Kent Safeguarding Children
multi-agency partnership

Harm to Under 2s in Kent

May 2022

Each bumblebee represents one of the children considered in this report.

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Date:	13/05/22

1. Executive Summary

This study builds on the previous KSCMP Non-Accidental Injury (NAI) deep dive study undertaken in 2021, with a broader scope to consider significant harm of all under 2s notified to KSCMP in a 3-year period. Through case analysis, identifying positive practice in similar cases, and engaging directly with professionals, the aim has been to identify key themes that help us understand when and why harm occurs, and what practice can safeguard young children from harm. There were 19 children aged under 2 who were seriously injured or died in the period considered, and whilst only 17 of these were included in the analysis (explained in section 3.1), we have reflected all of these children in the illustration on the cover of this report.

The majority of the cases analysed related to harm as a result of NAI, with a smaller number of children harmed through co-sleeping and neglect. Analysis of the cases showed that the majority of children were harmed at age 3-months or under. This is congruent with research underpinning the ICON programme, that harm to babies is often inflicted due to a loss of control during periods of infant crying. It may also be reflective of the physical vulnerability and dependency of young babies. Of note is the fairly even split between only children and those with siblings – i.e. neither group appears more likely to be harmed than the other.

Children who experienced NAI were more likely to be in families where there were not obvious risk factors and who were only open to universal services. In these cases it appeared that individual parental resilience levels had been surpassed. In contrast, children who were harmed through co-sleeping and neglect were mostly in families where a number of visible risk factors were present, and professionals were more likely to already be involved and concerned. Although signs of neglect or concern were apparent to professionals quite early on, they may be harder to reverse, or fail to be fully understood by professionals given the complex nature of the families. There is also evidence in both cohorts that Covid-19 had impacted on appointments with the family, which might have led to some missed opportunities for further identification of concerns.

Practitioners, when presented with case scenarios, identified risks and concerns for children; they also identified the actions they felt should be undertaken to effectively safeguard. They reflected openly on the challenges in practice which could prevent those measures from being put in place in reality. What became clear was that despite their passion, increasing demand for services is impacting on the ability to deliver beyond what is absolutely required as well as on their capacity for multi-agency working. Additional challenges include confusion and anxiety around submitting Requests for Support and Support Levels Guidance (thresholds), conducting difficult conversations, and variations in practice across the county. In identifying positive practice, it became clear that basic practice is what works. There is no need for new innovation, but a need for a more ‘back to basics’ approach.

Through the study three specific practice themes emerged:

1. Early identification and referral
2. Consideration of family history

3. Assessing the impact of parental issues on risk to the child.

Early preventative work should be seen as the role of all universal services, not only KCC Early Help once the Tier 3 threshold is met. To reduce missed opportunities and ensure the right support is given at the earliest point, families need to be engaged and understood before concerns become very visible. Understanding in all services that harm occurs in families which do not necessarily present as 'risky' is needed and practitioners must be prepared to think the worst, including in families which exhibit less obvious warning signs.

This report makes five specific recommendations, although the authors also urge reflection on the broader themes identified.

	Recommendation
1.	Kent and Medway CCG to present an update on the roll-out of the ICON programme and provision of future training in Kent.
2.	KSCMP Executive to seek clarification on current Health Visiting operating standards around face-to-face visits.
3.	The Kent Support Levels Guidance course be reviewed to ensure it adequately covers terminology in the SLG and details on completing a Request for Support. Delivery of the course to be reviewed to address consistency and provision issues.
4.	Early Help assessments and plans to be shared with involved multi-agency partners (with family consent).
5.	The positive practice audit to be published and shared as a standalone report, as a reminder that familiar, expected, basic practice works, and to avoid a sense of needing to wait for learning from individual LCSPRs to be published before seeking to change or improve practice.

2. Introduction

In October 2021 the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) Business Team undertook a deep dive study into the surge of Serious Incident Notifications (SINs) related to the Non-Accidental Injury (NAI) of babies in August and September 2021. The study outlined the key themes and factors of the cases; however, it was acknowledged that it considered a small sample group, and that further SINs related to NAI had been received which were outside the scope of the inquiry. It was therefore recommended and agreed that a broader study be conducted, to consider all SINs related to harm in the under 2s in Kent in over a three-year period.

This report encompasses three areas of work undertaken as part of this study:

1) Analysis of the SIN data for all Under 2s in Kent between 1st March 2019 and 31st March 2022.
2) A Positive Practice Audit of cases which shared characteristics with the six cases from the previous NAI deep dive.
3) A NAI Practice Event held in March 2022 with practitioners.

We would like to acknowledge the scale of harm considered in this report. We identified 19 children aged 2 or under who had been subject of a SIN to the KSCMP over the period considered. Of these 19 children, 5 children had sadly died, whilst others had sustained serious and/or life changing injuries. We hope this study will help to develop understanding of the issues and of tools that can be effectively employed to reduce the risk of this harm occurring again in the future.

We also acknowledge that since 31st March 2022, further SINs related to NAI have been received by the KSCMP. It is not proposed that this study be re-visited to encompass these newer cases. However, learning identified during the individual rapid reviews or subsequent Local Child Safeguarding Practice Reviews (LCSPRs) will continue to be taken forward by the KSCMP.

3. Analysis of Serious Incident Notifications

3.1 Serious Incident Notifications

The scope of this review was to consider incidents relating to children aged 2 and under over the period 1st March 2019 to 31st March 2022 and which had been notified to the KSCMP. In this report the term Serious Incident Notification (SIN) refers to cases considered either through statutory or local frameworks. There were 19 notifications relating to children aged under 2 over this period. One of these children had died as a result of a medical issue and was only notified due to being a child looked after by the local authority. To add to this, one child had died as a result of choking in an early years setting. Due to the specific natures of those notifications, they were removed from the cohort addressed in this study, leaving 17 cases for analysis.

3.2 Methodology

This study focuses on 62 indicators across 17 cases of serious harm in the under 2's. There were varying levels of detail recorded in each case that the authors were able to draw upon. As a result, the following methodology has been used to make comparisons across indicators.

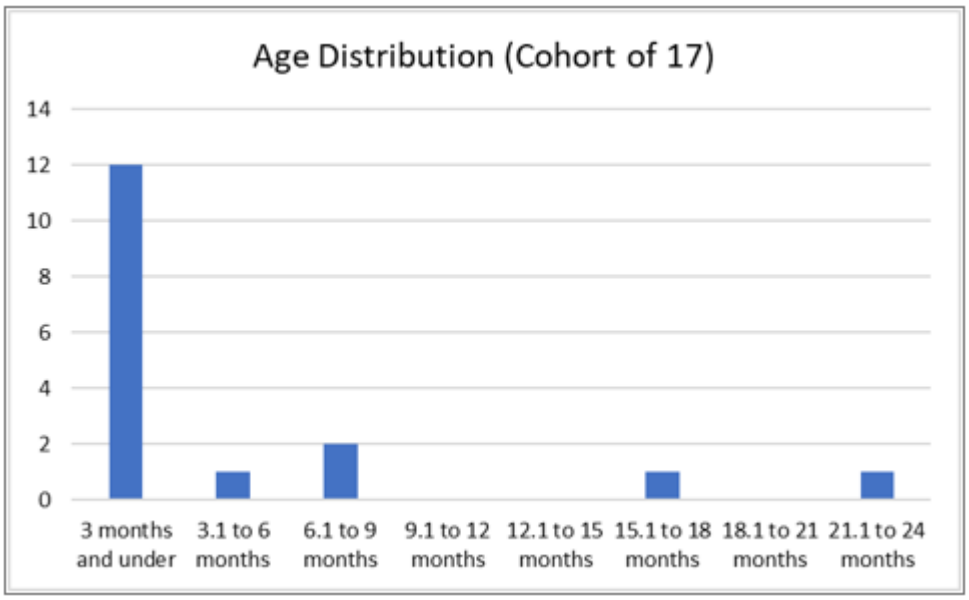
Where there were fewer than 17 cases which had information recorded for that indicator, the base number would be the number of children who had information recorded. For example, KSCMP has information relating to mother's mental health for 11 children out of the 15 children that the information was available for, so the proportion of cases where this was a known factor was 11/15 = 73.3%. This was felt to be a more comparable measure than always having the base number as 17, if there was no information given related to the indicator (and so was 'unknown') or if the indicator was not applicable.

The same method of calculating proportion has been used throughout this analysis to allow us to look for themes and make comparisons across indicators. This approach was also helpful when breaking down the sample of 17 into an NAI cohort (13 children) and a co-sleeping/neglect cohort (4 children).

Overarching themes relating to the 17 cases are discussed, alongside comparisons between the NAI and co-sleeping/neglect cohort. We recognise that all of these are small sample sizes from which to draw comparisons, but the co-sleeping/neglect group is a particularly small group.

3.3 Data analysis

3.3.1 Cohort demographics



Only two of the children were aged over 9 months at the time they were injured or died, with the majority being aged under 3-months. This is congruent with general understanding, and principles behind programmes such as ICON[1], that the majority of abusive injuries caused to infants are as a result of a loss of control when a baby's crying becomes too much. The infant crying curve[2] suggests that babies begin to cry less from around 3 months onwards.

Recommendation	
1.	Kent and Medway CCG to present an update on the roll-out of the ICON programme and provision of future training in Kent.

District	No.	District	No.
Folkestone & Hythe	3	Canterbury	1
Thanet	3	Dover	1
Ashford	2	Tonbridge and Malling	1
Dartford	2	Gravesham	0
Maidstone	2	Sevenoaks	0
Swale	2	Tunbridge Wells	0

The geographic spread of the children, based on their home address at the time of the incident, is relatively even.

Only 2 of the children had parents that were both 'young parents' (aged 21 or under) and a further child had one young parent.

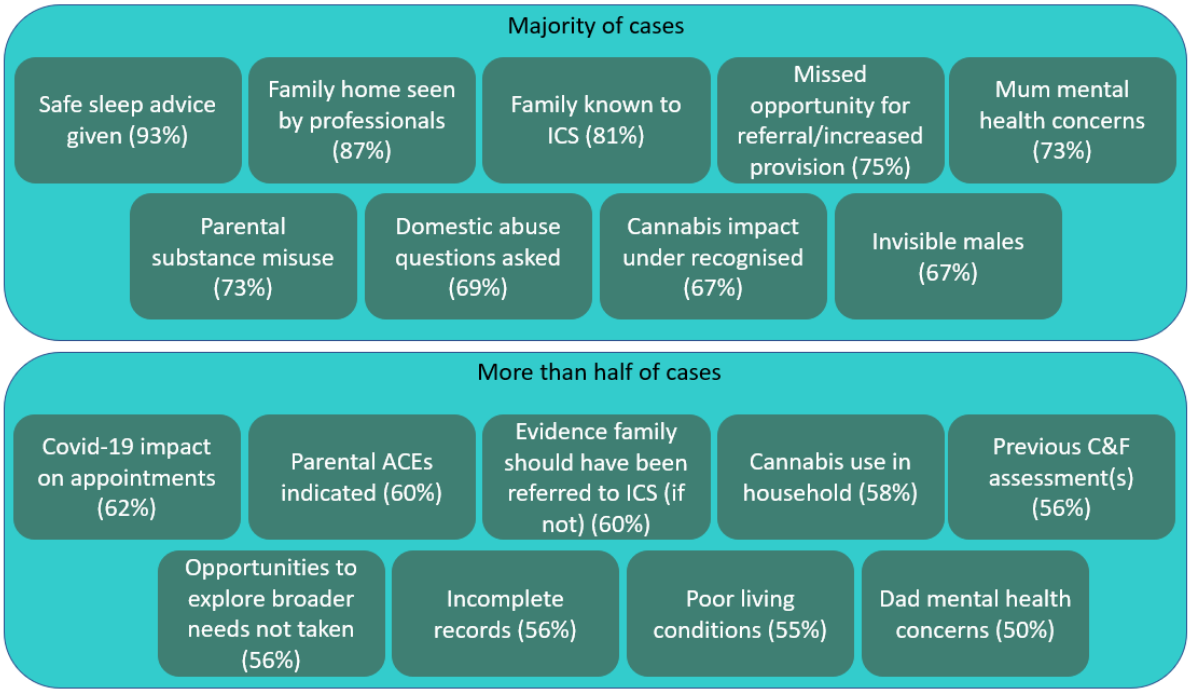
[1] https://iconcope.org/for-professionals/
[2] http://purplecrying.info/sub-pages/crying/why-does-my-baby-cry-so-much.php

No. of siblings	No. of cases
0	6
1	5
2	2
3	2
6	1
Unknown	1

In 35% of cases the child had no siblings, and in a further 30% the child had only one sibling; however this included a child who was a twin. Therefore 41% of cases involved a 'first born' child. When looking only at the 12 NAI children for whom it is known whether or not they had siblings, 50% were first born. Overall then, there is not a clear set of evidence to show whether a first born, or single child is any more or less likely to be harmed than a child with siblings.

3.3.2 Characteristics

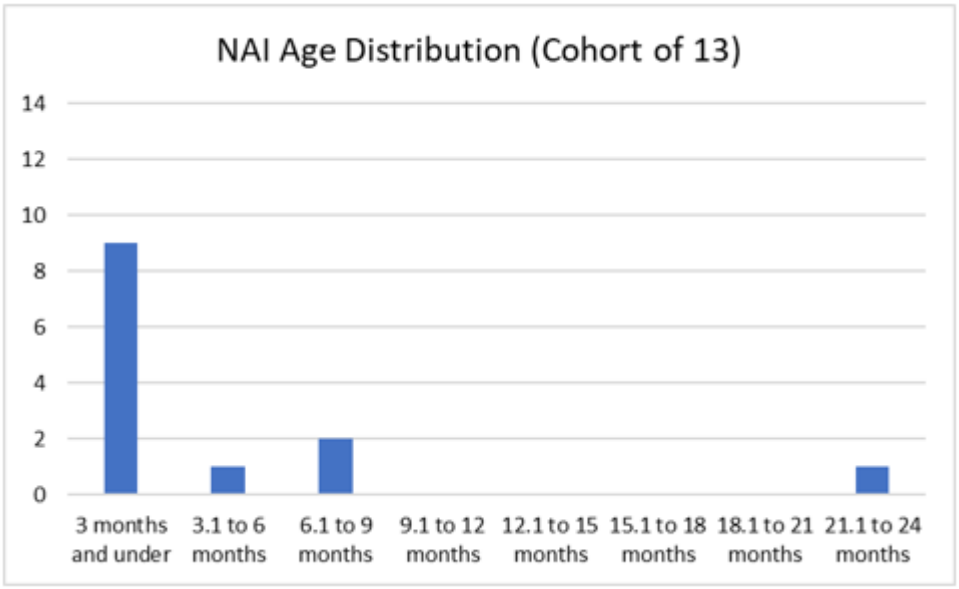
The graphic below gives an overview of which of the 62 indicators were prevalent across the entire under 2's cohort considered.



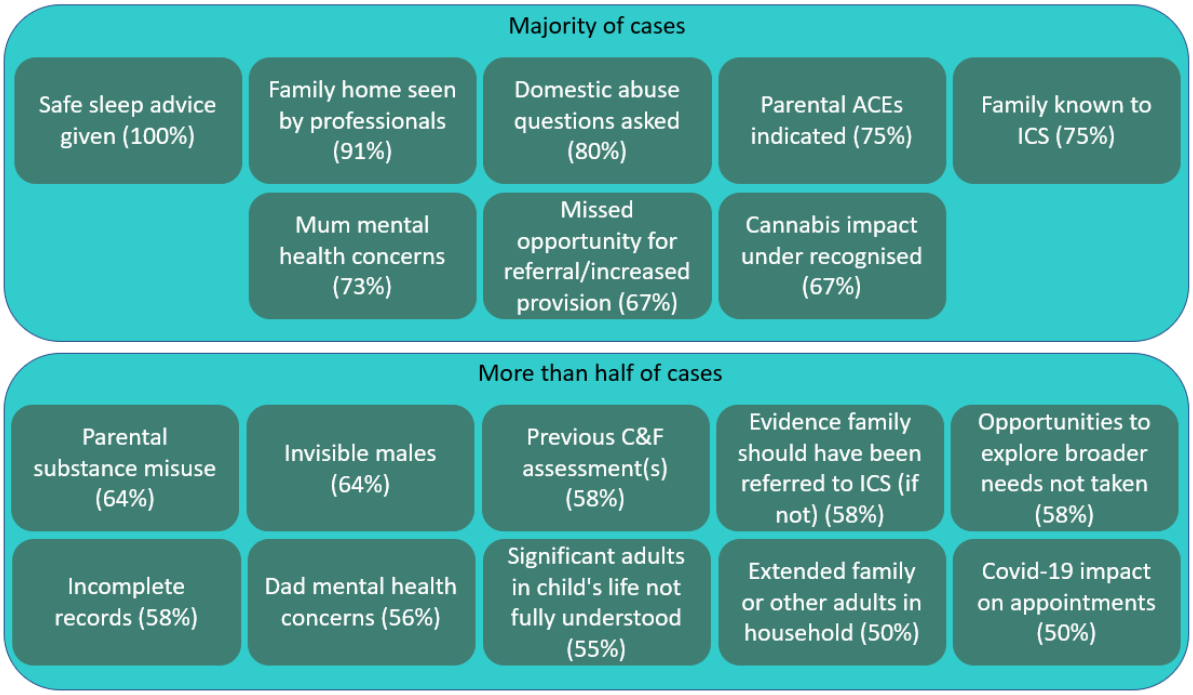
The indicators include a range of family context issues (such as parental mental health concerns or poor living conditions) and practice themes identified in review of the individual cases (such as missed opportunities and incomplete records). A particular note should be made in regard to the **Family known to ICS** indicator. This **does not mean that the individual child was open, or even known** to KCC Integrated Children Services at the time of the incident but includes families where a sibling or parent has been known to ICS. A separate indicator was included for children open to ICS at the time of the incident, and another for children who had previously been open to ICS prior to the incident. Only 29% of the whole cohort were open to ICS at the time of incident, whilst 44% had previously been open. There was significant divergence between the two cohorts, explored in the respective sections below.

3.3.4 NAI characteristics

None of the children in this cohort died, however 3 sustained life changing or serious injuries, including one child who is not expected to live beyond early childhood.



In the NAI cohort of 13 children, 92% were under 9 months and 69% were aged 3 months or under. As indicated in section 3.3.1, this is in-line with expectations and is most likely linked to the stress of a young infant, and in particular, babies crying.



In the indicators above, there are some significant changes to the indicators most present for the whole cohort of under 2s. Less of the families in this cohort were known to ICS prior to the incident of NAI and there were less 'missed opportunities' identified – although these remain in the 'majority' or cases category. However, a small increase was observed in the percentage of cases where there was evidence

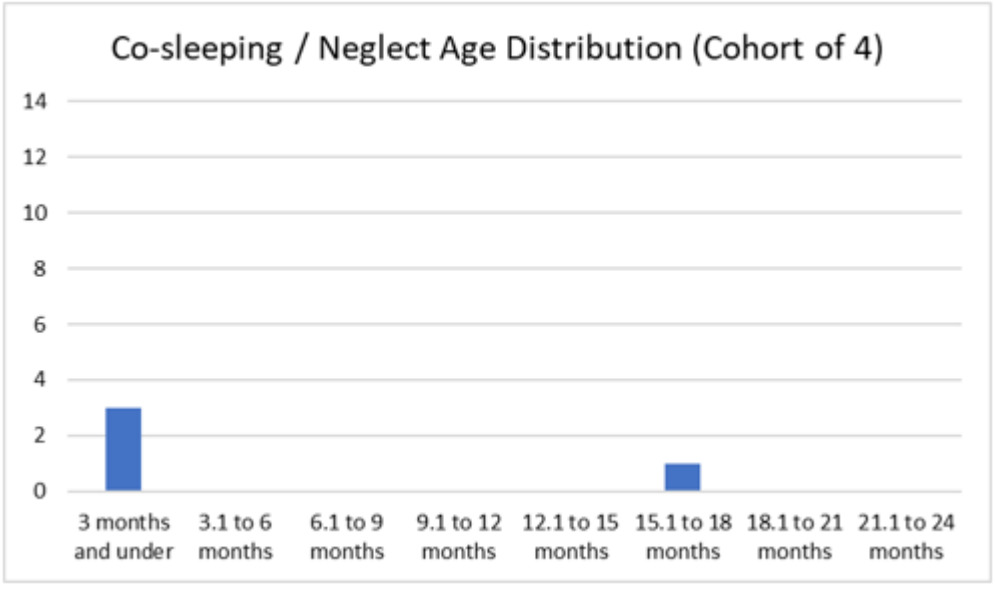
the family should have been referred to ICS (this may be due to the lower percentage already known). There was also a small increase in the number of children where there had been a previous Children and Families (C&F) assessment. In this cohort only 23% of children were open to ICS at the time of the incident, and 33% had previously been open to ICS.

A shown, maternal mental health issues and the impact of under recognised cannabis use remained static, although there was also a decrease in parental substance misuse in this cohort. Indications of parental Adverse Childhood Experiences (ACEs) increased in proportion within this cohort, moving up to being present in the majority of cases. Paternal mental health concerns increased in proportion, whilst the theme of invisible males within case work was slightly less present.

The Covid-19 impact on appointments was less apparent in this cohort, which also potentially accounts for the increase in family homes being physically seen by professionals. It is of note that poor living conditions is not reflected in 50% or more of the NAI cohort, whilst this was a greater factor in the entire under 2s cohort.

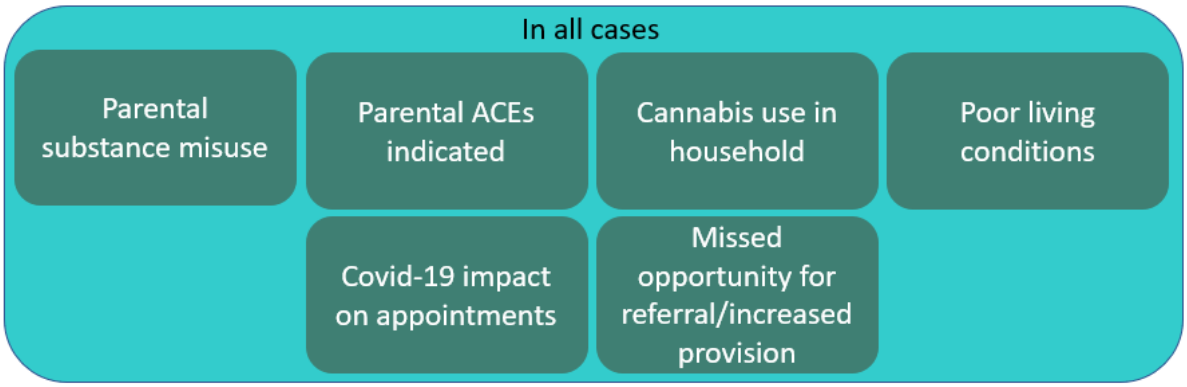
3.3.5 Neglect & Co-sleeping characteristics

In this cohort, 3 of the children died, all as a result of co-sleeping; in 2 cases neglect was also a factor in the child's death.

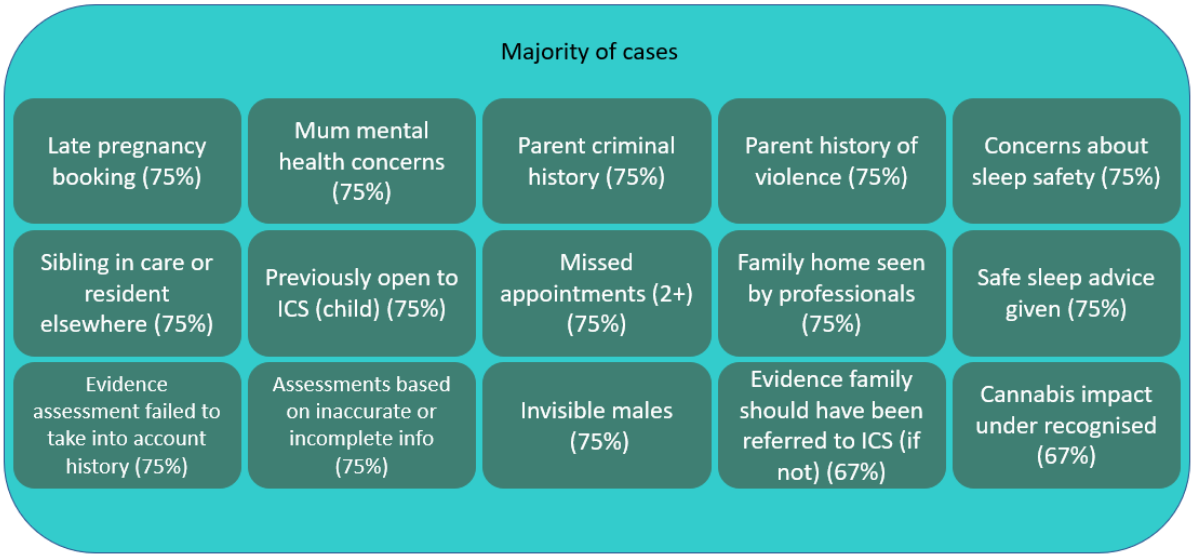


Three quarters of these children were aged 3 months and under at the time of the incident. It might have been expected to see a larger spread of ages in this cohort, given the broader nature of harm, which is not necessarily linked to crying infants, however there are some additional considerations. For example, taking into consideration that this is a very small sample size. Very young babies are more dependent on their needs being met by their parents and carers and are less physically robust to withstanding neglectful conditions or co-sleeping.

It is significant that there were six factors which appeared in all of the co-sleeping and neglect cases, illustrated below.



The graphic below further shows the indicators present in the majority of cases in this cohort. Parental substance misuse and cannabis presence in the household was a consistent feature, which is likely to be a contributing factor towards neglect and is a known risk factor in co-sleeping deaths. It could be speculated whether there is also correlation between the poor living conditions and the Covid-19 impact on appointments (potentially meaning that more appointments were telephone based rather than in person), although below it is noted that 75% of the family homes had been seen by a professional. Parental ACEs were also noted for all the children in this cohort, potentially highlighting the impact of unaddressed childhood trauma on parenting capacity as an adult.



Moreover, additional points of note presenting in this cohort are that potential signs of neglect or at least unpreparedness that may be indicative of a chaotic lifestyle and often are seen in early pregnancy, with three quarters of the mothers booking late for pregnancy-related health services. Missed appointments were also a common feature both pre and post birth. There are also more obvious risk factors evident for this cohort. For instance, parents with a criminal history or a history of violence, and

elder siblings who were already in care or resident elsewhere (with limited or controlled contact arrangements) were over-represented in this group. Concerns were further noted about sleep safety in 75% of the cases, and despite this being noted and safer sleep advice being given in all of those cases, these were the 3 children that died as a result of co-sleeping or co-sleeping and neglect.

Half of the children were open to ICS at the time of the incident. Furthermore, in this cohort there was an increased proportion of children previously having been open to ICS and evidence that the family should have been (re)referred to ICS. This latter issue may be linked with evidence which shows assessments failed to take into account the family and child's history appropriately in 75% of the cases examined. If this had been achieved, then possibly the requisite referral would have been made.

Recommendation	
2.	KSCMP Executive to seek clarification on current Health Visiting operating standards around face-to-face appointments.

4. Non-accidental Injury Practice Event

4.1 Purpose and structure

In March 2022 an NAI Practice Event was held to measure impact and changes in practice and attitudes, to understand whether current working practice would lead to a better identification of risks relating to children already at risk of NAI. The event was structured in two parts. The first saw attendees split into five groups (with equal multi-agency distribution). These groups were provided with a different anonymised case example of the circumstances of one of the cases included in this study and asked to identify:

1) What are the risk factors or characteristics you are concerned about, and rank them in order of concern?
2) What further information do you need?
3) What action or support do you feel is needed?

The second exercise saw the groups tasked with identifying what policies and procedures they were aware of that would be relevant to the scenario they discussed, and identifying what barriers exist to them being used in practice.

4.2 Attendance

The event was advertised through KSCMP communication channels, with spaces capped at 25 and distributed as evenly as possible across services. In total 52 professionals registered their interest to attend, the spread of multi-agency representation of the requests can be seen below.

Agency/Service	No. registered	Agency/Service	No. registered
Kent Police	14	KCC Children's Social Care	11
East Kent Hospital University Foundation Trust	3	KCC Early Help	4
Kent Community Health Foundation Trust	3	KCC Disabled Children's Services	1
Kent and Medway NHS CCG	1	KCC Public Health	1
Maidstone & Tonbridge Wells Trust	3	Voluntary and Community Sector organisations	1
The Education People	1		

Of the 25 places allocated, 20 professionals attended the event including: Safeguarding Children Nurses, Midwives, Social Workers, Early Help Workers, Children Centre Managers, Child Protection Investigators, and Safeguarding Advisors. Representation of attendees is shown below.

Agency/Service	No. registered
Kent Police	6
East Kent Hospital University Foundation Trust	2
Kent Community Health Foundation Trust	3
Maidstone & Tonbridge Wells Trust	2

Agency/Service	No. registered
KCC Children's Social Care	3
KCC Early Help	3
The Education People	1

KSCMP would like to thank the professionals who attended and engaged in the event. All attendees approached exercises openly and engaged in honest reflection and discussion. The format was based on a previous practice event linked to an individual practice review case and will continue to be considered for future learning opportunities.

4.3 Case scenario feedback

This exercise allowed for a 'mirror on the system' to see whether the prevalent risk factors that had been identified in the previous NAI deep-dive study would be identified by multi-agency practitioners, and what the likely response to the scenarios of the 5 children presented would be. It was also hoped that this would enable us to gain a better understanding of what the key differences were between the 5 children that had been referred and were known to services and those who were not known prior to the NAI occurring.

In all 5 cases professionals identified **parental mental health** (of one or both parents) as a risk factor which featured high in the risk order for all groups. In 3 cases professionals identified the **history of the family and previous involvement** as a relevant risk factor, although this was not overwhelmingly identified as a high-risk factor. In 3 cases **substance misuse** was identified as the second most concerning factor, however this was often not in the sense of the impact it may have on parenting more broadly. **Domestic abuse** was identified in 2 cases, in one as the most concerning factor, but much less a risk factor in another. A lack of, or lack of knowledge of, **wider family support** was also identified in 2 cases at the lower end of the risk spectrum, as was **professional optimism.** In 2 cases professionals speculated whether the **parents may have had ACEs** which impacted their parenting capability.

In all 5 of the cases professionals identified a need for further information sharing – either sharing risk information, or to obtain a better understanding what other multi-agency information existed, in order to inform the assessment of risk. Only two of the groups specifically stated that a multi-agency response would be needed, whereas

others indicated that further information was needed in order to understand whether there was a need for this. In one case professionals were very clear that whilst if all the information was shared there should be a multi-agency response to the risk to the child, that it was more likely that single agencies would hold information individually and so a multi-agency response would not be triggered. It was interesting that professionals noted this likelihood, as this was exactly what had happened in that case in reality.

What was overwhelmingly apparent was that as impartial observers presented with the case scenarios, professionals quickly identified a range of risk factors and the need for multi-agency information sharing/discussions, which had not always been identified in the reality of the cases considered. A certain degree of 'hindsight bias' might have affected this, as the professionals were aware that the scenarios they were considering had resulted in the NAI to a child; this may have led them to search more for the potential risk factors.

4.4 Challenges to offering effective support and safeguarding

The second exercise encouraged professionals to share the challenges and barriers that exist in practice, that may inhibit the pro-active multi-agency working they had identified as being necessary in exercise one. The challenges identified mostly fell into four areas.

4.4.1 Referrals and thresholds

Challenges were identified in the referral making process, such as the **language used in the request for support (RfS) form** which does not necessarily resonate with multi-agency practitioners; an anxiety amongst practitioners leading them to include **inappropriate or irrelevant information** into the RfS form; and a **lack of understanding about consent and information sharing**. It was highlighted by professionals that the wording in the RfS form makes a significant impact on the outcome- more so, in some instance, than the actual circumstances of the child. Some also suggested that there have been examples of schools **holding safeguarding concerns internally** and not making referrals, meaning the full risk picture for a child is not understood. To add to this, some agencies highlighted that their **limited window of contact** with a child or family poses a challenge to them identifying safeguarding concerns and making appropriate onward referrals.

Professionals also discussed the Kent Support Levels Guidance (SLG) and its application. It was commented that the SLG is worded in a way that is **primarily suited to older children**, making it difficult to apply to situations involving infants. Professionals also spoke of a *perception* that over time there has been an **increase of thresholds** for service provision and an increased **tolerance of poor or risky situations** for children. There was a consensus that the **complexity of cases allocated to Early Help** has increased, which previously would have been considered via a multi-agency strategy meeting and held within Children's Social Care.

A recent LCSPR published by Northamptonshire Safeguarding Children Partnership[3] noted similar perceptions of staff had led to referrals not being made: "However, when the Serious Incident Investigator explored… their rationale for not referring Child Au to the MASH sooner, two of the Health Visitors shared their belief that if they submitted a referral to MASH it would not be accepted. This decision was apparently influenced by their previous experience of referrals being rejected on more than one occasion, a view that was generally shared with members of their team. As the Serious Incident Investigator points out: "this assumption is concerning as it potentially has the ability to create a 'culture' within a service that prevents practitioners from submitting timely referrals and this will impact on the welfare of the children at risk."."

Recommendation	
3.	The Kent Support Levels Guidance course be reviewed to ensure it adequately covers terminology in the SLG and details on completing a Request for Support. Delivery of the course to be reviewed to address consistency and provision issues.

The outcomes of referrals into the Front Door were also discussed. Professionals highlighted that in their experience there can be **delays in arranging joint visits out of hours**. A further concern, also highlighted in wider practice events, was that those submitting RfS are **not always informed of the outcome** of the referral.

4.4.2 Organisational capacity

There was acknowledgement that most, if not all, services are currently experiencing challenges in terms of organisational capacity. **Demand on services has risen**, particularly as a result of the Covid-19 pandemic, and demand versus capacity seems to have led to **less multi-agency working**. The demands have also led to **high caseloads** across a range of services, which professionals felt had on occasion impacted on their ability to adequately assess risk, in order to manage workloads. It was also felt that **safeguarding is not a priority for every organisation** or service, particularly as they have become more stretched.

One specific development was highlighted regarding high caseloads. As a result of the NAI notification spike in 2021, Integrated Children's Services introduced a policy that children who were opened to Children's Social Care for a pre-birth assessment would not be closed until the case had been reassessed and the baby was at least 3-months old. Professionals praised the intention behind this change to safeguard very young babies. However, there was an indication that in practice this has led to some social workers holding cases which are deemed lower risk by their supervisors, and therefore not being counted in their overall case numbers when new cases are allocated. Nonetheless, the Social Worker is still required to conduct the requisite visits and assessments but their time is stretched across an increased number of cases.

[3] http://www.northamptonshirescb.org.uk/about-northamptonshire-safeguarding-children-partnership/scr/child-au-child-safeguarding-practice-review/ paragraph 4.2.20

4.4.3 Working with families

Professionals identified difficulties in holding challenging conversations with parents about safeguarding concerns. For some services they are operating in **settings which are inappropriate to discuss concerns** (due to a lack of privacy for example). It was acknowledged that practitioners can often be **anxious about damaging relationships** by addressing concerns or making a RfS, and sometimes staff **lack confidence to have difficult conversations** with families. It was also highlighted that not all practitioners are confident in navigating parent vs. child rights as to the appropriate course of action, and that there remains a stigma attached to making referrals to Children's Social Care with both families and professionals.

4.4.4 Multi-agency working

A **lack of understanding of each other's roles and responsibilities** was highlighted as a key challenge in multi-agency working, alongside a sense that the environment is '**policy and procedure rich but action poor'**. Professionals highlighted that there is also a **variation in practices** and expectations between different districts across the county, which for some services spanning multiple areas can be confusing and lead to a sense of inconsistency. The nature of the **health and education economies** and the number of different organisations that make up each, with varying areas of responsibilities, was similarly highlighted to be confusing and difficult to navigate. Two specific points were raised as being a challenge, firstly the **removal of the 'link worker'** role which was responsible for coordinating multi-agency involvement with a child and family. The second was **Early Help assessments and plans not being shared** with other multi-agency professionals involved with the child/family. The latter did appear to have some variance depending on area of the county or individual worker, but the majority of professionals indicated that this does not happen routinely in their experience.

Recommendation	
4.	Early Help assessments and plans to be shared with involved multi-agency partners (with family consent).

4.4.5 Single issues

Two further single issues were identified by professionals as challenges relevant to NAI.

1) **Lack of understanding and assessment of parental cannabis use**, in particular how cannabis use interfaces and potentially amplifies other issues (a point raised in the Child Safeguarding Practice Review Panel report on safeguarding children under 1 from non-accidental injury caused by male carers[4]). This was identified both as an issue in assessments, but also a broader concern in the child protection landscape, as even when an individual

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

assessment does fully incorporate this, it is not consistently accepted and recognised within the family court framework.

2) Professionals also acknowledged challenges in fully understanding male carers and fathers within services and assessments. Health colleagues specifically noted a challenge in that **fathers' records cannot necessarily be linked to their children's**, as the national spine only allows for a link to mothers.

5. Positive Practice Audit

5.1 Context

Following the deep-dive study into NAI in the under 1's in September 2021, the Executive Board endorsed a recommendation to pursue a positive practice review of cases sharing similar risk characteristics, but which had ended with positive outcomes.[5] The aim of the audit was to identify what has worked well to enable effective safeguarding so that good practice can be shared across the Partnership, allowing us to build on what is already working well.

5.2 Case identification

In January 2022, the KSCMP Business Team presented to DivMT in Kent's Integrated Children's Services (ICS), requesting the identification of cases matching the risk profile of the original 6 in the NAI deep dive as closely as possible. These characteristics included:

- Parental mental health issues
- Parental substance misuse issues, including during pregnancy
- Cannabis use in the household
- Premature birth

And of significant interest but less importance:

- Family history of ICS involvement
- Deprivation/financial issues
- Housing issues
- Parental Adverse Childhood Experience's (ACE's)
- Older sibling in care or living elsewhere

Each of the 4 districts were tasked with identifying 3 cases and providing their Liberi ID numbers to the KSCMP Business Team, with a view to the 6 most closely matched being selected for the positive practice audit. The 6 selected demonstrated 6 or more of the 9 identified characteristics at the time a Children and Families assessment (C&F) was undertaken for the unborn (therefore 'premature birth' was removed as a characteristic and substance misuse concerns/maternal use during pregnancy were separated). The final 6 were represented by the districts as follows:

ICS District	No. of cases in report
North	2
South	1
East	1
West	2

These cases were then reviewed in a desk-top exercise using records available on Liberi.

[5] 'Positive outcomes' meaning the children were appropriately safeguarded, with no direction regarding how that may have been achieved e.g. accommodated by the Local Authority, or family supported and case stepped down to Early Help services due to decreased risk.

5.3 Positive Practice – key themes

From the desk-top review of Liberi records, the following key themes were noted in relation to these cases:

Agency checks

These cases demonstrated clear evidence of multi-agency checks for the purpose of informing the Children and Families (C&F) assessments. It was evident that the checks were used to establish a picture of the families' circumstances over time and to corroborate details shared by the families themselves. This enabled a more holistic assessment of risk, and reduced reliance on 'face value' parental accounts.

C&F Assessment (pre-birth)

As noted above, assessments evidenced the gathering and corroboration of information from multi-agency partners. They also analysed this information in the context of what was already known about the families and whether current circumstances resembled previously observed patterns or indicated new risks.

Assessments tended to explore family and wider support networks, as well as associated risks. They thought beyond immediate family and/or the household, to consider others who were likely to be relevant to the babies' lives.

Some assessments drew links between current circumstances and behaviours, and the risk of Sudden Unexplained Death in Infancy (SUDI)[6]. This demonstrates foresight and an understanding of safeguarding issues relevant to the local and national landscape.

Referrals to Family Group Conferencing Service

In all 6 cases, a referral had been made to the Family Group Conferencing (FGC)[7] service. Whilst the impact of FGC support on safeguarding is less easy to gauge as part of this review, what can be assumed is that the professionals in these cases were mindful to consider and explore existing and sustainable support networks to help safeguard the subject children.

This resonates with the 'Think Family' approach in Health and the AWARE principle adopted by Kent Police. Further information and relevance to Kent Local Child Safeguarding Practice Reviews can be found in KSCMP's Family Context and Professional Curiosity 5-minute fact sheet[8].

Case notes

Some excellent practice in relation to case recording was observed, with particular case notes modelling how it is possible to capture the lived experience and voice of

[6] The National Child Safeguarding Practice Review Panel undertook a thematic review into SUDI which can be found online.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

[7] Family Group Conferences - Kent County Council

[8] Family-context-and-professional-curiosity-final.pdf (kscmp.org.uk)

a child. Some offered insight into the relationship between the social worker and the children in the families. For example, in one case note, the social worker described how the baby became unsettled and was handed to her by the mother as she went to prepare a feed. The social worker described her interaction with the baby, including how the baby looked, how she may have been feeling, and the behaviours that led her to believe that. An absence of this type of relationship being reflected in case notes has been highlighted as an issue of concern in historic case reviews locally and nationally, such as that of Peter Connelly[9].

Supervision

Each of the Liberi profiles evidenced supervision and oversight by senior managers. This enabled progression to be tracked and support for the social workers to plan next steps.

One social worker commented "supervision enabled me to reflect. It was always open and non-judgemental and helped me to recognise what my own limitations might be in relation to the case." The views of the social workers are explored in more detail in the next section.

5.4 Positive Practice – feedback from professionals

Alongside the desk-top review of available records, efforts were made to contact the allocated social workers who completed the C&F assessments for the unborn babies[10]. They were invited to engage in semi-structured discussions over MS Teams to share their views on what worked well to ensure the effective safeguarding of these children. The KSCMP are very grateful to these social workers who willingly offered their time and valuable insight to assist with this report. The key themes arising from these discussions are detailed below.

Early Request for Support via the Front Door

Several of the social workers commented that the Request for Support submitted via Kent's Front Door service occurred at the very early stages of pregnancy. This enabled the time required to establish a relationship with the families, gather relevant information for assessment, complete chronologies, initiate any relevant proceedings well in advance of birth, and front-load support so there was adequate time to measure impact prior to birth.

Exploring the family support network

Social workers commented that from the outset they wanted to understand who was going to be relevant in the lives of these babies. This may have been in a supportive role that provided practical and emotional help for the parents, or more directly as potential care-givers for the babies themselves. Also of note was the importance of understanding who was relevant to the lifestyle of the parents, and if these individuals would likely pose risk if in contact with the babies.

[9] Haringey serious case reviews: child A - GOV.UK (www.gov.uk)
[10] 5 of the 6 identified social workers contributed to this report, with the 6th being on maternity leave.

Relationship building

It was felt that some of the most important and meaningful visits were for 'a cup of tea and a catch up' rather than a targeted intervention. It was noted that capacity does not always allow for this, however, when it does, it helps establish a positive and trusting working relationship that can subsequently support better safeguarding. It was commented that this helped to break-down some parents' preconceptions about working with professionals and made them feel more comfortable about engaging in subsequent processes.

Multi-agency responsibility for co-owned and created support plans

Those interviewed commented on the support provided by wider colleagues (namely Health, Education, Housing, Probation and Substance Misuse services) in assessing risk, creating plans and communicating effectively in relation to any observed changes in the family's presentation or circumstances. One social worker described a multi-agency exercise involving ICS, the school and Health Visitor, where Mother's history was discussed and triggers for increased risk of harm identified. Behaviours that might indicate Mother was struggling were noted, meaning that when her presentation did in fact change, it was quickly picked up and communicated to the wider professional network, leading to an immediate multi-agency response.

Several commented they felt those in the professional network took equal responsibility and accountability for safeguarding, which meant that concerns were responded to promptly and proactively across the board and were not left solely for Children's Social Care to address.

Creative and practical support

Two of the social workers commented they created visual aids and timetables for parents who might otherwise have struggled to structure their time or remember and keep to appointments. Although quite a basic task, they were confident this facilitated positive engagement and could be used as a tool to measure what parents were proactively engaging with (e.g. by crossing off days on the calendar or adding their own images to the timetable).

5.5 Observations and analysis

In all the cases considered for this positive practice review, the family had a history of involvement with ICS. This is significant for 2 reasons: firstly, when a Request for Support was submitted to the Front Door the history of involvement would have indicated the significance of current concerns, lending to appropriate triage. Secondly, once allocated to a social worker, the historical records helped to establish patterns of behaviour over time, avoiding current concerns being considered in isolation, and lending to effective forward planning.

It is important to contrast this with breadth of NAI cases the KSCMP is currently reviewing, which includes several where the family had not had a history of ICS involvement, having only been supported under a universal offer. With this in mind,

consideration should be given to how the positive practice identified in this report can be shared and embedded in universal services, such as midwifery and health visiting, to facilitate the identification of safeguarding concerns that require a RFS at an early stage.

What has been noted to have worked well in these cases will come as no surprise to safeguarding professionals. Multi-agency collaboration, good quality assessment and case-recording, management supervision, building meaningful relationships with families and offering creative and practical support are basic requirements that most would likely highlight as essential for effective safeguarding. What it might indicate for the Partnership, is a need to 'get back to basics' following the interruption caused by the pandemic to 'business as usual.'

Recommendation	
5.	The positive practice audit to be published and shared as a standalone report, as a reminder that familiar, expected, basic practice works, and to avoid a sense of needing to wait for learning from individual LCSPRs to be published before seeking to change or improve practice.

6. What does this tell us?

The purpose of this study was to identify key factors which may assist in identifying children most at risk of harm and understand what practice is likely to make most impact in safeguarding the under 2s. Analysis of the cases which have been referred, engagement with professionals, and reviewing positive practice have all provided different lenses on these issues. The findings indicated through these activities are outlined in this section.

6.1 Differing context of harm

A picture has emerged of different circumstances and appearance of risk between the cohort of children who were harmed because of NAI, and those harmed as a result of co-sleeping and neglect.

For children harmed through NAI it appears that there were less obvious warning signs of risks which would be apparent to practitioners on a surface level. It appeared that parents in those cases had reached a point where their resilience was stretched beyond capacity, and then in those moments of stress (potentially related to infant crying) a loss of control followed resulting in abusive injury to a young infant. These are not necessarily the families where safeguarding concerns are immediately evident, and the exhaustion of resilience would only be realised through thorough exploration of the individual family's context and support measures. It is less about specific factors putting a child at risk in these cases, but rather a general amalgamation of factors which outweigh the parental threshold for coping.

These are families who are more likely to only be open to universal services, which means the emphasis has to be on those services to think beyond a surface picture presenting with no major risks. In most of the cases it seemed that everything looked fine, until the NAI occurred, however with hindsight it can be seen that a few further questions might have opened a window to individual struggles and challenges. This should not just be seen as a lack of 'professional curiosity' however. There is a need to acknowledge that, in the context of NAI, 'risky' families are not easy to identify. As such there is a need for universal services working with parents, families and babies to explore beyond face value, and for a focus on early prevention to begin in those services at 'Tier 1'. It is important that the role of universal services in preventative work is recognised, and that safeguarding of young babies is not just seen as the responsibility of ICS once a threshold for Early Help or Social Care has been met. By engaging in that preventative work, it will also be possible to detect escalating risk that may put a child under threat at an earlier time.

For the children and families in the co-sleeping and neglect cohort, risk was more visible and from an earlier point in time. Late pregnancy booking is already recognised as a potential risk factor, and was evident in this study, as was this broadening into a pattern of missed appointments following birth. It appears the tone of laxity for the children in this cohort was established from the outset of their lives, with concerns about not following safety guidance (such as safer sleep guidance) noted. These were families where there were also a range of other clear risk factors which were obvious to professionals (such as substance misuse and parental

violence). Families were more likely to be receiving enhanced services above universal and professionals were already concerned about the safeguarding of the child. This, however, possibly presents a complicated and 'busy' family picture for professionals, in which it may be difficult to determine pressing or escalating risk amongst the level of 'noise' in the case.

6.2 Practice themes

Three specific practice themes emerged which could make a difference in safeguarding children from harm in the future.

1. Early identification and referral

It was noted in the data analysis that most children harmed through NAI were not known to ICS, but in a high proportion missed opportunities were identified in hindsight where they should have been referred either to ICS or have received an enhanced service provision (for example, from Health Visiting). Early identification of need is clearly important, and agencies need to understand this not just in the context of provision of KCC Early Help services. Where there are needs which do require assessment or support from ICS, good engagement with universal services will enable prompt referrals.

2. Consideration of family history

In the cohort of children harmed through co-sleeping and neglect, it was noted that assessments often did not thoroughly consider the family history and the context this provides for a risk to children. Patterns of un-sustained change, or cycles of repeated concerns are relevant considerations to assessments of current need and in establishing realistic expectations of progress. When previous change has not been sustained, it is important that professionals consider what evidence there is that short-term change presented a) actually exists, and b) will continue. There were also examples in both cohorts of older children having been removed from the care of a parent due to previous concerns. However this was not considered in terms of what this might suggest about the capability of safe parenting of the current child.

3. Assessing the impact of parental issues on risk to child

A range of indicators present in both cohorts related to parental issues. Mental health concerns featured fairly frequently, alongside substance misuse and other concerns. Whilst mental health issues do not equate to a parent being unable to safely care for their child, it is necessary to assess the impact of parental issues on risk presented to the child. In one case a father reported significantly deteriorating mental health, which was identified as requiring a priority response. The relevant referral was made for support to the father, and whilst the young baby was listed as a protective factor for the father, it was not recognised that the deterioration in his mental health could have posed a risk to the baby. Where parental concerns exist it is right that they are identified and support given as appropriate, but this must also be reflected when assessing the risks for the child.

6.3 Moving forward

In the positive practice audit, it was clear that the things which are working well are familiar basic concepts. They do not represent new ways of working and would likely be what professionals would describe as expected practice. This primarily revolves around good coordinated multi-agency working and taking time to build relationships with families. Whilst these are not new or revolutionary ideas, what is clear is that this work needs to be taking place sooner, not only once the family is in a clear position of risk.

What has been clear throughout this study is that professionals from all services are passionate about their work. Nonetheless, the demands on services cause challenges as the desire to safeguard children and do the best for them, is impacted by the capacity individual workers have to be really interested in individual cases and delve into detail with families when they are affected by time constraints. This can result in professionals resorting to achieving what is required to 'tick off' a task, rather than allowing for natural inquisitiveness to be followed and a richer, more accurate picture to be understood.

7. Conclusion and Recommendations

At the outset of this report, we acknowledged the number of young children being considered in this study who had been seriously injured or died. It is right as we draw conclusions to also acknowledge the commitment to safeguarding children that exists across the range of Kent practitioners from various agencies and the very difficult contexts in which they are often working. Throughout the study our objective has been to identify where practical change can be made to support multi-agency working, and to hear directly from practitioners the challenges that exist to enacting effective practice.

It is also useful to acknowledge existing Partnership work that is underway or planned, which will provide further learning and support to address the issues raised in this study. As part of the KSCMP multi-agency audit programme, for example, an audit will shortly be commencing regarding Front Door and Requests for Support. Separately, and resulting from the deep dive study in 2021, the KSCMP Independent Scrutineer will be undertaking a review of multi-agency expectations and requirements of engagement with fathers to help us better understand broader family involvement. Five recommendations have been made throughout the report, which are collated below:

	Recommendation
1.	Kent and Medway CCG to present an update on the roll-out of the ICON programme and provision of future training in Kent.
2.	KSCMP Executive to seek clarification on current Health Visiting operating standards around face-to-face visits.
3.	The Kent Support Levels Guidance course be reviewed to ensure it adequately covers terminology in the SLG and completing a Request for Support. Delivery of the course to be reviewed to address consistency and provision issues.
4.	Early Help assessments and plans to be shared with involved multi-agency partners (with family consent).
5.	The positive practice audit to be published and shared as a standalone report, as a reminder that familiar, expected, basic practice works, and avoid a sense of needing to wait for learning from individual LCSPRs to be published before seeking to change or improve practice.

In addition to the specific recommendations, the need for universal services to be more inquisitive and alert to less obvious risks has been clearly identified, particularly when considering the inherent physical vulnerabilities of children under 2. It is on this point in particular that the authors would encourage the KSCMP Executive to reflect and discuss. This does require a shift in mindset of what a ‘risky family’ looks like and it is clear most of the children harmed who were considered in this study were not necessarily those where there were existing concerns about safety. This study has also been a reminder that practitioners, against human instinct, must be prepared to think the worst – even where there are not clear ‘red flags’. Professionals in all services need to understand that significant harm occurs to children in families where risk is not obvious, where universal services may be the

only ones engaged, and to consider whether there is one more question which might help identify an obscured risk. Experience shows us that people do not volunteer information unless they are specifically asked and one more question might be just enough to prevent the tragedies seen with the children considered in this study from occurring again.