MSCP LLR Briefing sheet

Learning Lesson Review Smith Family 2020

Local Safeguarding Children Partnerships undertake Learning Lessons Reviews (LLRs) when the criteria for a local Child Safeguarding Practice Review (previously known as serious case review) has not been met but partners feel there is multi-agency learning that can be identified in the case. The purpose of such reviews is to learn lessons and improve practice.
This publication aims to share the learning from the Smith Family LLR to allow professionals to reflect on their own practice.

Trigger event

Following an anonymous report of a child crying the police attended an address and removed five children (aged between 1 and 5) under police protection.
The children were taken to hospital where a child protection medical confirmed evidence of neglect and development delay. All five had suffered a significant impact of neglect and psychological deprivation.
The parents were arrested and charged with neglect. They both received custodial sentences for child cruelty.

Summary of known background

The review looked at the time period from Mother's first pregnancy aged 16/17 years old. She had been known to social care in her own childhood due to abuse and neglect. The households she lived in were reportedly chaotic and abusive with difficult relationships with parents and siblings. She was accommodated by the local authority and later received support as a care leaver. There were also ongoing concerns about mother's mental health.

The five children have three different fathers. The eldest child's father played no part in the child's upbringing. The second eldest child's father was involved in the child's early years but little was known about him, or referenced in assessments. The relationship broke down, both parents alleging domestic abuse. The three youngest children share a father, who was the one arrested and imprisoned. Little is documented on his background or his relationship with the children.

Housing was the main issue during Mother's first pregnancy but she was supported by her Personal Advisor and an assessment concluded mother had experience of caring for children in her family. A later request for an assessment suggested a CAF (Common Assessment Framework, now known as an Early Help Assessment). This was followed by a further referral for non-engagement and the appalling state of the home but resulted in no further action.

Mother and child's home life remained unstable and arguments in the home led to police involvement. A further assessment was triggered and work undertaken by a family support worker. Contact with Mother was inconsistent but the conclusion was for a CAF due to support from other professionals. Concerns about mother's ability to care for her child and the state of the home continued.

A child in need referral was made during mother's second pregnancy and an assessment began. There was no further action due to midwifery involvement.

At this point there had been eight referrals to children's social care in relation to possible neglect, domestic violence, lack of engagement with professionals, difficulty gaining access and mother's ability to cope.

A further assessment (the fourth) took place after the second child was born due to concerns about the child being in contact with someone who posed a risk. No concerns with parenting or risks were identified and the case was closed. Again, it was recommended other professionals involved could support i.e. the health visitor and personal advisor. After this there was no further contact with social care until the children's removal 3 and a half years later; and after 3 more children had been born.

A pre-birth assessment was not deemed necessary in the next pregnancy (for twins) although professionals from health and housing recorded concerns about the poor state of the home. Subsequent home visits by professionals either recorded no concerns for the children or no record of seeing the children. The pattern of non-engagement continued and a number of attempts for home visits were not followed up. This resulted in the children not being seen for a year.
The fifth child was then born. At the new birth visit the home was reported as clean but there was no mention of the other children. At the next visit nearly 10 months later the twins were not seen. They had not been seen by a health visitor for 2 years. The older 2 children were seen and described as clean. The home

was untidy. There was no further contact with health. No concerns were raised by the school or nursery.

The family moved abruptly, the eldest child was taken out of school and the second eldest out of nursery. No contact is reported by professionals for the next 3 months until the police attend the home address and remove the children.

Findings and learning

Mother's vulnerability both from childhood experiences and mental health needs was well known but there was no in-depth assessment of how this impacted on her parenting. Decisions to undertake assessments were correct but they were poor and didn't address mother's vulnerability or the needs of the children. Evidence suggests mother was only just managing with two children and there were repeated concerns about the state of the home that went away when the home was cleaned. The extra stress of further children was not recognised.

Mother consistently missed appointments with a range of professionals but there was no multi agency response to address the reasons.

Little is known about mother's partners, yet the review identified all were known to police. There were allegations of domestic abuse against two, one was known to have been involved in drug supply and one had disabilities severe enough to receive disability living allowance. The importance of father/partners was not recognised; even when caring for children that were not their own. A common finding in reviews.

There is little evidence throughout the review of the children's experiences or of the parent's experiences of parenting a number of young children. On visits the children were not seen even though they had missed immunisations and developmental reviews. The family history appears to be lost between a high number of changes of health visitors and delayed allocation. There was no professional curiosity demonstrated.

Parents accounts have suggested they did not bond with the twins who arrived prematurely. The known impact of prematurity on bonding was not considered.

From a purely objective point of view any family would struggle to cope with five children under five years of age. This family had particular vulnerabilities, and this was not recognised. It is not possible to say whether early targeted and sustained multi agency support and intervention would have made a difference but without it the parents were inevitably going to struggle to cope.

Recommended service improvements

The LLR identified the following areas for service improvement:

- MSCP to provide training in respect of roles of father/male partners in families and establishing paternity and taking into account childhood experiences in undertaking assessments.
- MSCP to provide training to highlight the need for professional curiosity and provide managers with guidance on how to explore professional curiosity in supervision; and how this can be evidenced through management oversight.
- MSCP develop protocols for repeat referrals, repeat assessments without interventions and missed appointments.
- The CCG make representations to NHSE regarding access to GP records for case reviews.
- The CCG and GP Local Management Committee, devise and implement a mechanism to enable clinical electronic recording systems to link to the records of parents' children and siblings so that records can highlight the wider family circumstances.
- MSCP consider making representations to the Department of Health and Social Care and the Department for Education in respect of a statutory requirement for all children to be registered with a General Practitioner and to receive basic health and developmental checks up to the age of five.

The action plan that has been developed as a result of these recommendations is monitored by the MSCP Learning Lesson Subgroup.

Agencies involved in this review identified additional recommendations for their services. Actions from these will be monitored by the MSCP Learning Lesson Subgroup.

Notification and referral to the MSCP

The safety of children in Medway is our priority and it is everybody's responsibility. It is important that professionals and organisations protecting children should reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

To ensure that children are safeguarded properly by agencies working effectively together the MSCP supports a "Partnership Practice Alert" and "Case review referral".

To make either a notification to the MSCP of an incident/adverse event/prevented incident for the Learning Lessons Subgroup or make a referral for consideration for a case review/audit (including serious case reviews) please complete the form (available on the MSCP website) and return it to the MSCP

Worried about a child in Medway?

Phone: **01634 334466** Out-of-hours: **03000 41 91 91**

Police emergency: **999** Police non-emergency: **101**