Local Child Safeguarding Practice Review

‘Alvah’

Author: Sam Page

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Overview

This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Wandsworth Safeguarding Children Partnership (WSCP) following the presentation of Alvah, a male 3-month-old baby at a South London hospital in August 2020. Alvah was brought to the hospital by his mother, Ms M, due to swelling in his left leg. Examination revealed facial bruising and fractures to the tibia and foot and skeletal survey confirmed no further fracture or soft tissue injury. Professionals concluded that the injuries were possibly caused by non-accidental injury (NAI). Alvah, and his 20-month-old brother Rafa, were immediately subject to Child Protection procedures and placed in foster care.

The report identified three key findings:

1. The reasons are believed to vary between individuals but safeguarding professionals struggle to hold babies in mind when identifying vulnerabilities and risks, particularly those who are non-mobile and too young to speak for themselves.
2. There is no standardised approach to information sharing between urgent care, and primary care and community services, resulting in an associated risk of significant information being lost.
3. When a family is mobile between boroughs, the histories of its members is lost too easily.

Conclusion

The review highlighted that professional practice should remain child and outcome focussed. It acknowledged that working with the complex issues of child protection requires professionals to be constantly vigilant, curious and caring. Parents who have had adverse childhood experiences themselves and who often respond negatively to the best efforts to help them, require high degrees of professional competence and support.

The need for improved practice has been recognised by the relevant agencies and restorative actions taken under the oversight of the WSCP. This consisted of re training, policy updates for non-mobile children, and on-going work on the issue of human factors that influence professional behaviour.

1 Outline of the case

1.1 Summary

August 2020 Alvah was taken by his mother to the Emergency Department (ED) at Lewisham Hospital due to swelling in his left leg. His mother told ED clinicians that Alvah had had his routine childhood immunisation 4 days earlier and seemed to be crying more than normal. She had noticed 3 days earlier that Alvah was not moving his left leg very much and when it was touched, he was in pain. On the 19th of August she noticed swelling in his leg.

Following the examination, the following injuries were recorded:

- Facial bruising
- Fractures to the tibia and foot

Skeletal survey confirmed no other fracture or soft tissue injury and the absence of callous' suggested that the tibia fracture was recent. Ms M was unable to provide an explanation for the injuries and health professionals concluded that the injuries were possibly caused by non-accidental injury.

A strategy meeting was held, and care proceedings initiated to safeguard the children who were both placed in foster care. A police investigation is on-going.

1.2 Family composition & anonymisation

Anonymised Name	**Relationship**	**Heritage**	**Age at event**
Alvah	Subject	White North African	3 months
Rafa	Brother	White North African	20 months
Ms M	Mother	White North African	
Mr D	Father	North African	

1.3 Pen portrait

Ms M had a history of mental health difficulties, a period of homelessness, and her relationships with her family had at times been challenging. She moved between boroughs and attended different hospitals during her pregnancies in the early months of the children's lives.

At the time of his injuries, Alvah was living at a property in Wandsworth with his mother and his older brother, Rafa, who was 20 months old. The children's father was also living in the home, although his relationship with Ms M, going back to the time of her pregnancy with Rafa, was unclear and little was known about him.

Both children sustained minor injuries in their first few weeks of life. Rafa was taken

twice to the GP and once to ED by the time he was 5 months old. Alvah had also been taken to ED at 5 weeks old, before his attendance in August 2020 with significant injuries. None of these incidents was considered to have reached a threshold of concern that required action.

When they were brought to health professionals, following what were reported to be minor accidents, their injuries were not identified as significant. Information was not shared between the GP and the health visitor, and the ED liaison information was not followed up by either service.

Ms M was mistakenly placed on the 'universal' health visiting caseload in Wandsworth and so was not receiving an enhanced service with a named health visitor, as would have been expected as this was due to the health visitor information from Lewisham not being shared with the Wandsworth health visitor.

Ms M presented very late in her pregnancy with Alvah and then changed hospitals. She was not 'tracked' across maternity services to ensure that she had booked with the new unit, and her subsequent antenatal and postnatal care was impacted by the evolving Covid-19 pandemic response.

2 Methodology, expertise, and independence

Aims:

The aim of the review was to identify:

- **Case findings**: judgements about the handling of a case, identifying what went well and where practice was poor
- **Systems findings**: explanations for why things have happened, identifying generalisable learning about enablers or barriers to good practice that have influence beyond the single case
- **Questions for consideration:** questions which focus on what to do to tackle systems findings, and minimise the reoccurrence of similar case findings

Methodology:

A hybrid model was used which incorporated the SCIE Learning Together principals, alongside some Review in Rapid Time processes. The report focuses on key findings identified during the process, and the system challenges underpinning them.

Process:

- The Panel consisted of senior leaders from each of the organisations who had contact with the family during this period and met 7 times to review progress.
- A full chronology was collated and analysed by the review team, and 3 key practice episodes identified.

- For each of these time periods, a set of areas for discussion were described with the aim of supporting a curious approach to engagement with practitioners.
- A well-attended practitioner event used these discussion questions to draw out an understanding of the circumstances in which decisions were made, i.e., the 'view from the tunnel.'
- The review panel used these insights to draw out key findings and questions for the Wandsworth Safeguarding Children's Partnership (WSCP) to consider.

The chair offered to meet with the children's parents to understand their experience of accessing services and support. Unfortunately, they did not accept requests to meet during the writing of the report and prior to publication, so their views are not available to inform the learning from this review.

Review Team:
The writing/review team consisted of the following professionals who have had no previous or direct involvement with the case:

- Head of Safeguarding St George's University Hospitals NHS Foundation Trust
- Associate Director of Safeguarding, Central London Community Health NHS Trust
- Named Nurse, Central London Community Health NHS Trust
- Head of Service Safeguarding Standards, London Borough of Wandsworth

Supervision, Oversight, and Independence:
Independent supervision was provided by an experienced SCIE reviewer, with oversight and scrutiny from the WSCP chair.

3 Case Findings, System Findings, and Questions for the Board to Consider

This section contains the priority findings from this LSCPR, including references to key examples from the work done with Alvah's family. Recommended actions in response to each finding are set out for consideration by WSCP.

Key Finding 1
There are systemic barriers to holding small babies in mind and 'hearing their voices' when identifying vulnerability and risk, particularly babies who are non-mobile.

Key Finding 2
There is no standardised approach to information sharing between urgent care and primary/community services, resulting in the potential for significant issues to be missed.

Key Finding 3
The history of the family can be lost when situations change, particularly when a family is mobile between boroughs.

3.1 Key Finding 1

There are systemic barriers to holding small babies in mind and hearing their voices when identifying vulnerability and risk, particularly babies who are non-mobile.

Hearing the voices of preverbal young children requires professionals to be curious and imaginative in order that their lived experience is not ignored or overlooked.

National guidance from the National Institute for Health and Care Excellence (NICE), 2009, updated in 2017[1], states that clinicians should suspect maltreatment if they observe bruising in a child who is not independently mobile, and includes the consideration of inadequate supervision as an indicator of neglect.

This review has found that practitioners continue to lack the appropriate level of inquisitiveness about what might be happening in a child's life.

How did the issue manifest itself in this case?

Due to the ages of Alvah and Rafa they were unable to speak and let others know what was happening to them. They were dependant on their care givers to understand their needs, be able to interpret their behaviours and provide appropriate and responsive care.

When seen by health professionals following reported minor accidents at home, Alvah and Rafa had no significant injuries which would be an obvious indicator of abuse. There appears to have been little consideration of the family history or context, and no consideration of the possibility of domestic abuse, with the result that a threshold for discussion with the health visitor or referral to Children's Social Care was not reached.

How do we know this is an underlying issue?

In the 2021, Child Safeguarding Practice Review Panel Fieldwork report: National Review of Non-Accidental Injury in under ones[2], the reviewers found evidence from the fieldwork that policies and procedures on bruising and marks in non-mobile infants are still not always followed by practitioners.

[1] Child Maltreatment: when to suspect maltreatment in under 18s, NICE, 2017
https://www.nice.org.uk/guidance/cg89
[2] The Child Safeguarding Practice Review Panel, 2021
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017227/National_Review_of_Non-Accidental_Injury_in_under_1s.pdf

This has been reflected in several reviews from across England. In 2020, reviews into the deaths of Baby L, Child K, Child A, and Child S[3] included recommendations to review procedures regarding the response to injuries to non-mobile babies, having found a lack of awareness of, or adherence, to safeguarding procedures.

System Challenge Questions for the WSCP to consider:

1. Is WSCP assured that practitioners know what to do in response to a pre-mobile baby with injuries?

2. Is WSCP confident in primary and urgent health care processes for identifying children who may have been abused?

3.2 Key Finding 2

There is no standardised approach to information sharing between urgent care and primary/community services, and to primary care triage of the information as it comes in.

Information regarding contacts with acute health providers will routinely be shared with the patient's GP, often via automated systems, meaning that GPs hold a unique oversight of their patient's engagement with a range of health services.

In the case of children, information regarding hospital attendance may also be shared via a system referred to as 'paediatric liaison.' This process is used to flag children who may be vulnerable due to the nature of their attendance, their circumstances, or because of their young age, and who may need to be followed up by primary or community services.

However, different hospitals identify their own thresholds and timeframes, and in an area like Wandsworth, providers of primary and community healthcare may work with multiple hospitals, meaning that they may receive inconsistent types of information about children.

In addition, different GP practices will triage and manage information in their own way, with no standardised approach as to who has clinical oversight of information as it comes in.

These variable processes, both within and between organisations, mean that there is the potential for significant issues about vulnerable children to be missed.

How did the issue manifest itself in this case?

[3] NSPCC National case review repository NSPCC Library Online

Having already been brought to the GP twice following reported accidents, Rafa was taken to the Emergency Department, following another accident. This information was shared with the GP practice via the paediatric liaison service but was not reviewed in the context of the previous injuries. None of the injuries were 'flagged' on the GP record keeping system and opportunities were lost at each of the contacts, to recognise the vulnerability of the family and potential risks to a young baby.

When Alvah was taken to the Emergency Department, the information was shared with the GP, but the information was not brought together.

How do we know this is not a one-off event but an underlying issue?

There is currently no standardisation between EDs, of how and when information is shared when a child attends the hospital, making triage within primary care and health visiting services difficult.

There is no standardised way of triaging information as it is received by GP practices.

System Challenge Questions for the WSCP to consider:

3. Does WSCP have a view on the need for a standardised liaison process from hospitals to GP and HV services?

4. Is the WSCP confident that there is a robust process for triaging information coming into GP practices that will identify and flag injuries in non-mobiles babies?

3.3 Key Finding 3

The history of the family can be lost when situations change.

The challenges of working with mobile families is well known to services working with children and families, with the accompanying risk that services 'start again' when they meet the family for the first time.

Brandon et al (2010)[4], describe the 'start again syndrome', as a helpful way of conceptualising practice and decision making. In these circumstances knowledge of the past is put aside with a focus on the present and on short term thinking. This way of thinking and behaving tends to happen when workers are overwhelmed, and it prevents workers from having a clear and systematic understanding of a family.

This is further explored in the Child Safeguarding Practice Review Panel Fieldwork report, 2021[5] which focused on the role of fathers and stepfathers. They found

[4] Brandon et al, 2010, Building on the learning from serious case reviews: a two-year analysis of child protection database notifications 2007-2009 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/192887/DFE-RB040.pdf

[5] Child Safeguarding Practice Review Panel Fieldwork Report, 2021 National_Review_of_Non-

evidence that mothers may not disclose father's details due to issues about housing tenancies and welfare benefits, and that fathers were not proactively engaged.

Additionally, the transfer of information between health /housing services is not automatic if families move across borders/local authority areas.

The review finds that services continue to 'lose track' of salient information as circumstances change and the opportunity to intervene can be lost.

How did the issue manifest itself in this case?

In the case of Ms M, the circumstances of her late pregnancy presentation, alongside the unfolding pandemic response, appears to have meant that the family were not seen holistically and in the context of their complex history.

Ms M's pregnancy with Alvah coincided with the onset of the Covid-19 pandemic and resultant changes in service delivery. At the point that Ms M became aware of her pregnancy, people were being advised to avoid hospital attendance where possible, and maternity services were implementing new ways of working which reduced face to face contact with pregnant women.

We know that Ms M edited her story, particularly with regards to her mental health history and her relationship with Mr D, depending on who she was speaking to, and that a triangulation of information did not take place. This was compounded by the fact that Ms M did not formally move across boroughs, but she moved between her home and her parents following the births of both children.

System Challenge Questions for the WSCP to consider

5. Are WSCP assured that health information systems and processes support robust information sharing when vulnerability is identified in pregnancy, and settings or situations change?

6. Is the WSCP aware of the impact and implication for new ways of working implemented during the Covid-19 pandemic?

7. Are there further measures the WSCP needs to take to understand the risks associated with having indirect or restricted contact with families during the Covid-19 pandemic response?

The review posed assurance questions of the WSCP about pre-mobile infant injury, hospital and community liaison, and information triage. An additional briefing paper provides assurance in response to those questions, redefines the learning and concludes with recommendations.

Accidental_Injury_in_under_1s.pdf

Appendix 1

System Challenge Questions for the WSCP to consider

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