Child Safeguarding Practice Review

REVIEW REPORT

Baby known as Alfie

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[1] Suzy is an experienced and knowledgeable senior leader with over 25 years social work practice experience at both an operational and strategic level. She has a particular interest and skills in quality assurance , practice development and training.

Introduction

1.1 This Child Safeguarding Practice Review (CSPR) was undertaken to identify learning from the Telford and Wrekin Safeguarding Partnership in respect of Alfie[2] aged 4 months who suffered non-accidental injuries in early 2021.

1.2 Alfie came to significant harm whilst in the care of his parents, at the time Alfie was receiving universal services and there was no history of statutory services involvement. He was a healthy and much wanted first baby. During a routine health appointment, Alfie was observed to have three bruises on his body, Alfie was 4 months old, and a non-mobile baby.

1.3 At the time of the incident both parents reported to the health visitor, police, and social work professionals they were suffering from anxiety and depression and had self-referred to Improving Access to Psychological Services (IAPT)[3] Relationship issues and coping were raised and discussed, respectively.

1.4 A medical and skeletal survey was undertaken where significant injuries were identified. Both parents were arrested, and father admitted to intentionally injuring Alfie. Father was subsequently convicted of grievous bodily harm and neglect.

1.5 Alfie was immediately safeguarded. A joint police and Social Services investigation commenced, and legal proceedings were initiated. Alfie is well and does not appear to have suffered any long-term physical harm from his injuries and is now living in the care of his mother. This review does not seek to provide a detailed account of Alfie and his family's life but sets out to understand the helpfulness of how and why services involved with Alfie worked together to ensure his safety and wellbeing.

2 Process for the child safeguarding practice review

2.1 Telford and Wrekin Partnership commissioned an independent author experienced in safeguarding to undertake this review and consider systems and practice within and between partner agencies specifically with regard to non-accidental injuries of a child under one.

2.2 Integral to the review was engagement with the Partnership, engagement with senior managers and with front line professionals, engagement with family and timeliness. Principles were centred on a no blame culture, focussing on practice and systems at the time, analysing this and exploring strengths as well as areas for learning and improvement.

[2] Anonymisation to protect identity

[3] Improving Access to Psychological Services provides evidence based psychological therapies to adults with anxiety disorders and depression. The interventions are part of a National Health service initiative that aims to increase the provision of talking therapies to adults across the country to overcome depression and anxiety and better manage their mental health .

2.3 It was acknowledged that due to capacity issues within the Partnership this Review had been delayed so a timely review was important. This has not delayed the initial learning identified at the Rapid Review being taken forward and this will be discussed within the report.

2.4 Terms of reference were developed and built upon with the Partnership following learning identified from the Rapid Review[4] meeting and additional guidance suggested by the National Panel. This formed the basis of reflective discussion within agencies to support the single-agency chronologies, reports, and single-agency learning.

2.5 The agreed time frame for the Review information covers the antenatal period from March 2020 to March 2021 when the Child Protection investigation concluded.

2.6 Analysis of the chronologies, in this case, identified periods of intervention that help understand the role that practitioners and agencies had in the period under review from a practice and learning perspective. These **identified areas for consideration** were used to help frame the reflection at the Learning event and directly informed the thematic analysis in this review

2.7 It is of significance that the timeline for this Review mirrors completely with the timeline of UK coronavirus lockdowns, from March 2020 to March 2021[5] and will be considered further below.

2.8 Whilst many Covid 19 restrictions were eased at the time of completing this review, many services still followed a level of face-to-face restrictions and hybrid working arrangements remain in place. This has continued for the process of this review, therefore, engagement with the Partnership and senior managers was via video technology. A Learning event was held in person with practitioners in July 2022 as was a face-to-face meeting with mother. A separate video meeting with father was held in September 2022. Parental views are captured and identified within the Report.

3 Case summary and context

3.1 Alfie has no siblings, and his parents were first time parents in their early 20's. The couple had met when teenagers and have been a couple since this time. Alfie was developing well, and mother accessed support appropriately and as needed. Mother did not report any worries about her wellbeing or her relationship with her partner at any point with maternity or health visiting services when regular checks and questions were asked in line with practice procedures. These covered domestic abuse and wellbeing.

3.2 Both parents were in employment, however, due to covid father was furloughed for periods of time, mum was on maternity leave at the time of the incident. This led to financial pressures. Mother worked in an allied health role that is familiar with safeguarding processes.

3.3 There was identification of some extended maternal family support self-reported by both parents. In reality family and social connections were limited to protect the most vulnerable, this included the very

[4] The system of Rapid Reviews was established in 2018 its purpose is to promptly (15 days) gather the facts about a case as far as they can be reasonably established , determine any immediate safeguarding action, share learning, and decide on next steps including consideration for undertaking a child safeguarding practice review.

[5] https://www.instituteforgovernment.org.uk/sites/default/files/timeline-lockdown-web.pdf

young. It was recognised that COVID restrictions affected available community support networks and how they were delivered and accessed. The family received support for Alfie from universal services, which meant the GP and health visiting services. The practitioners meeting shared that due to the impact of Covid restrictions services had to review their support offers, for example, midwifery evaluated what it *needed* to do and looked at what it could not do, this meant in practice fewer contacts and face-to-face contact limited to one parent. Within health services, it was recognised many staff were redeployed leaving services affected by the availability of the workforce. Health visiting contact was also delivered differently, checks were made before home visits and only one parent was seen in the home. Clinic settings were carefully managed to ensure only one parent and child was seen at a time. Normal support services and informal social interactions such as parent and baby groups, opportunities to socialise with other parents were not available to the same extent to new parents. The IAPT service was delivered online, and this was its usual delivery method.

3.4 Both parents sought support with their mental health within a day of each other in early February 2021 when Alfie was three and half months old. They were assessed by the IAPT service separately on the same day, each shared a history of anxiety and depression.

3.5 Bruising was identified on Alfie during a routine health appointment within 3 weeks of these self-referrals, the period the injuries occurred is not known exactly. A skeletal survey identified significant internal injuries; rib fractures to both sides of his body, a fracture to his left arm, a potential fracture to his right arm, a potential fracture of his femur and soft tissue swelling.

3.6 In the Rapid Review meeting it was acknowledged there was inconsistent and incomplete information about father's surname and ethnicity held between organisations. Mother was recorded as white British and father as Pakistani, subsequent paperwork recorded father as Pakistani, and this led to suggestions from the National Panel to explore cultural aspects of support within the case. It was later confirmed in the practitioners meeting that father was white British and his name had been changed by deed poll and he reported he wanted the family to have the same name. The importance of services holding correct core information[6] and triangulating this, particularly men and partners is significant for understanding the family context and removes any risk of assumptions being made.

Learning point 1 it is important that core family details are recorded accurately by organisations and triangulated in case any discrepancy exists to prevent this information being perpetuated in error. Research supports that information about fathers is routinely less well known or sought.[7][8]

4 Professional Involvement

Mothers' pregnancy coincides with the start of the Covid 19 first lockdown when the whole country was having to adjust to the impact and risks of the pandemic. Front line services such as maternity adjusted their working practice and whilst they continued to deliver services that were needed and met with expectant

[6] The Child Safeguarding Practice Panel ;Annual Report 2020

[7] The Myth of Invisible Men: Safeguarding children under one from non-accidental injury caused by male carers 2021 CSPRP

and new mothers in person where possible, it was acknowledged this was more limited and many antenatal appointments were transferred from face to face to phone call appointments. Priority was given to seeing mothers, this directly impacted on fathers' inclusion in appointments and the level of his involvement.

4.1 Mother engaged well with antenatal services and appropriate screening and health checks were carried out under the restricted arrangements. These appointments increased appropriately in the last three months of the pregnancy as foetal growth had been identified as a concern. There was no disclosure of any historical mental health or relationship difficulties.

4.2 There were no notes or information held about the father of the unborn baby other than his name, address, and telephone number. His name was not consistently recorded across services.

4.3 Midwifery services have reflected on this case and learning has directly informed their practice in the implementation of a new electronic management information system (MIS) for record keeping. This now prompts and requires more specific information in respect of biological fathers and partners, this can directly inform a risk assessment and pathways to services should this be needed. In training appropriate emphasis is included on the risk of men who are ***'unseen'*** and appropriate curiosity being practiced.

4.4 Both parents registered with the GP practice in this period and the practice had reduced face to face contact due to Covid. There appeared to be no historical information shared about parental mental health from the GP practice.

4.5 It was reported father was fully involved at delivery and post-delivery planning (Alfie experienced jaundice and was readmitted to hospital for treatment on two occasions). A maternity home visit is recorded where dad was in the house but not seen, as he was in another room. This would have been practice at the time, it was at the start of the second national lockdown and major pressures within the NHS [9] was evident.

4.6 In the first few weeks of his life Alfie was treated for jaundice a good level of support was provided to mother and Alfie from midwifery and the health visiting service, including breastfeeding support. His care was transferred to universal[10] community services within 3 weeks and the health visitor had already made contact and undertaken a home visit, evidencing positive practice.

4.7 Learning in the Rapid Review recognised the support needs of families where babies were born during COVID restrictions and acknowledging additional pressures this could bring. It highlighted the need for midwifery to understand the arrangements parents make through support bubbles and recommended that it should be discussed with mothers when they leave the hospital. It is important that this does not exclude fathers and partners and is informed with core information evaluated during the pregnancy. This mother engaged early and well but did not disclose any historical mental health or relationship issues. There was no engagement with father and minimal information was known about him.

Learning point 2 it is important that fathers and/or partners are considered and included in developing these support bubbles for new parents, both within and outside of COVID restrictions.

[9] 31st October PM announces a second lockdown in England to 'prevent a medical and moral disaster' for the NHS

[10] Universal services are the term used for indicating there were no additional needs that cannot be met through services available to all children and families i.e., GP, community health visiting , children's centres, Schools etc

4.8 Appropriate post-natal mental health and domestic abuse screening was undertaken with mother and support offered as needed. Mother had one home visit (new birth) where father was recorded as present and three visits to the clinic by mother, all were in person, however, clinic visits were managed and restricted to one person at a time. Mother also received telephone support from the service.

4.9 In early February 2021 father contacted 111 seeking support with his mental health, he was signposted to his GP. A nurse practitioner from the GP practice responded the next day which was good practice. Father shared that his mental health had got worse over the last few months, and he was not engaging with any services. He shared he struggled to deal with his emotions and disclosed he self-harmed (biting his hand) when he got angry. In the conversation, he shared his isolation and his family circumstances. The agreed outcome was that father would access IAPT and he made a self-referral the same day.

4.10 Whilst the plan of intervention for father was appropriate in terms of what was known at the time there was limited curiosity and rigour shown about fathers lived experience, his parenting and wellbeing given what was known and emerging about the impact of covid on parenting stresses, isolation and increased mental health.[11]

Learning point 3 This was a missed opportunity to ensure the families circumstances were triangulated within the GP practice and a discussion held with the health visitor and additional support offered. This is information that was *knowable* but not known.

4.11 Research, review, support, and guidance from the *Fatherhood Institute* highlights the impact of parenthood on fathers and how mental health[12] can adversely affect parenting and their relationship with children and partners. This includes increased stresses where both parents experienced mental health difficulties. A study of fathers with post-natal depression showed how fathers perceived feelings of inadequacy and powerless "could sometimes turn into anger and frustrations".[13]

4.12 Reviews analysed by the *Fatherhood Institute* show the challenges in fully including fathers in maternity and health support; The Review Bringing Baby Home: UK fathers in their first year June 2022[14] emphasises the need and increased benefit of engaging with fathers in the perinatal period and identifies this as a 'golden moment' to address wellbeing and behaviours within the family unit. This initiative has been compromised during the pandemic where fathers had more restricted access to maternity services and support. Many fathers have spent extended periods at home with limited consideration, increased stresses but less support or visibility to services.

[11] June 2020 https://learning.nspcc.org.uk/media/2246/isolated-and-struggling-social-isolation-risk-child-maltreatment-lockdown-and-beyond.pdf

[12] http://www.fatherhoodinstitute.org/2018/fatherhood-institute-research-summary-fathers-and-postnatal-depression/

[13] 1. Pedersen SC, Maindal HT, Ryom K. "I Wanted to Be There as a Father, but I Couldn't": A Qualitative Study of Fathers' Experiences of Postpartum Depression and Their Help-Seeking Behavior. American Journal of Men's Health. May 2021. doi:10.1177/15579883211024375

[14] http://www.fatherhoodinstitute.org/2022/bringing-baby-home/

4.13 On the same day that father contacted 111 and the GP mother attended the GP practice to have Alfie's immunisations. The next day mother self-referred to IAPT and within 6 days both parents received a telephone consultation and assessment separately but on the same day. Mother shared she had had anxiety for several years but because of her son she now "needed to change." Mother also shared that she and her partner had issues with their moods and coped differently. This was putting a strain on their relationship. Mother identified her partner as her main support. There were thoughts of self-harm, but these were not acted upon because of her son.

4.14 Father also shared he had struggled with his mental health for some time, it had recently got worse after the birth of his son he experienced a lot of negative thoughts about not being a good father, he shared he was "snappy" with his partner. He described not wanting to socialise, the impact of Covid "keeping him in the entire time," feeling unmotivated and sometimes feeling he wanted to "punch things." When he felt overwhelmed, he had self-harmed (biting). Risk was assessed in relation to his son and partner, he shared if Alfie cried a lot he could cope, and mum would take over. He shared physical arguments between himself and partner, but this was some years ago. Support for the couple was identified from mothers' father, with limited discussion of what this looked like.

4.15 Father shared with his IAPT worker his understanding of the guidance offered by the online support around crying babies. Positively work across maternity and community services promoted access to the ICON [15] offering online guidance and support as part of a national campaign. This seemed to have provided some mitigation for father who was able to share strategies about what to do in his sessions with IAPT. Risk was assessed as being low for father.

4.16 Information about the adult's mental health was not shared. Whilst both adult assessments identified individually "no safeguarding concerns" it was identified during the process of this review that a discussion and referral to 0-19 services (including health visiting services) to offer support would have enabled a less adult focussed response and broadened thinking to consider the lived experience of all family members.

> **Learning point 4 The** opportunity to offer support to the parents was overlooked, ensuring the health visitor was aware that both parents were open to the IAPT service could have provided additional assessment, support and intervention centred on Alfie's needs.

4.17 Confidentiality was given as the reason not to share information outside of the IAPT mental health team, this included information about each other and with other professionals such as the health visitor. However, the GP practice was certainly fully aware of father's self-referral as they had supported this and would have been kept updated. The GP practice was also updated regarding mother's referral and progress.

4.18 The rationale for not sharing was because there was no identified risk to the adults or child safeguarding concerns that would have necessitated this. This was a limited understanding of information sharing which meant the whole family situation including the needs of a vulnerable baby was assessed with partial information. Neither parent had refused consent to share information, they were simply *not asked* about their support needs as new parents, and the potential impact, needs and risks in relation to a new

[15] https://iconcope.org/

baby in the household was not developed. Sharing information is a core principle of Working Together[16] and continues to feature as an issue in learning from Rapid Reviews and LCSPR's[17], we have seen here that obtaining consent to share information is not on its own sufficient to protect children. What, when and how is more nuanced and involves an understanding of how adult issues such as mental health can impact on the needs, safety, and wellbeing of children in households. Professionals here acted in isolation, working with limited appreciation and question about a vulnerable baby meaning they had incomplete information to consider their assessment of need, support, and risk upon as a basis to share information.

4.19 There has been some positive and significant learning and practice changes already put into place in the IAPT service regarding consent to share information at the start of any intervention by adopting a holistic 'think family' ethos to assist with understanding of the family situation.

Learning point 5 Good and effective practice would be for adult mental health workers involved with (new) parents to discuss their feelings about parenting in relation to their mental health and coping and then consider access to appropriate parenting interventions and support.

4.20 Within 13 days of the assessments Alfie suffered significant harm. Mother was placed on a waiting list for input from the adult mental health team. Father shared he had commenced some online intervention work and did not want to wait.

4.21 Alfie's bruising was identified at a routine and planned health check by the nursery nurse at clinic, this was good practice and demonstrates effective knowledge about bruising in non-mobile babies. Immediate advice was sought from the child's health visitor who confirmed the concerns about the bruising and gathered key information. This information indicated that father may have been rough when changing Alfie, also shared by mother was that both parents were accessing support from IAPT.

4.22 Some learning was identified about the process, referral pathways and context immediately following identification of the bruising to ensure all professionals were clear about their role in the referral pathway. Mother was asked to visit the GP that day by the health visitor to review the bruising, mother did this and the GP then asked mother to send photos. Whilst a child protection referral was made it was recognised this did not follow the correct procedure which is for an immediate child protection referral to be made to children's social care. The child protection medical should be undertaken by the hospital paediatrician and showed over optimism that mother was a protective factor. The learning event identified space limitations at the clinic due to COVID-19, whereby appointments were pre-booked, and space affected the process of enabling mother and baby to remain in the clinic while a child protection referral was made.

16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf

17 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/984770/Annual_review_of_LCSPRs_and_rapid_reviews.pdf

4.23 It also highlighted difficulties in accessing online procedures in a clinic setting. The Practitioners meeting discussed some confusion about ownership of a flow chart (illustrating the process) used by health practitioners. This will need clarification and assurance that it is fully aligned with the agreed procedures.

> **Learning point 6 Alfie** was safeguarded, and all professionals demonstrated a good understanding about what bruising in a non-mobile baby could mean. Whilst there is a clear procedure identified in the West Midlands Procedures there was some confusion about the process and practice across the child protection system that needs strengthening here, particularly for health visitors and General Practitioners.

4.24 Following the referral to Children's Social Care, child protection procedures were undertaken, Strategy and joint police and social care investigation progressed.[18] Arrangements to undertake a child protection medical was an immediate outcome of the meeting. Concerns were appropriately raised at the Rapid Review about the arrangements for this because parents travelled to the hospital unaccompanied, the reasons given for this was both time and organisational issues. The last planned child protection medical was 4.00 pm not allowing time for the social worker to travel to the house to collect mother and Alfie. Similarly, the Police Vulnerable Persons Team also concluded at 4.00 pm leaving insufficient time. It was good practice to ensure a paediatric child protection medical was arranged in the time frame and whilst parents were fully cooperative this does raise questions about risk and safety and the need for a clear action plan from the strategy meeting. West Mercia Police have now extended the hours specialist police officers are available and given assurance that this would be supported from the wider service should a similar situation arise.

4.25 It needs to be clear procedurally that if a child protection medical cannot be scheduled by the hospital and the matter is not an emergency, arrangements need to be made to ensure the safety of the child in a safe place i.e., hospital / family /foster care until this can take place.

4.26 Following the medical the plan for Alfie to remain in hospital to enable a full skeletal survey to be arranged was the right decision to safeguard him while further investigations were taken.

5 Parents views

5.1 Both parents were spoken to separately and their willingness to share their views is a valued contribution to the learning in this review. It was fully acknowledged that the time between the incident and the Review process has increased anxiety, and it is hoped following the conclusion of the review process this will be reduced.

5.2 **Mother** was distressed by events around the injuries to her son and her focus is now on the impact of the separation between her and her son. This includes the length of time he spent in foster care, the manner of the child protection investigation and subsequent involvements where she felt she was not heard accurately. There is a need for some restorative conversations to enable mother to gain trust and be open to any future help from services.

5.3 Mother was able to reflect on what was happening in the period that led up to the injuries to her son and then what she felt would have been helpful. She reflected on the relationship with Alfie's father and

[18] Assessment under Section 47 of the Children Act 1989

whilst they had known each other for around seven years, they were self-contained and had little experience of what she described as 'healthy' relationships. They both experienced anxiety and living in the same house meant there was no one to share with and nowhere to go. The impact of COVID contributed to the level of anxiety, and significantly worries about money (father was furloughed and mother was on maternity leave) for the family.

5.4 Mother shared they had recognised that they needed to seek support for their anxiety and positively both agreed to seek help for their mental health. Mother shared that she found the telephone and online support offered difficult, she preferred to speak face to face. Mother fed back that this was about remote access and complicated because they were living in the same house, they had a baby and she felt there was no private space or good time to speak via the phone to the IAPT service.

5.5 **Father** shared his long-standing struggles with anxiety throughout much of his life, it was present when he was working, and he described this as a difficult relationship with feelings of insecurity and anxiety about 'doing something wrong.' Furlough meant he had extended periods not working and this added to his anxiety and preoccupied his thoughts

5.6 Father talked several times about not feeling 'connected' to Alfie and that he experienced internal struggles right from Alfie's birth where he did not think he was going to be a good dad. Whilst he was able to be present at the birth this time was limited due to restrictions, he shared he never really felt like 'a parent.'

5.7 Father shared the same understanding in discussion as a couple that they both needed to seek help in their own right. He had never accessed support before, but Alfie was the motivation to seek help. Father experienced anxieties with the telephone and described his nervousness about using the phone to firstly make the referrals and then to engage in the process including online workbooks and feedback. Whilst he was open about his struggles with the phone and online intervention his rationale was that he did not want to be placed on a waiting list and this work could start. He shared that doing the remote work was hard and felt disconnected. He did not talk about his parenting or how he was coping.

6 Analysis and key learning

6.1 Initial learning in the case was identified at the Rapid Review and single agency actions have been highlighted. Opportunity to build on this through the review process has supported additional reflection and learning for the Partnership. These can be summarised below

6.2 Adult mental health was a key feature in this case, and this identifies learning from the work of the National Panel particularly in relation to non-accidental injury and the role of fathers where they found many fathers had a "*variety of mental health issues whether ADHD, anger management, anxiety, or depression…. (*And intervention is focussed) not *on their role as parents but as adults. Learning from local reviews suggests that maternal mental health concerns were sometimes not recognised and factored into the overall assessment of risk"*[19] The co-existence of parental mental health increased the parental stresses and vulnerabilities for Alfie in a period of limited protective factors. Father disclosed ongoing issues with anxiety

[19] The Child Safeguarding Practice Panel ;Annual Report 2020

and depression and reported feeling increased irritability and anger. Following arrest Mother disclosed a historical domestic violence incident to the Liaison and Diversion (L&D) team (approximately 5 years ago) and shared a much more extensive history of anxiety and depression.

6.3 Whilst agencies were keen to demonstrate that service delivery had been maintained and strategies put in place to support families, situations were changed due to the conditions created by COVID. The impact of this is evidenced in research and these show the increase in parent and family stressors presenting increased 'situational risks."[20] Parent and family stressors were the most significant factor in escalating safeguarding risks referred to the National Panel involving COVID. Of relevance here was the family's isolation with a new-born, decrease in mental health wellbeing and financial pressures (parents in this case cited financial worries, where one parent was furloughed and one on maternity leave.) Learning from the NSPCC Report Isolated and Struggling [21]linked many of the conditions and stresses during COVID when "adequate support (was) not available, such tensions may lead to mental and emotional health issues and the use of negative coping strategies." These factors combined to place Alfie in a position of increased vulnerability and therefore risk.

6.4 Alfie's father was not unknown in this situation but there was very limited information known about him and the focus of assessment and support was centred on mother. Father lived with and cared for his child in the same household, but the most basic information was not known about him. Whilst COVID presented additional restrictions on visiting this did not prevent opportunities to assess and engage with both parents and ensure all opportunities to offer support to men in their role as fathers is "maximised." [22] *The Myth of Invisible Men* report fully recognises that whilst maternal health and wellbeing are, and should be, the main focus of maternity services, it does highlight that insufficient attention to engaging men often means that support to enable them to be active and confident fathers is limited. **SEE RECOMMENDATION 1**

6.5 Research shows the use of online therapies can be just as effective as in-person therapy, however, this review has found the families situation, particularly during a pandemic can have an impact on connectedness. Both parents were consistent and clear in their feedback of what could have been differently, and this included some face-to-face interaction and connection to support engagement. **SEE RECOMMENDATION 4**

6.6 There were missed opportunities to engage with father particularly when he was seeking help for his anxiety. Father self-referred for support with his mental health via 111, his GP and then the IAPT service for assessment and intervention. Father talked about how he was feeling with different professionals however there was no consideration of his role as parent and the impact of his feelings and potential support needs in relation to a vulnerable new baby during COVID. **SEE RECOMMENDATION 2**

6.7 Sharing information about both adults' current mental health issues prevented opportunities to see the while family situation and offer support and assessment about the family's functioning, vulnerability, and risk. Whilst strategies have been put in place to manage information sharing and consent at the start of

[20] Child Safeguarding Practice Review Panel January 2021 Thematic analysis of Rapid reviews featuring COVID.

[21] NSPCC June 2020 Isolated and Struggling. Social isolation and the risk of child maltreatment in lockdown and beyond.

[22] https://www.gov.uk/government/news/new-review-investigates-babies-harmed-by-fathers-and-stepfathers

IAPT interventions it is important to ensure that essential information about adult parents and carers is shared from key adult services so the whole picture is being seen, risks to children are minimised and support can be put in place. **SEE RECOMMENDATION 3**

6.8 The identification of bruising was critical to safeguarding Alfie, this was good practice. Whilst there is absolute clarity about identification and what it means in terms of risk immediately following identification there was some confusion regarding the referral pathway, process, and procedure for injuries to children under one for professionals. Practitioners were familiar with the consideration that babies "(Those) who don't cruise rarely bruise"[23] . Alfie was clearly safeguarded but different parts of the safeguarding system had managed the process in an unusual way. This was attributed to COVID (lack of rooms/appointments/access to procedures) and availability of staff out of their working hours to manage a medical. The bruising procedure for under ones is reported to be under review but there needs to be a clear rationale for this and Partnership ownership and implementation to ensure it is fully embedded and consistent. Clear practice guidance may be the most effective way to support learning and apply practice. **SEE RECOMMENDATION 5**

7 Conclusion and recommendations

Summary Learning in this review has been identified in respect of the impact of COVID 19 on parental mental health, the need to 'see' fathers, information sharing and consent and responses to risk.

7.1 Alfie was barely four months old when he suffered significant injuries. He lived with both his parents up to the point of identification of bruising symptomatic of underlying hidden injuries. Professionals had a good understanding across the partnership of the implication of bruising in non-mobile babies and safeguarded him from potential future harm.

7.2 Alfie was conceived and born during COVID, the family were isolated and limited in the social contact they could access, both parents were at home caring for him during the first 4 months of his life due to mother's maternity leave and father's furlough. The family had no history with social care and were open to universal services. There was minimal information or engagement with father. Mother had engaged well with maternity and community health services but not disclosed any mental health issues despite being fully aware of support services due in part to her job role.

7.3 Both parents self-referred for mental health support at the same time and were assessed concurrently, this information was only looked at through a single adult lens. The needs of the family were not fully considered. There were a couple of missed opportunities to offer support to the family and to consider impact of the adult behaviours upon family functioning. This requires thinking differently about consent to seek and share information and understanding about the potential impact of adult issues on children. This requires an inclusive rather than exclusive conversation about consent.

7.4 In addition to the identified learning in this report the following recommendations are made to the Partnership

[23] https://jamanetwork.com/journals/PEDS/articlepdf/346535/poa8307.pdf

1. That all efforts are undertaken to ensure fathers/partners are fully known and engaged in their unborn/new-born babies lives across universal and specialist services, this is evident in record keeping and support plans. Fathers as well as mothers' demographic details are checked regularly.

2. That fathers/partners are engaged and offered support and parenting intervention particularly during the perinatal period.

3. Adult mental health services should work with Children Services to ensure Consent to Share Information reflects the family's situation, any support needs and impact on parenting and children.

4. Consideration of the family's situation and confidence in engaging in online or in-person therapies should inform the agreed intervention in a timely way.

5. In line with the National Panels guidance [24] the Partnership review its current policies on bruising in non-mobile infants to check for consistency with the evidence base and national guidelines. This needs to be clearly communicated to practitioners.

6. The learning from this review is disseminated across the Partnership.

[24] https://www.gov.uk/government/publications/the-management-of-bruising-in-non-mobile-infants-paper