MSCP Local Child Safeguarding Practice Review (LCSPR) Briefing Sheet

Julia – December 2024

Local Safeguarding Children Partnerships undertake a Local Child Safeguarding Practice Review (previously known as a Serious Case Review) when a child dies or is seriously harmed and it is considered that there is potential to identify improvements to practice. The purpose of such reviews is to learn lessons and improve practice. This publication aims to share the learning from LCSPR Julia to allow professionals to reflect on their own practice.

Trigger event

In May 2023 Julia was found to have drowned in the bath after being left unsupervised, she was five years old. At the time of her death Julia was in the care of Medway Local Authority and had been living with her four siblings in a foster home provided by an Independent Fostering Agency for 7 months in another Local Authority area, Bexley.

Julia had been born prematurely at 30 weeks and subsequently contracted Meningococcal Sepsis with Meningitis. This resulted in hemiplegia (muscle weakness) of the left side, which resulted in strength and mobility issues, global developmental delay and delayed speech and language.

Summary of known background

The children in the family were subject to Child Protection plans and Medway Children's Social Care had initiated the Public Law Outline (PLO) process (a statutory pre care proceedings process) in July 2022. However, in September 2022 after a significant incident the children were taken into Police Protection and then an Emergency Protection Order was granted, and they were placed with Foster Carers later that same day as an emergency placement.

Julia's parents are of European nationality and spoke their first language within the family home although all the children were born in the UK. The older children were bilingual while Julia and the younger two siblings, at the point of becoming looked after, only spoke and understood the parent's first language.

The Access to Resources Team (ART) had no available in house foster carers and so looked to their approved Independent Foster Care (IFA) agencies. They were informed by an IFA, that one set of Foster Carers were available and had no other foster children at that time. The request from Medway was initially for the youngest three children to be placed together recognising it would be highly unlikely to find a foster placement able to take all five children. However, the foster carer stated that they would be willing to take all five children as she had been raised within a large family and thought it was important to keep siblings together wherever possible. The foster carers approval status allowed for placement of a sibling group without the need for an exemption. They were experienced foster carers, and their last annual review was detailed and overwhelmingly positive about the carers in terms of their approach to the children, their skills and their ability to support children from different cultural backgrounds. However, the family were not a cultural match to Julia and her siblings and were not experienced in caring for a child with disabilities.

During placement planning Julia's mobility issues were not addressed in terms of needing safety equipment and that she was awaiting health appointments and assessments. There was a delay in some equipment such as stair gates, car seats and a pushchair for Julia. The individual Risk Assessment and Safe Care form for Julia did state that "Julia is 4 years old and therefore foster carer to ensure Julia is supervised at all times".

Findings

The Rapid Review identified three specific key lines of enquiry which were agreed by the national panel. Learning under these practice themes are summarised below:

- **Matching process and placement for large sibling groups and children with complex needs:**
  - Information about the children as part of the matching process needs to be appropriately detailed and up to date.
  - Appropriate safety equipment and beds need to be provided without delay.
  - Risk assessments of children need to be adhered to and reflected upon in supervision.
  - Professionals could take the opportunity outside of statutory care planning processes to reflect/identify any gaps in information/documents and emergency placements and large sibling groups could be reviewed at professional network meetings.
  - The ART form which requests placement should be shared with the foster carers as it was very detailed and contained the history of social care involvement, the concerns and reasons for requesting an Emergency Protection Order and provided details of Julia's health and identified the challenges in her walking, delayed speech and that a wheelchair was being made for her. It also stated Julia needed support sitting upright and climbing stairs.

- **Julia's health condition and the health needs of looked after children placed out of area**
  - There were delays in the Initial Health Assessment process which did not meet statutory requirements. Julia's IHA was not informed by Medway health services but appropriate referrals were made for her needs. It was a "start again" approach that lacked her historical health information. This delayed Julia receiving specialist support and delayed the EHCP process.
  - Focus was on the complex care proceedings and not the lived experiences of the children, including Julia's health needs.

- **The importance of race, ethnicity and culture.**
  - It was recognised that the foster placement was not a cultural match for the children. Records indicate there had been some consideration of the children's culture around food, but this was not detailed in the planning process for the children and there was no consideration given to the children's language barriers outside of children's services interactions. Agencies need to record explicit exploration of the family culture and the impact this may mean for the children's lived experience.

Good Practice and key learning episodes

The commissioning and quality assurance process is thorough but in discussion with the Head of CSC Placements and the QA Programme Lead they suggested that in the case of both emergency placements and with large sibling groups these could trigger a review /reflection at a Professional Network meeting which could afford the opportunity to review the original planning meetings/decisions.

Paperwork associated with the process of children going into care was detailed and reflected the children's needs, but this was not always shared in a timely way and with all parties that could have benefitted from seeing it.

It is clear that there is inevitably an impact of emergency placements made without planning, despite the effective practice of all practitioners involved.

In addition to the recommendations in this review the MSCP will be incorporating bath safety into their "Safer babies and toddlers" work stream.

Recommendations

1. The IFA and Medway Commissioning function to audit their records to ensure that the most recent information is provided in Foster Carer profiles to ensure the matching process for looked after children is fully informed.

2. The IFA consider the learning around delay in the provision of key basic safety equipment for the children and audit to ensure that these issues are addressed in a timely manner and recorded in placement planning meetings.

3. MSCP and BSCP, through the dissemination of learning from this review ensure that the terminology of "short term" in relation to the placement of looked after children is fully understood by practitioners/foster carers/other practitioners within the children's workforce. It does not reflect the amount of time but that the arrangement is not a formal long term approved placement.

4. Medway Local Authority to consider using existing mechanisms such as Professional Network meetings to reflect on situations where emergency placements and/or large sibling groups are placed.

5. Medway Local Authority to consider sharing the ART form with foster carers when there is an emergency placement to facilitate the timely sharing of information with the IFA and foster carers.

6. Bexley SCP ensure that action is undertaken to address the delays to the Initial Health assessment process identified in this review:

- Oxleas NHS Foundation Trust and South East London ICB to revise their procedure to ensure that the IHA and the report are undertaken within 20 working days.
- Oxleas NHS Foundation Trust and South East London ICB to review their procedures to ensure that there are no additional delays caused by the request for ongoing delegated consent forms or the attendance of the social worker which are not statutory requirements.
- South East London ICB review their QA pathway for Initial Health Assessments to consider timeliness and quality.

7. South East London ICB and Kent and Medway ICB review the current arrangement where the IHA is quality assured by both the home and the host ICB.

8. The Local Authority and Kent and Medway ICB need to be assured that the current process involving the transfer of health information between the Local Authority/ICB/Health Trusts in relation to Looked After Children is effective and the procedure updated.

9. MSCP should share the learning from this review with Medway LA Corporate Parenting Board in relation to the effectiveness of the Initial Health Assessment process for looked after children and request they monitor performance.

10. MSCP should share the learning from this review with DfE/DHSC to consider when updating the National Statutory guidance on Promoting the Health and Wellbeing of Looked After Children to be clear on the responsibilities of agencies.

11. Medway Children's Social Care should ensure that KCHFT are routinely invited to Looked After Children Reviews and reports requested to ensure timely sharing of health information.

12. Medway Children's Social Care to ensure that the focus of the IRO in Looked After Children Reviews is primarily on the lived experiences of the children and that delays in basic statutory requirements i.e. Looked After Children Health Reviews and PEP meetings are escalated.

13. MSCP should seek reassurance from partner agencies that they are ensuring that their workforce is being supported, equipped and required to work in a culturally competent way.