MSCP Local Child Safeguarding Practice Review (LCSPR) Briefing

Laura – January 2025

Safeguarding Children Partnerships undertake a Local Child Safeguarding Practice 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 for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of children. This publication aims to share the learning from LCSPR Laura to allow professionals to reflect on their own practice.

Trigger event

In 2023 Laura, her mother and two older siblings having been away with relatives at a caravan park returned home late, and all slept in the same bed. The following morning, mother woke to find Laura unresponsive, she could not be revived and sadly died, she was 20 days old. The older two siblings were immediately placed into Police Protection.

Summary of known background

At the time of Laura's death, her and her family were being supported by Early Help services.

In the past and before Laura's birth, the family had been subject to court proceedings, child protection and child in need planning. Laura's mother had herself been a child known to children's services due to parental substance use and domestic abuse.

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. In addition, the children's fathers were largely unknown to services during the timeline.

Findings

Findings from the LCSPR in respect of learning are summarised below:

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

- There is no doubt that the multiple moves experienced by these children impacted enormously on their wellbeing and education.
- The family had 14 moves in 7 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. This number of moves is excessive and should have elicited more curiosity about the impact of this.

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

- Through the review, the children's situation became clearer in terms of the chronic nature and longevity of neglect that they experienced through their lives.
- Opportunities to fully understand the children's situation including 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 were not utilised.
- 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.

- There were times when reports of concern were 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.
- There was a lack of professional curiosity about mother's relationships and the panel noted missed opportunities to assess mother's capacity to parent effectively.
- Despite clear expectation the Graded Care Profile 2 (GCP2) tool was not used to assess neglect risk over time and to plan interventions. The tool is critical in identifying, naming and understanding neglect.

The identification, referral and assessment of need and risk in pregnancy.

- This area of practice has been identified as needing improvement from previous LCSPRs in Medway and the review acknowledges that the issues are similar and cover the parallel period.
- Four areas of practice were identified through the review 1) considering history, information sharing and referral to the Medway Safeguarding Maternity Hub, 2) the Did Not Attend policy and its implementation, 3) safe sleeping advice and 4) multi-agency pre-birth assessment.

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

- Written submissions to the review gave 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. Neglectful episodes were seen in isolation, instead of gathering more routine information about their day to day lives.
- The many reports of mother and the children being with 'extended family' were accepted without practitioners understanding what that meant for the children
- Balancing what children report with the differing accounts of their parents 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.
- There was very limited information about the children's specific identities. Exploring issues of intersectionality[1] would also have been a helpful framework to aid practitioners' understanding of them.
- The children had different fathers and therefore different extended family which was not explored. One of the children is a mixed heritage child 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.

Good practice and improvements from previous Medway LCSPR

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 was good joint working and evidence of relationship building with the family and direct work.

Safer sleeping and the risks associated with it were discussed with mother by the midwifery service and the health visitors; unsafe co-sleeping was a factor in the death of Laura. This is a repeated theme from previous LCSPRs, and improvements have been made to this area of practice since this time.

Changes have occurred to the referral and criteria for the Maternity Safeguarding Hub.

[1] 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

Changes to the maternity services Did Not Attend policy have been implemented and was live at the time of the LSCPR. It requires practitioners to evidence the date it commenced and provides clarity that it should start as soon as there are 3 *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.

Recommendations

1. The Medway Safeguarding Children Partnership (MSCP) 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.

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.

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.

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 subgroups.

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. The MSCP 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.

7. The MSCP's implementation of the 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.

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.