Background and reason for this Child Safeguarding Practice Review

In February 2021, Worcestershire Safeguarding Children Partnership (WSCP) commissioned a Local Child Safeguarding Practice Review (SPR) following the murder of Alfie.

Alfie was killed by his mother's partner; he was convicted of murder and child cruelty and received a lengthy custodial sentence. Alfie's mother was convicted of manslaughter and child cruelty and has also received a significant custodial sentence.

The review was due to start in 2021 but was paused while the criminal investigation and trial was ongoing. During this time the immediate lessons learned from the response to Alfie's circumstances led to a range of activities by the WSCP including training, audits, briefings, and refreshed guidance about the role of the multi-agency partnership in child protection.

The criminal trial ended in early summer 2023 and the review recommenced.

Coventry Safeguarding Children PARTNERSHIP

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One Minute Guide

Learning from a Child Safeguarding Practice Review

Alfie

July 2024

Overview

This SPR found that professionals working with Alfie showed care and commitment to Alfie and his family but were often obstructed by his mother and her partner who sought to deliberately lie, mislead, and cover up what was happening. The Independent Reviewer made it clear that Alfie's mother and her partner were responsible for his death. It is important to remember that the review covered the period during the Covid-19 pandemic where agencies had to change and develop their procedures and work with depleted resources in terms of staff, but also increased tasks and new approaches to their working practices. It meant usual safety mechanisms were absent and this enabled Alfie's mother to keep him at home and despite considerable support and reassurance from Alfie's school, she did not change her mind. The pandemic restrictions also provided Alfie's mother and her partner with an opportunity to isolate Alfie from family, friends and neighbours under the guise of shielding and his poor health.

Throughout the report themes, lessons learnt and practice considerations are highlighted and offer those who are responsible for the delivery of services to children and families an opportunity to reflect on their own practice against the findings in the report.

The key findings and learning points are summarised below:

Key Findings

- Mother's partner had a known history of violence; friends, neighbours, school staff and members of the community reported they had seen him behave aggressively and abusively towards Alfie; however this did not alter the professional view that supervised contact was necessary. Risks were not fully explored or understood and were therefore left unaddressed.

- Initial concerns about the possibility of Alfie's mother's being the victim of domestic abuse were understandable given the history. However there was no evidence of coercion and control of Alfie's mother by her partner but evidence did emerge that she herself was physically abusive to Alfie. Professionals became fixed in their thinking and in the absence of any information to support the initial concern, the risk that mother presented to Alfie as a perpetrator should have been recognised earlier.

- There was concern about Alfie's mother's partner and his history of violence and criminality; there were many incidents of concern, such as neighbours and members of the community reporting harsh and aggressive parenting of Alfie - they were often treated in isolation from each other and were not discussed holistically during joint investigations between the police and Children's Services with no plan to respond.

- Alfie was subject to a child protection plan for a period of 18 months. Monthly core group meetings were held but they were often incident led with insufficient focus on the cumulative impact of these incidents on Alfie, and the effectiveness of the child protection plan was not discussed or reviewed. The focus on incidents meant that the core group did not sufficiently consider Alfie's lived experience.

- There were six known incidents of concerns raised with the police or Children's Services that Alfie's mother and her partner were physically abusing him. Each incident was followed up by a police or social worker visit. Often he was described as 'safe and well' when he had not been spoken to. Alfie and his mother gave causal explanations but they were often inconsistent with his injuries. These incidents should have led to a strategy discussion and consideration of the need for a child protection medical examination.

- There was an over reliance on Alfie to share concerns and evidence that he was being abused and he was consistently asked if he had any worries or to describe what had happened in the context of allegations of abuse and aggression. There was increasing evidence that Alfie was cautious about what he said, seemed anxious when asked about home and worried about saying the wrong thing. This was acknowledged and discussed as a concern by professionals at the core group meeting but no new approach or action was agreed and professionals did not seem certain of what could and should have been done about this. There was an absence of discussion of Alfie's lived experience and reflection on the contrast between what was known about what life was like and what he said about it.

- Referrals made by friends and neighbours were always responded to but they were discussed with Alfie's mother who consistently denied any allegations of abuse, despite the evidence. Alfie was seen alone but made no disclosures of concern and in the absence of disclosures, the lack of a more robust response to the reports from neighbours ultimately led to a lack of direct challenge to Alfie's mother and her partner meaning neither of them were held to account.

Learning

Contact arrangements need to be crystal clear so that children are kept safe within these arrangements. Careful assessment is required for any family member providing supervision, which considers their capacity and willingness to provide safe contact arrangements. This should be documented in a safety plan.

Agencies should challenge their views and hypotheses in cases when there is no evidence to substantiate those views; professionals need to be supported through supervision and reflective case discussions to be able to recognise 'fixed' thinking and the need to change their analysis.

Joined up partnership working partnership is essential to keeping children safe. Intelligence held on those involved in the lives of children and young people on child protection plans needs to be shared and used to reduce risk.

Core group meetings should monitor progress and evaluate the effectiveness of the child protection plan and whether it's creating positive change for the child. Professionals
need to be confident to raise their concerns even where this is difficult for parents to
hear.

Where there are concerns about physical abuse, the explanation for injuries is not quite consistent or corroborated and the child's demeanour is of concern there should always be a strategy discussion with consideration given for a child protection medical.

Children are never responsible for telling professionals what is happening to them when they are being abused; it is the responsibility of the professionals to collect and weigh up the available evidence and triangulate this with their knowledge and understanding of the child's development, their voice and lived experience to make a professional judgement about the likely risk of abuse.

It is important that friends, neighbours and people in the community are encouraged to share concerns about children being abused and that the multi-agency safeguarding system responds appropriately. This is part of the whole focus on '*safeguarding being everyone's business*'.

Key Contacts and Further Information

- Read the full report here
- Coventry Safeguarding Children