Local Safeguarding Practice Review 'William' for Kent Safeguarding Children Multi-agency Partnership

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Introduction for William: why has this report been written?

1. Dear William, I am hoping that you will read this when you are a teenager. I wanted to tell you about why there is a report about you and Brooke, your sibling. This is a multi-agency Local Child Safeguarding Practice Review of the work of the different agencies that worked with you and your family from the time that your mum became pregnant with you in 2019.

2. My name is Josie Collier and I have worked as a social worker, although now my job title is 'Independent Reviewer', which means I write these reports! I don't work in Kent and didn't know any of the professionals (the people that worked with your family) that I have met. The rest of this report is going to be written for all of the professionals (nurses, midwives, nursery workers, doctors, early help workers) working with children and families in Kent. So if you do read it, sorry if it is a bit long!

3. Reviews like this are carried out to see what help worked well for your family and what made that help work well. The Partnership also wants to know what professionals might have done differently and what might need to change to make all help for all families in Kent really good. This review has been carried out by agencies writing reports and through conversations with the professionals that knew your family. I also met with your mum to ask her about the help your family had received.

4. Kent Safeguarding Children Multi-agency Partnership carried out this review because someone, possibly close to or in your family, hurt you when you were only 22 months old. After this happened, professionals worked hard to make you safe and make you well again and you moved to live with a foster carer.

5. At this moment, in early 2023, I don't know quite what happened to hurt you. The police are trying to find out. What happened to you was a shock to professionals that knew you and your family and none of them could have known it was going to happen. The police are still trying to find out who hurt you and to decide if anyone might go to court because of this.

6. Hopefully this report will be a good thing for all children, because people like me write these reports to help professionals do the best job that they can. Some professionals do really great work to keep children safe and happy when they are living at home with their families.

7. It might be that when you get this report, some words are covered up – this is because they might be about other people and so private to them. This might include quite a bit about Brooke. You will also see that the names of professionals that worked with you are not mentioned – this is because they have a right to privacy and this report will be published so that anyone who wants to can read it.

8. This version calls you William, we did this to protect your privacy. I hope you get some help reading this from a trusted adult in your life who will help you understand it. The next part of this report is also for you, William. It is a summary of the rest of the report with the main findings and learning points.

Summary of the report for William

9. Getting the words right so you understand this report is important. I hope that I have written this part in a way you can understand.

10. Paragraphs 20-26 are about **how** I was asked to write the report (this is called the '*Terms of Reference*'). This part also talks about what we have tried to learn about other small children living in Kent who were hurt by people in or close to their family.

11. From paragraph 27-34 I have written about which professionals were involved with you, your sister and your mum, before you were injured. This happened when you were living with your mum and sister at your grandmother and grandfather's house. Your family had help from midwives, health visitors and nursery nurses, Early Help professionals, doctors, police officers, two nurseries and other organisations that help families in Kent.

12. All of the organisations they worked for (sometimes called agencies) such as hospitals, doctors' surgeries, and Kent Integrated Children's Services (social services) wrote reports about what had happened. Some of the professionals met together with me to talk about their work with your family. There was lots of help from some really kind people. They knew your family well. Some facts about your family are written at paragraph 35 but I know that there is much more to your family than these.

13. If you go to paragraph 42, you can read about how important it is for professionals to try and understand if they should be worried about a child, like if they might be being hurt or not cared for properly. When professionals are worried about a child, they should report it. If a family needs help, the professional should ask or request help and support. We call this *'making a referral.'* People that worked with you were good at seeing when your mum was struggling or listening to your mum when she needed help and always tried to get the right people to help your family.

14. If you go to paragraph 52, I write about how important it is that professionals should understand families and one part of that is to understand the family's history. Things in the past often help us explain what is happening to children now. But it takes time to find out about and sometimes people are busy trying to help families now and don't have time to look at the past. So, I have made a recommendation about how to help professionals know about a family in the past as well as work out what is happening for that family now.

15. From paragraph 58, I have written about how important it is for professionals to understand a child's *'lived experience.'* This means seeing what everyday life was like for you and your sister. So, *what you ate, what you wore, what your bedroom was like? Where you played and who with, what you liked to do, what you were good at and what your mum was like with you? Who were the important people in your life?* You were quite a small baby but Brooke was a busy toddler. Professionals working with you and Brooke were really good at understanding your lived experience. They visited you, played with you and saw you with your family. William, you were a smiley baby who was always clean and well fed and who really liked playing with his sister.

16. Professionals also need to understand what is working well for children and what could be better for children, as well as understanding if there are any people who do things that might be dangerous to you. These dangerous things are sometimes called *'risks'* and it is the job for professionals try to find out about the risks - if something has happened near a child and whether it might hurt them. I hope that professionals are good at knowing about these risks and what to do when they see them. I write about this at paragraph 70. Professionals were sometimes worried about your mum being depressed and sad, but also that some of the adults in your family had fights which might have been scary for you and for Brooke. Sometimes professionals were really good at seeing and understanding these possible risks and getting help for your mum.

17. In paragraph 87, I write about how different professionals worked together to help your family. We call this '*collaboration.*' We know from lots of other cases that are reviewed that this is a good thing. Some of the collaboration was really good. For example, the health visitors and Early Help Worker spoke to each other quite often. Nursery workers talked about Brooke with the health visitor. However, the GPs (family doctors) could have been more involved. It would have been best if everyone had met together with your mum to talk about helping your family and whether their help made a difference to your family.

18. When you were hurt, none of the professionals knew that one of the people around your family might be dangerous. I hope that wherever it is possible, that all professionals and organisations can share information about people that are known to be dangerous to children, so we can stop them hurting you. Some of the law around information is complicated. The last section at paragraph 97 is about what agencies might be able to do differently: it is possible to put a flag on the computer records so that everyone will know that person might be dangerous to children.

19. The last section is about my suggestions or recommendations to help make safeguarding children in Kent even better. I hope that this helps you read the parts of the report you might want to read. But if you don't want to read it, stop reading now! Spoiler alert: The rest of the report is written slightly differently as it is for the professionals and their bosses and their bosses' bosses. This report will be shared with all the people that helped me to write it. Then the Kent Safeguarding Children Multi-agency Partnership should work to make these recommendations in the report happen so that it makes it even safer for children in Kent.

Terms of reference, methodology and timescales for this LCSPR

20. The incident which caused the injuries to William took place in March 2022. A Rapid Review was conducted and sent to the National Panel for Child Safeguarding Practice Reviews in April 2022, recommending a decision to hold a Local Child Safeguarding Practice Review (LCSPR). In May 2022, the National Panel responded, agreeing with the KSCMP's decision, commenting on the key lines of enquiry that *"it might be useful for Safeguarding Partners to build on analysis of, and the impact from, previous local reviews and action plans featuring non-accidental injury in young children."*

21. The Terms of Reference were drafted and finalised. This review has been conducted using an Appreciative Inquiry approach – an explanation of which is given in the Terms of Reference.

22. The Independent Reviewer was commissioned and began work in September 2022. The five agencies completed their single agencies reviews at the end of November 2022 and a professional engagement event was held in December, including a midwife, health visitors, an Early Help professional and a police officer. Regrettably the GP was not in attendance but both the family GP and the GP for Partner 3 later contributed through conversations with the Independent Reviewer.

23. This version of the report has been signed off by the KSCMP on 4th May 2023 – it is intended that it will be published once any criminal investigation and proceedings and family court proceedings are completed.

24. The key questions that have provided a framework for the review and this analysis are:

- **What are the areas of good practice in this case and strengths in the system that can be identified and built upon?** *(E.g. effective liaison between professionals)*
- **What are the contributory factors to good practice or these strengths?** *(E.g. professional 1 already knew the mobile number of professional 2 as they work on another case together.)*
- **What might be done differently in order to improve or enhance practice or the effectiveness of the safeguarding system?**

25. During the period under review, the mother and her children had received support and intervention from the following agencies – all of these agencies submitted an agency report:

- Kent Integrated Children's Services (ICS): including social work and Early Help.
- Kent Community Health NHS Foundation Trust (KCHFT): health visiting including the delivery of the Family Partnership Programme (services commissioned by Kent County Council).
- East Kent Hospitals University NHS Foundation Trust (EKHUFT) – community midwifery, paediatrics and acute services.
- Kent and Medway Integrated Care Board (ICB) commissioning General Practice.
- Kent Police.

26. In December 2022, a professional engagement event was attended by professionals from Early Help; health visiting, midwifery and Kent Police. After this event, there were some follow-up conversations with two Early Years settings (to be referred to though the report as EY1; EY2), who contributed to the review via a conversation with the Independent Reviewer. The reviewer also had a conversation with GP 1 (GP for partner 3) and GP 2 (previous safeguarding lead at the family's practice, who reviewed the file but did not have direct contact with the family).

Summary of the case and professional intervention.

27. The start of the period under review is August 2019 when the mother became pregnant with William by a man (Partner 2). The mother told professionals she had had a *'one-night stand*' with this person. At this time the mother had one child, Brooke (born in 2018), with a man (Partner 1) with whom she had a relationship characterised by domestic abuse and conflict.

28. The end point of the review period is the incident which led to William sustaining serious injuries to his leg and arm in March 2022 whilst at home with his family. At the time, the mother and her children were living in an annex at the maternal grandparents' home. The

incident was unexpected and not preventable. No service had had contact with the mother since November 2021.

29. Professionals working with the family did not know that the mother had a partner during this time, apart from the local nursery that Brooke had attended. Staff there had heard mention of Partner 3's name but had no other knowledge or concerns about him. After the incident, it became known that the mother had commenced a relationship with Partner 3 approximately 10 weeks before the incident. Partner 3 was subsequently understood to have visited, rather than co-habited with the mother. It also became known that Partner 3 had several relationships with women at the same time. Both the mother and Partner 3 were arrested after the incident and at the time of writing (in April 2023), they remain on bail.

30. After the incident, it was identified that Partner 3 was known due to an incident involving another child under 2, to present a risk of physical harm to small children. He had not received a conviction for this, this fact had been established, on the balance of probabilities, by the Family Court in 2019.

31. William and Brooke remain in foster care and are said to be doing well. William has ongoing medical intervention due to the injuries sustained in March 2022.

32. During the period under review, Brooke had attended two different nurseries. She was also referred at points for further developmental assessments due to her mother's concerns regarding her behaviour, however, these did not proceed due to non-engagement with developmental assessments by the mother. It is also known that the mother was referred to other interventions or community groups by Early Help and midwifery – these included Porchlight, Home Start, Building Blocks, a Solihull parenting online course, and the Mother and Infant Mental Health Service (MIMHS). She was also referred for counselling by the GP. The mother did not engage successfully with any of these services.

33. At the practitioner engagement event, the attendees offered an honest appraisal of their intervention. The mother regularly approached services to get help from professionals and made contact when she needed help, although was less easy to contact at other times. Professionals agreed that she needed help. Professionals reflected on the mother's pre-occupation with her phone, social media and deep anxiety around what others thought of her. It was suggested that she was not dissimilar to other young mothers of her age in the locality. Professionals felt that there was a deep-rooted lack of self-efficacy underpinning the mother's behaviours. Whilst they suggested that *"she got it,*" the professionals who worked most closely with her felt that they were at times repeating themselves, whilst the mother reported the same continuing concerns regarding her children. Nothing seemed to change as a result of intervention. Possible reasons for this will be described later, but the lack of change suggests that the mother had not *"got it."* The mother appeared to rely less on professionals only when she moved back to live with the maternal grandmother. The mother's recollection of this is different. From her perspective, professional support to her family had disappeared once William turned one.

34. In discussion with the mother, she recalled asking for help several times – when Brooke was born; when she was having a difficult time with Partner 1 and when William was born and she did not know how to manage the needs of a toddler and a baby. Mother recalled she

had wanted some help to make it better for herself and her children. Mother spoke about how she felt she lacked confidence and how anxious she felt about everything – that the slightest negative thought could get bigger and bigger in her mind. The mother felt that this was a major issue for her and that no one had helped her with this.

Features of the family

35. This report will be anonymised and so a genogram will not be provided in order to preserve confidentiality, however a summary of what was known by professionals working with the family during the period under review can be offered:

- The mother was nearly 20 when Brooke was born and 22 when William was born. This was the family unit that this review of practice focusses on.
- Brooke's father (Partner 1) was a similar age to the mother and the relationship broke down whilst Brooke was a small baby. There had been a series of low-level Domestic Abuse notifications between the mother and Partner 1 – allegations and counter-allegations during 2018-9, which resulted in the case being discussed twice at MARAC (the Multi-Agency Risk Assessment Conference) in late 2018 and early 2019. Then this father was not involved with his child during the period under review due to a non-molestation order being in place.
- The parental relationship was fraught then they had minimal contact, although professionals understood that Brooke's paternal grandparents often had Brooke and then also William to stay with them.
- William's father (Partner 2) was not known to be in a relationship with the mother: she reported that it had been a one-night stand. She mentioned he was on licence at the time. Partner 2 disputed paternity and the mother told professionals that William's paternal grandmother (Partner 2's mother) regularly harassed her about her assertion that Partner 2 was his father.
- Partner 3 was involved with the mother at a time after active agency interventions had ceased. Professionals were not actively involved in the family at the time, apart from Brooke attending EY2.
- At that time, Partner 3 was known by some agencies that he posed a risk of physical harm to young children. He has a history of mental illness, criminal activity and substance misuse.
- The wider maternal family were visible to services. The maternal grandparents have 6 children in total. The mother is the oldest – at the start of the period under review in August 2019, there were 4 other children aged 17 to 3 years in age. The ICS records show that the maternal grandparents had another baby, a month before William was born.
- Between 2015-2017 there had been 4 referrals to Early Help regarding the wider maternal family. These were made due to difficulties regarding parenting difficulties for the maternal grandparents with their 3rd child, but also for allegations of domestic abuse, particularly around coercive controlling behaviours by the paternal grandfather.
- The paternal grandfather went to prison on remand during the period under review for serious drug-related offences and is understood to be on remand.

Local Learning Themes and their relevance for this case.

36. In May 2022, the KCSMP published a thematic study regarding a cohort of children under the age of 2 that were notified to the Partnership over a 3 year period: the Thematic Review of Harm to under-2s. The majority of these children had suffered non-accidental injuries and some of these children were under 3 months and had not been known to agencies other than those offering universal services.

37. The methodology for the KSCMP thematic study included some innovative engagement with those in practice that shone a light not only on practice in individual cases, but also more broadly on some of the challenges in safeguarding practice in Kent. Some commentary is offered here regarding that analysis in relation to this case.

38. The thematic review acknowledged the complexity of families in some of the cases and identified features such as a family history of violence or criminality. The study suggested that in some cases, the deeply engrained family patterns were too significant for professionals at early stages of intervention to reverse. Some of these features are recognisable in William's wider family network, with at least three reported incidents of domestic abuse between the maternal grandparents whilst the mother was a child, and 2 more whilst the mother lived with them after Brooke was born. As well as domestic abuse in the mother's adult relationships, the mother was also known to have a long history of poor mental health and a diagnosis of depression by the GP in 2018. In discussion, the mother referenced her life experience and suggested that she did not know what a 'normal' relationship was, having grown up in her family where parental conflict and domestic abuse, as well as emotionally harmful parental behaviour were the norm.

39. All of the professionals involved in the review observed that there were high levels of deprivation, vulnerability and risk in the local area. William's family did not stand out as unusual in any way – domestic abuse and mental illness are common features in most of the families that use universal or targeted services at support level 1 and 2[1]. Professionals offering services at this level of need reflected on the increasing complexity in families within the caseloads for their services, which are offered on the basis of voluntary engagement. The Early Help professional in this case stated that the wider family had been known to Early Help *"for years."*

40. The evidence in Kent's thematic review indicated that professional response to the needs of families were impacted by the restrictions of Covid-19 lockdowns. The impact of lockdowns included national instructions to some agencies not to conduct home visits. Employers, on the medical advice at the time, instructed some staff to shield. This was significant for the family in this case as well as the professionals and the inconsistency in how national instructions were applied was noticeable. This is vital context for this case and is referred to throughout.

41. A key conclusion of the KSCMP review is that basic practice with families works. This is defined as "*Multiagency collaboration, good quality assessment and case-recording, management supervision, building meaningful relationships with families and offering*

[1] https://www.kscmp.org.uk/guidance/kent-support-levels-guidance

creative and practical support are basic requirements that most would likely highlight as essential for effective safeguarding." This is the basic benchmark for what good practice might look like in this case. In this case, in some of these practice areas, professionals excelled – especially around the relationships they tied to build and the nature of some of their support.

Themes specific to terms of reference

42. The following themes were specified in the terms of references as lines of enquiry. However their ordering has been adapted in order to avoid repetition or duplication of content.

Early identification and referral

43. There was good practice in this area by all agencies. From the point of Brooke's birth, she and then William's birth were regularly seen by professionals until approximately July 2021 after the mother had moved back in with the maternal grandmother and her siblings. Throughout that time, professionals identified changes in the family circumstances, often a decline in the mother's mental health and her increased anxiety. In reflecting upon the case, professionals identified that much of the mother's difficulties lay in the fact that she needed her own mother to parent her: the mother clearly felt this absence as a gap and professionals understood that the mother's own challenges in parenting her children were affected by her own experience of a lack of availability by her mother.

44. There was a recognised need for ongoing parenting support: *"this mother needed something more."* Across the key agencies involved, there appeared to be a sense that the mother lacked confidence, the emotional attributes and practical strategies to effectively parent her children. However, at the same time she was able to meet their physical needs around clothing and food more than adequately. In the system, professionals observed this and responded to this at the initial stages of their own intervention, but also ensured that they referred, signposted or handed-on the family when their intervention was ending or Mother began to dis-engage. Professionals were proactive and saw it as their role to ensure that the family had the appropriate support at those points in time. So, for example, when the mother had moved into her flat with Brooke and her engagement had become more sporadic with Early Help, there was a useful closing summary but also a conversation with health visiting who initiated the involvement of a Health Visiting Nursery Nurse to commence some parenting/behaviour management support with the mother, thus ensuring ongoing professional contact.

45. Another episode which demonstrated this sense of professional accountability to ensure a family had the 'right' help can be seen in the pattern of referrals to other related services made by the midwife. Just prior to William's birth, the midwife requested Early Help support which was responded to in a timely way. She also ensured that the specialist mental health midwife held a conversation with the mother. Just after closing the case at 28 days post-partum, the distressed mother contacted the midwife. The midwife provided an appropriate response but also made a referral on to the MIMHS, now the Perinatal Mental Health Community Service. Again, good practice here can be characterised by kindness and a proactive response by professionals.

46. During a second period of involvement, Early Help were proactive in referring to community organisations after William was born, (including Homestart, Building Blocks, KCC Family Fund, Porchlight) as well as advocating for Brooke to be in nursery when COVID resulted in a delay with being offered a place. All of these services were relevant to the family's needs, however, there was a need to co-ordinate these in order to maximise their potential impact for change. When adding these to the existing involvement of Early Help, Health visiting (with a more intensive offer from Family Partnership workers); the Mother and Infant Mental Health Service (MIMHS), the GP, and visits to the Emergency Department as well as the Ear Nose and Throat clinic, this amounts to potentially 10 agencies being involved or making offers of help with the family in the summer and autumn of 2020. Without effective co-ordination, this could feel overwhelming for a parent.

47. Although operating somewhat separately from the safeguarding network, evidence was given by GP2 which suggests that appropriate action was taken to address mother's poor mental health, offering her medication, attempting to contact her when the prescription needed renewing and making referrals to counselling for her. In discussing the case with GP2 and colleagues in the practice, it is clear that mother was well known to the practice and known to not comply with any treatment for her mental health for long. There is no evidence to suggest mother's non-compliance was shared as a source of concern by the GP practice with other agencies working with her. From the mother's perspective shared with the review, none of the interventions around her mental health offered made a difference to her and what she felt her underlying problems were, neither the medication nor the counselling.

48. It is of interest that this pro-activity and willingness to help or find help for this mother sits alongside the erratic nature of her engagement and the statements which she made to some staff e.g., to the nursery in early 2021 that she had no help; to the GP pharmacist in July 2021 that she had no one to help her. Professionals and other staff who contributed to the review agreed that there was something about the mother which encouraged the willingness to offer help and even *'mothering'* from a network of caring professionals. However, even this did not seem to meet the mother's needs.

49. Professionals working in this area of Kent demonstrated a real commitment to help and support to families who needed it, taking the initiative to try to make services work for the mother as well as going beyond e.g., making referrals after their involvement had finished. For the professionals involved, '*doing nothing'* in their work is not an option, and if their service was not working there would be consideration of who else might help. The mother was able to reflect upon what she had found helpful. She suggested that her health visitors that she had with both children had been "*amazing"* and *"good."* When she was asked why, it was because the health visitors had helped her get certain things *"sorted out,*" such as securing medical appointments around her concerns for Brooke's health, confirming the sense of accountability that professionals had demonstrated.

50. An additional contributory factor to the strength of practice in this area with the professionals involved is that several of them have worked in the area for a long time and know the area well. Local knowledge combined with existing professional relationships meant that the family were helped or signposted in the right direction.

Learning point (a) : *Good safeguarding practice is enhanced when it takes place within a culture of accountability, proactivity and willingness to offer help or find help for families, with established and stable professional networks.*

Consideration of family history

51. The need to understand a family's history, pre-existing risk and vulnerabilities and to recognise cumulative harm within families is emphasised in the overview of learning from Serious Case reviews by Sidebotham et al[2]. This is also a key theme in the KSCMP thematic review. As already identified, the family were known to have a history of contact with agencies. This history was referenced by professionals although the understanding of this history appears as vague. Subsequent consideration of the impact upon the mother of her history within this period under review appears as limited to professionals having some knowledge. But extending that knowledge to inform or target their practice or interventions was limited, for example, actively exploring the significance of the history with mother.

52. This statement is not news for some of the professionals involved. This was not an oversight or shortfall: the Health Visitor, also a Family Partnership lead, described the frustration of the limitations upon her due to Covid-19 restrictions. This prevented them from fully implementing the Family Mapping exercise when commencing work with the mother and children. This exercise was designed to put the focus upon unpicking some of the deeply entrenched family patterns as part of an intervention. But it was not possible to complete over the telephone as it requires the professional to utilise some very nuanced relationship-building skills. In conversation, the mother echoed the frustration felt – she recalled being offered services over the telephone as *"awful"* and recalled the extent of her isolation at that time.

53. Prior to the period under review, there had been two child and family assessments conducted by Children's Integrated Services where Brooke was a subject child. Mother and Brooke were residing with the maternal grandparents. The first assessment was commenced after Brooke was seen to have had an injury to her ear. This was not evidenced to be non-accidental, so the case was stepped down to Early Help. The second assessment was initiated due to a *'high risk'* domestic abuse incident between the maternal grandparents. Their own 5 children had been present as well as the mother and Brooke. This assessment led to a Child in Need (CIN) plan for the maternal grandparents and their children, whereas the mother and Brooke's case was stepped down to Early Help. The agency author evaluated that it was at this point where the significance of the history of domestic abuse in the wider family but also between the mother and Partner 1 was lost to the Early Help professional who first held the case. The reason for their subsequent intervention appears to be around a single issue, that of supporting a move to appropriate housing for mother and Brooke away from the wider family. Moving them away from domestic abuse was a protective solution, but the ongoing help failed to recognise the ongoing often traumatic impact of having lived with domestic abuse as a child, and then experiencing it as an adult. The mother, in conversation, alluded to this having been her experience.

[2]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf

54. However, despite these previous assessments, knowledge of the family history amongst professionals involved from 2020 appears to have lacked clarity, especially around the history of domestic abuse. There are two aspects to this:

- The level of understanding of professionals working with the mother regarding her experience of growing up with domestic abuse appears as perhaps basic (there had been at least two police reports during her childhood and further allegations by the maternal grandmother regarding her husband during a self-referral)

- the absence of understanding and consideration of the professionals that worked with the mother from late 2019 as to the nature and ongoing impact upon her of the relationship with Partner 1 (see paragraph 22) and whether it had resulted in the involvement of an IDVA. This resonates with a recent briefing by the National Panel that suggested that it is hard to understand from the content of rapid reviews as to whether domestic abuse services had been involved with the family and how this might have contributed to safeguarding [3].

55. The Health Visiting Service's Family Partnership programme, in offering family mapping, potentially would have increased an understanding of and offered a solution to the practice dilemma identified in the KSCMP thematic review: that adverse, deep-rooted family patterns take time to understand and unpick. It might also be difficult to help young mothers, such as in this case, to understand why a professional might want to explore their family history when they want practical help e.g. sourcing a double buggy. Professionals in this case described well how they gently tackle this challenge in practice and how they hold these conversations in a way that avoids resistance (see paragraph 67 below). However in this case professionals struggled to truly address the significance of history with mother, due to the erratic nature of mother's engagement with services; possibly that her difficulties were more complex than was obvious; as well as the context of trying to work effectively during Covid-19. It may simply not have been a good time to open up difficult conversations with a mother who was vulnerable and isolated with two small children.

Learning point (b): An understanding of the nature and scale of the history of domestic abuse is key, as well as the experience of and impact on the survivor receiving current service.

56. For this case, the recorded family history did not seem to be utilised effectively by the professionals in Early Help. Health visitors who contributed to this review as part of the learning event also identified that they recalled that a migration of case level data to the new recording system (Rio) in 2019 had resulted in only partial information regarding families now being accessible to health visitors. However, there are processes and key points in the family's journey where is it possible to pull historical information together, for example at the point of a new birth visit or where a Request for Support is made to the Kent Front Door. For all agencies, the point of case allocation the family's history should be part of the information shared or a case direction made to establish the key facts around history and to establish their significance for future intervention.

[3] National Panel Briefing regarding "Multi-Agency Safeguarding and Domestic Abuse" September 2022 accessed here

Recommendation One: All agencies should ensure that available family records are reviewed at the point of referral and allocation to establish any known family history of risks or vulnerabilities. Where relevant, the manager/supervisor (at the point of referral or case allocation or the first supervision) should consider the possible impact of this history upon the family and upon how professional intervention may be received.

How the lived experience of the children in the family was understood by professionals.

57. Despite the challenges to home visiting for some agencies and unusual working conditions for all from lockdown, professionals in this case continued to prioritise seeing children and understanding their lived experience. This case demonstrates that professionals use a range of skills, experience and attributes to understand what it is like for children in their families. This was enhanced by commitment and creativity by professionals who had children at the centre of their practice. Brooke and William were brought to life by professionals involved in the review in great detail, demonstrating the extent which they knew the family. The Early Help professional recalled being able to work in a more intensive way due to pared-back caseloads and visited the home regularly. This lies slightly outside the more negative picture as summarised by Research in Practice for OFSTED (2022; 47)[4].

58. There is evidence to suggest that the family received timely allocation and contact as well as responsive visits when the mother had worries or concerns:
- The Early Help professional visited the home throughout the first lockdown and beyond for 6 months;
- the midwife saw the mother and older child Brooke 5 times at midwifery clinic during lockdown and observed their interaction;
- health visiting commenced intervention by telephone after William was born due to the professional shielding;
- Health visitor home visits commenced when he was approximately 2 months old after completion of a risk assessment.

59. Also particularly notable was the recall of Brooke's lived experience by the professionals from EY1 and EY2. EY2 was a small setting with only 16 children at each session. The professional descriptions of Brooke evidenced real care and understanding for her as a child, but also conveyed a sense of respect for Brooke. Brooke's experience at EY2 was deemed to be protective and offering stability so that after she became looked after, she returned to EY2 until going to school 6 months later. This appears as outstanding care planning which will have been valuable to Brooke's stability.

60. Early Help, Health visiting and Midwifery described the mother's presentation as consistently immaculate as were the children – clean, well dressed and provided with healthy snacks by their mother. The mother, during her pregnancy with William was often distressed with the state of the flat where she had a tenancy – she complained of damp and pest infestation. The flat was on the 3rd floor with no lift and it was a challenge for the mother and Brooke, aged 2, who the mother maintained could not get up and down the

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1053868/Early_help_Research_in_Practice_2022.pdf

stairs. At home, when professionals were there, she was attentive to where the children were and what they were doing, however, some professionals observed that there may have been much less interaction when the family were home alone together. The mother gives the reason for not completing the online Solihull offer as due to needing to focus on the children and the household tasks, indicating some understanding of the need to prioritise the children's care.

61. Whilst still in mother's care, professionals observed Brooke as bright and engaging whilst William, although quite small for his age, was a smiley, happy baby. Together, the children were observed as developing a playful and close sibling bond as William grew older. However, the mother regularly described Brooke's behaviour as difficult and that Brooke did things '*on purpose'* to get at the mother. Mother regularly suggested that that there was *'something wrong'* with Brooke.

62. The 'problems' that the mother described were felt by Early Help, health visiting and early years professionals as *'normal toddler behaviour.'* Much of their intervention was aimed at trying to help mother understand that. The mother informed the Independent Reviewer that she had not understood that and had thought there was something wrong with Brooke. All professionals recall challenging the mother appropriately and promoting the mother's reinforcement of Brooke's positive behaviours. Brooke's development was recorded as meeting all of the milestones apart from a dip at the point of her 3-year developmental check. In discussion with the mother, her experience of intervention around this issue is very different. She recalled being helpless and not knowing what to do with two children. The mother recalled her concern that William didn't talk when he was one and being persuaded that it was because he was a *'pandemic baby'* – evidencing the input that professionals were trying to give in order to educate and inform the mother.

63. The professionals described the range of skills they utilised: playing with the children and the mother, observing mother-child interaction whilst at midwifery appointments, observing the family at the critical points where mother identified problems, for example doing the walk to nursery with mother and Brooke; seeing the child in the nursery; observing the family getting up and down the stairs to the flat. This is the type of creative and practical support that the KSCMP thematic review identified as good practice. Professionals used their knowledge of child development to make sense of what they observed but felt the children were developing on a suitable trajectory.

64. The mother's account to the GP and to EY1 and EY2 suggested that Brooke might have autism or hearing problems. The GP followed the appropriate pathways for this and referred on to ENT and to the child development centre, although there were no observations of Brooke's presentation noted on the GP record. There was evidence of several hearing infections from one presentation at the ENT clinic, however, the mother did not bring Brooke to key appointments at the ENT clinic, leading to her being discharged. Nor did the mother contribute to the initial information gathering to support the social communication team identify any conditions, by returning a form.

65. There is a clear pattern of mother's requesting help but then not engaging in what is offered, and of professionals not consistently following this non-engagement up. This inconsistency, offers of help requested but not acted upon, was part of the children's lived experience. In

discussion, the mother suggested that she may have struggled to understand or take on information and understand practitioner suggestions for making changes.

Learning point (c): In order to support effective engagement and to understand parental motivation, it is vital that professionals check the understanding of a parent as to what has been offered or suggested on a regular basis and in a way that is creative, e.g., asking the parent to recap or run through the plan themselves.

66. When William was very small, he was often asleep when the Early Help worker visited and so she did not see him. This worker reflected upon this: having subsequently completed training on child observation since her involvement with this family, she would now ensure she observed the mother and baby when awake. A health visitor also reflected that she had not seen the children's bedroom when the mother and two children were living back at the maternal grandmother's annexe and that this was learning for her future practice.

Learning point (d): observing interaction with parents and carers and observing the spaces and different places that small children experience are critical to really understanding the child's lived experience.

67. In working with the mother, professionals reflected on the importance of building relationships to facilitate positive change. One professional expressed some concern regarding the importance of a simple conversation becoming lost in the shift to evidence the use of more structured interventions by Early Help workers in their case recording. However, developing the skills of professionals in this area is a useful response to the increasing complexity of families receiving Early Help. Professionals described working in a very strengths-based way using active listening skills, offering practical help to address immediate concerns but also supporting the mother to identify her own issues and potential solutions to the challenges she faced in parenting her children. This may not have been obvious to the mother – professionals reflected on how they held difficult conversations whilst engaged in play with the children or in another task. However, for this mother, it did not seem to be possible to sustain any change – the professionals suggested that she wanted a 'quick fix.' However, it should be noted that until the injury to William, the mother had 'managed' – there were no further requests for help or referrals regarding her parenting for almost two years, apart from the reports of an altercation with her mother and the EY settings had not raised concerns about Brooke.

Learning point (e): Having a specific objective e.g., a change in a parenting behaviour as a goal for help and/or intervention helps professionals to focus their intervention, understand when intervention is not effective and identify the parent's inability or reluctance to engage with the intervention.

68. The account of the investigating police officer after William was injured is in stark contrast to other accounts. The annex that the mother and the children had lived in back at the maternal grandparents, visited at times by Partner 3, was described as the opposite to what professionals had seen before. It was dirty and strewn with rubbish such as empty beer cans, suggesting a deterioration in the children's experience that had not been visible to anyone outside the family. In their own attempt to establish what had happened to William, the investigating officer recalled having to use all of his communication skills to try to grasp an understanding of what happened inside the family.

Assessment practice: understanding risk in the family.

How Information regarding any risk to or from the children and adults in the family network was shared and responded to by professionals e.g. domestic abuse.

69. As far as can be seen within the period under review, information was shared appropriately regarding the family and within the agreed systems and processes. Individual agency reports recorded that professionals in this case, on the whole, used case recording to support their practice, this would include using recording to reflect upon what information should be shared. One agency report emphasised the need to ensuring recording the source of information that the professional had received. Another suggested that recording could be improved by including the plan for the next steps for working with the family.

70. The only information shared regarding domestic abuse in November 2021 was a telephone call to the mother after the health visiting service received a Domestic Abuse Notification (DAN). There had been an altercation between the mother and maternal grandmother. This DAN had not been received by Kent Integrated Children's Services. Apart from this, there was no other known domestic abuse in the family during the period under review.

71. As mentioned previously, there was significant information prior to the period under review regarding domestic abuse, both in the wider family and in the relationship between mother and Partner 1. What each agency should receive and might know regarding the DANs during 2018-9 was not entirely clear. This is reflected in some inconsistency provided in the agency reports. On request, the police author provided a summary of the Domestic Abuse Notification process that was in place during 2018-9. Although not being able to clarify exactly the process at the time, this confirmed that there was less information shared e.g. around unborn children; that the process was subject to change; and that there was a level of subjectivity in decision making regarding what information was shared if the case was not open. However the process appears to have evolved in terms of how it was utilised over time.

72. From January 2023 there is a welcome initiative to develop the practice approach to tackling domestic abuse in the county: Kent Police's new AWARE principles, designed to encourage more holistic reflection around the significance of an incident. The Domestic Abuse Notification (DAN) process has been clarified and made more consistent in terms of the level of risk assessed and more inclusive of wider family information, for example, regarding the unborn child. All domestic abuse involving children will now be reviewed by the police's Central Referral Unit regardless of the outcome of the police's Domestic Abuse Risk Assessment (DARA) or the Domestic Abuse, Stalking, Harassment and Honour-Based Violence Assessment (DASH) used by other agencies. Other key aspects are that AWARE Child Protection and Adult Protection risk assessment processes include a child and unborn baby risk assessment for all domestic abuse offences. Police colleagues within the Central Referral Unit can access social care records and so can check for significant information which supports understanding risk. These are passed to Health visiting and midwifery. However, GPs are not recipients of this information, which appears as a gap in information sharing.

73. How much information about risk is known, should be known, is shared or can be shared is often a challenge when working at the level of preventative help and safeguarding when engagement with families is made on a voluntary basis. A comment from professionals was that they have to rely upon families as the primary source of information. The key practice issue to arise from this is the extent to which professionals feel confident to challenge that information and the point at which a professional feels that they need to ask that next question of the family. As already noted, there was good practice around challenge in some parts of the professional network around the information the mother had shared, e.g., mother's descriptions of her child, and there was also demonstrable curiosity about some of the concerns or information mother shared regarding a range of aspects of her life with professionals e.g., contact with ex-partners and her father being in prison.

74. There was good practice in sharing information regarding the mother's increasingly poor mental health – this was done in a timely manner via the Maternity Support Form. Used within the health system to indicate need, the Maternity Support Form (MSF) is shared, reviewed and updated on a regular basis. It led to appropriate levels of support from the midwife and identified increased concern which then prompted appropriate referrals to other services by the midwife in a timely way. However, it was noted that at the point of William's birth and before ending her involvement, the MSF did not prompt a response from the GP. The GP reported that they had ended the safeguarding alert on their system, after they received notification that all was well, however, this appears to be the point at which the midwife ended her involvement, rather than a perceived reduction in risk, suggesting that conversations offer a better opportunity to reflect on risk than an electronic exchange.

75. The level of risk does not appear to have exceeded the expected response – the midwife suggested that she had the Kent Support Levels 'in her head' when making referrals regarding safeguarding concerns. The process for the MSF is that it is reviewed by the Midwifery Safeguarding team – i.e., an extra pair of eyes – and there is a discussion around the need to refer to the Front Door. This appears as robust practice. The Kent ICS agency report author emphasised the importance of early flagging of risk with vulnerable mothers so that they are referred to social care at 20 weeks as useful for planning. It does not appear that this case met that threshold for that, either in November 2019 or Feb 2020 or May 2020.

How did professionals assess the impact of parental issues on risk to the child, for example domestic abuse and parental mental illness?

76. During the period under review – the following assessments were completed in each agency:
    - the midwife completed a Maternity Support Form which appears as a dynamic assessment tool to monitor vulnerabilities and risk for the unborn child.
    - the health visitor completed a strengths and needs assessment for the family.
    - the Early Help worker completed an Early Help assessment.

    These assessments were completed as appropriate to each agency's procedures, however, they appear as single agency activities rather than a shared multi-agency assessment of need and risk.

77. On the whole these assessments appear to have been done to a good standard. From the single agency reports, it is noted the midwifery and health visiting assessments picked up upon a key concern regarding the mother – that of her poor mental health, whereas the Early Help assessment was not so strong on this. Historic domestic abuse is noted, however, as already discussed, there was not so much focus on how that impacted upon the mother.

78. The mother's mental health needs appear to have been well understood. Pathways to the *right* help were followed and professionals had good contact with the children. It is important to note that across the agencies who worked with the family and participated in the review, that there was no apparent evidence of harm or adverse impact upon the children. However, this did not prevent the appropriate concern for the mother's declining mental health in the last trimester of her pregnancy with William – the use of the Maternity Support Form in both provide a dynamic picture of risk for pregnant women appears as good practice.

79. As part of the Strengths and Needs Assessment, the Health visitor identified family conflict from the paternal grandmother of William who was harassing her as she did not believe that her son was William's father, but mother also reported support from her family. Professionals reflected upon whether this was really her experience. It was also unknown if there was any risk to the children from extended family or their fathers, as no full history was documented about them apart from that Partner 2 was on licence. Overall, the involvement by the fathers and the attempt to involvement in these assessments is missing and the nature of their role in the family not visible.

Learning point (f): The need to focus on fathers and other males in the family is well established. It is vital that professionals explore this with families, even at preventive levels of support.

80. The Early Help worker was the only professional visiting the family home from the point of referral during May 2020 until July 2020 and so did not have the opportunity to triangulate her observations of home life or of some risks with others. However, it is not known that any key risks were missed here, and in fact the contrary is more likely: in ensuring regular visiting and maintaining real contact with this vulnerable mother and her small children, the Early Help worker will most likely have reduced the possibility of harm arising from a greater decline in the mother's mental wellbeing arising from her known significant isolation during the lockdown.

81. In summary, single agency assessment practice appears as good and supported a shared understanding across some agencies regarding need in the family. But a multi-agency Early Help assessment and plan would have provided the basis for a more holistic and joined up offer of support to the family. This appears as a shortfall in expected practice, to an extent influenced by Covid-19 (see section below). It is noted that the new Early Help strategy and practice framework identifies that the new Early Help Assessment process should be streamlined but should also include the views of other professionals as per Working Together 2018[5].

[5] https://www.kscmp.org.uk/guidance/kent-support-levels-guidance/intensive-support-level-3/early-help

Did the Assessments of the family (Mother, Fathers/Partners, Maternal Grandparents, William and Brooke), including of risk, determine the right level of support afforded to families open to Health Visiting Services; also whether the identified levels of support are being adequately recorded upon allocation and/or subsequent visits?

82. In the agency report from KCHFT, there was an anomaly recognised in the provision of services offered to this mother and her children, which suggested that the appropriate pathway to the level of service provision may not have been followed. In 2020, there was an expectation that whilst the family was open to Early Help, that the mother and children could not be open at the same time to the Family Partnership Programme[6] which at the time was in an early stage of implementation. It is noted that this guidance has changed and families thought suitable for the programme after an assessment would now be offered the programme, regardless of Early Help involvement.

83. In this case, during the unusual year of 2020, the health visitors, who also were Family Partnership Leads, saw a vulnerable mother that needed more support than they felt might be offered from the health visiting team and so used some of their additional skills to offer the family support. However, it is valid to say that there is no evidence that the mother was fully informed of the different aspects of this intervention and what the intended outcomes from this intervention were. Again, ascertaining the understanding of those received intervention as to its purpose is vital.

84. This led to the mother and children having contact from two health visitors within the health system at the tier of what was called at that time 'Universal Plus.' These two professionals brought additional skills and knowledge from their experience of the Family Nurse Partnership and Family Partnership model. The health visitors reflected upon the confusing nature of this offer to the family at the professional engagement event: it appears as though this anomaly occurred due to a range of particular circumstances. Covid-19, restricted access to families, the nature of this mother's vulnerability and isolation appears to have led to the health visitors wishing to offer as much as they could to this family. Whilst the reviewer recognises the offer made to the mother as outside of accepted guidance, it appears as a genuine offer of help from kind and caring professionals.

85. Evidence to the reviewer from the agency report writer and from the health visitors themselves clarified that the levels of risk and the current pathways to universal, targeted and specialist health visiting provision and to inclusion on the Family Partnership model are now clearly understood and implemented within KCHFT.

Multi-agency collaboration and communication: Did professionals/agencies take the opportunity to work together when involved with the family rather than in isolation?

86. In their 'back to basics' approach, KSCMP identifies multi-agency collaboration as key to effective help and intervention that works for families. Co-ordinated multi-agency practice within a multi-agency plan of intervention that was regularly reviewed was missing for this family. As already mentioned, this family had a lot of different agencies offering intervention

[6] https://www.kentcht.nhs.uk/service/kent-baby-health-visiting-service/health-visiting-services-for-you/family-partnership-programme/

during the period under review. On the whole, when there was active intervention or increasing concern regarding the family, there appears to have been good communication and liaison around the family between individual professionals. However, it is not clear that agencies informed each other at points of closure or when the level of engagement changed within the family.

87. At points, the intervention of the different agencies complimented rather than duplicated each other's work, for example the Early Help worker sourced a double buggy as the health visitor had been supporting mother with trying to get Brooke to walk to nursery. The division of tasks between professionals worked, however, it is not evidenced that progress against identified changes needed was being measured in any structured way. This may have led to the sense amongst professionals when reflecting on the case, that they had a sense of repeating themselves in terms of the advice they offered to the mother around strategies. There was a missed opportunity in effecting real change in this family by not planning together.

88. There were no multi-agency meetings held between the key professionals with the mother. A meeting may have allowed intervention to focus on a shared set of outcomes for William and Brooke and the mother to aim for. There are at least two points in the period under review when the mother told an agency or professional that she had no help, when in fact she was receiving a service from at least two other agencies at that time. The Early Help procedures in place from 2016 until now reads that*: "The Early Help worker will meet with the family to undertake an assessment and agree an outcomes focused family plan which will be reviewed regularly with the family and key agencies supporting the plan,"* whilst the agency report writer suggests that co-ordination via an initial and review meeting would have enhanced a shared understanding of concern as well as overtly measured progress. The mother had no recollection of having a clear plan of intervention from agencies or of any multi-agency meetings.

89. The GP for the family (GP2) appears as largely absent from the multi-agency network conversation. The former safeguarding lead at the practice was able to give an overview of their intervention as was the GP for Partner 3. Whilst processes for safeguarding and pathways appear to be adequately understood, it was noted the health system is fragmented and makes safeguarding practice hard to achieve. Working together to safeguarding unborn children relies heavily on the Maternity Support Form. Previously, a midwife had visited the surgery once a week. Whilst the MSF regarding the mother this was sent in quite early and was discussed within the GP practice at the monthly safeguarding meetings, there was no discussion with other key health professionals.

90. This lack of regular contact for GPs with midwifery and health visiting may compromise the quality of risk assessment: reviews of written information cannot always provide the information to make effective assessments of the needs of families. It is noted that health visitors and GPs now have access to patients records in both services through a Shared Care Record. However information has to be manually sought rather than an alert being sent, for example, to a GP when the health visitor has recorded something significant. Whilst this is an improvement, it is not a substitute for multi-agency conversations regarding risk to children in more vulnerable families or more broadly around patterns of incidents regarding risk in the local area.

91. A current lack of regular off-case liaison between health visitors and midwives in the locality was raised by professionals during the learning event. The reason for this disappearing appears to be due to changes in commissioning of health visiting, perhaps compounded by changes to working norms arising from the pandemic.

Recommendation Two: That the KSCMP considers, with all partners, how best to re-engage GPs with other key professionals working with children and families in a meaningful relationship-based way. Liaison and risk assessment should not rely solely upon the exchange of electronic information-sharing.

92. One consequence of the lack of multi-agency co-ordination to meet assessed needs and agreed outcomes was the lack of monitoring of which services the mother had been referred to but did not engage with. Whilst health visiting had some oversight of mother's engagement in the first module of the Solihull Programme, the impact of that was not possible to be measured elsewhere. The absence of monitoring progress may also have meant that the appropriate referral by the outgoing midwife made to the Mother and Infant Mental Health Service (MIMHS) in June 2020 would have then been followed up with suitable intervention. The service had an initial consultation with the mother in July 2020 and provided a care plan to the referrer and the GP in July 2020. By late September the mother had declined the service as it was too hard for her to get to the appointment. Although regrettable, it is possible that the mother, with a toddler and a four-month-old baby – felt overwhelmed. The mother suggested to the review that she had tried counselling and that is was "talk, talk, talk" but that it didn't help her.

93. There is a sense of the offer to the family being quite 'cluttered' and perhaps not tailored to the mother's needs. Multi-agency planning and reviewing may have meant that the mother was enabled and supported to develop and then engage with a clearly targeted plan of purposeful intervention to meet her needs and those of her children. The nature of engagement by her and from professionals would be the focus of reflection in this process.

Recommendation Three: That guidance for improved multi-agency planning is offered to all of those working alongside families at Kent's Support Needs Levels 2 and 3. Multiagency plans should be reviewed collaboratively through regular meetings and should :

- **agree the intended outcomes;**
- **establish the purpose of intervention;**
- **monitor the progress of intervention;**
- **understand the nature of engagement with the plan.**

94. The multi-agency response to the incident and injuries to William stands out as effective and of a high standard, after William was presented at the Emergency Department of the hospital by the maternal grandmother. The police described the response of the hospital as 'fantastic safeguarding,' where the police, hospital staff and children's social care worked well together. Accounts from the medical team suggest that this included the recognition of the injuries as NAI; the immediate recognition of the potential risk to Brooke and the other children in the maternal grandparents' family, requesting that they bring the other children to hospital for review. The hospital kept the children much longer after the preliminary investigations in order to promote their safety. Key operational staff attended the strategy meeting as well as the safeguarding team. Gaps in one procedure were

recognised swiftly by the hospital safeguarding team who were involved early in the case. This meant that medical photography was requested.

95. The hospital staff interviewed for this review by the agency report author reflected on the factors for good practice – there were existing excellent working relationships between the examining doctors and nursing staff who had previous experience working together on other cases of suspected NAIs. That experience and professionalism brings contributed to the positive outcome in terms for William and Brooke in terms of the plan for their safety.

96. During a conversation with the EY2 setting, the professional mentioned how unexpected the injury to William was and how they had reviewed all of their records afterwards to ensure that the setting hadn't missed anything that might have prevented this, despite Brooke, not William attending this setting. This is also an example of professionalism and conscientiousness. It is also important to note that this experience was shocking and upsetting for the staff at the setting and the two Designated Safeguarding Leads supported each other. However, the professional said that the setting had nowhere to go for support.

Learning point (g): Some professionals may only experience a serious incident involving a child once in their careers. It is important that they are supported to access emotional support in cases such as this.

Hazards/flags are recorded on case management systems against an individual who may pose a risk to children and whether perceived risks are therefore easily identifiable on case records/profiles.

97. In this case, a flag would not have been placed on the record of William that could have prevented the incident occurring. Mother was not a perceived risk to the children and the other suspect in the incident, Partner 3 was not known to be involved with the family. However, a question arose regarding the practice of flagging hazards. The practice and process appears to differ across the different agencies involved in this review and depends on the subject of concern as well as the nature and the level of risk.

98. Flags are variously used across Kent partners to denote that an individual may pose a safeguarding risk when:
    - a child is at known or suspected risk of harm from the individual, i.e., on a CP plan or a child of a victim of domestic abuse reviewed at MARAC - the child's record is flagged as is the record of relevant family members, usually those that live in the same house;
    - the individual is known to MAPPA;
    - or in some agencies known to be living at an address which is flagged.

    Some addresses are also flagged to highlight a risk for a staff member visiting. There is evidence to suggest that the management of sensitive data in agencies is appropriate, with information being held only by a particular team and shared only on request (e.g., the safeguarding team at EKUHFT); or monitored and reviewed for relevance regularly (ICS Management Information team or KCFHT Information Governance); or at safeguarding meetings (GPs).

99. In this case, the mother was flagged by health agencies due to MARAC involvement, which supported good information sharing between the Emergency Department and the hospital safeguarding team.

100. However, there is a divergence in practice between agencies around flagging an individual who poses a risk outside of the above scenarios – a perpetrator of domestic abuse, or abuse of children[7]. It can be more straightforward and perhaps come more naturally for police and children's services, with their statutory power to investigate child abuse, to have a clear rationale for the flagging of those individuals who have been assessed (e.g. under MARAC), charged with offences, or found to have harmed a child on the balance of probabilities (within care proceedings). However, for EKUHFT and for GPs, there is no flagging for these individuals, despite the very real opportunity for a perpetrator to present with or to discuss children in their health appointment.

101. The Kent and Medway information sharing agreement[8] appears to reflect an appropriate legal footing to share and flag information about individuals that pose a risk in order to safeguarding children. The General Data Protection Regulation was incorporated into law in the UK by the Data Protection Act 2018. There must be a legal basis for sharing information in a case; these are set out within the UK GDPR (Articles 6 and 9). Whilst there is no single 'best' basis, the most relevant for the purposes of safeguarding and promoting the welfare of children are a '*legal obligation'* (article 6(1)(c) to do so, or to do so *'in the public task'* (article 6(1)(e). Whilst it is recognised that for some settings, any individual that has a flag should not be treated any differently within the purpose of the intervention offered e.g., emergency medical treatment, it is always important to recognise that that individual might attend with a child or with a vulnerable adult. There are a range of scenarios where staff might be concerned with what they are seeing – a flag and the information behind that might add vital extra information to the assessment of immediate risk, without compromising their duty to respond to immediate need.

102. An observation by the reviewer is that there was a varied degree of understanding of professionals around hazard flagging and that there was no clear multi-agency approach. This review has only touched on this area of practice – there was no opportunity to have prevented harm through the use of hazard-flagging in this case. However, this is an area which must be considered carefully, it does appear that there is an opportunity to develop a shared understanding of risk across the system. The mother, when asked what she would like to say to KSCMP, suggested that she thought there should be alerts to warn of people like Partner 3. The following is suggested:

Recommendation Four: The statutory KSCMP partners should the review current arrangements across agencies for flagging safeguarding risks, and if required, devise a process for the sharing, flagging and reviewing and removal of risk identifiers to ensure that children are as safe from harm as possible, within the legal framework of the GDPR. ***NB This might include an initial exercise to 'walk through' some possible scenarios where sharing information regarding an individual that poses a risk might support safeguarding.***

[7] Information Sharing
See for the descriptions of individuals that pose a risk
[8] https://www.dartford.gov.uk/data-protection/kent-medway-information-sharing-agreement

Conclusions and additional learning arising from the review process.

103. The standout strengths in the preventative safeguarding system are the resources offering help for families. The professionals in this case were committed and appeared to share similar values and approaches to working with families such as William's, despite some of the challenges. A sense of professional accountability was evident and kindness towards this family was consistent. It is clear that the complexity of families who receive services at Levels 2 and 3 of the Kent Support Level Guidance[9] is understood by professionals and the review found that some parts of the system have sought to develop professional skills to meet this.

104. Practice in this case could have been enhanced by ensuring that outcomes as a result of offering support for children and their families are reviewed and measured. Professionals could see that the mother needed help and were incredibly helpful and responsive to the needs of the family, especially around some of the tangible resources. The professionals involved were clear that the mother needed more than just this, that she needed her own mother who was not available, and that she also needed help with her poor mental health and emotional wellbeing. However, with no clear lead professional or agency or multi-agency planning the offer was not clearly established. It is regrettable that at the time the family may have most benefitted, the Family Partnership Programme was not available for them.

105. In conversation with professionals, it was not clear that the multi-agency escalation process was fully understood or embedded in practice. This is not a challenge confined to Kent only, however, it is important ensure professionals are aware of this.

Learning point (h): Professional challenge and escalation should be emphasised as part of everyday practice. Professionals should be reminded of the KSCMP Escalation and Professional Challenge Policy, to inform those in practice what to do if they have concerns around the poor practice of other agencies. [10]

Recommendations

Recommendation One: All agencies should ensure that available family records are reviewed at the point of referral and allocation to establish any known family history of risks or vulnerabilities. Where relevant, the manager/supervisor (at the point of referral or case allocation or the first supervision) should consider the possible impact of this history upon the family and upon how professional intervention may be received.

Recommendation Two: That the KSCMP considers, with all partners, how best to re-engage GPs with other key professionals working with children and families in a meaningful relationship-based way. Liaison and risk assessment should not rely solely upon the exchange of electronic information-sharing.

[9] https://www.kscmp.org.uk/guidance/kent-support-levels-guidance
[10] Kent-Escalation-and-Professional-Challenge-Policy-May-2024.pdf

Recommendation Three: That guidance for improved multi-agency planning is offered to all of those working alongside families at Kent's Support Needs Levels 2 and 3. Multiagency plans should be reviewed collaboratively through regular meetings and should :

- **agree the intended outcomes;**
- **establish the purpose of intervention;**
- **monitor the progress of intervention;**
- **understand the nature of engagement with the plan.**

Recommendation Four: The statutory KSCMP partners should the review the current arrangements across the different agencies for flagging safeguarding risks, and if required, devise a process for the sharing, flagging and reviewing and removal of risk identifiers to ensure that children are as safe from harm as possible, within the legal framework of the GDPR. *NB This might include an initial exercise to 'walk through' some possible scenarios where sharing information regarding an individual that poses a risk might support safeguarding.*

Thanks

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Josie Collier, 2023.