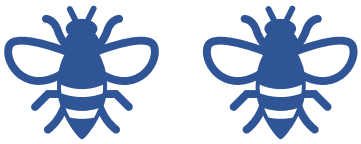
Kent Safeguarding Children
multi-agency partnership

KENT SAFEGUARDING CHILDREN MULTI-AGENCY PARTNERSHIP

LOCAL CHILD SAFEGUARDING PRACTICE REVIEW (LCSPR)

'Eli and Micah'



A benchmarking and impact review of Non-Accidental Injury in young children

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1. INTRODUCTION

Trigger for the Local Child Safeguarding Practice Review (LCSPR)

In May and July of 2021, the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) convened separate Rapid Reviews for the children named in this report as Eli and Micah.[1] These children, from different families, both suffered brain injuries whilst in the care of parents, with neither expected to survive due to harm caused. Eli tragically passed away in 2022 as a result of their injuries. Micah is reportedly thriving in Local Authority care, albeit limited by the impact of significant health issues caused by the harm suffered.

Purpose and scope

Using the Partnership's understanding of family circumstances and professional involvement with Eli and Micah, this LCSPR seeks to benchmark their cases against the Kent thematic review of Harm to Under 2's published in May 2022[2]. Eli and Micah were both children considered in that thematic exercise, however, the purpose of this review is to explore if any unique characteristics of their cases warrant recommendations or actions in addition to those already being progressed by KSCMP. This is to ensure the safeguarding 'system' is as responsive and robust as possible. Given time elapsed since these serious incidents of harm, this review is also an opportunity to consider if actions taken by Partners since 2021 have gone far enough to mitigate harm to young children in similar circumstances today.

Harm to Under 2's in Kent thematic review (May 2022) – a summary

This study considered significant harm of all under 2's notified to KSCMP in a 3-year period (between 1st April 2019 and 31st March 2022). Through case analysis, identifying positive practice in similar cases, and engaging directly with professionals, it identified key themes that help us understand when and why harm occurs, and what practice can safeguard young children from harm.

The Harm to Under 2's review analysed a total of 17 cases, 13 of which involved Non-Accidental Injury (NAI), and 4 where children were harmed through co-sleeping and neglect. For the purposes of benchmarking the cases of Eli and Micah, only those in the NAI cohort will be considered in this LCSPR.

Source material and methodology

The analysis contained in this review was developed from Rapid Review summaries and Independent Management Reviews (IMR's) requested of statutory and other safeguarding partners. In Micah's case, this included collaboration with the Croydon Safeguarding Children Partnership (CSCP), for which KSCMP is very grateful.

Individual professional engagement events were held for Eli (an in-person event for Kent professionals) and Micah (two virtual events, one for Kent professionals and one for those from Croydon). This was an opportunity to engage with front line workers who knew the families leading up to the serious incidents, or who had line managed those workers, and to check with them an understanding established from written reports.

[1] Non-gender specific pseudonyms to protect the anonymity of the children and families subject of the review.
[2] https://www.kscmp.org.uk/__data/assets/pdf_file/0003/137577/KSCMP-Harm-to-Under-2s-final.pdf

This LCSPR adopts a systems approach consistent with principles in Chapter 4 of Working Together to Safeguard Children 2018[3] and methodology recommended by the Munro Review[4]. This enables reflection upon systemic multi-agency work, looking at and analysing frontline practice as well as organisational structures and learning, and aims to determine *why* things happened. It allows for honest reflection on areas of weakness without punitive judgment, and importantly, recognises good practice and strengths that can be built on as well as things that need to be done differently to encourage improvements.

Family engagement

KSCMP's ambition is to engage all families in reviews of their circumstances. Other KSCMP reviews have benefited from a depth of understanding otherwise unachievable, when family members have met with us, shared their stories, and challenged or qualified our interpretation of how services worked with them. Their insight has been invaluable when designing recommendations with a view to preventing harm and improving support for other children in the future.[5]

For this LCSPR, the KSCMP Business Team liaised with professionals currently working with Eli and Micah's families when writing to advise a review was being undertaken. The professional network further supported the author to identify an appropriate time to invite families' direct engagement. Both sets of parents and wider family members were written to inviting them to meet with the author. At the time of writing this report, neither family had responded. This of course is each family's right, and KSCMP appreciate the very difficult circumstances they find themselves in are likely to make this a daunting prospect. KSCMP would like to extend its best wishes to the families of Eli and Micah and will be happy to meet to discuss this review should they wish to in the future.

2. BENCHMARKING AGAINST HARM TO UNDER 2'S IN KENT

Characteristics in the majority of cases

The Harm to Under 2's in Kent study included a statistical analysis of 62 indicators across 17 cases, each with varying degrees of information available to reviewers. Due to the small sample size and varying quality in case information, the prevalence of each indicator was based upon the proportion of cases where it was a known factor. (For a full description of data analysis methodology, please follow the link to the report in footnote 2.)

In a separate piece of work not considered by this review, Croydon Multi-Agency Safeguarding Hub (MASH) Operational Group undertook an audit into multi-agency contributions to decision making in cases for under 2's. The Croydon Safeguarding Children Partnership anticipate publishing a briefing in May 2023 and may wish to consider Micah's case alongside that in a separate piece of work.

The following headings highlight **most prevalent** indicators in the cohort of 13 children victim of NAI *in Kent*, of which Eli and Micah were a part. Characteristics of their cases will be benchmarked against the general findings. At the time of writing the Harm to Under 2's report, none of the children had died as a result of their injuries, though 3 had sustained life changing injuries. Subsequent to that report's completion, Eli tragically passed away as a result of harm suffered.

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/942454/Working_together_to_safeguard_children_inter_agency_guidance.pdf
[4] TheMunroReview-Part_one.pdf (publishing.service.gov.uk)
[5] See 'Lost in Plain Sight' https://www.kscmp.org.uk/procedures/child-safeguarding-practice-reviews/published-local-child-safeguarding-reviews

Safe sleep advice

In **all** cases, including Eli and Micah's, there was clear evidence of safe sleep advice having been given to parents by professionals, often on multiple occasions. KSCMP should be assured from its reviews, including recently published Baby T,[6] that *delivery* of safe sleep messages is well embedded in standard practice, particularly amongst midwifery and health visiting professionals, and should look to *build* upon this to prevent its feature in future instances of harm to young children.

SAFE SLEEP – WHAT REVIEWS HAVE TAUGHT US – WHAT NEXT?

In January 2023 KSCMP published its benchmarking of Baby T's case against the national SUDI review 'Out of Routine.' The Partnership determined it requires a proactive approach to checking how information about safe sleep delivered to parents is understood and acted upon. As such, a recommendation to audit the use of motivational interviewing across the Partnership will be actioned by the Learning and Improvement subgroup, as will measures to effectively embed knowledge around predisposing SUDI risk factors, guidance and referral pathways.

Whilst sleeping conditions are not believed relevant to the harm ultimately suffered by Eli and Micah, in Eli's case, police officers responding to the serious incident found them in a room where conditions were in stark contrast to the rest of the property. The extent to which family homes were seen by professionals follows in the next section.

Family home seen by professionals

The Harm to Under 2's review identified the family home had been seen in 91% of NAI cases notified to KSCMP. Readers should be mindful that Eli and Micah's parents were receiving pregnancy and other support during the UK Covid-19 lockdowns. Despite challenges to practice the pandemic created, their families were 2 of those where homes **were** observed by professionals. Specific vulnerabilities had been identified during pregnancy in both cases, leading to assessment of need and delivery of support that incorporated home visits. In neither case did home conditions flag any observable risks to visiting professionals, however:

- Micah's mother reported to only smoke cannabis outside. The Health Visitor did not smell cannabis when she visited the property, though some contacts were virtual with calls replacing visits due to revised operating procedures resulting from the pandemic. This limited the opportunity to corroborate what Mother was saying.
- Whilst professionals in Eli's case had met with parents several times in the lounge, they had not seen the rest of the house. Whilst the lounge was described as clean, tidy and well furnished, the room in which Eli slept with their parents on discovery after the serious incident, was described as very different to the rest of the house with dirty baby bottles, nail clippings on the side, soiled nappies spilling from a bin, and drug paraphernalia. Police stated

[6] Baby T LCSPR report can be found at https://www.kscmp.org.uk/procedures/child-safeguarding-practice-reviews/published-local-child-safeguarding-reviews

they would have made a referral to Kent Children's Front Door Service based on the conditions of that room alone.

Eli's case in particular highlights that conditions in which babies and young children are sleeping are important for professionals to understand and observe where other risk factors are already identified, such as substance misuse and poor mental health. The Panel for Eli and Micah suggested the practical application of how observing safe sleep environments with families could be routinely incorporated should be actioned by organisational safeguarding leads, and could for example, be included into discussions with families about ICON.[7]

SUGGESTED GROUP EXERCISE: HOME CONDITIONS

Professional engagement events for Eli and Micah highlighted those indifferent roles had varying expectations around how much of the children's homes they could and should be looking at. Many did not want to appear intrusive when offering support to families engaging on a voluntary basis.

As a group, reflect upon *when* you should ask to see more of the home. How do you *feel* about asking? Are you *confident* asking to do so? Role play scenarios to explore and share your skills with colleagues. *How* do you analyse and record your observations? *How* can you incorporate safe sleep environments into discussions with families about ICON?

Domestic abuse questions asked

The Harm to Under 2's report found that standard domestic abuse questions were asked in 80% of the NAI cases it reviewed. In those where it was not, it was often recorded that due to contacts being virtual the practitioner was unable to ascertain if it was safe to explore the subject. In some cases, however, practitioners did not subsequently create a new opportunity to revisit domestic abuse questions.

There was no suspicion of domestic abuse between Parents in Eli's case and it is not considered a factor relevant to their harm. Mother and Father consistently described a supportive and loving relationship, and this was observed by professionals working with them. A Family Partnership Practice Lead did use an opportunity during one visit when Father left the room to broach the subject of domestic abuse with Mother and no disclosures were made. There is no evidence to suggest that Father was asked the same question.

Micah's mother was understood by the professional network not to be in a relationship at any stage of their involvement with her, apart from one comment she made to a Community Midwife in the post-natal period where she said she was well supported by her 'husband.' During a telephone ante-natal contact by a Health Visitor at 34 weeks gestation, Mother confirmed she was no longer with the baby's father and also that she had not experienced domestic abuse. Whilst further exploration

[7] ICON is about helping people who care for babies cope with crying https://iconcope.org/about-icon/

of Mother's personal relationships and details of Micah's father was lacking, there is no indication domestic abuse was a relevant factor to the serious incident.

Parental Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences (ACEs) can be described as,

'highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to, and breaches of, a young person's safety, security, trust or bodily integrity. These experiences directly affect the young person and their environment, and require significant social, emotional, neurobiological, psychological or behavioural adaptation.' (Young Minds, 2018)[8]

The Harm to Under 2's study found that Parental ACEs were known in 75% of the NAI cases reviewed. Information submitted to the review suggests that Eli's father had been adopted as a child in a different Local Authority area. Little about the specific details of this adoption, such as precursors to it and his age at the time, are known by agencies contributing to this review, though it was suggested the relationship between Father and his adoptive parents was strained. Eli's Mother had been known to Kent's Integrated Children's Services as a child following missing episodes. Her older sibling had been accommodated by the Local Authority as a teenager following a period of aggressive behaviour in the home, contributed to by substance misuse. It may be assumed that Eli's parents experienced ACEs, particularly when considered in conjunction with mental health concerns below, though it is not 'known' and has not been checked with them.

No information was known or provided to the review about Micah's mother's experience of childhood. There are multiple factors reported in her adult life which may be indicative of ACE's, however, to date there has not been an opportunity to clarify this.[9]

PROFESSIONAL RESPONSE TO PARENTAL SUPPORT NEEDS IN ELI'S CASE

A Maternity Support Form (MSF) for Eli's mother highlighting a history of self-harm and a suicide attempt was completed at 14 weeks gestation and sent to the Health Visiting Service. Subsequent contact was made by the Family Partnership Practice Lead (FPPL) who learned from Mother that Father had also experienced poor mental health and a difficult childhood. Coupled with their young age, this gave cause to offer ongoing targeted support from the Family Partnership Programme, which Parents accepted and engaged with. Records did not identify Parents' experiences as 'ACE's', but support offered nevertheless recognised particular vulnerabilities dating back to childhood would likely impact parenting capability.

[8] https://www.youngminds.org.uk/media/ojpon1ut/addressing-adversity-infographic-poster.pdf

[9] Croydon Health Integrated Safeguarding Team have incorporated ACE's into their Level 3 training package as a result of learning from local LCSPR's. KMPT now also capture ACE's in all Level 3 safeguarding training.

Family known to Integrated Children's Services

Families had been known to Kent's Integrated Children's Services (ICS) ***at some point*** in 75% of NAI cases reviewed in the Harm to Under 2's report. Far fewer were open to ICS at the time of the serious incident. This is consistent with both Eli and Micah's cases.

Eli was not known to ICS prior to the serious incident, though their mother and maternal uncle did have a history of support. Details of Eli's father's reasons for adoption in another Local Authority area are not known by the author of this report. Micah had been subject of a Child and Family assessment (C&F) in Kent as an unborn having been referred to the Front Door by a midwife. The outcome of that C&F was No Further Action (NFA) and the case was closed prior to their birth, though Mother was linked to a local church offering an 'Essentials Supermarket', a mentor for financial advice and guidance, and sourcing of baby items. Mother also had a history of involvement from Children's Services in Croydon, where her first child had been removed from her care (this is explored in more detail in section 3).

A family history of involvement with Children's Social Care provides an opportunity to understand the context in which current issues are emerging. Patterns of behaviour can be identified using chronologies, and potential risks can be better understood. However, this can only be done where the information is available. Eli was not open to ICS either as an unborn child or baby, so midwives and the Family Partnership Practice Lead were reliant *to an extent* on parental accounts of their history of involvement. Micah's case was complicated by the fact Mother had moved Local Authority areas during pregnancy and since her first child was removed from her care. In their case, the transfer of relevant information between areas significantly impacted the assessment of risk.

SUGGESTED GROUP EXERCISE: BUILDING A BETTER PICTURE

In your organisation, how do you build a picture of a family's relevant history? Do you know of any useful chronology tools? Where do you get your information from? How familiar are you with software your organisation uses? To what extent are you reliant on family accounts and how/when should you corroborate their information?

Maternal mental health concerns

Maternal mental health concerns were a feature in 73% of the NAI cases in the Harm to Under 2's review. The mental health difficulties in cases reviewed were not necessarily 'perinatal' i.e. resulting from the pregnancy itself, and were often historic. Public Health England figures indicate between 10%-20% of women are affected by perinatal mental health problems during pregnancy and the first year after having a baby.[10] What this indicates to KSCMP, is that frontline professionals must be mindful of the link between maternal mental health difficulties and cases of NAI, and make provision for mothers to be adequately supported, whilst maintaining oversight of *how* any difficulties may impact parenting capability and the safety of children.

[10] https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

Eli's Mother told midwives and the Health Visiting Service about mental health difficulties she had experienced during adolescence. This included anxiety and depression, which she attributed to difficulties in peer relationships when at school, resulting in self-harm and 3 suicide attempts by overdose. Coupled with other identified vulnerabilities, this information prompted the midwife to raise a Maternity Support Form and initiate a pathway via which targeted support from the Health Visiting Service was offered and accepted. This support was ongoing at the time of the serious incident.

Information about Micah's mother suggests she had taken an overdose at the age of 10. Sometime later, and seven years prior to Micah's birth, records indicate self-harming behaviour and auditory hallucinations instructing Mother to kill someone she knew, leading to her being sectioned in an acute psychiatric unit under the Mental Health Act. Despite this history, Mother denied previous or current mental health concerns when she booked in with the midwifery service in Kent, and her subsequent Health Needs Assessment undertaken by the Health Visiting Service flagged no concerns with regard to emotional wellbeing, so it can be assumed Mother chose not to disclose her history at this point also.

Kent professionals initially became aware that mental health issues may be a cause for concern when the Health Visiting Service in Croydon made contact with the Kent midwifery service, sharing valuable information about substance misuse, mental health difficulties and that fact a child had already been removed from this mother's care as a result of neglect. It was this cross-border sharing of information that led to a Request for Support being made to Kent's Front Door, and the initiation of a C&F assessment (pre-birth).

As an opportunity to explore how mental health might be a relevant factor in the assessment of risk for unborn Micah, however, what this assessment failed to identify was the extent to which this might be a concern. This was in part due to a lack of relevant information shared with the social worker from various organisations when requested for the C&F assessment, and partly due to a lack of curiosity around what was shared. What is not clear from reports provided to this review, is whether the transfer of medical records between GP practices in Croydon and Kent was a relevant factor. It is likely the quality of the pre-birth assessment impacted the understanding of links between Mother's cannabis use and her mental health, and how these factors could be a trigger for unsafe and neglectful behaviours.

LEARNING POINT – EXPECTATIONS REGARDING REQUESTED INFORMATION

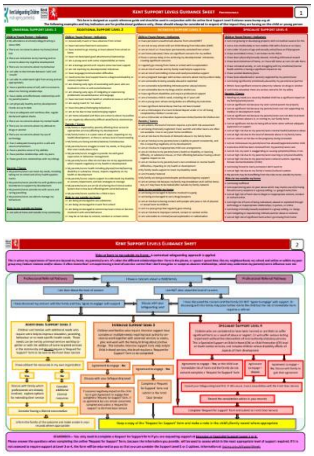
Practitioner engagement events for Eli and Micah, along with others the KSCMP Business Team has coordinated, indicate a culture of 'acceptance' that some professionals are unlikely to return information requested as part of a C&F assessment, and that information provided can be of poor quality or relevance. In addition, some organisations have found that information requests sometimes contain incorrect or incomplete family details, making a search of the records challenging. Kent Partners should revisit with staff the *expectation* that information requested as part of assessment of risk and need by ICS, is provided in a timely way and is proportionate to the context of concerns, Also, that information requests contain accurate family details.

Missed opportunity for referral/increased provision

One section of the in-person learning event held in March 2022, forming part of the Harm to Under 2's study, invited frontline professionals to identify challenges and barriers inhibiting pro-active multi-agency working. One area highlighted was 'referrals and thresholds.' This is pertinent given the review identified missed opportunities for referral and increased provision in 67% of the NAI cases.

Eli's case resonates with the findings of the Serious Case Review for Children O&P[11] published in July 2022, where a key learning point was some professionals lack an awareness of how parental mental health problems impact parenting capability and 'need to recognise the relationship between adult mental health and safeguarding children' (p. 16), in order that safeguarding referrals are made in a timely way. This is explored further in relation to Father's needs in section 3 below.

Potential for missed referral for increased provision in Micah's case points KSCMP to look at its relationship with the third sector, who in this case received safeguarding guidance from an independent consultancy who was unaware of the family's history. This too is explored in section 3 of this report.



KENT SUPPORT LEVELS GUIDANCE

All professionals with safeguarding responsibilities in Kent must make themselves familiar with the Kent Support Level Guidance (SLG). This regularly reviewed document outlines criteria used to match the needs of children and families to appropriate support. See here for the SLG document and information on referral pathways.

Cannabis impact under recognised

Frontline professionals at the KSCMP NAI event as part of the Harm to Under 2's study identified 'Lack of understanding and assessment of parental cannabis use' as a key Partnership challenge. In particular, professionals raised how cannabis use interacts with and potentially amplifies other risk issues, such as poor mental health. Of the NAI cases reviewed by the thematic, it was noted 67% featured the impact of parental cannabis use having been under recognised.

Records provided to this review demonstrate a lack of clarity around whether Eli's mother had ever used cannabis, though there was consensus she was not using it in the period prior to Eli's serious injury. There was an understanding however, that Father did use cannabis and there was evidence to support this at the scene of the incident.

With the benefit of hindsight, we are able to see that Micah's mother had a lengthy history of cannabis use, which could be linked to criminality and poor mental health. This history was not

[11] The Serious Case Review for Children O&P can be found by following https://www.kscmp.org.uk/procedures/child-safeguarding-practice-reviews/published-local-child-safeguarding-reviews

known by all professionals working with Mother in Kent due to the quality of information sharing, and this obscured the level of risk Micah was at in her care.

Various KSCMP events have demonstrated growing discomfort and discontent amongst multi-agency professionals around the lack of robust mechanisms to support them in the analysis of and response to parental cannabis use. Whilst cannabis is a class B drug and its possession and use can be addressed with criminal disposals, professionals have described feeling unclear where a threshold for what is not acceptable sits in terms of its use in relation to impact on parenting and child safeguarding. They have described difficulty in raising cannabis use as a concern with parents and within their organisations, when culturally it carries a level of acceptance similar to that of low-level alcohol use. What is clear from this and other KSCMP reviews, is the associated ambiguity is likely to be a contributory factor in the serious harm of several Kent children and a clear and coordinated multi-agency strategy should be progressed as a matter of urgency. As such, this review endorses the relevant recommendation in the KSCMP Child S LCSPR[12], and suggests the following in addition:

KSCMP addressing parental cannabis use - additional ideas		
KSCMP Executive to write to the Child Safeguarding Practice Review Panel highlighting the number of cases notified where cannabis use has been a feature, and request proactive guidance and response at national level.	KSCMP Learning and Improvement Group to champion a multi-agency public awareness week, where links between cannabis use and harm to children are highlighted and support pathways referenced.	Kent ICS to review pro-formas used to request information of multi-agency partners and include a specific question around known cannabis use.

3. SPECIFIC FEATURES IN THE CASES OF ELI AND MICAH

"Mother and Father spoke warmly to each other and to Eli and were observed to handle them gently and confidently. Eli seen responsive to parents' interactions."

Understanding the role of wider family

Eli lived with their parents in the home of maternal grandparents. From information provided to the review, it is clear professionals did little to explore the role grandparents would play in Eli's life, or the extent to which they could provide support or present risk. Records imply assumptions were made that by virtue of them being present they were a support, without any curiosity around what that support might look like practically or what role they may have as caregivers.

[12] KSCMP to develop a Substance Misuse strategy with a specific focus on cannabis use to support practitioners to have a shared understanding of the risk, appropriate interventions and decisions on threshold for concern/escalation.

Further, Eli's maternal grandmother was an Ofsted registered childminder and professionals were aware of this. There was some indication at the engagement event this reassured professionals she was therefore someone who could be relied upon to provide a safe environment for Eli and would be mindful of issues relevant to safeguarding. This reassurance was misplaced when we consider the stark contrast in living conditions between the room Eli slept in and the rest of the house. None of this was explored with Grandmother and she was not spoken to directly or included in assessment of the family's strengths and needs.

Young parents

In contrast to the majority of parents considered as part of the NAI cohort in the Kent Harm to Under 2's review, Eli's parents were both young (i.e., 21 or under). National research of NAI in babies under 1 by the Child Safeguarding Practice Review Panel found that almost one third of cases involved those born to young parents (30 cases out of 92 under review).[13]

The age of Eli's parents formed part of the reason they met the threshold for targeted support from the Family Partnership Practice Lead, and written evidence/in-person accounts of what that support involved suggests a service bespoke to this family's needs being built upon with each visit. Sessions explored healthy relationships, how to respond to Eli and share care of them, and how to resolve differences in opinion, amongst other things. What was perhaps less explored, but appears would have been in time had the serious incident not occurred, was the impact of how Mother and Father had been parented themselves, and the implications this had for their wellbeing and care of Eli.

Paternal mental health concerns

12 days before Eli's serious injury, Father sought support from his GP reporting paranoia, visual and auditory hallucinations that were controlling of him, losing his temper, feeling out of control in heated situations, and suicidal thoughts. Father had a known history of drug related pseudo hallucination and reported he smoked 2 joints in the evenings to avoid overwhelming and intrusive thoughts. The GP made an urgent referral to Single Point of Access (SPoA) on the same day to access support for Father, but no Request for Support was made to Kent's Front Door for Eli as Father was not perceived as a risk to them. Instead, Eli was recorded as being a 'protective factor' for Father's wellbeing.

2 days later Father was telephone triaged by SPoA and reported fluctuating mood, irritability, and constant suicidal thoughts with no current plan or intent. He reported experiencing angry outbursts since he was young, including chasing his sister with a hammer and someone else with a knife. He identified his child, partner and partner's family as protective factors, but also that hearing voices was taking over his life and he was self-medicating with cannabis. Records of this contact do not evidence the safeguarding of Eli was considered in the context of potential risk posed by Father.

Other Kent reviews have also identified this worrying feature, suggesting actions taken to date to mitigate reoccurrence of children being considered protective factors in situations of parental mental health difficulties have not gone far enough. A recommendation of this review is for KSCMP to take a different, hard-hitting approach, targeted at professionals.

[13] https://www.gov.uk/government/publications/safeguarding-children-under-1-year-old-from-non-accidental-injury

RECOMMENDATION – CHILDREN ARE NOT PROTECTIVE FACTORS

This review recommends that KSCMP commission a short video targeted at professionals.

A parent describes their mental health difficulties to a professional, and contrasts this with the love and support of a family member that protects them. The professional asks to meet this family member, at which point they are introduced to a new-born baby.

The subsequent message on screen is that children should never be considered protective factors, with a link to Kent's Front Door Service.

"Observed warm, caring and responsive mother and baby interactions. Micah was dressed appropriately for the environment and was observed to have normal tone and colour. Micah appeared to be awake and alert."

Sibling subject to a Special Guardianship Order

Micah has a sibling who is approximately 4 years older. When Health Visiting Services in Croydon undertook a new birth visit, they quickly identified Mother's need for additional support given her mental health difficulties and cannabis use. Problems with housing soon followed when Mother was evicted due to anti-social behaviour. Multiple services and Mother's family referred Sibling to Croydon Children's Social Care who commenced a C&F assessment.

Within months and amidst escalating concerns, Sibling was removed from Mother's care under police powers of protection and care proceedings were initiated. These concluded when Sibling was made subject of a Special Guardianship Order, moving to live with Maternal Aunt, who subsequently moved to Kent.

Similarities to this pattern of concerns were beginning to emerge during Mother's pregnancy and Micah's early life, including Mother's behaviour, cannabis use and mental health difficulties. However, the full extent of historical concerns was not understood by Kent services, several of whom did not know Sibling had been removed from Mother's care (as she did not disclose this to them) making it more difficult to predict potential risk to Micah. Although Kent Children's Social Care did complete a C&F assessment, poor information sharing and communication between Local Authority areas impacted the quality of that assessment and its usefulness in determining the necessary level of ongoing support and oversight. When it was closed with No Further Action (NFA) and without being shared with universal services, those services understood this to mean there was no or low risk to Micah and remained unaware of the level of risk Sibling had been at in Mother's care before being removed.

What would have been helpful, and is now standard practice in Kent, would have been for the reason for the referral, identified risks and next steps to have been formalised in a letter to Mother, copied to the services working with her. Kent ICS may wish to audit this process to ensure it is being embedded effectively. In Micah's case however, the ability of that threshold decision making and

NFA conclusion was impacted by the quality of information shared between areas, as explored in the next section.

Cross border communication

At the time she fell pregnant with Micah, Mother was still residing in Croydon and initially registered with midwifery services there. The midwife completed a notification to the Health Visiting Service who recalled previous concerns about Mother's mental health, cannabis use and neglect of Sibling who was subsequently removed from her care. When the Health Visitor called Mother and discovered she had moved to Kent, they immediately called and emailed the Kent Midwifery Service to share the history of concerns. This led to the referral to Kent's Front Door cited in section 2 of this report.

When information was sought of Croydon Children's Social Care by the Kent Social Worker undertaking the assessment, what was received did not detail the quality of care Sibling received from Mother, or the reasons why they were removed under police protection and care proceedings initiated. The level of information provided by Croydon was disproportionate given the final outcome, however, further clarification was not sought by the Kent Social Worker completing the assessment, as could reasonably have been expected. This provides further evidence for the need of Recommendation 1 in this report.

Support from the 3rd sector

As noted in section 2 above, Micah's mother was referred by a social worker to a voluntary, religious organisation for practical support. The social work Team Manager at the professional engagement event commented their team has good links with this organisation and refer several families to it. Micah's Mother first received essential food and baby items, and soon began to visit regularly, taking advantage of other support including guidance in relation to budgeting and starting a business.

The first note of any concern the organisation had was approximately 3 weeks before the serious incident. This was regarding Mother's apparent use of cannabis in relation to her breastfeeding. It was recorded the safeguarding lead spoke to an independent consultancy operating a safeguarding helpline at this time. There is discrepancy in the records supplied to the review, from these organisations, about the exact date this consultation happened. The consultation recognised Mother had historic involvement from Children's Social Care and 'previous children that she didn't see any more.' It advised a supportive approach with Mother about the impact of cannabis on breastfeeding and finances, and suggested she speak to the Health Visitor. On reflection, the consultancy highlighted it would have been best practice to explicitly reference that the religious organisation should make a referral the Health Visitor, and would have been helpful to suggest a referral to Kent's Front Door Service.

3 days before the serious incident, Mother visited the religious organisation wearing what was described as a 'fancy dress' and no shoes, appearing 'very low and not in a good place.' Micah was with her in a pushchair. Mother reported she was dressed this way and feeling low as she had not had electricity for 4 days and had not done any laundry.

The day after the serious incident (at which point the organisation were unaware of it), Mother was observed by a volunteer to be dancing in the street with no shoes, in the rain, apparently intoxicated. These concerns were raised to the organisation 3 days later. 3 days after that (1 week after the serious incident), the organisation submitted a request to Kent's Front Door Service given their safeguarding concerns.

In contributing to the review, this organisation commented despite apparent stressors in their lives, Mother always ensured Micah was well dressed and responded to. Mother was well known at the church, which meant when there was a clear decline in her presentation, she was offered additional practical and emotional support, and safeguarding advice was sought.

The voluntary, religious organisation offers a safe place and practical support to people who know they will always be welcomed. This perhaps creates an environment in which individuals feel comfortable opening up about their lives, and relationships formed whereby staff and volunteers are likely to pick up on subtle cues and changes in presentation. Because of this it is an environment, replicated similarly across the county, where further safeguarding flags are likely to emerge with other families being supported in the future.

For this reason, it is imperative Partners forge stronger links with the 3rd sector to encourage a timely response to safeguarding issues, and the KSCMP Business Team support this with a targeted communications strategy. Any delays either due to liaison with a separate, private consultancy, or in reporting to the safeguarding lead within an organisation should be mitigated as far as possible, with consultation via the Front Door Service if in any doubt. What private safeguarding consultancies do not have and the Front Door Service potentially does, is a record of any historic difficulties and support needs relating to Kent families, offering context and help to determine the significance of any current concerns.

4. CONCLUSION

This LCSPR provides KSCMP with an opportunity to build upon ongoing work improving multi-agency approaches to the safeguarding of young children. Whilst the Partnership has already identified improvements required through its Harm to Under 2's thematic review and other published and completed LCSPR's, an analysis of the cases of Eli and Micah have generated further learning to identify action required for the continued improvement of the safeguarding system.

This review has identified the Partnership needs to foster a culture of expectation that relevant information must be provided by Partners in a timely way for the purposes of assessing risk and need, and steps taken to address when this does not happen. Organisations must be confident they are providing proportionate information reflective of historic concerns, so the context of current issues can be better understood.

The Partnership should seek assurance regarding the consistency of information sharing with universal services at the point of case closure to Integrated Children's Services. This will enable professionals providing ongoing support to be mindful of areas where additional support may be required, and potential patterns of behaviour likely to increase risk to young children.

Although previous reviews have seen recommendations and actions aiming to address the perception children can be seen as protective factors in relation to parental mental health, this review reminds us there is further work to be done in order that safeguarding of children is routinely considered in hand with the support needs of parents.

The cases of Eli and Micah provide further evidence for the need of a substance misuse strategy where response to cannabis use is a is a key feature. This review suggests additional pieces of work to support the Partnership's approach to addressing this.

The KSCMP Learning and Improvement Group are not currently progressing any recommendations regarding relationships with 3rd sector organisations. Micah's case highlights the need for new work in this area, to ensure such organisations are aware of training and guidance available to them, and referral pathways to be followed when safeguarding concerns exist.

5. ELI AND MICAH'S LEGACY - SUMMARY OF RECOMMENDATIONS

KSCMP proposes taking forward the following recommendations, in addition to others currently being progressed by the Partnership, in direct response to what happened to Eli and Micah.

Recommendation 1: Observing sleeping environments.

- Organisational safeguarding leads to review how observing safe sleep environments with families can be routinely incorporated into practice, and report this back to the KSCMP Learning and Improvement sub-group.

Recommendation 2: Information provided for the purposes of assessment.

- Kent Partners to revisit with staff the *expectation* that information requested as part of assessment of risk and need by ICS is provided when requested and proportionate to the context of concerns.
- Kent ICS should ensure information requests contain accurate family details, and there is recorded evidence of follow up/escalation when requested information is not received.

Recommendation 3: Support work towards developing a substance misuse strategy, with a specific focus on cannabis use, further to Recommendation 6 in the LCSPR for Child S by,

- KSCMP Executive to write to the Child Safeguarding Practice Review Panel highlighting the number of cases notified where cannabis use has been a feature, and request proactive guidance and response at national level.
- KSCMP Learning and Improvement Group to include links between cannabis use and harm to children in their planned public awareness week relating to Sudden Unexpected Death in Infancy and other harm. Support pathways to be referenced.
- Kent ICS to review pro-formas used to request information of multi-agency partners and include a specific question around known cannabis use.

Recommendation 4: Children are not protective factors.

- KSCMP to commission a short video targeted at professionals in relation to parental mental health and children not being considered protective factors.

Recommendation 5: Audit of information sharing at the point of case closure.

- Kent ICS to consider including in its audit schedule a review of information sharing at the point of case closures. Are closure letters to families being routinely copied to services providing ongoing support?

Recommendation 6: Cross border information sharing.

- Croydon's Front Door Service to consider dip-sampling information provided to other Local Authority areas for the purposes of assessment and enquiry, to ensure sufficient detail is provided for the analysis of risk.

Recommendation 7: Engagement with the 3rd sector.

- Partners to consider ways to improve engagement with 3rd sector organisations.
- KSCMP Business Team to consider communication strategy with 3rd sector organisations, highlighting local pathways for guidance and referral in relation to safeguarding concerns.