Local Child Safeguarding Practice Review

Child M

January 2021

Hartlepool & Stockton-on-Tees
SAFEGUARDING CHILDREN PARTNERSHIP

Case Synopsis

Child M lived with her mother, father and older sibling. She was 6 weeks of age when she was admitted to hospital following a choking incident. On examination she was seen to have two small bruises on her forehead. Further medical investigation identified a potentially life-threatening bleed on the brain, along with additional bruising to the thigh and a fractured humerus. The examining paediatrician concluded, in his professional opinion, the injuries had been caused by aggressive handling, commonly known as "shaken baby syndrome[1]".

Child M's elder sibling had previously been on a child protection plan due to concerns in relation to domestic abuse in the family home. At the time of the injury to Child M, the child protection plan had been discontinued and a child in need plan was in place. Due to no ongoing concerns in relation to the care and protection of the sibling, the plan was for the case to close.

Due to the plan to close the case in relation to Child M's elder sibling, a referral and pre-birth assessment had not been completed for Child M, therefore, whilst sibling was open to Children's Social Care at the time the non-accidental injuries occurred, Child M was not.

Review Methodology

This review was carried out using an Appreciative Inquiry model. An Appreciative Inquiry model is used in order to understand what has happened, within a participative framework that embraces professional curiosity and challenge, and focuses on what works well and what is valued. Key learning themes that were identified through the Rapid Review meeting were explored through a facilitated event undertaken with multi-agency middle managers. The event examined the identified learning through a systems approach to discussing multi agency best practice rather than specifically examining actions of individual organisations in this particular case. This approach supports systemic learning and practice improvement and focused on the following identified learning themes:

- Communication, information sharing and joint working;
- Holistic assessments;
- Evidence based decision making;
- Fixed-thinking and Seeking / undertaking Safeguarding Supervision; and
- Making change happen.

Systemic Learning and Practice Improvement

[1] Shaken Baby Syndrome is a serious brain injury or head trauma, caused by the shaking of an infant.

The cross-cutting theme of 'Fixed-Thinking' was highlighted in aspects of multi-agency working which impacts upon professionals' ability to understand risk, evaluate and integrate new information and reflect and challenge themselves on how this changes working hypotheses. Four key inroads to **unlocking fixed-thinking** have been identified.

Father Inclusive Practice

The extent to which fathers are engaged within the safeguarding process can have a considerable impact upon the understanding of risk for the child and family. Professionals can have fixed-thinking in terms of the role of fathers in a family and in their role in parenting children. Fathers can be overlooked; both as a resource for their children as well as in terms of their own vulnerabilities and how these might impact upon the child and the family dynamics as a whole.

Child M's Father was an integral member of the household; he was not an 'absent parent', yet his vulnerabilities and how these might impact upon parenting were absent from professional understanding and analysis.

When working with vulnerable children and their families, it is important to consider which agencies may hold relevant information that could help to develop an in depth understanding of role of a father in the family, his lived experiences, strengths and vulnerabilities and how these might potentially impact upon parenting, protection and risk for the child(ren). Professionals should seek to:

- Understand who holds information about the father. Is the father involved with professionals that are different to the rest of the family? If so, are those professionals actively involved with the father now, have they been informed of involvement other agencies and asked to contribute / share relevant information? Have professionals requested consent to gather and share information?

- Gather information about what other services are or have been involved with Father. If father has had involvement with other agencies in the past, what information do they hold, what assessments have been completed, and how is this relevant to or impacts upon, parenting, risk and the life of the child(ren)?

- Give one to one time to the father in a family – Taking the time to speak to and work with a child's father on his own is as important as one to one time with a child's mother. Ask a father direct questions about his role in parenting / feelings about new parenthood / relationships and family dynamics /strengths and vulnerabilities?

- Evaluate the engagement of a child's father, does he attend meetings, is he present at appointments, if not, ask why.

- Record the father – Is he visible in the child's records? Do records give an understanding of father's role in parenting the child/ his background / any vulnerabilities or risk factors?

• Identify what father's needs are and how these impact upon his parenting capacity. What work can be done with the child's father to meet his needs and reduce risk factors, be specific and record this, alongside his response to proposed interventions?

• Asertain the child's father's wishes and views, his aspirations for his child? His perspective on family life, what works well, what needs to change? Ask what he will be doing to promote his child's wellbeing and life chances.

Self-Reported Information – Clarify, Reflect and Verify

When working with families, much of the information and insight into the family comes from them directly and is 'self-reported'. Professionals need to ensure that they triangulate what parents are saying by establishing the facts, gathering evidence, and communicating well with all involved. There is a need for all professionals to have a conscious and healthy inquisitiveness, not taking information at face value but clarify, reflect back what they are being told and verify information. It is important to make it clear in recording the origin of a piece of information and if it self-reported, this avoid the risk of it becoming assumed as fact through the passage of time. Wherever possible, check out details of self-reported information by asking who, where when and confirm/validate the information.

Child M's mother told professionals that there had been previous social work involvement with her eldest child but the case was closed. This led to new professionals being unaware there was ongoing social work involvement. Professionals should seek to:

• Understand where a piece of information originated from – If it was from a parent or family member, has this been checked and confirmed by a relevant professional? If the information was provided by a professional, did it originate from their organisation or can it be tracked back to self-reported information and therefore not necessarily a known fact?

• Clarify and verify the accuracy of the information wherever possible – If it is self-reported information, has consent been sought to share information with others or gather further information in order to confirm? Find out more information to better understand the information you are being told.

• Reflect upon the self-reported information and what this means in the context of safeguarding and promoting the welfare of children, what impact it may have and what implications it has in terms of the plan for the family. Do practitioners need to change the plan or their approach to working with the family in light of this information?

Adaptive and Responsive Thinking – Evidence-Based Decision Making

Professionals need to take time to hypothesise in order to be able to adapt their thinking and respond to changes in family circumstances and risk. When professionals encounter new information, a new development or a practice dilemma, they need to take time to hypotheses about

what is happening, how this situation or new information changes their working assumptions, what the impact could be and what this means in terms of adapting or reviewing the existing plan.

For Child M, the elder sibling's case was due to close and therefore, with no ongoing concerns for the sibling, a pre-birth assessment was not considered.

Understanding the potential impact of new information or changes in a family with existing vulnerabilities is fundamental. Being open to allowing new information in and re-evaluating a working hypothesis; allowing professional thinking and understanding to adapt in light of changes is essential to fully understand and respond to risk. Professionals should articulate within their records where they have received new information, an incident / development or a practice dilemma and how they consider this impacts upon their decision making, what factors they have taken into account and why they are reaching a specific decision. This promotes evidence based decision making and avoids hindsight bias.

"What hindsight does is it blinds us to the uncertainty with which we live. That is, we always exaggerate how much certainty there is. Because after the fact, everything is explained. Everything is obvious. And the presence of hindsight in a way mitigates against the careful design of decision making under conditions of uncertainty."— Daniel Kahneman

Professionals should seek to:

• Understand what impact or implications any new information / developments / changes might have for the child and family – Does this alter the current nature or level of risk? Be dynamic in the assessment and planning processes, these are not fixed, but constantly changing as families evolve, use multi agency meetings to discuss new information / developments / changes. Does the assessment or plan need to change in light of this?

• Reflect upon new information and developments in the context of past / historical information or concerns and current strengths and vulnerabilities - Is there any information shared that impacts upon these and changes our working hypotheses? Is there anything that makes us more / less worried? Has there been an impact on the level of engagement either from the family or other professionals? Are we seeing impact of intervention and will this change?

• Reflect with colleagues and families – Ask them for their perspective on the case and work being undertaken, should anything be done differently, what would you do if you were in my shoes? What do they perceive the potential impact or risk to be?

• Use a decision making tool to show your workings out as to what information was received, what did it tell you, what possible options there were and which option has been selected and why.

Creating Space—Opportunities for Multi-Agency Reflection

Nurturing professional curiosity and challenge are a fundamental aspect of working together to keep children and young people safe. For many agencies, the use of effective supervision is a means of improving decision-making, accountability, and supporting professional development among practitioners. Supervision is also an opportunity to question and explore an understanding of practice in specific cases.

Group supervision and multi-agency reflective discussions can be even more effective in promoting curiosity and safe uncertainty, as practitioners can use these spaces to think about their own judgments and observations. It also allows multi agency partners to learn from one another's expertise, discipline and experiences, and the issues considered in one case may have similarities to other cases.

Professionals should seek to:

- Create and allow time and space to reflect, ideally as a multi-agency 'team around the child' when thinking about a specific case.

- Ask managers and colleagues who may bring a fresh perspective to a particular challenge or dilemma for alternative hypotheses.

- Present cases from the **child, young person**, adult or another family member's perspective to help see things in other ways - What does it feel like to be this child living in this household today? How would the child describe it?

- Invite a multi-agency colleague along to case supervision

Summary

The learning from this review demonstrates the importance of giving managers time and space to think critically and reflect on their work. The use of an appreciative inquiry approach prompted fresh thinking and a focus on real service improvements.

The four areas of systemic learning are part of creating a culture that unlocks fixed thinking and moves to a system that promotes professional judgement and evidenced based decision-making.

The importance of real time information sharing is highlighted as is the need to understand how we use this to analyse and plan. We have stressed the value of using incisive questions as a tool to review cases collaboratively and examples are given to encourage and build professional curiosity

Most of all, the learning is underpinned by a need to remember the lived experience of children and ensure that this is at the heart of our practice.