

## Multi-agency Learning Review – May 2025

In May 2025, Westmorland and Furness Safeguarding Children's Partnership undertook a multi-agency learning review with partners. The review sought to understand the relevant history, identify key themes and areas for single and multi-agency improvement. Agencies known to have been involved with the family contributed to the review, reflecting upon what agencies working with the family knew about their lived experiences and how well risks were understood and managed. Learning from this review is summarised below:-

**Agencies support for the family** – There were key individuals working with the family and positive changes had occurred in the year prior to mother's death. However, support for the family seems to have primarily focused on meeting the children's health and learning needs, without sufficient focus on wider issues which could have impacted on parenting capacity. There were opportunities for **greater professional curiosity** and understanding of what life was really like for the children. Furthermore, greater understanding of mother's history and the **potential impact of trauma** could have been explored further to help support the family.

**Whole Family Approach** – All agencies to ensure sufficient attention is given to **wider family dynamics** and issues which could **impact on parenting capacity**, cooperation and resilience (particularly in circumstances where there may be indicators of Domestic Abuse and/or Neglect).

**Increase awareness of Trauma** – All agencies should ensure that they have a **trauma informed approach** to support children, young people and families. This should include reference to the **cumulative impact of trauma on resilience and response**.

**Domestic Abuse and Neglect** – Information obtained to inform the review indicated that the children had witnessed Domestic Abuse and experienced Neglect. There is evidence to suggest that the Domestic Abuse perpetrator undermined mother's parenting capacity. This diverted professionals attention away from the Domestic Abuse and made Neglect the main issue of concern. **The Domestic Abuse Act 2021 makes clear that Children who have experienced Domestic Abuse should be considered by agencies as victims in their own right.**

**MARAC processes** – agencies involved in MARAC need to be **active participants** with meaningful, measurable actions assigned and followed up at future meetings to help manage risk and support victims and their families.

**Engagement with Health services** – There is learning about the importance of continued, accurate and timely **communication across health providers**, particularly for children who have input from multiple health services. This communication helps build up a **cumulative picture**, particularly where there may be concerns emerging (for example in relation to missed appointments). Efforts were made for health providers to see the children in school; however, this then meant that the children missed appointments when they were absent from school.

**Multi-Agency involvement in Strategy (and Statutory Safeguarding) meetings** – The review highlighted the importance of ensuring that key safeguarding meetings **include all relevant multi-agency professionals**, including different elements of health and education. This helps to ensure that **decision making and safety planning is informed** by all relevant agencies.

**Professional Curiosity and Healthy Scepticism** – The review highlighted circumstances where the DA perpetrators opinion was **taken at face value**, which **overlooked behaviours** that may have intended to discredit the victim. In situations of coparenting, whereby there is disagreement between parents, **all agencies need to remain sufficiently curious** about both parents, acting impartially and in the **best interests of the children**.

### **What worked well**

**Stability of services** – There was **stability of services** involved with the family and evidence of strong, **honest relationships** between mother and key workers

**Immediate aftermath of mother's death** – Agencies responded **thoroughly and sensitively to support the children** in the immediate aftermath of their mother's death.