Contemporaneous and comprehensive recording of discussions, plans and agreed actions for safeguarding and promoting the welfare of children, including discharge from hospital. For children discharged over weekend/holiday period, this information becomes more critical if EDT are to be notified or are contacted.	Dedicated reflective learning event related to the findings from this CSPR will be held with multi-agency staff in the MASH with particular emphasis on the quality and depth of recording when case responsibility is not clearly held at transition points.	Audit of cases where children are discharged out of hours to assess the handover to day services. Audit of cases where there is cross-boundary referral to assess the quality of planning and handover of responsibility. General dip sample audit to test the quality of "whole episode" recording.
Somerset NHS Foundation Trust	When recording concerns about a child, the nature of the concern and an evaluation of <u>its impact</u> on the child's safety and wellbeing should be recorded rather than simply a description or narrative of what constitutes the concern. Greater use and understanding of Effective Support for Children and Families	Develop a) Neonatal Intensive Care Unit (NICU) safeguarding document integral to this should be a patient/service user risk assessment tool documentation to promote clarity and analysis of level of need including risk and protective factors. Integrate the Effective Support for Children	Audit of: - a) NICU clinical records b) NICU safeguarding document Safeguarding Supervision Audit Use of Effective Support for Children and Families in Somerset guidance audit. Review of Resolving Professional Differences escalations. S11 Audit

	in Somerset guidance to support a wider understanding of concerns/needs between agencies as well as with families.	and Families in Somerset guidance within Trust Polices, Standard Operating Procedures, Safeguarding Supervision, L3 Training and referrals and reports for Children's Social Care.	Review of serious incidents to evaluate use and application of Effective Support for Children and Families in Somerset guidance. Use of situation, background, assessment and recommendations (SBAR) tool by Safeguarding Service.
Somerset Public Health Nursing (PHN)	Health Visitors, once aware of a baby's admission to NICU, to participate in regular liaison with the family and NICU to build a relationship with the family and to contribute to assessments of the child's needs and subsequent service planning.	Confirm and disseminate the process for timely notifications from NICU to the PHN Service for babies that are in NICU. Develop and disseminate a narrative to inform Health Visitor (HV) contact and assessments for babies in NICU to include weekly contact with parents and NICU in addition to core contacts. Health Visitors once aware of a baby's admission to NICU to participate in regular liaison with the family and NICU to build a relationship with the family and to contribute to	Agreed process for NICU to inform PHN of babies admitted to NICU. Number of incident reports where a health Visitor has not been notified of a baby's admission to NICU. Compliance with weekly and mandated core contact for babies in NICU. Audit of clinical records to monitor assessment of need and service planning (completed as part of annual record keeping audit).

		assessments of the child's needs and subsequent service planning.	
Somerset and other area CCGs	GP registration questionnaires to capture information about vulnerability (NB this links to learning from a previous SCR where a looked after child from another area placed in Somerset died). Explore known risks and vulnerabilities when a woman becomes pregnant/ gives birth and further develop awareness and application of pre-birth safeguarding protocol/ standard operating procedure.	Discuss with GPs and Local Medical Committee (It is recognised this is a complex piece of work as the registration form is not a national form). Named GPs for Safeguarding Children in Somerset and other Local Authority area to use the learning from this case to support exercise of professional curiosity, identification of risk/vulnerability factors and application of pre-birth safeguarding protocol.	Change to registration form and evidence of its use across Somerset and practice (this may take some time to fully achieve). Deep dive/audit, in conjunction with Public Health Nursing, to evaluate use of pre-birth protocol where safeguarding concerns have been identified.

4.2. The learning that will be taken forward within individual agencies will support them to deliver their statutory responsibility to safeguard children by strengthening capacity to:

- Contribute to and/or co-ordinate assessments.
- Exercise professional curiosity.
- Explore and challenge professional thinking and decision making.
- Build relationships with parents/carers.
- Evaluate need/risk.
- Develop plans to promote children's safety and well-being.

5. Partnership Learning and conclusions

5.1. The analysis of multi-agency safeguarding practice in this case identifies five learning themes, with a sixth, professional knowledge of safeguarding legislation, guidance and procedures, underpinning all five themes. These learning themes have wider application and can therefore be used to improve future multi-agency safeguarding. They are set out at Table 2 below.

Table 2

Learning Theme	Why did the review identify this learning theme?
Understanding and defining levels of need/statutory thresholds: - The analysis of this case and the findings from the practitioner survey completed as part of this CSPR, and discussions with partner agencies, indicate that there is further work to do to ensure a shared and consistent understanding of levels of need; including children defined as a 'child in need' in accordance with Children Act 1989.	1. In this case, the level of assessed need changed significantly and rapidly with likely or actual risk of significant harm being considered but a safeguarding response was not progressed as the level of need was then re-evaluated. To illustrate, a 'schedule of expectations' was put in place to manage risk however the following day, the professional thinking was to manage the case at Early Help level of need. The difference of opinion amongst professionals about Alex's level of need following the second strategy discussion is an example of the needs of the child not being clearly defined and agreed. The review found that professionals currently use numerical 'levels', e.g. 'Level 4', to describe a child's needs rather than describe the concerns and critically, the impact of these on the child's health and development. This practice will impede a shared understanding of the needs of individual children and families amongst professionals. A lack of clarity about a child's needs will in turn impact on the quality of decision making. 2. A local practice norm appears to have been established whereby 'Level 4, currently described as 'acute' in the Effective Support Framework, is perceived as 'child protection' as opposed to a level of need that requires a statutory social work response. The review found limited understanding of the legal definition and statutory duties in relation to 'child in

	need'; this is reinforced by the limited focus on 'child in need' in the Effective Support Framework. In this case, the local authority determined at the outset that there were no concerns about mother that met a 'safeguarding threshold'. The focus in the first strategy discussion on the 'child protection' risk that father presented appears to have resulted in 'tunnel vision' and so a limited focus in the Child and Family Assessment on the broader risk factors that had been identified in relation to mother's parenting capacity. 3. Family member contribution to the CSPR reinforces the need for practitioners to think holistically and define the needs of a child. In situations where a parent is considered to present a risk to a child, an assessment of the child's need for safety, right to family life, protective factors, including the impact of any rehabilitation programme in managing risk, is a more appropriate response to securing a child's welfare than offering advice that no contact should take place between a child and a parent who is considered to pose a risk.
Strategy Discussions: - The analysis of this case, previous SCR learning and a multi-agency audit completed in November 2019, indicate that there is further work to do to improve the effectiveness of multi-agency strategy discussions.	1. <u>Invitations</u> – Not all relevant agencies were invited to contribute to strategy discussions; this has been identified in previous local SCR learning and audit activity. There is a need to increase understanding of the health system to move away from the current practice of one health professional being invited to represent 'health' and for the GP for both child and parents/carers to be routinely invited. 2. <u>Organisation</u> –The chairing and minuting responsibilities rest with one individual. Ideally these tasks should be separate to allow the chair to focus on facilitating the meeting. There is an inconsistent approach to distributing the record of the strategy discussions to those agencies in attendance/invited, with most partners in this and other cases, not receiving the record of the meeting. This was significant in this case as it meant that some partners were not aware a s47 enquiry had not commenced following the second strategy meeting. The working environment in the lead agency during the holiday period did not provide the conditions conducive to a good quality strategy discussion. The review has identified that a

	creative solution would be to co-locate staff during office shutdown in a suitable office environment in another partner agency or to use a virtual platform to host such meetings. 3. Structure – There is a need for a consistent approach to the conduct of strategy discussions, including explicit consideration of the significant harm threshold. It has been suggested that strategy discussions in respect of cases held in the First Response Team are more structured because this team has dedicated staff who regularly participate in strategy discussions. Effective strategy discussions require practitioners to have the required level of knowledge and confidence to contribute as required. In addition, partner agencies should provide the *context* to information held on their records, e.g. nature and details of offences committed in addition to conviction details or the impact of compromised parenting on the child's health and development. 4. Decision making – strategy discussions should conclude with clear actions, timescales, and decision making, including the rationale for decisions made in respect of actual or likely significant harm. This is because action taken under S47 Children Act, 1989 can only be effective if it is clear, purposeful and timely. Defining why or why not the actual or likely significant harm threshold is met provides a shared framework to inform the scope of the S47 enquiry/Child & Family Assessment, future decision making and clear parameters to explore any future professional differences. 5. Governance – In this case, there is a lack of consensus about the outcome of the second strategy meeting and Somerset Children's Social Care determined 'no further action' as the outcome of the strategy meeting. In the future, and as required by statutory guidance, any decision as to whether to conduct a S47 enquiry or not, should be made at a strategy discussion, involving all relevant partners.

Embracing and Resolving Professional Differences: - The analysis of this case and the findings of the practitioner survey completed as part of the CSPR indicate there is further work to do to support organisations and professionals to embrace 'difference' as an opportunity to share expertise, evaluate need/risk and promote a culture of shared accountability.	1. The fifth learning theme for the partnership is in respect of the culture of partnership working (see page 19) or in other words 'how' partners work together. Research provides insight into the common errors in human thinking. Nobody is immune from making such errors and in fact, busy work environments could make them more likely. Respecting different disciplines, involving all relevant professionals and working through any differences of opinion promotes good safeguarding decisions and outcomes. This approach will maximise the capacity of the partnership to safeguard children and should mean that use of 'formal' resolution processes become the exception because the cultural norm is one of mutual engagement and cooperation to deliver the common purpose of safeguarding children. 2. There is also learning from this and other cases in relation to when professionals do need to use a formal process to resolve differences. Professionals responding to the practitioner survey reported varied experiences of using the Resolving Professional Difference protocol. Positively, most professionals knew about the protocol; however, those who had used the process, had mixed experiences of its effectiveness. Some of the feedback includes a perception that its use could create a barrier to positive working relationships, and it is a time consuming/ bureaucratic process. This feedback is again relevant to the culture of partnership working. Enablers to the effective use of the protocol were identified as agencies being reflective and open to differing perspectives and recognition that use of the professional difference protocol does not equate to criticism of another professional. In addition, the CSPR has identified that the language used in the document, i.e. 'challenger' and 'challenged', could convey a message that the process is adversarial as opposed to one that is designed to promote good safeguarding outcomes. 3. There were three factors that informed the use of the Resolving Professional Difference Protocol which are set out below; they remained unresolved despite the use of the Protocol:

	i. Different understanding about the outcome of the second strategy meeting. ii. Concerns about how safe Alex would be if discharged into mother's care. iii. The accuracy of the record of the second strategy discussion. Despite the use of the Resolving Professional Differences protocol, there was no multi-agency reconsideration of Children's Social Care's decision not to complete a S47 enquiry, there was no plan in place to support mother to care for Alex upon discharge and the record of the second strategy discussion has not been updated to reflect the professional difference about the outcome of the meeting. If Alex's needs had been more clearly defined by partner agencies at the strategy discussions, it is considered that the concerns in relation to decision-making could have been more effectively explored and resolved by partners. 4. In addition, there were gaps in the application of the protocol in this case, e.g. no manager from the agency receiving the challenge attended a meeting to explore the professional differences and there was no further escalation within the organisation making the professional challenge. Furthermore, when the matters were not resolved at stage two, the case did not formally progress to stage three and instead, further discussions took place at stage two. This indicates further work is needed to increase professional knowledge of the protocol. It is considered that the protocol would be enhanced by providing guidance on the roles of those who should be involved at the various stages of the protocol. In light of learning from this and other cases, the SSCP, in conjunction with practitioners, is reviewing the Resolving Professional Differences protocol. They may, given the feedback from practitioners, wish to take the opportunity to also review the timescales set out in the current version of the protocol as there may be times when there is a need to resolve issues sooner than the timescales that are currently prescribed in the protocol.

Case Transfer Protocol: - The analysis of this case indicates that there is a need for a clear process for transferring child in need cases between local authority Children's Social Care services.	1. In this case, the decision to transfer the case to the local authority covering the area where Alex and mother would reside after Alex's discharge was based on the fact that Alex would not be residing in Somerset as opposed to the Child and Family Assessment being completed in full. This decision was made immediately after the second strategy discussion. However, the minutes of the second strategy meeting indicate that further information was required from Police and record the professional concerns of the hospital, Police and Children's Social Care about Alex being discharged to mother's care at maternal grandparents' home. 2. Feedback to the review was that it 'felt like there was something missing' from the assessment. To illustrate, it was through the rapid review process initiated in response to Alex being seriously harmed that the full extent and nature of the domestic abuse concerns about mother's partner were identified. Assessments, informed by information held by and the expertise of all partners, should be completed in full by the original authority to identify needs prior to case transfer. Family member contribution to this review reinforced this learning point, in particular for known risk indicators to inform decision making. 3. The SSCP Children Moving Across Local Authority Boundaries procedures covers child protection cases, however, it does not address 'child in need' cases. Guidance on this issue will assist all agencies to understand the process to follow when cases are transferred between local authority areas because children move out of the area. 4. The case transferred without determining a date of transfer of responsibility and led to two local authorities having open cases with both making contact and arranging visits to Alex. This is confusing for children and families and results in a lack of clarity about case responsibility.

Culture of partnership working and shared accountability: - The learning theme that supports all the learning arising from this CSPR is in respect of the culture of partnership working and shared accountability for the partnership's common purpose of safeguarding children. The review reinforces that shared accountability needs to operate at an individual, organisational and system level.	1. This case, like any other, illustrates that the 'way' partners work together is equally and arguably more important than the processes that are in place to promote the safety of children. Whilst the local authority is the lead agency in terms of safeguarding activity, all partners have a responsibility to assess need, to contribute to decision-making and to provide interventions to children and families. When exploring the culture of partnership working in Somerset, one comment made was 'partnership is meant to be joint, some people are more equal than others'. Whilst this is feedback from one individual, it serves as a powerful reminder, that the way partners work together is fundamental to how safeguarding services are delivered and so their effectiveness. The multi-agency CSPR Panel have positively identified that a future focus on developing the culture of 'partnership working' will have a greater impact improving practice and outcomes than purely focusing on 'process' focused actions. The reviewer considers that this insight and openness is refreshing and ambitious. 2. In terms of shared accountability, the review identified that, in this and other cases, a decision to proceed to S47 enquiries appears to provide a sense of security for partner agencies that a child will be safeguarded through this process and by Children's Social Care. S47 enquiries and Child and Family Assessments, whilst led by the local authority, require the planned contribution of relevant agencies; for s47 enquires, this should be agreed at a strategy meeting. The local assessment protocol addresses the need to plan for and secure the contribution of all relevant partner agencies to Child and Family Assessments. The review debated the extent to which a 'refer on' mindset exists amongst professionals and organisations; and how a cultural change programme could promote greater shared accountability for individual children and families and across the system. As a result of the reflection on this case, a Partnership Forum will be held to explore how partners work together and the experiences of children and families who receive help; this is a positive

	action, as is the intention to use expertise from other partnerships to shape and inform this work. 3. In terms of organisational accountability, employers have a responsibility to ensure that their staff are knowledgeable about, and can apply, safeguarding law, statutory guidance and procedures. There were examples in this case, reinforced by those professionals who contributed to the review, that there are gaps in relation to knowledge in these areas, e.g. S47 enquiry to be completed as mother not 'engaging' as opposed to the threshold for significant harm (actual/likely) is met. There is also learning for organisations about the environment that they provide for their staff, e.g. reflective supervision. The dissemination of learning from this CSPR provides an opportunity for organisations to review what else they can do to support practitioners to have the knowledge, tools and environment needed to support good safeguarding outcomes. Regular engagement with practitioners, especially at a partnership level, will provide the opportunity for the safeguarding leaders to be sighted on the experiences of frontline staff. *4.* Finally, the statutory safeguarding partners, in their strategic leadership role, have a collective responsibility to oversee continuous improvement of the safeguarding system. An audit of strategy discussions completed in November 2019 identified similar learning to that identified by this review. This finding provides statutory partners with the opportunity to reflect on how learning from audits, and possibly learning from serious incidents, has been/is being used. Statutory partners could also explore the arrangements to evaluate the impact of training on professional knowledge and practice given the overarching learning theme identified by the review.

6. Learning already implemented

6.1. The CSPR has identified a range of activity that has been initiated in response to the incident that led to this CSPR including:

- Establishing multi-agency pre-birth tracking meetings.
- Reviewing the pre-birth toolkit; including discharge planning meetings.
- Determining a timeframe (24 hours) for the distribution of strategy meeting minutes.
- Public Health Nursing and Somerset NHS Foundation Trust have devised a process to confirm strategy meeting minutes have been received and reviewed by those who were in attendance.
- Public Health Nursing and Somerset NHS Foundation Trust are developing health-specific strategy meeting guidance.
- Review and update of the guidance and templates for strategy discussions for Children's Social Care professionals and a workshop with Children's Social Care management group to support good practice.
- Practice evaluations to explore Children's Social Care practice in relation to children under two years of age.
- Multi-agency supervision provided by Children's Social Care Quality Assurance Lead, Public Health Nursing, Somerset NHS Foundation Trust and Midwifery Named Nurses for safeguarding children; in due course, the Named Doctor from Somerset NHS Foundation Trust will also be involved in this collaborative arrangement.
- Development of a module-based workbook to help professionals focus their intervention when working with families where there is an unborn baby or infant.
- Discussions between CCG and Children's Services to develop an approach to invite GPs to all strategy discussions have commenced.

6.2. At the time of writing, it is several months since Alex was injured and it is recognised that evidence of the impact of the above activity will be, at best, in its

infancy, as time is needed to both embed and evaluate new ways of working. SSCP will in due course need to determine the most appropriate way to seek and provide assurance about the impact of single agency learning.

7. Action timeline for implementation of learning and development.

A focused set of actions to take forward the learning has been developed by agencies in Somerset as part of this review. They are set out below along with proposed timeframes:

1. Strategy discussions

a) SSCP Strategic Plan to reflect strategy discussions as a strategic improvement priority for 2021-22 and to include outcome measures to evaluate the impact of work completed.

Leads - Chair of Partnership Business Group/SSCP Business Manager
Deadline - 31/03/2021.

b) Multi-agency task and finish group to develop a revised strategy discussion process including:
   (1) Template for recording the outcome; including the agreed contribution of partner agencies to any assessment of need/risk.
   (2) Invitation lists.
   (3) Template for record of the strategy discussion and timeliness of its distribution.
   (4) Arrangements and circumstances for dedicated minute takers to record strategy discussions.

   Lead – Head of Assessment and Safeguarding, Children's Social Care
   Deadline – This work is already in progress, deadline for completion is 31/03/2021.

c) Develop a webinar that supports front line practitioners to have the knowledge and confidence to effectively contribute to strategy discussions.

Lead - SSCP Training Manager with support from Workforce Development Group.
Deadline - 30/04/2021.

d) Evaluate the impact of improvement activity in respect of strategy discussions.

Lead – SSCP Training Manager – evaluation of impact of learning and development opportunities.
Lead – Chair of Quality and Performance Subgroup

Deadlines – evaluation of impact of learning and development opportunities to begin on roll out of learning and development - May 2021 onwards.
Multi-agency audit to evaluate quality and effectiveness of strategy discussions to be completed by the end of March 2022.

e) Somerset Children's Social Care to provide learning opportunities for managers within the service to support them to chair and minute strategy meetings effectively.

Leads - Head of Service, Quality Assurance, Children's Social Care/Head of Assessment and Safeguarding, Children's Social Care.
Deadline - This work forms part of an ongoing rolling programme for managers, deadline for completion is 30/11/2021.

2) Levels of need/statutory thresholds

a) SSCP Strategic Plan to reflect Effective Support for Children and Families in Somerset guidance as a strategic improvement priority for 2021-22 and to include outcome measures to evaluate the impact of work completed. The focus of this priority should be on defining the needs of children and families and understanding the extent to which there is shared understanding of levels of need and how assessment of need is used to inform decision making and step up/step down activity by all partner agencies.

Leads - Chair of Partnership Business Group/SSCP Business Manager plan.
Deadline - 31/03/2021.

b) A multi-agency task and finish group to be set up to review the Effective Support for Children and Families in Somerset guidance, to include a focus on needs not thresholds and to expand on the definition of child in need.

Lead – Chair of Partnership Business Group.

Deadline – 31/03/2021 to establish group; 30/12/2021 to revise the Effective Support for Children and Families in Somerset guidance.

c) Use local protocol for assessment to support the implementation of the practice learning in relation to planning and securing the contribution of all relevant partner agencies to assessments completed under Section 17 and 47 of Children Act, 1989 .

Lead – Chair of Learning and Improvement Subgroup supported by Independent Scrutineer.
Deadline – 30/04/2021 for discussion at Learning and Improvement Subgroup. 30/06/2021 for work to increase knowledge of local protocol for assessment.

d) Create opportunities for frontline practitioners to learn/reflect on 'real' cases including the benefit of multi-agency collaboration in making decisions. e.g. Multi-Agency Professional Interest Groups (MAPIGs).

Lead - Chair of Workforce Development Group.
Deadline - 31/05/2021

e) The Somerset Safeguarding Children Partnership to create opportunities for multi-agency case review involving safeguarding children supervisors/ safeguarding leads, with a focus on reviewing real life cases and learning from good practice, e.g. safeguarding conversations.

Lead - Chair of Learning and Improvement Subgroup
Deadline - 31/05/2021

3) Professional understanding of the health system

a) Statutory partners to agree a programme of activity to develop a shared understanding of the different components of the health system and the contributions they can each make to information sharing, assessment and decision making; this should include emphasising the pivotal role of GPs.

Lead - Chair of Health Safeguarding Children Partnership, supported by a range of multi-agency partners as part of a workshop approach.
Deadline - 30/03/2021

4) Embracing professional difference

a) Statutory partners, in conjunction with frontline practitioners, to revise the Resolving Professional Differences protocol and co-produce with multi-agency practitioners the principles that should underpin the use of the protocol.

Lead - SSCP Business Manager
Deadline - 31/03/2021

5) Case transfer

a) Statutory partners to share the learning about transferring child in need cases with the Avon and Somerset Strategic Safeguarding Partnership and explore the development of a South-West region 'child in need' case transfer protocol.

Lead - Chair of SSCP Executive
Deadline - End of April 2021 to present to Avon and Somerset Strategic Safeguarding Partnership; subsequent actions and deadlines to be agreed by Avon and Somerset Strategic Safeguarding Partnership.

6) Culture of partnership working.

a) Recognising that cultural change is achieved over a sustained period, statutory partners through a weeklong Partnership Forum to explore the system conditions, including infrastructure, that will lead to strengthened partnership working and a shared accountability for improving outcomes for Somerset's children at all levels of the system. The outcome of the Forum should inform a cultural change programme which will involve all partner agencies.

Lead - Chair of Partnership Business Group
Deadline - June 2021.

February 2021