**MEDWAY SAFEGUARDING CHILDREN PARTNERSHIP**

**Local Child Safeguarding Practice Review (LCSPR)**

# Laura

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## 1 Introduction

1.1 This Child Safeguarding Practice Review (CSPR) was commissioned by Medway Safeguarding Children Partnership after the death of a 20 day old baby (known as Laura in the report) in 2023. The cause of death is unascertained at the time of writing, but her and her family were being supported by Early Help services in Medway at the time of the baby's death. In the past, the family had been subject to court proceedings, child protection and child in need planning. A feature of the family's experience in the previous 7 years was the number of housing moves they had had, which totalled at least 14 in that timescale. This entailed many moves between local authorities which paused and interrupted service delivery on many occasions.

1.2 Laura has two older siblings (known in the report as S1 and S2). The day before Laura's death, the family had been away with relatives at a caravan park. They returned home late, and all slept in the same bed. Mother had been drinking heavily during the day and so bottle-fed Laura. The following morning, Mother woke to find Laura unresponsive and could not be revived. The older two siblings were immediately placed into Police Protection and care proceedings commenced.

1.3 The death was notified to the Safeguarding Children Partnership in Medway and a Rapid Review meeting took place a few days later. Members felt that there was learning for the Partnership from the circumstances of this family but were keen to avoid replicating the learning from other similar CSPRs. At the time, their recommendation to the National Panel was to incorporate learning from this rapid review into the other similar ones and advised the National Panel accordingly. On reviewing the documentation however, the National Panel noted new learning associated with services for this family and recommended that Medway Safeguarding Children Partnership review this decision. This resulted in the commissioning of this CSPR.

1.4 At the time of writing, police enquiries and the coroner's inquest were ongoing.

## 2 Terms of Reference

2.1 The Terms of Reference were agreed by the panel. Agencies involved with the family were asked to analyse their involvement via a brief written submission. The review covers the period from February 2021 (transfer of family to Islington from Kent) to July 2023 (date of Laura's death). The report focuses on services provided to Laura, her siblings and her parents during that time, including those provided during the pregnancy and the few weeks of Laura's life. The review period coincides with the main impact of COVID -19, and the panel asked agencies to consider the impact of the disruption caused during this time.

2.2 The report is based on the agencies' submissions and a practitioner event with key staff that had worked with the family and knew them.

2.3 In line with expectations, the family were invited to contribute to the review. They did not respond to communications from the partnership in Medway and have not indicated that they wish to take part. Whilst this represents a gap in the information, the panel

understood that this was a difficult period for them as Kent police had renewed their investigation. The parallel processes that caused delay in the publication are now however, resolved.

2.4 Information from the rapid review strongly suggests that the children had experienced chronic neglect over a number of years. Given that much of the initial learning from the rapid review is replicated elsewhere in recent Medway LCSPRs, the panel were keen to include what has already been put in place and to evidence a level of practice improvement already.

2.5 Therefore, broad areas included in the Terms of Reference that the panel agreed were the most important to look at in relation to this practice area were:

- Professional awareness and curiosity - were these sufficient to effectively respond to the needs of the family in relation to chronic neglect.
- The impact of the multiple house moves experienced by the family.
- The history of the family and whether historical facts were known or sufficiently considered by agencies.
- The effectiveness of local policies and procedures in relation to neglect and transfers between local authorities.
- The quality of the multi-agency collaboration for this family including liaison with housing professionals.

## 3 Background information

3.1 Mother has a history of social care involvement when she was a child due to parental domestic abuse and substance misuse. She was accommodated (s20 Children Act 1989) as a teenager and subsequently became a care leaver in the London Borough of Bromley. She had an older child who was placed for adoption who is not subject of this review.

3.2 Following the birth of S1 in 2016, he was also subject to care proceedings. Mother demonstrated that she had made sufficient progress, and the family were supported under a Supervision Order. S2 was born in 2018. In this period there were intermittent interventions – Child In Need, Child Protection, and Early Help. There were also periods of no intervention other than universal services.

3.3 Between 2018 and 2022 there was involvement with Kent Police attending the home address on 8 separate occasions for a range of concerns including domestic abuse, where mother was the victim and/or perpetrator. Mother also assaulted a Police Officer. There were further concerns about cannabis use in the home, the ‘dirty’ home conditions and the lack of safe supervision of the children. The police visits led to a range of actions including referrals to Children’s Services and a Domestic Abuse Risk Assessment (DARA). This led to some very brief involvement with domestic abuse services. The family however, had 14 accommodation moves over a seven-year period and were transient across Kent, Bromley, Islington, Medway, Dartford, and Maidstone.

3.4 The children’s fathers were largely unknown to services during the timeline.

## 4 Timeline of the family's journey through services

4.1 The agencies' submissions as part of the review process have been co-ordinated into a combined chronology and briefly summarised here. This is not intended to be an exhaustive list of day-to-day contacts with services but highlights the main interactions and highlights opportunities for multi-agency activity and collaboration.

**Practice Episode: January/February 2021 the family transfer from Kent to London Borough Islington**

4.2 In February 2021, the family were involved with Children's Social Care in Kent on a Child In Need plan. Kent's involvement however was very short as the family moved to the London Borough Islington soon after the Child In Need plan was made.

4.3 The transfer between Kent and Islington went smoothly and there was a good exchange of information and attendance at a transfer meeting between the two authorities. Little progress was made in Islington and Mother's engagement and commitment to promoting the children's welfare was sporadic and superficial. During the time they were allocated in Islington, further concerns came to light about possible drug use, poor school attendance and complaints from neighbours about anti-social behaviour.

4.4 In view of the lack of progress and further concerns about the family, a Child Protection Plan was made under the category of neglect for S1 and S2. This again was short lived in Islington as the family moved to Medway.

| **PRACTICE LEARNING POINT** |
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| The move from Islington was the latest in a series of moves experienced by the family and the transfer to Medway did not go smoothly. This caused disruption to the services offered.<br><br>**More is said about housing and this practice area in paragraphs 5.1 – 5.6** |

**Practice Episode: December 2021 to March 2022 – Transfer In Child Protection Conference in Medway**

4.5 There was a delay in transferring the family from Islington to Medway possibly due to Medway's perception that the family were transient and therefore likely to move again. The Transfer in Child Protection Conference took place in December 2021 and the children were made subject to a Child Protection Plan under the category of neglect. The plan centred around Mother's 'long standing alcohol problem' which affected her care of the children. There was a provision in the plan that Mother would refer herself to for some support with this. The plan also referenced unsafe adults and asked that Mother refrained from exposing to the children to them.

4.6 Limited work was completed over the next three months – Mother missed some visits, and these had to be rearranged but there was a sense that progress had been made. S1 had started school, and the home conditions were acceptable. There was good joint work with the health visitor with joint visits. Regular health checks demonstrated S2 was

meeting her development milestones.

4.7 At the Review Child Protection Conference in March 2022 (first review), the family were stepped down to a Child In Need plan. There was no follow up to the issue of alcohol misuse or unsafe adults and these areas of risk remained untested.

4.8 Bromley Housing completed a visit to the property at this time and noted that there was damp which they put down to the lack of ventilation. A fire risk was also observed as clothes were being dried on heaters. Mother was given advice about how to deal with this. Housing were however not part of the core group and were not invited to multi agency meetings to progress the plan so were unaware of other issues affecting the family.

| **PRACTICE LEARNING POINT** |
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| Good practice was seen by the Medway social worker in being persistent in ensuring visits took place even when they had to be rearranged. There is good joint working and evidence of relationship building with the family and direct work.<br><br>The decision to end the Child Protection Plan at the first review however was premature. This did not match the longevity of the concerns or follow local protocol in Medway. Further, there was no provision made to complete a Graded Care Profile 2 (GCP2) to address the impact of chronic neglect. **More is said about this in paragraphs 5.7 – 5.15** |

**Practice Episode: April – August 2022. The family are supported on a Child in Need Plan.**

4.9 The family continued to be supported by a Child In Need plan in the summer of 2022. Mother fell pregnant during this time but miscarried. There was a mixed picture at this time in terms of reducing risks to the children – S1's school attendance was good, and he presented well in school. Whilst this was positive progress, there were also two concerning referrals. In May, school were called by an anonymous referrer who reported the children asked for food and S2 said that her mum was 'getting drunk'. Mother denied these allegations saying that they were malicious. No further action was taken in relation to this but the Child In Need Plan continued without reference to Mother seeking support for her alcohol use. **NB** Mother would have been pregnant at this time of this referral.

4.10 Early in May, Mother contacted her GP practice with pregnancy associated sickness and was signposted to the community midwifery services. At this time, it was also disclosed that she had had seven unregistered pregnancies. Agencies were largely unaware of these.

4.11 At the next Child In Need meeting, it was noted that S1's school attendance had significantly deteriorated, and Mother was struggling with having miscarried and was said to be 'low'. Not long after this, another anonymous referral was made to the 'Out of Hours' service – the caller was concerned that the children were left alone for long periods and Mother had been heard shouting at them. There was no response to this, and it was not discussed with Mother or other agencies. Reports at the next Child In Need review meeting were positive and the family were closed to Medway Children's Social Care.

**PRACTICE LEARNING POINT**

The multi-agency assessment of Mother's care of the children during this period was optimistic. Given previous concerns, the referrals should have elicited a formal response to support the network's understanding of the children's day to day experiences and make improvements to their outcomes.

There was a lack of curiosity from the GP about Mother's pregnancies and no exploration of how her relationships may have impacted on the children. The GP noted many miscarriages, but this information was not collated, analysed or shared with anyone in order to support the family.

**These areas are explored further in paragraphs 5.11 – 5.15**

**Practice Episode: January and February 2023 Referral to the Maternity Safeguarding Hub and issues with housing.**

4.12 Mother fell pregnant with Laura in the autumn of 2022 and booked her pregnancy with the midwives. At booking, Mother disclosed previous social care involvement. In 2023 (the main period of antenatal care), there were a number of missed or rearranged appointments and Mother was offered targeted support for the duration of her pregnancy due to her history. An appropriate referral was made to The Maternity Safeguarding Hub (MSH) and discussed there in January. The decision was to provide the extra support but not to refer to social care at that time. A transfer to Team Connect[1], a 'Did Not Attend' (DNA) checklist and a Maternity Support Form (MSF) were all commenced at this time.

4.13 At the same time, Mother was reporting issues to Bromley Housing about her property in Medway. She contacted them stating that the property was damp and mouldy, and she was staying with her sister. Housing staff visited and noted that the conditions of the house were very poor and uncared for. This had not been the case when the property was allocated. Mother was again advised about how to deal with the mould which had worsened since the previous visit. Mother had not acted on the advice, and housing workers hypothesised that Mother was not living there most of the time.

**PRACTICE LEARNING POINT**

The detail of the family history was shared at the Maternity Safeguarding Hub including information about the recent social care involvement, but the decision was not to refer to social care at that time. Women referred to the Maternity Safeguarding Hub and how these are assessed in Medway is an issue from previous Child Safeguarding Practice reviews, and this has resulted in changes to the system.

**These and other improvements to the DNA policy and safe sleeping are discussed in more detail in paragraphs 5.16 – 5.20**

[1] Team connect is a specialist safeguarding team within Medway's maternity service. The team delivers Medway's continuity of care pathway for women who have complex social needs.

**Practice Episode; March 2023 – Referral from school and further concerns from Bromley Housing**

4.14 In March 2023 S1's school contacted Medway Children's Services as Mother had requested help with S1's behaviour. The referral noted that Mother was pregnant. A few days later Bromley Housing also contacted Medway Children's Services because of the condition of her property. They had inspected and found evidence of drug paraphernalia and 'white powder'. The property was also extremely dirty. The family did not appear to be living there and as a result Mother was served with a 'Notice to quit'. Later in the month, Bromley Housing contacted Children's Services again as they were concerned about the extent and the way Mother was heard to be shouting at the children.

4.15 The family were allocated to the Early Help Service (Family Solutions) in Medway and an assessment was completed (initially delayed due to Mother staying with extended family out of the area). The emphasis of the planning was to get the children back into school and nursery, the need for long term housing, the family's limited finances, and preparing for the birth of the baby. Mother is said to have good support from her sisters, one who has recently moved nearby. The assessment did not address concerns raised about possible drug and alcohol use or neglect of the children.

4.16 The children did not return to school after the Easter break in March 2023.

| **PRACTICE LEARNING POINT** |
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| It is difficult to understand the rationale for the allocation to Early Help rather than statutory services under s17/s47, given the recent history and the concerns.<br><br>Multi-agency planning in terms of the network coming together to share information and plan the interventions would have given practitioners a fuller picture and supported a shared understanding of the children's lived experiences. There was no consideration to complete a pre-birth assessment.<br><br>**This is discussed further in paragraphs 5.24-5.25** |

**Practice Episode: April 2023 – June 2023 Missed antenatal appointments and further issues with housing**

4.17 Mother continued to miss antenatal appointments. This appeared to be due to a mixture of forgetting, staying with extended family out of the area, and not being able to attend appointments through lack of childcare. When appointments were attended, Mother engaged well, and the pregnancy was progressing as normal.

4.18 The family were offered further temporary accommodation in Medway, and they moved in the middle of May. This necessitated a change in health visiting team.

4.19 Laura was born in June with no concerns and discharged home soon afterwards. Good practice was seen when the two health visitors (one who was new to the team as part of her induction) visited together to complete the 'New Born Visit'. This was a

comprehensive visit, and many issues were discussed including immunisations, feeding advice and safe sleeping. Mother reported that she felt 'experienced' and described Laura as the easiest of her babies so far. She also mentioned however that she was trying to give up smoking and alcohol. This was different information than had been disclosed during the booking where Mother had said that she did not drink. The health visitors erroneously completed this visit under the universal pathway as, due to the change in health visitor team) they were unaware of safeguarding concerns.

4.20 The Early Help services continued working with the family through this period, but the multi-agency involvement and planning was very limited. This was not in keeping with policies and procedures in Medway.

| **PRACTICE LEARNING POINT** |
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| Safer sleeping and the risks associated with it were discussed with Mother by the midwifery service and the health visitors; co-sleeping was a factor in the death of Laura. This is a repeated theme from previous CSPRs, and improvements have been made to this area of practice since this time.<br><br>**These are outlined in paragraphs 5.21-5.23** |

4.21 In early July Laura sadly died and this Child Safeguarding Practice Review was commissioned to look at the collaboration between agencies for this family in the months leading to her death.

| **PRACTICE LEARNING POINT** |
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| There is a dearth of information about these children, their identities, lived experience and the impact of parental behaviour and what that meant for them.<br><br>**This practice area is explored in paragraphs 5.26-5.31** |

## 5 Findings/Lessons

### The impact of multiple house moves and homelessness on children's wellbeing and education.

5.1 There is no doubt that the multiple moves experienced by these children impacted enormously on their wellbeing and education. The family moved at least 4 times in the period under review and many more times prior to it. This was across local authority boundaries as well as within Medway. Mother often did not feel safe in the properties she was allocated and as a result often took the children to stay with family members. This was a major stressor for the family, and this is acknowledged in the written submission by Bromley Housing.

5.2 The difficulties in providing adequate housing in the south east is well documented and the demand for temporary accommodation outstrips supply. Housing departments often place families outside of their borders due to the shortfall, and the dichotomy between high rents and homeless families on a low income, is not unusual. Families placed in

temporary accommodation have little or no recourse to raise a complaint when properties are unsuitable or in disrepair, whilst their housing entitlement is being assessed. In this instance Mother did raise complaints about her property in Medway due to it being damp and subsequently cold. She was given advice about needing to stay there (she was often with family), keeping the property tidy and reducing the risk of fire. The property however, continued to deteriorate.

5.3 The review has noted difficulties for Mother in both navigating her way round the system and her lack of choice in where she was housed. The disruption caused by moves away from family networks, are all covered in guidance and housing departments try to avoid them. In this instance the suitability check list was completed and found to be appropriate but in reality, the choices on offer were very limited. This is due to the chronic shortage of available housing stock. Further, a reduction in the availability of spot purchased nightly paid accommodation over the last two years, has made it increasingly difficult for councils to procure 'in borough' temporary accommodation. At one point Mother was known to be residing between her property in Medway and family in Bromley, because she was finding it difficult to live there.

5.4 Local authorities are duty bound to provide suitable and affordable accommodation and to consider certain criteria before placing families in temporary housing. In this case there is evidence that the principles from guidance for best practice when placing families out of area was used and the property deemed suitable. Such guidance as provided by the LGA [2] offers a range of considerations for homeless families, not least about distance from amenities, networks and schools. Whilst the properties were the best available, they were still not ideal for the family. This, coupled with the lack of knowledge practitioners from other agencies had, meant more collaborative work was indicated.

5.5 This family had fourteen moves in seven years, across many different boroughs. They were placed in temporary accommodation and were subject to very disruptive life events such as 'notices to quit' and potential intentionally homeless decisions. During the period under review, whilst Bromley remained responsible for their housing, the responsibility for statutory services such as social care and education changed many times, creating further barriers to effective work. The number of moves is excessive and should have elicited more curiosity about the impact of this.

5.6 Bromley Housing's absence from statutory children's processes utilised throughout this period, hindered a mutual understanding of each other's issues, and therefore added to the risks faced by the family. The frequent moves between different local authorities hampered and delayed services to the children but also added to the challenge of practitioners really understanding the impact of their many moves. Bromley Housing struggled to offer more settled accommodation and had to make decisions (as they do for other families) that had far reaching consequences for them in every aspect of their lives. Bromley Housing consistently made s208 notifications but more direct contact with those working with the family would have been more effective. Housing staff in contact with Mother were unaware that agencies were working with her, and they were not part of the

[2]LGA guidance –2023 Guidance setting out best practice and procedure on out of area placements in another local authority area within England.
https://www.local.gov.uk/publications/local-government-out-area-placements-guidance

family's network. This is despite the fact that they had made safeguarding referrals themselves. **A recommendation is made at 6.4 to try and address this practice area.**

**The challenges of cross borough working to safeguard children experiencing chronic neglect.**

5.7 Through the process of the review, the children's situation has become clearer in terms of the chronic nature and longevity of neglect that they experienced through their lives. It is true that Mother was avoidant of some services, but the many moves (not of her making) placed barriers in the way of a consistent approach to identifying and addressing the neglect. There is an inherent risk for transient families in that although practitioners understand the need to exchange thorough information, the detailed information becomes headline, rather than comprehensive understanding.

5.8 Two further opportunities to fully understand the situation were not utilised – one in the premature ending of the Child Protection Plan in 2022 and another when Children's Services received referrals from Bromley Housing and school in 2023. In these referrals a number of parental issues went unassessed – e.g. Mother's drinking, lack of supervision for the children, possible drug use, children being hungry and asking neighbours for food, the poor home conditions and Mother's relationships.

5.9 The neglect experienced by the children was rarely named in Medway and although assessments were clear about the family history and contained good analysis, this didn't lead to robust intervention. The panel acknowledged from this review and from broader research that if neglect is not responded to it becomes worse, unhelpful parenting approaches become entrenched, and parent child relationships deteriorate. From relatively early on in the timeline we can see that Mother struggled with S1's behaviour. This became ingrained and the gap between S1's presentation and S2's presentation grew. School noted frequently that S1 came to school unkempt and at times without appropriate clothing for the weather, whilst in contrast S2 was extremely well dressed, very clean with elaborate hairstyles. School were very supportive to Mother and provided clothes and uniform to both children.

5.10 From March 2023, each report of concern was dealt with individually and there was no follow through to reassess on a statutory footing. Individual responses and fragmented information sharing meant that no one agency or practitioner held the overview of the family at any one time, and this facilitated the slow growth of neglect over time. This ended with significant cumulative harm at young ages for these children. Further gaps have emerged in relation to the dearth of exploration about Mother's excessive drinking and possible substance misuse and how much this was linked to the neglect of the children. The premature ending of the child protection plan in 2022 perhaps gave a false reassurance that these issues had been dealt with.

5.11 Agencies involved in the review also highlighted a lack of professional curiosity about Mother's relationships. Many pregnancies and subsequent miscarriages are a feature of her health records and 'unsafe' adults were referenced in the child protection conference in 2022. It would have been useful to explore more fully the events of the seven unregistered miscarriages to perhaps elicit more information about safeguarding concerns. These would include history of domestic abuse, drug or alcohol misuse, mental

health issues and the possible long term effects of these events may have had on Mother. The GP did not have access to mothers' previous history and so was unaware of much of it. The panel noted that opportunities to assess Mother's capacity to parent effectively were not unutilised.

5.12 Through the specific periods of intervention with the family, the available specialist tools, namely the Graded Care Profile 2 was not used to assess risk over time and to plan interventions. The tool (and others like it) is critical in identifying, naming and understanding neglect. It is particularly useful in helping practitioners understand causal factors of neglect and leads to solutions through agreed multi agency plans. It provides a framework for clear goals regarding children's progress (or lack of it) which are regularly reviewed and updated over time.

5.13 Medway Safeguarding Children's Partnership have been investing in the GCP2 neglect tool since 2019. The implementation across Medway is led by the Neglect Strategy Implementation Group, with partners from agencies across the district. Training on the use of the tool is provided and over 500 practitioners across Medway agencies have been trained. There are licenced practitioners across children's services in e.g. social care, Medway Community Health, Early years, education settings, and NELFT.

5.14 Despite this and the clear expectation that it is used, evidence from audits in Medway demonstrate low take up and the tool is not routinely seen on children's records. Another issue the review highlighted was that there is no centralised place where completed tools are saved, leaving the network unaware of what work has been done. There are clear learning points in ensuring that GCP2 assessments are completed for any child where issues of neglect are present, the sharing and review of these assessments is crucial, and that contingency planning ensures capacity where individual practitioners are not yet trained.

5.15 To achieve this sustainability, there is further work planned to implement this with the support of the neglect strategy implementation group and an action plan is in place. **This is linked to recommendations 6.7 and 6.8.**

**The identification referral and assessment of need and risks in pregnancy**

5.16 This is an area of practice that was identified as needing improvements from previous CSPRs in Medway and the review acknowledges that the issues are similar and cover the parallel time period. Many improvements therefore have already been put in place and will be the focus of reference in this section.

5.17 Four areas of practice in particular were identified.

- Considering history, information sharing and referral to the Medway Safeguarding Maternity Hub
- The DNA policy and its implementation
- Safe Sleeping advice
- Multi-agency pre-birth assessment.

***Maternity Safeguarding hub***

5.18 The review has recognised the lack of professional curiosity in relation to the areas cited above and in recognition of this new practice is currently being embedded. The changes have occurred to the referral and criteria for the Maternity Safeguarding Hub. This continues to be under review, but a summary of the changes are set out here.

- The Terms of Reference (ToR) have been reviewed and criterion have been agreed between social care and maternity services.
- The referral form to the MSH has been amended to prompt for more detailed referrals
- There is a new section on the referral form for Maternity Safeguarding staff to review the referral and add in the rationale if a referral is not accepted based on the new ToR; or, if it will be heard, it includes additional actions for the community midwife if needed.
- The new ToR and new referral form have been shared widely across organisations for feedback.

***DNA policy***

5.19 Changes to the DNA policy have also been implemented. The policy has been revised and is now live. It requires practitioners to evidence the date it commenced and provides clarity that it should start as soon as there are three *missed* appointments rather than 3 *consecutive* appointments. All checklists are reviewed by senior managers, and these are subject to audit arrangements to ensure compliance and address issues arising from them

5.20 Further, issues identified in relation to antenatal appointments are now taken to safeguarding supervision for further guidance and management oversight.

***Safe Sleeping***

5.21 Safe sleeping and advice given to families by both midwives and health visitors has also been revised since the death of this child and resonates with other reviews in Medway. Staff have been advised of the importance of clear documentation on the records about what was discussed with a family and that just 'ticking the box' is not sufficient. All staff are now expected to document exactly what was discussed.

5.22 Procedures have been updated to reflect that sleeping areas should be seen by the community midwife and documented as a minimum. Staff are encouraged for this to be seen at all contacts alongside safe sleepings discussions. Lullaby Trust leaflet should be given at all first day visits, with specific discussion on substance or alcohol use and co – sleeping.

5.23 These changes are new and need time to be embedded. There are no specific recommendations made regarding these as they are familiar issues with ongoing actions in place. Evaluation of the changes will be subject to governance and monitoring through normal channels.

***Multi agency pre-birth assessment***

5.24 In relation to the lack of pre-birth assessment, there is an acknowledgment in the review that this should have been considered more robustly both within the referral to the MSH and further along the timeline. The safeguarding partnership has a pre-birth procedure which outlines the importance of undertaking a pre-birth assessment in the context of vulnerability, and where the safety and well-being of parents and the unborn baby might be compromised. The procedure sets out the criteria for a pre-birth assessment and Mother met 3 out of the 12 listed. I.e. a child previously removed (albeit a considerable time previously), concerns about drug and alcohol use (prior to the pregnancy and as recently as March 2023) and missed antenatal appointments throughout the pregnancy.

5.25 From information captured in the review, this was overlooked, largely due to the lack of a co-ordinated multi agency approach within the Early Help plan. As mentioned earlier in the report, the rationale for Early Help support rather than statutory services is difficult to fathom in the context of this family's history. Moreover, it would appear that there were no multi agency meetings to plan and support the intervention, therefore the entirety of the information never came together. This is not in keeping with the practice standards for families in Medway who receive early help services which states there should be six weekly review meetings. **Recommendations are made at 6.3 and 6.6 to provide clarity to practitioners about pre-birth assessments and to strengthen multi agency engagement in Early Help.**

**Assessing the needs of the children (including the unborn) and their lived experience.**

5.26 Although there is evidence of direct work in the assessments conducted, the written submissions give very little sense of who these children were. There was no exploration of wider family members (including their respective fathers) and relationships that the children had, no expression of how they saw themselves, their unique identities, sense of belonging or key friendships they may have had. S1's behaviour was challenging at times but there is scant detail about what this meant for his relationship with this Mother and sibling. He is a child who appeared to 'stand out' as different and this is an important factor in his development and sense of belonging.

5.27 A genogram is a useful tool to start further exploration of the nuances of families, including where they spent their time and who with. The many reports of Mother and the children being with 'extended family' (sisters, maternal grandparents) were accepted without practitioners understanding what that meant for the children. Specific exploration with the children after the various concerns were raised, would have provided a more complete picture, and enabled further understanding of the children and their lived experience. This in turn would have assisted in planning and likely to have led to increased intervention that was more readily viewed through a safeguarding lens. At the conclusion of the review there was little additional information about the children's fathers or their extended families which is likely to reflect the lack of records on this subject.

5.28 Relationship based practice and direct work with trusted adults empowers children to be able to tell their story and be part of the solution to resolving difficulties. Practitioners therefore need to be skilled in eliciting the wishes and feelings of children and using their words and stories to assess risk and plan accordingly. Children need to be spoken to alone and practitioners (with help from their managers) should apply an analytical

approach and consider all the available information when children disclose concerning information.

5.29 Balancing what children report with the differing accounts that parents may have is common in multi-agency work, and represents a challenge when accounts conflict. The concept that, first and foremost, practitioners should listen to children does not seem to have been applied. For example, the children's account of asking the neighbours for food and Mother getting 'drunk' was dismissed in favour of Mother's account that the referral was 'malicious'. Neglectful episodes were seen in isolation, instead of gathering more routine information about their day to day lives.

5.30 Through the process of the review, these children's experiences have become clearer but there is very limited information about their specific identities. Exploring issues of intersectionality[3] would also have been a helpful framework to aid practitioners' understanding of them. As a family they encountered multiple disadvantages, and multiple barriers to accessing services.

5.31 The children had different fathers and therefore different extended family which was not explored. S1 is a mixed heritage child (White and Black Caribbean) brought up in an otherwise white family. The children were brought up in a single parent household, were adversely impacted by poverty, poor housing and multiple moves. The cumulative effect of these factors was not evident across the multi-agency network. Services who support children in Medway, need to be cognisant of the impact of specific factors such as race, gender and family background and use these factors to establish risk. **Recommendations are made at 6.1 and 6.5 to equip practitioners with the skills and knowledge to assess children's needs through the lens of intersectionality.**

## 6 Recommendations

6.1 The Medway Safeguarding Children Partnership should reassure itself that all partner agencies have robust systems in place to ensure that fathers and other significant males are actively considered in assessments and ongoing work with families.

6.2 Medway Foundation Trust and Kent and Medway Integrated Care Board should continue their work on ensuring robust liaison between Midwifery services and GPs for pregnant women. This should include reviewing and modifying current systems to ensure that there is an exchange of information (I.e., two way communication) about both parents (and partners) during pregnancy. This work should pay attention to the importance of professional curiosity when exchanging information.

6.3 The Partnership should issue reminders to practitioners and managers about the importance of following the established multi agency procedure for the pre-birth assessment pathway. The procedure should be reviewed and updated to reflect the learning from this review and the steps that should be taken where there is a lack of certainty about the need for an assessment.

[3] Intersectionality is the interconnected nature of social categorisations such as ethnicity, race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage

6.4 To promote and support best practice between the Local Authority Housing Services, and Children's Social Care, Medway Safeguarding Children Partnerships should review relevant protocols to ensure effective joint working. This is with particular relevance to families where housing issues are identified as an additional need (e.g. where it is causing interruption to services) or are integral to children's protection. The Partnership should also review Housing representation in the Partnership through relevant sub groups.

6.5 Considering the findings in this review about children who experience multiple oppressions and disadvantage, professionals in the MSCP should also be equipped with the knowledge and understanding of intersectionality to properly identify and consider these factors when assessing and managing the risk to children.

6.6 Medway SCP should oversee a programme of work that focuses on strengthening multi agency involvement and contribution to assessment, planning and review for vulnerable children across services that provide Early Help.

6.7 The MSCP's implementation of the Graded Care Profile 2 (GCP2) should continue to progress the consistent use of the tool with families who have Child Protection Plans for neglect. Also ensuring that all families that have neglect identified in a Child in Need and Early Help assessments and plans are being offered the earliest opportunity to engage with the GCP2.

6.8 Progress is underway to review MSCP's Neglect Strategy. A recommendation from the review is to provide clarity for practitioners that for families where a key concern is their living arrangements, the impact of homelessness, poor housing or many moves must be incorporated and assessed along with other factors.

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January 2025