MSCP LLR Briefing sheet

Learning Lesson Review Williams Family - October 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 Williams Family LLR to allow professionals to reflect on their own practice.

Trigger event

Following reports from a member of the public to Kent Police that two very young children were running naked in the street, police attended the address and spoke with the mother who told them she was ill. The children (aged 2 and 3 years old) were described as dirty and beyond her control. Police officers did not enter the house "due to the pandemic" but referred the incident to Medway Children's Services who were initially unable to contact the mother by telephone and wrote to her.

Two days later Police attended the address again. The children's father was concerned that he had not heard from the children's mother for over a week. Police were unable to get a response but entered the property and placed the children in police protection due to the conditions they found. The mother was arrested for neglect but later her health deteriorated, and she was admitted to hospital.

Summary of known background

All agencies known to have been involved with the family since the birth of the oldest child in 2007 produced a summary of their involvement which informed the learning review.

Mother was living with her two children aged 2 and 3 at the time of the incident. The older child was residing with his father. Mother was briefly known to the police as a victim of two assaults in 2006, but this was not related to domestic abuse.

The family first came to the attention of Children's Services in 2012 when the oldest child told his teachers that he had been hit and kicked by his mother. This information does not appear to have been shared with the police. An initial assessment was completed which concluded no further action. In 2013, the eldest child again disclosed that he was being beaten at home, a child and family assessment was completed with the same outcome.

A further referral in relation to physical abuse was received in 2013, a strategy meeting was held and a joint visit undertaken with Children's Services and Kent Police. A police investigation was not progressed but following a child and family assessment, the case was opened as a child in need for work around physical chastisement. The case was closed later in 2013.

In 2014, the landlady contacted Children's Services in relation to the conditions in the home which were reported to be disorganised and damp. In 2015, there was a referral from the school in relation to mothers aggressive behaviour and unhygienic home conditions. No action was taken.

There was no further contact until 2017 when the school again made a referral as the oldest child had disclosed fear of physical chastisement. No action was taken but following a further allegation a strategy meeting was held with police and a child and family assessment undertaken. During the course of the assessment the eldest child went to live with his father. The assessment identified no concerns to the youngest child (aged under 1) and there were no concerns noted about the conditions in the house.

In 2018 a referral was made to children's services following an incident of domestic abuse between mother and her partner when both children were present. Mother refused to support a prosecution and a referral was made for early help support.

Early help were unsuccessful contacting mother by phone so made an unannounced visit but mother would not allow workers into the home. At a later visit, home conditions were noted to be a concern but subsequent visits noted some improvements. The case was closed.

The family next came to the attention of the police in 2020 in relation to the trigger event. Despite the conditions of the house, the ages and condition of the children and the fact that mother was visibly unwell with the police concerned about possible Covid-19, no action was taken apart from a referral to children's services.

Following the receipt of the police referral, children's services rag rated it as amber and a telephone call was made to mother the following day. There was no response to the call, a letter was sent and a decision made to conduct a child and family assessment. Following the police's second visit to the address, the children were taken into police protection and placed in foster care.

Findings and learning

Inter agency communication in this case was poor. Health services seem to have had no knowledge of the previous referrals to children's services. At the time of the children and family assessment in 2017 there was no contact with the health visiting service in respect of the youngest child at the time. Children's services records do not reference key health information for mother or missed appointments for the children.

Recording guidelines were not followed; the health visiting records are incomplete and the details of who attended health and antenatal appointments were not recorded. The GP records are also missing key information.

Fathers and other significant adults are missing from the records of all agencies. Names, addresses and details of involvement with the family are not recorded.

Guidance in relation to missed appointments (DNA's) was not followed.

The response from children's services to the referral in 2018 following an incident of domestic abuse did not demonstrate that historical information about the family had been adequately considered.

The trigger incident occurred at the height of lockdown during the covid-19 pandemic. Although both agencies should have been responding to emergencies as usual it seems clear that the responses were affected by covid-19.

A number of these issues were apparent in a previous Medway Learning Review, the Smith family review, which concluded in January 2020.

Recommended service improvements

The LLR identified the following areas for service improvement:

MSCP should:

- In light of covid-19, require all agencies to have a safeguarding protocol addressing how agencies will ensure their working practices continue to safeguard children and young people from initial response onwards and how interagency information sharing will be promoted.

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?

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