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Child Safeguarding Practice Review

Lloyd and Mark

May 2022

Contents

This report was originally endorsed by the Wandsworth Safeguarding Children Partnership in the summer of 2021, and recommendations were agreed. Following the Crown Prosecution Service [CPS] decision in December 2021 to charge the mother and her partner it was agreed to update the report considering local developments since the original report was endorsed by the Safeguarding Children Partnership.

Use of Footnotes

The Review contains Footnotes to explain safeguarding processes and terms for those who are less familiar with them. The agreed processes for safeguarding children are set out in statutory guidance ***Working Together to Safeguard Children*** *which applies to England. The version used here is 2018, in which, there are some small changes from the 2015 version which would have been applicable during the earlier part of the period under review. Working together to safeguard children - GOV.UK (www.gov.uk).*

There are agreed multi-agency procedures and guidance for London and for Wandsworth which amplify how the national procedures are to be used locally.

London Safeguarding Children Procedures: (londonscp.co.uk). The procedures have a useful search facility for key words.

The local Multi-Agency Procedures and the locally agreed Threshold Document for Wandsworth can be found on the website for the Wandsworth Safeguarding Children Partnership, Home - Wandsworth Safeguarding Children Partnership (wscp.org.uk)

1 Executive Summary

1.1 The Review was commissioned after Lloyd's death in 2019 (age 16 months). Given the family circumstances and the history of involvement with local multi-agency child and family services over the previous five years it was agreed that the analysis and learning should be drawn from the multi-agency work to support both Lloyd and his older brother Mark (age 4 years at Lloyd's death) and their mother, Ms A. They had been in receipt of universal, early help and later child protection services.

1.2 Attempts to work with Ms A were disrupted by several moves to temporary or safe housing across four London Boroughs. The moves broke links with practitioners from midwifery, domestic abuse, early help, social care, and preschool services. Ms A had a troubled history, was subject to domestic abuse in different ways and reported her own previous problems with alcohol and drug use, because of child and adult trauma.

1.3 Ms A often avoided workers and did not keep to agreements to use local child and parenting services. There were, at times, gaps of several months when no workers saw the children even though they were assessed as vulnerable and met thresholds for early help intervention; however, early help services are not compulsory.

1.4 From autumn 2018, when Mark briefly attended a nursery, increased concerns were noted, a thorough multi-agency assessment was undertaken, and the children were made subject of Child Protection Plans in December. The family was moved urgently to an out of borough refuge for protection from domestic abuse and coercive control.

1.5 The Child Protection Plan initially concentrated on the immediate risks of that domestic abuse but was not then later further refined to meet the assessed underlying needs and neglect identified in the Child and Family Assessment.

1.6 The move out of borough again disrupted the professional network; and key agencies such as Housing were not represented in the Core Group. Ms A appeared to respond to some of the domestic abuse counselling but did not engage fully. Mark's signs of developmental delay had been noted but were not being fully assessed or dealt with.

1.7 After a few months, the family moved again to temporary accommodation in a third borough before soon returning to Wandsworth, once more disrupting the Core Group of professionals, and working relationships with Ms A and the children. In July 2019, the Child Protection Plan ended. Despite disagreement by practitioners newer to the case the decision to step down from child protection to a "robust child in need" plan was not escalated. From that time Ms A avoided contact with professionals and the boys were not seen again before Lloyd's tragic death, in late August.

1.8 After Lloyd's death it was learned that Ms A had started a new relationship, which she had previously denied when questioned, at the time. It was also discovered that the children had been exposed to adult drug use, over time.

1.9 In December 2021, Mr D was charged with Lloyd's murder and Ms A was charged with causing or allowing the death of a child. Their trials are scheduled for February 2023.

1.10 The Review has used this case as an example of how the wider agency and multi-agency child safeguarding systems were operating at the time.

1.11 Learning and recommendations are made in the following areas:

- The need for better monitoring of family support at the Universal Plus Level within the National Healthy Child Programme Pathway, when families do not cooperate.
- The need to have curiosity about children under 5 who are not being seen in pre-school services where there is non-engagement by parents, and how agencies form and record a clear picture of children's daily lived experience, including siblings when only one child is being seen or considered.
- Child Protection Plans must fully address children's underlying needs as identified in assessments even when having to respond in crisis to new acute threats of harm, such as newly disclosed serious domestic abuse.
- Core Groups must closely monitor Child Protection Plans and their progress and change their planned outcomes and interventions if there is insufficient progress.
- It is important that key agencies are fully represented in Core Groups, including Housing or Police or other domestic abuse services, as needed.
- Moving families across Local Authority boundaries from the services disrupts professional networks and the established professional relationships with children and parents. Priority re-housing systems need to be well understood by frontline staff and their managers. Such moves can allow parents who are reluctant to engage the chance to avoid concerns as workers can get caught up in practicalities and a history of parental avoidance can be lost as workers change.
- Housing provision has become complex in the mixed economy of local authority, private, independent, and voluntary sector providers. There must be good cooperation in child safeguarding at a strategic level as well as at a practice level across this complex and often confusing sector.
- The Review has shown that although risk from domestic abuse was recognised, responses were not as well co-ordinated as they should have been, with some workers expressing lack of confidence in this area. At the time there was no clear multi-agency leadership of domestic abuse responses at a strategic level.
- Ms A avoided contacts with professionals and made agreements that she did not keep. This was not sufficiently challenged.
- Ms A was a young woman with a troubled childhood and adolescence, with a known history of trauma leading to alcohol and drug misuse. She was often asked about drug or alcohol use and her denials were accepted. This area of practice may require greater support to practitioners about challenge and exploration of drug use.
- Ms A avoided ante-natal and post-natal support services. For Mark she was a young, vulnerable, and new mother and later had difficulty parenting him. This raises a question about how best to ensure parenting education and support to young and, or first-time parents.

The recommendations and their rationale are explained in Section 6, and they are collated together in Section 7. A separate action plan for delivering them will be created.

2 Reason for review and methodology

2.1 Lloyd died from significant non-accidental injuries in late August 2019, aged sixteen months. He was also assessed to have significant injuries caused over several episodes before the fatal injury.

2.2 The Wandsworth Safeguarding Children Partnership (WSCP) commissioned a Rapid Review1 and agreed that a Child Safeguarding Practice Review (CSPR) should be undertaken. The CSPR was to learn from local agency services provided to Lloyd and his older half-brother Mark (aged four years) as it was assessed that Mark had also experienced significant harm over time.

2.3 The purpose of a CSPR is to learn through a systems analysis of the family dynamics and of the single and multi-agency work undertaken to assess and support the child and family. The review should make recommendations where changes may be required in the way that local services for children and families are provided. The process seeks to involve family members and practitioners as much as possible, to learn from their perspective.

2.4 It was agreed to concentrate on the two years from the pregnancy with Lloyd but also to analyse and learn more generally from agency involvement during the period from the previous pregnancy with Mark.

2.5 Ms A, Mark's Father, Mr B, and Mr D, Ms A's Partner, were advised of the review and invited to contribute. They did not respond. Lloyd's father had had no contact with him from birth and no services had been in touch with him.

2.6 The criminal investigation into Lloyd's death was impacted by a long period awaiting the results of the post-mortem and biopsies; this is a known systemic issue for such investigations which impacts on learning reviews as well as criminal justice processes. The Chair of this Review Panel has written to the National Child Safeguarding Review Panel to highlight this issue.

2.7 During the main period of the review, the Covid-19 pandemic prevented face to face meetings. An online reflective focus workshop was held with practitioners and their immediate managers who had worked directly with the family to learn from them.

3 Family Background Information

3.1 At the time of Lloyd's death, at the end of August 2019, the family composition was:

Lloyd **Subject**	Aged 16 months Died August 2019	Mixed White British & Black British heritage
Mark **Subject**	Aged 4 years	Mixed White British & Black British/Caribbean heritage
Ms A **Mother**	Aged 29	White British
Mr B **Father to Mark**	Aged 42	Black British – Caribbean heritage
Mr C **Father to Lloyd**	Not known. Mr C had no contact with any local services	Not known but described as Black
Mr D **Mother's partner in 2019**	Aged 29	White British

Ms A also had occasional contacts with her mother and a brother.

[1] A Rapid Review is required by statutory guidance **Working Together to Safeguard Children 2018**. One of the outcomes may be a Child Safeguarding Practice Review as set out in Chapter 4.
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Background

3.2 Ms A (aged 5) and her siblings first came to the attention of Children's Services from 1995. Concerns, over time, included an allegation of indecent assault to Ms A, domestic abuse, alcohol abuse, poor supervision, poor school attendance, neglect, and physical abuse.

3.3 Ms A (aged 14) and her siblings were made subject of **Child Protection Plans**[2] for neglect, following concerns about physical chastisement. There were also later concerns about the children using alcohol and cannabis.

3.4 Ms A's father subsequently left the family home, and sometime later died, when Ms A was 23. She found the circumstances of his death particularly traumatic and said that it had led to her abusing alcohol.

4 Summary account of key events and agencies' involvement with Lloyd's and Mark's family 2014 – August 2019

4.1 Ms A and her family were in receipt of public welfare services for several years because of domestic abuse, universal services provision around the births of Lloyd and Mark, concerns about parenting, housing, and later education, and about the children's development. The pathways of support from universal to child protection services and step down to Early Help were affected adversely by the movement of the family across different boroughs.

July 2014 to September 2015 - Pregnancy and birth of Mark (February 2015)

4.2 Ms A was rehoused several times in different boroughs for her own safety before returning to Wandsworth. There was a missed opportunity to consider a child protection approach before Mark's birth. There was no liaison between two boroughs, each undertaking its own separate Child and Family Assessment. Ms A did not cooperate with assessments or subsequently with offers of Early Help.[3] Domestic abuse services were hampered by Ms A not responding and information not passing, as expected, from MARAC[4] to MARAC and finally back to Wandsworth. There was a pattern of non-engagement by Ms A.

4.3 Both Midwifery and Health Visiting Services observed the interaction between Ms A and baby Mark as good. Without the fuller prior history, and with reassurance from Ms A that she was not in contact with Mr B and that she was supported by friends and a Children's Centre the decision was made to offer her the Universal Plus Health Visiting Pathway[5].

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[2] **Child Protection Plans** are multi-agency agreements setting out the actions that families and local agencies will take to safeguard children who have been assessed to be at risk of significant harm. The decisions are made at a Child Protection Conference with key agencies and the parents present. The plans are reviewed regularly until the risk is minimised or until different actions are required to protect children. More information can be seen in the statutory guidance for England: **Working Together to Safeguard Children, 2018;** Working together to safeguard children - GOV.UK (www.gov.uk); pages 49 – 54

[3] [3] See the local Threshold for services to children. Thresholds for intervention - Wandsworth Safeguarding Children Partnership (wscp.org.uk)

[4] **MARAC** – Multi-Agency Risk Assessment Conference is a local multi-agency meeting with a primary focus on the safety of adult victims who are at high-risk of domestic abuse. - 12. Risk Management of Known Offenders (londoncp.co.uk)

[5] **Universal Plus Pathway** Pathways - NHS Healthy Child Programme A Universal Plus Pathway can be agreed where a Health Visitor has assessed that a child or family needs additional support because of an identified vulnerability

4.4 In September, a Team Around the Child Meeting decided that Mark was making good progress. Children's Social Care withdrew, and the Health Visitor took over the Lead Professional role. Mark and Ms A were thought to be attending a Children's Centre, but that was not so. There were concerns about the number of missed contacts with professionals and whether Ms A was using excess alcohol. These were not followed up.

4.5 From September 2015 to January 2016 no service had contact with Ms A or Mark.

2016 (Mark 11 months to 1 years 10 months)

4.6 In March, Mark was assessed in clinic to be developing well (aged thirteen months). Ms A reported attending the Children's Centre; this was not so. It was agreed with Social Care that there were no grounds to step up to child in need services. Ms A agreed to attend a Parenting Course and to take Mark to Play Sessions, plus other support but she did not follow through on these.

4.7 In July, Police were called twice to the home. There was a fight between adults, involving drugs and alcohol, Mark was present, but Ms A was not. Ms A refused to assist the Police enquiry. Later Police attended a third-party referral that Ms A's 'partner' was refusing to leave but Ms A said that the allegation was untrue. A new Child and Family Assessment resulted in a Team Around the Child meeting to devise a plan. Ms A did not attend, and it was thought that there were no grounds for child protection measures. Ms A subsequently avoided meetings with the Health Visitor and / or Social Worker, despite agreements to do so. In October she finally met the new social worker and signed a written agreement to keep unsuitable visitors from the home. Children's social care ceased its involvement in November. Mark was 21 months old.

2017 to May 2018 – birth of Lloyd (April 2018)

4.8 No agency seems to have seen Mark from the summer/autumn of 2016 until May 2017. This review has found no evidence that he attended any Early Years Services, a GP, or a hospital. The Health Visitor tried unsuccessfully to visit in January, March, and April. Mark was not brought to his Two-Year Development Check in March 2017.

4.9 By persistence and unannounced visiting the Health Visitor was able to get Ms A to respond in May 2017. Ms A said that Mark was immunised and that she was seeking a nursery placement for him; *there is no evidence of that.* Mark's development was in line with his age (27 months). Good interaction was noted between Ms A and Mark. Ms A described his tantrums and said that she knew that she was not consistent in managing them. The Health Visitor gave advice. There was no evidence for concern of neglect or harm for Mark that could be noted in that contact.

4.10 In July, Police were called to a domestic disturbance involving Mr B. They completed a risk assessment, but had no concerns about Mark and gave Ms A advice. Ms A was referred to Social Care and to the Community Safety Independent Domestic Violence Advisor Service but did not respond; the case was not therefore progressed to an assessment.

4.11 No agency had contact with Mark (from aged 2 years 5 months to 2 years 10 months) or Ms A from July until December 2017 when she made a late antenatal booking (at 22 weeks).

4.12 The Midwife noted the history of concern. Ms A declared cannabis use and tested positive for this. When asked in routine enquiry about risk of domestic abuse Ms A said that it was not an issue for her. Ms A missed several ante-natal appointments and declined to be seen at home by the Community Midwife. It was noted that Social Care had closed the case in 2017. This appeared to lead to an assumption that there were no grounds for concern whereas the closure had been because of non-engagement. No consideration was given to informing the Health Visitor – the Lead Professional.

4.13 Lloyd was born in April 2018. The Community Midwife followed up with several visits in May and initially had no concerns. However, she later referred the family to Children's Social Care as Lloyd was in a 'chaotic household' and at risk of neglect. It is not clear from records if the Midwifery Services saw Mark, during visits.

May 2018 to mid-October 2018 (Mark 3 years 3 months to 3 years 8 months; Lloyd 1 month to 6 months)

4.14 The Health Visitor decided that the Universal Plus Health Visiting Service was the appropriate level of intervention given Ms A's vulnerability. Mark was not seen and was said to be attending nursery 15 hours per week; but no evidence of that has been found. Children's Social Care started a new Child and Family Assessment. Both boys were seen and there were no concerns about them. The Social Worker and Health Visitor visited jointly in early June. Mark was seen and said to be in nursery, which was accepted. The Health Visitor assessed Lloyd at the six-week check and had no concerns. Good mother-baby interaction was noted. A new Health Visitor was introduced.

4.15 At the end of June, Police were called to the home to check on a baby's welfare. The Police saw a woman and child but did not check that this was Ms A and Lloyd and there is no information that Mark was seen. The woman said that the call was malicious and denied any domestic disputes. The call out was not shared with Children's Social Care. A DASH risk assessment was not done. This was a missed opportunity to alert children's agencies.

4.16 The Child and Family Assessment concluded that there was no role for Children's Social Care as Ms A "was co-operating with the Health Visitor". There was no evidence of this.

4.17 The only service to have contact with the family after the end of July seems to have been Mark's new Nursery, which he started in late September.

October to December 2018 (Mark 3 years 8 months to 3 years 10 months; Lloyd 6 months to 8 months)

4.18 In October Mark's nursery referred the family to Children's Social Care concerned about Ms A's parenting abilities and engagement and worried about neglect. Ms A was not being truthful or co-operating with the nursery's attempts to resolve issues. Mark was hungry and dirty, and he smelled strongly of cigarette smoke. There were concerns about Ms A's and Mr B's behaviour and on the few occasions they were seen at the nursery they appeared disorientated. The nursery queried cannabis use. A further Child and Family Assessment was agreed. Ms A stopped bringing Mark to the nursery.

4.19 A Social Worker visited at the end of October, unaware of the allegation of drug dealing. The home was in good condition. The Social Worker followed up Mr B's renewed involvement. Mr B's Probation Officer was unaware of Mr B's contact with Ms A. The Health Visitor was advised of the concerns. It became apparent that despite advice from professionals Mr B was very much part of the children's lives.

4.20 In early December Lloyd and Mark were made subjects of Child Protection Plans for Emotional Abuse. Mr B posed a risk to the children and Ms A was unlikely to co-operate with services. There were concerns about Mark's delayed speech development and he was to be referred for a speech and language assessment. In the Child Protection Conference Ms, A said that Mr B was abusive and controlling and that she was scared of him. As a result, the family was immediately moved to temporary accommodation and then to a refuge out of the borough.

4.21 Because of responding to the immediate safety issues the Core Group did not further refine the Child Protection Plan to clarify what changes were required to keep the children safe and meet their needs. The case should have been referred to MARAC but was not. Housing should have been a key agency to form part of the Protection Plan but was not included. The move of borough also required a change of Health Visitor.

January 2019 to August 2019 (Mark 3 years 11 months to 4 years 6 months; Lloyd 8 months to 1 year 4 months)

4.22 The refuge offered counselling to Ms A, including work on Power and Control[6] in abusive relationships, and about future housing. She was thought to have shown insight and to have benefited from this. There were no concerns about her care of the children.

4.23 An investigation into an unrelated, serious assault on Mr B suggested that he may have been dealing in drugs from the family address from which Ms A and the children had been moved.

4.24 The new Core Group met at the beginning of February at the out of borough Children's Centre. The initial outline Child Protection Plan was not further refined, as it should have been.

4.25 In late February there was a further Core Group meeting. The Health Visitor and Housing Officer did not attend. The children were well, and Ms A was "cooperating". The referral to Speech and Language Therapy had not been progressed.

4.26 The first Review Child Protection Conference was held at the beginning of March, in Wandsworth. The meeting was technically inquorate but went ahead. Housing, the Police, the Children's Centre and the nursery were not in attendance. Ms A and the boys were still in the out of borough refuge. Ms A was said to be increasing her understanding of risks from domestic abuse. Mark had settled into the local nursery and "Lloyd was attending a Children's Centre" with his mother. (In fact, he only attended on four occasions.) Mark had speech delay but had not been referred. The Health Visitor and Social Worker recommended that the children should be stepped down to children in need. The refuge worker abstained; said to be the refuge's policy. The Independent Chair of the conference did not agree and decided that the children would continue on Child Protection Plans for Emotional Abuse. No professional dissented to that decision.

[6] **Power and Control Wheel** http://www.stopdomesticviolence.org.uk/violence-wheel/

4.27 At the end of March, Ms A, Mark, and Lloyd were moved to temporary accommodation in Croydon and then back to Wandsworth in late April; again, disrupting the Core Group of professionals. The Social Worker visited the children at home. They were said to be well, but the disruption caused by moves over the last few months was noted. Ms A reported that she was not taking drugs or smoking and that she was not in a relationship.

4.28 In the second week of June the new Core Group was held at the family home, to support Ms A's attendance. The children were said to be attending a children's centre; however, the centre was not invited to the meeting. The children's immunisations were not up to date. There had been no progression of a referral for Mark's speech delay. A support worker was looking for a school place for Mark from September; (he was now four years and four months old). She reported that she was not using cannabis or alcohol. *Information from after Lloyd's death shows that Ms A had been using drugs during this period.*

4.29 Ms A did not attend the children's centre until the end of the first week of July, despite agreements. The Health Visitor liaised with the children's centre manager and stressed the need for a place for Mark and his need for Speech and Language therapy. There was also a worry that Ms A said that she was not able to control Mark's behaviour and that he may need to be referred to the Child and Adolescent Mental Health Service (CAMHS) for under 5s.

4.30 Lloyd's development check was completed in July (age 1 year and three months). His development and abilities were age appropriate. Ms A's relationship with Lloyd was noted to be responsive. There were continued concerns about Mark's speech and Ms A said that she often left him to his own devices and on-screen activity to avoid tantrums.

4.31 A Core Group was held, again in the family home. The new children's centre had not been invited. Mark had not been taken for a planned Speech and Language therapy appointment. Ms A had not yet consented to his referral to CAMHS. Mark was described as lashing out at Lloyd. She agreed to take the boys to play group sessions and Mark to CAMHS. Ms A said that she had no contact with Mr B and that she was not using drugs. A view was formed that there was progress in the Child Protection Plan and that the children were doing well.

4.32 The Review Child Protection Conference was held in late July. Ms A was reported to have made some progress, but there were still actions from the original outline Child Protection Plan which had not been progressed. The Health Visitor and children's centre representatives who were both new to the case recommended that the children should remain on a Child Protection Plan. However, it was agreed that the case could be stepped down to Child in Need with a "robust Child in Need Plan". This was to include referrals to CAMHS and to Speech and Language therapy for Mark.

4.33 Subsequently, Ms A prevented visits from the Social Worker, one because they were "on holiday". When asked by phone if she was in a new relationship, she said "no". *Information gained after Lloyd's death shows that Ms A did not go on holiday with the children and that she was in the new relationship with Mr D.*

4.34 At the end of August, Lloyd (aged one year and four months) was brought to hospital, in cardiac arrest. He had significant bruising to his head, eyes, face, and body. These were assessed to have been non-accidental. Mr D was present in the home and was said to have found Lloyd in a state of collapse.

4.35 No agencies were aware of Ms A's relationship with Mr D or that he was visiting or probably living in the home. Information about Mr D, gained after Lloyd's death, showed that he had history of drug misuse and violence. He had separated from his partner at the beginning of August.

4.36 Ms A and Mr D were both arrested and the criminal investigation into Lloyd's murder began.

4.37 Lloyd died from blunt force trauma to the head. He had sustained multiple impacts to his body, head face and abdomen, over the preceding weeks, throughout August.

4.38 Mark was taken into protection. Child protection medicals and skeletal surveys showed no signs of physical abuse to him. *Evidence showed that he had been exposed to cannabis and cocaine use, probably passively.*

5 Practitioners' involvement in the review

5.1 An online Reflective Workshop7 was held for practitioners and first line managers from Children's Social Care, Health Visiting, Children's Centres, Nursery, the Refuge, and the Police. The practitioners in the event were involved mainly between September 2018 to September 2019. Some of them had only limited or one-off contact with the family, others more frequent. The Police representative had not worked with the family.

5.2 The practitioners endorsed the learning identified by the Panel. It was suggested by them that that families like Ms A's and responses like these were not uncommon in wider practice.

5.3 There was a view that the fundamental question about the cause of Lloyd's death was still unanswered. However, that is not the task of a Child Safeguarding Practice Review but that of a criminal investigation.

5.4 The Practitioners' analysis and their response to the Panel's suggested learning are included in Section 6 of this report. Several of the practitioners noted that their reflections were now influenced by hindsight. This is unavoidable. We can learn from hindsight but must try to understand what dynamics or systems prevented the information or conclusions from being seen at the time.

6 Analysis and Key Learning

6.1 The Review's purpose is to use the case as an example of how well the local child welfare systems were or are working singly and together, and whether there are any actions which should be taken to improve services and their delivery to reduce possible harm to other children.

6.2 This review highlights some learning for local agencies, some of which are sadly familiar, and some are not. It is easier to see these with hindsight and it would be unfair to judge practitioners and services by what was not apparent at the time, or which could not have reasonably been obtained. There were, however, missed opportunities to identify risks to Lloyd and Mark.

6.3 The analysis seeks to understand the assessments made and the actions taken in the context of the agencies within which practitioners were working and the dynamics of multi-agency systems.

6.4 It should be noted that the review covers a longer period than would normally be analysed because of the significance for these children; analysis of practice five years earlier may not reflect the quality of current service delivery. It does inform how later decisions were made in this case.

Key Learning

Early learning from the Rapid Review

6.5 The multi-agency Rapid Review held shortly after Lloyd's death noted the following areas for consideration as possible learning. No specific actions in relation to these were agreed at that time as the practice of Rapid Reviews under new guidance was being developed. Now there would be a separate action plan to address any identification of need for changes from a Rapid Review.[8]

- Domestic abuse practice and the vulnerability of babies and young children with regard to domestic abuse.
- Working with disguised compliance.
- Children's emotional and developmental indications of abuse and neglect.

They are more fully considered in the analysis below.

Learning from the Child Safeguarding Practice Review

The effectiveness of local multi-agency safeguarding children thresholds and pathways

6.6 Assessments and responses to levels of family need are decided against locally agreed "threshold criteria".[9] Ms A, Mark and Lloyd were in receipt of universal services at level 2 of the Wandsworth Threshold Document until the child protection plans in December 2018 (level 3). Several assessments were completed by individual agencies, such as Midwifery or Health Visiting; or were multi-agency Child and Family Assessments led by Social Care.

6.7 When the children were seen with their mother Health Visitors and Social Workers noted apparent positive relationships. Ms A appeared well presented and responded well. There appeared to be no evidence to make the boys subject of child in need plans until they were stepped down from child protection plans in July 2019.

[7] Practitioners were asked to reflect on their experience of the work with the family at the time (rather than through hindsight). Some were seeing a more complete picture than was available to them at the time. The Review Panel's draft learning was shared to gain practitioners' perspective of work with families like this one and of working in the wider multi-disciplinary safeguarding system.

[8] It was noted that the circumstances of Lloyd's death were particularly traumatic for the staff involved in the case and in the Rapid Review and that this impacted on the quality of the Rapid Review, at the time.

[9] The Wandsworth Safeguarding Children Partnership Threshold Document can be accessed at: Thresholds for intervention - Wandsworth Safeguarding Children Partnership (wscp.org.uk)

6.8 A systemic question arises for local Commissioners and Providers of Health Visiting and Midwifery Services about the local application of the National Healthy Child Programme Pathways[10]. It seems appropriate that after the births of both children and given that there was no clear evidence of current risk, that the Universal Plus Health Visiting Service was agreed, in recognition that Ms A needed additional support. Health Visitors made good attempts to meet with Ms A and the boys, including pro-active opportune unannounced visits when there was repeatedly no response from her to the contacts by Health Visitors. It is not clear to this review, however, how the need for that that level of service was then monitored and what the expected visiting or contact frequency is now, or how a decision is made to end a Universal Health Visiting Plus level of service.

6.9 A contextual systems issue to be noted in this case and more widely is that the contract for the provision of Health Visiting services changed from one Provider to another in 2018, during the period under review. As well as the change of provider there was a change in the commissioning specification for the overall Health Visiting services to be delivered to families like this.

6.10 This review has led us to ask: How does Health Visiting Management keep an overview of those children who require an enhanced level of Health Visiting, such as Universal Partnership Plus? Mark became lost to services on several occasions. This became more of concern as he was rarely receiving any other services such as pre-school, children's centre or nursery which could have picked up his changes in circumstances and emerging development delay – especially speech delay. This must be seen in the context of available Health Visiting resources and high caseloads, which are set by the commissioning specifications. This review was advised that the Health Trust has since adopted the London Continuum of Need as a guide to monitoring a family's ongoing need for services.

Recommendation 1

The Wandsworth Public Health Services, as Commissioners of local Health Visiting Services, with the Providers, and with consultation from the Clinical Commissioning Group, should commission an audit of a random sample of cases, across teams, at "targeted" level of service (Universal Plus) which, are not multi-agency child in need or child protection cases, to review how such cases are supported and monitored over time.

The purpose of this audit of frontline health visiting practice is to provide assurance that when families have been assessed to require a higher level of Health Visiting Service that cases continue to be monitored by the agreed method and frequency to ascertain if any change (particularly increase) in provision is required.

Wandsworth Public Health Services should report the outcome of this review to the Wandsworth Safeguarding Children Partnership.

[10] Pathways - NHS Healthy Child Programme
www.healthychildprogramme.com/pathways/links-to-national-pathways

The Child's Lived Experience

Seeing children and holding them in mind

6.11 A challenge in this case is that Mark, and then Lloyd, were not seen for significant periods until they became subjects of Child Protection Plans. When Mark was seen there were concerns about his speech and language development, appearance, head banging and tantrums. These are signs that he was possibly experiencing neglect or emotional abuse. This was seen in the Child and Family Assessment prior to the children being made subject to child protection plans but later took second place to concerns about domestic abuse to Ms A and its impact on her and on the boys. From the time that the children were made subject of Child Protection Plans there were several changes in professional workers and the work appears to have concentrated more on preventing domestic abuse and re-housing rather than on the children's needs.

6.12 Regarding universal services there are questions for Midwifery, and possibly the Police, about when observing or considering a child how they also consider the welfare and needs of another child in the same household. It is not clear if midwives saw Mark as he does not appear in their records, yet he would have been evidence of Ms A's parenting ability. This may be a recording issue.

6.13 Given what was known of Ms A avoiding services, a question in hindsight is: Was Mark being kept hidden from view and, if so, why? Local children's welfare systems need to promote and ensure curiosity about children under five who are not in services and who are not being seen when parents or other children are in contact.

Recommendation 2

Services which assess children or parents, and their welfare or safety must take into account all the children who are usually resident in the household, or children in frequent contact, as their welfare may be an indicator of well-being or need for other household / family members.

Local children's agencies, Midwifery Services and Adult Services should review their practice guidance, information gathering and sharing arrangements and supervisory arrangements to ensure that when one child or parent is being seen and considered that there is curiosity about and consideration of the welfare of other household members or family members in regular contact, especially children under 5.

6.14 As noted in the timeline, a challenge was that on occasions when Ms A and one or both boys were seen the children appeared to be physically well cared for and to be "developing well" when they were infants, especially in pre-arranged visits, but not later for Mark. The observed parent-child interaction was seen to be good, in the here and now of single contacts, all that is often available for a brief one-off assessment. It is easier for parents to meet a professional's expectations in short visits or contacts. It was when the nursery was able to gain a clearer picture of Mark over a few days from late October 2018 that his needs and potential neglect began to be recognised more fully. This led to the referral under the local threshold for an assessment, first as a possible child in need and then for a child protection assessment.

6.15 There is no clear picture in agencies' records over time of Mark's and Lloyd's daily lived experience; nor are there records about how the children's appearance and behaviour were reflected on and considered as possible signs of neglect or emotional abuse.

6.16 Mark's needs, and potential neglect, were well-recognised in the Child and Family Assessment which was provided for the Initial Child Protection Conference of December 2018, but they were not translated fully into the Child Protection Plan and were not later acted on.

6.17 It is noted that Mark had tantrums and headbanging, but it is not clear which professionals saw this and how this was later taken into account.

6.18 There were good attempts by the Social Worker during the period of the Child Protection Plan to do some direct work with Mark, even though he had speech problems; and there was consideration about his identity and possible need for safe contact with his father, Mr B.

6.19 It can often be the case that the welfare needs of very young children (under 5) can be overlooked if they are not engaged in pre-school activity where they can be observed. When Mark was seen in nursery the staff quickly became concerned about his welfare and potential neglect and referred him to Social Care appropriately.

Recommendation 3

The Wandsworth Safeguarding Children Partnership Safeguarding and Continuous Learning Subcommittee should commission agency and multi-agency practice audits to ascertain how services are assessing and recording the daily lived experience of children, including those in a household who are not the index child. These audits should consider how children's behaviour and appearance are recorded and taken into account when assessing their welfare and safeguarding needs, in addition to what children say, for those able to speak.

From this audit a decision can, be made whether additional practice guidance is needed. This review should include children who are identified as vulnerable but who are not seen as often as they should be.

Use of the Local Threshold Arrangements at Tier 3 – Referrals and Multi Agency Assessments

6.20 At Tier 3 an assessment should be led by a social worker. Between March 2016 and July 2018 Children's Social Care received a total of four referrals leading to three separate assessments and one child protection assessment. Three were in relation to alleged domestic abuse incidents and identified several similar risks and concerns, and in turn concluded that there was no role for Social Care. Ms A appeared to have an ability to both evade professionals and yet provide them with enough reassurance that all was well.

6.21 Supervisors and managers have an important role in stepping back and checking that all the previous history and contacts have been considered to quality assure new assessments. This was not done for the first three assessments and so the overall picture and possible pattern was missed. It was not until the referral in October 2018 that all the information was brought together to form a complete and more worrying picture.

6.22 In relation to Lloyd and Mark, the assessments fell short of expected standards. Some of the reasons this may have happened were seen to include:

- A variety of workers and managers were involved so there was little or no consistency in dealing with Ms A. This may have contributed to each having an individual view of the concerns in isolation and in the present rather than seeing the whole picture and adding sufficient weight to the history.
- There appeared to be a lack of professional curiosity about the risk factor of Mr B being back in the family's life. The evidence that the couple were not in a relationship was never tested and this applied on several occasions; referrals suggest that he was part of the family's life.
- The referrals and contacts came in before the MASH[11] in Wandsworth was operating in the way it is currently. Now the MASH triages all referrals and undertakes mapping to consider all the information available. Previously this history and information gathering would have been the responsibility of individual workers. Although this would have been good practice, it is acknowledged that this was not custom and practice in Wandsworth during this period.
- Much of the earlier work with this family was during the time that Wandsworth Children's Social Care was operating at less than an optimal level. It received an "Inadequate" judgement from OFSTED in February 2016. Much has improved in the service since that time and progress in relation to the quality of the "front door" was noted in the subsequent inspection in May 2018.
- Meetings with Ms A seem to have allayed professionals worries and she was able to demonstrate that her care of her children was good enough. Much of the content of the assessments relied on information provided by her and this was not challenged or checked with information held by other agencies.
- There is no evidence that the poor practice associated with this period was ever raised as a practice issue either by an audit process or other Quality Assurance activity (e.g., by the Child Protection Co-ordinator). An audit conducted in February 2019 noted the previous involvement but does not comment on the quality of the practice in this earlier period.

[11] MASH – Multi-Agency Safeguarding Hub A service which receives and triages new requests for assessments of children and families, using information held by several agencies and involving officers form social care police and health.

6.23 It is difficult to explain the lack of curiosity about Ms A's own childhood and self-reported abusive experiences and how they were impacting on her ability to prioritise her children's needs. This information was available as it is summarised succinctly and clearly in the original pre-birth assessment conducted in 2014/15. Consequently, the assessments did not lead to provision of services, no formal plans were made or implemented to assist Ms A or the children, and they were stepped down to Early Help and Universal Services.

Child Protection Assessment and Child Protection Conference October to December 2018

6.24 In autumn 2018 Mark's new nursery was appropriately concerned about several factors relating to his care. The new (to the case) Social Worker was concerned about the immediate and longer-term welfare of the children. The assessment was a thorough piece of work which analysed the family history, the previous involvement by local agencies and which highlighted the potential risks for the children. It took account of all the information held by Children's Social Care and presented a clear, cogent evaluation of the children's experiences. This led to the Initial Child Protection Conference in December 2018. This was good work at the expected level.

6.25 The assessment and the other information presented at the Initial Child Protection Conference was the first time the concerns over the previous four years were brought together coherently and a formal plan was made to seek to reduce the risks to the children. It was also the first time that Ms A had been properly challenged in terms of her children's safety and confronted with the reality of her circumstances. The decision to make the children subject to Child Protection Plans was unanimous and appropriate.

6.26 The Conference was split in its management so that both Ms A and Mr B (father of Mark) could attend, which was good practice. After Mr B left the meeting Ms A alleged that he was abusive and controlling but that she could not end the relationship as she feared him.

6.27 The decision to take immediate protective action for her and the children and the social work practice over this period was excellent. It was balanced between showing compassion and being mindful of the risks. It included conversations with Wandle Housing to ensure that the family were not temporarily moved to an unsafe area, close to Mr B.

Effectiveness of the Child Protection Plan and Core Groups (December 2018 – July 2019)

6.28 In line with procedure, common in many Children's Social Care systems, the family's case was transferred from an assessment service to a longer-term service, the Child in Need Service. This led to a further change of Social Worker to lead the multi-agency Child Protection Plan. This is a systemic issue in that parents get to know and possibly start to form a working (therapeutic) relationship with a social worker through an assessment but then must change workers because the system requires this when the case must move on to another team for longer term work. This change of worker can also lead to a parent being able to deny conversations and resist the previous worker's perceptions.

6.29 A Child Protection Conference in agreeing that a child should be the subject of a Child Protection Plan sets the Outline Plan, led by the experienced, senior and independent chairperson. The key members of the Core Group to work with the parents on achieving the Plan are also agreed. The procedural expectation is that this Outline Plan will then be refined further by the Social Worker and confirmed by the Core Group. This latter step rarely seems to happen, and the Outline Plan remains the Plan until it is reviewed at the next Child Protection Conference. It is a difficult task for a new to the case Social Worker, assuming the Keyworker responsibility, to lead the refining of the Plan when they do not yet know the case. An additional systems complication in this case was that the Social Worker and Manager who were to take over responsibility for the case were not present in this important Child Protection Conference.

6.30 There were two Core Group meetings before the Review Child Protection Conference (RCPC) in March 2019. The first one just before Christmas 2018 did not further specify the Child Protection Plan but focussed on the immediate crisis of the moves of accommodation to a refuge for safety from domestic abuse and related practical matters. This was understandable; however, it would have been beneficial also to ensure that Ms A understood what changes she needed to make in relation to her care of the children, especially for Mark. There should also have been further exploration about her possible use of alcohol and drugs. These were well-noted in the assessment and in the conference but not in the specific tasks forming the outline Child Protection Plan. The circumstances made it possible for these concerns to be deflected on to Mr B's abusive behaviour rather than, in parallel, possible neglect of the children – Mark in particular, by Ms A. The Core Group was to include the nursery, which Mark had ceased attending when Ms A withdrew him and did not include Housing which was to become a key agency, given the need to move Ms A for her and the children's safety.

6.31 The second Core Group Meeting was held six weeks later and had a completely new network, the new Social Worker, and a new group of professionals from outside the borough. No-one who had known Ms A previously and who was fully aware of the concerns was present. There was no Housing representative who would have a key role in supporting a final move back to permanent and safe housing after the period in the refuge. It is not clear in the record why they were not present or if they had been invited. This raises a common practice and systemic question about how well Core Group Meetings are supported administratively, and whether this falls on the shoulders of busy social workers. Also, the need to support workers to think reflectively when cases transfer across networks or borough boundaries. A key question is: Who holds the history – including intuitively?

6.32 The Core Group did not discuss the progress of the Child Protection Plan and whether Ms A understood its purpose. Because of the crisis of the domestic abuse disclosure the outline Child Protection Plan made at the Initial Child Protection Conference was not further developed by the new Core Group. It was strong in terms of trying to achieve some stability for the family and reducing the risk of domestic abuse but actions to meet the original Social Worker's assessment of neglect were missing. Useful additions would have included some further assessment of Ms A's own childhood, including her self-reported negative experiences. It would have been useful to agree to arrange a Family Group Conference to assess the strength of support being provided by her family who were described by Ms A as "supportive" and "helpful", but this had not been tested. Mark's behaviour was already a cause for concern but there was nothing specific in the Plan to support his development and help him manage his emotions or speech. Finally, given the seriousness of the domestic abuse the Child Protection Plan should have agreed to refer Ms A to the Multi Agency Risk Assessment Conference (MARAC). There is a record on file of this being done but there is no outcome from the referral recorded and the Wandsworth MARAC has no record of having received the referral.

6.33 The Keyworker is expected to chair and provide the notes of Core Group meetings as well as to work within the meeting to manage parents' reactions and feelings. The first Core Group meeting should refine/confirm the Child Protection Plan and subsequent Core Group meetings should monitor the progress of the agreed actions against the Plan and amend it, as needed, in the light of changes in circumstances.

6.34 Recent audits had shown that good Child and Family Assessments could lead to good Child Protection Plans, but although practice was improving there was still, in late 2020, variability in practice. Child Protection Coordinators were assisting with a lot of the detailed case planning in the conferences.

6.35 Work was done in the Social Care Department (from January 2021) to revise the process and to develop more outcome-focussed Child Protection Plans, including introducing a new contemporaneous template for summarising the conference and plan which would aid specificity of what was to be achieved, by whom, rather than simply stating tasks. These new style plans are to be monitored in case supervision by the Social Care Manager to ensure that the plan is moving forward.

6.36 The Child Protection Coordinators carry out mid-way reviews with the Social Worker and Team Manager to monitor and advise on the plan's impact and if outcomes are being achieved between conferences.

6.37 In addition, the Core Group will now be expected to meet four weeks prior to each Review Child Protection Conference. The expectation is that all relevant agencies and parents will attend and provide an update on the progress of the plan. Professionals are expected to provide a written report in support of the evidence of the family's progress. The allocated Social Worker will chair this meeting and review all the information provided. In complex or challenging cases, it is expected that the Team Manager may chair this meeting. The Core Group will then consider the recommendation of either continuing the Child Protection Plan or ending it at the upcoming Review Child Protection Conference. This provides time for parents to review the information, understand the recommendations and prepare better for the upcoming review conference. The Social Worker will be able to include the most up-to-date information in their report and share it prior to the Review Conference with everyone involved. This will help to make conferences concise as there will be less information previously unknown to the Core Group; and parents and young people will be clearer about the decision making. This revised approach was being introduced from January 2021 by the Safeguarding Standards Service. This development will sit alongside introducing motivational interviewing training as part of the introduction of Family Safeguarding by Wandsworth CSC from October 2021. Based on learning from this review it was agreed that as part of this revised Child Protection Plan process, the Core Group can and should be reconvened early if there is any significant change in level of concern, family dynamics or whenever a family moves home to ensure that the changed level of need and risks of harm are fully understood by the (new) core group. Practice Guidance is being produced to support practitioners develop best practice in Core Groups.

6.38 The Safeguarding and Continuous Learning Subcommittee of the Wandsworth Safeguarding Children Partnership Safeguarding will be leading Multi-Agency Audits of this revised approach and the contribution that partners make to Core Groups. Internally CSC Quality Assurance will be auditing Core Group quality as part of the yearly audit programme. It was also noted that more work was needed to support social workers with the knowledge and skills to chair multi-disciplinary meetings such as Core Groups. This is planned for 2021.

Recommendation 4

Formulation of and Management of Child Protection Plans and the Management of Core Groups

Given the centrality of Child Protection Plans and Core Groups to multi-agency safeguarding systems the Wandsworth Safeguarding Children Partnership is recommended to monitor the progress of the local initiatives to focus and strengthen Child Protection Plans and Core Groups by requiring feedback from the Safeguarding and Continuous Learning Subcommittee on the impact of Child Protection Plans and Core groups; initially at six months and then at least annually. Such quality assurance data should also include information about agency attendance at Core Group meetings.

6.39 The Child Protection System has been developed so that subsequent Child Protection Conferences scrutinise the multi-agency practice and the levels of risk and agree levels of priority and thereby access to resources. Conferences also have the benefit of an independent and experienced practitioner as chair, whose task is to reflect on the children's needs, including safeguarding and whether progress is good enough.

6.40 The first Review Child Protection Conference in February 2019 was held in Wandsworth which retained the case responsibility (as per protocol). Attendance was poor (due to the family's temporary move to a new borough and the necessary changes in personnel). It is not clear if thought was given to convening the Conference in the new borough where the refuge was based to facilitate attendance by the new Core Group members. The first Review Conference was inquorate, and the Chair made the decision to go ahead so that the Plan could be reviewed. This was appropriate. Only the new Social Worker and the new Health Visitor were able to express a view about progress, risk, and whether the plans should continue. It is understood to be a policy of refuges that their staff do not give views on this. No other agencies were represented, including a nursery (for Mark) and the children's centre that Ms A and Lloyd were said to be attending, on occasion.

6.41 The social work assessment presented to the February 2019 Review Child Protection Conference was about the family in the present and did not draw on the analysis of risk in the previous thorough assessment to think more widely about the historic issues for Ms A and their possible impact on her parenting of the boys. This raises a question about how social workers' practice and reports to conferences are supported by reflective supervision by managers so that the core issues of neglect or harm do not get lost as additional new and real practical issues come forward, or how seeming changes for the better are tested for their realism and sustainability.

6.42 The newer professionals present recommended "step down" to Child in Need. This did not take into account the history of concern such as the previous lack of engagement and that Mark was showing signs of harm in his behaviour and speech delay. It is a known phenomenon that the quality of parenting can improve when families are in 24-hour care environments with good support, caring relationships, and supervision. There is a systemic risk, however, that this can be a temporary improvement, because of the regular scrutiny by professionals; but an improvement that is not consolidated into every day and ongoing parenting.

6.43 Several dynamics may have come into play here. Ms A and her history, including her own behaviour and at times apparent avoidance of professionals, were not well known to the current network because of her move from Wandsworth. There was a possible honeymoon period where the care, support, and scrutiny of the living-in environment of the refuge enabled Ms A to provide an observable good enough level of parenting to the children.

6.44 The Conference Chair overruled the recommendation to step down to Child in Need and retained the Child Protection Plan for both children. This was a good decision, given the brief length of the plan at that time, the uncertainty of the situation, and the aspects of the Child Protection Plan that required more work.

6.45 The Child Protection Plan was revised at this Conference and was reduced. The minutes are not clear about the progress of the previous Outline Plan and what had been achieved but several things were removed from the Plan even though they had not been completed. These had originally included: advice about a non-molestation order, access to parenting support, access to mental health support and some work by Ms A about drug and alcohol use. These issues were lost in the second version of the plan and there was no clarity about Ms A's parenting capacity. There was also a new and unanswered question whether Ms A may have some additional learning needs, but no plan was made to explore this further.

6.46 The next Core Group, held at home, did not take place until June, nearly four months later. In this time the family had moved from the refuge back to Wandsworth, via a short residency in Croydon. The new Children's Centre was not invited to the Core Group meeting. The Core Group membership changed three times in the space of eight months**.** Mark's possible need for Speech and Language therapy had not been resolved.

6.47 The final Core Group, in July, was also held at the family home, with the children present. This would not have been conducive to a productive meeting. This raises a policy and practice question about the location of such meetings, especially when they are possibly being held at the family home to ensure attendance. It also raises a question about how parents are supported with childcare to attend such important meetings. It is not clear why the Children's Centre was not used.

6.48 At the final Review Child Protection Conference, in July 2019, there was a small network present (the Social Worker, the new Health Visitor and staff from the new Children's Centre). As the family had recently moved, the Social Worker was the only consistent person from the previous Child Protection Conference. The new Health Visitor and new children's centre had little direct contact with the family.

6.49 This conference followed the pattern of the others, there was not enough time to sufficiently consider Ms A's history and the impact of her own childhood and later abusive experiences as an adult, or her frequent non-engagement with professionals to support her as a parent to meet her children's needs.

6.50 The new assessment described Mark's behaviour as 'excessive'. His tantrums and aggression were acknowledged as going beyond those associated with his stage of development but were not analysed in the context of what the underlying causes may be, what he may have witnessed or experienced, and the lack of boundary setting for him. His behaviour was put down to the number of moves and the period of upheaval the family had faced.

6.51 The Social Worker recommended that the Child Protection Plan should be stepped down to a "robust" Child in Need Plan. The staff of the new Children's Centre and the new Health Visitor were not yet fully familiar with the case and thought it was too soon to take the children off a Child Protection Plan. They dissented from the decision to end the Plan but did not later consider using the formal escalation procedures to ask for the decision to be reviewed. There was no contingency plan built in to check Ms A's compliance with a new Child in Need Plan.

6.52 The Social Care independent analysis submitted to this Safeguarding Practice Review concluded that the quality of the assessment to the conference was probably because of an underlying wider systemic issue and not just related to this meeting, as these issues had not been discussed in depth at the core group meetings or during case supervision sessions. This limited the overall understanding of how Ms A was functioning as a parent. This was exacerbated by changes in the network due to the moves which the family had experienced, not just in this period but also in prior involvements. Although Ms A had completed some work about the impact of domestic abuse whilst resident at the refuge, she had not completed other agreed domestic violence courses, due to her non-attendance. This was never challenged. Work on parenting and on possible alcohol or drug use, although identified as needed, had not been arranged. Mark's need for assessment of his speech and language had not been achieved.

6.53 The practitioners who knew Ms A told this Review about how plausible Ms A could be. She appeared to be a loving parent and had shown strength by moving away from an abusive partner. This presentation and positive aspects of assessments contributed to the decisions made at the time.

Parental engagement and effective working relationships with parents / Working with parents who are reluctant to engage

6.54 Some of the practitioners told this review that they found Ms A to be friendly and co-operative and in single sessions she appeared to engage well. She seemed, at times to listen to advice, such as work using the Power and Control Wheel12 at the refuge, which was noted to have increased her understanding of different forms of abuse. Ms A allowed health visitors to see the boys, mainly in unannounced visits, she would be co-operative and agree to follow up referrals to other services, however, she did not then keep to those agreements.

6.55 One senior practitioner, who had some overview of the case at the time, thought that there was evidence that Ms A was able to engage with some practitioners and form working relationships but that these were disrupted too frequently by the moves. This practitioner also thought that a longer and trusting working relationship was required which would enable Ms A to look at her own life experiences in more depth and how these may be affecting her role as a parent. The current systems for work organisation (including volume of cases and other pressures) often do not permit such in-depth helping relationships to develop and continue over time.

6.56 There was suspicion at the time that Ms A delayed workers' entry to the home in order to tidy up before they came in. Several noted, in retrospect, that she did not always tell the truth. A supervisor noted that Ms A's own background history and long experience of working with children's services would have enabled her to know what information social workers and others were seeking and how they may use it and so lead her to be more careful about what she would share or how she behaved.

[12] http://www.stopdomesticviolence.org.uk/violence-wheel/

6.57 In retrospect, some practitioners have reflected that Ms A was probably actively concealing information from them. She was asked at the time, after the case was stepped down from the Child Protection Plan if she was in a new relationship, but she said not and although there was active curiosity about this there was no evidence. Another noted "*It is important for practitioners to understand why parents may not be honest with professionals – they fear losing their children*." "*There is a need to push professional curiosity and look for evidence of change*". Another comment was that "*Professionals do not always feel confident in challenging parents who do not comply with Child Protection Plans*". It was also noted that "*Information about fathers is often missing and sometimes mothers are reluctant to give it*".

6.58 There are many reasons why parents will not want to engage with child care professionals such as midwives, health visitors and early years' workers, more so with social workers and police. These can include fear of interference or that social workers will seek to remove a child. The barriers can be compounded by a negative history of childhood experiences impacting on the ability to form trust and relationships, including later working relationships with professionals. Women subject to coercive control, as Ms A appears to have been, can also be reluctant to engage with helping agencies for fear of retribution if they seek help.

6.59 Ms A avoided contacts with staff from different agencies and did not follow through on agreements she had made. However, she gave the impression that she was cooperating with plans. Core groups were arranged at the family home to ensure that Ms A attended. Hindsight has shown that Ms A did not answer truthfully about use of drugs in the home or about having a new partner.

6.60 "Disguised compliance" is an unfortunate and unhelpful, pejorative term which has come in to child protection thinking as a kind of short hand for non-cooperation when the behaviours behind it are more complex than avoidance or resistance. A question is, however, "how well are the child care workforce across health, education, early years, and social care able to recognise and work with and build trust with ambivalent parents?". David Wilkins helps us see that "disguised compliance" is not a helpful term and that it may be more productive for frontline practitioners to focus on building working relationship.[13]

6.61 At the time of the work to support Mark, Lloyd, and Ms A there was not a strong approach to building strong working and trusting relationships between workers and parents.

6.62 Working with parental non-engagement is an essential skill in child protection work. Wandsworth Social Care informed this review that a pilot of multi-agency group supervision has been introduced which will tackle this possible dynamic to support healthy scepticism, evidence based work and positive use of history, genograms, and chronologies to support reflective thinking about the experiences of children, to ensure trauma informed practice.

[13] We need to rethink our approach to disguised compliance - Community Care

6.63 Across 2021 Wandsworth Children's Services implemented two significant changes in the approach to practice across the system. Systemic practice in Children's Social Care and Early Help now work focusses upon the centrality of respectful, trusting relationships with families and ensuring children can grow up within a family to thrive and meet their potential. It is evidence and strengths based. Systemic practice supports working to manage uncertainty in confidently holding risk and in reflection upon our practice and value. In implementing systemic practice practitioners and leaders have been offered systemic training and Systemic Family practitioners are now in post to work alongside families and practitioners .

6.64 Family Safeguarding Approach was launched in January 2022. It is a whole systems change to support families where children are at risk of neglect and abuse to remain safely within their families. It is strengths based, collaborative and focusses upon relationships with families. The model provides for specialist adult facing domestic abuse, mental and substance practitioners to work as part of multi-disciplinary children's safeguarding teams, ensuring that families are holistically supported. Family Safeguarding uses motivational interviewing as one of its tools and relevant to the learning identified within national and local CSPRs as addressing the trio of vulnerability and is reflected within the make-up of multi-disciplinary family safeguarding teams. The model has been independently evaluated[14]. Its introduction in Wandsworth is being externally monitored and evaluated as part of the What Works for Children's Social Care national work on best practice.[15]

6.65 The next section explores some of the systems dynamics which may have prevented effective challenge and trust building with Ms A, and parents (female and male) like her. The work in this case raises the question about what more needs to be done locally to build greater competence and confidence in practitioners within and across agencies to improve working with particularly avoidant parents, given that most parents will not want childcare agencies prying in to their family life.

Recommendation 5 Wandsworth Children's Social Care should report the findings of the What Works in Children's Social Care ongoing evaluations of the Approach in Wandsworth to the Safeguarding Children Partnership. This will enable Partnership to monitor its impact on the delivery of safeguarding services to families identified to be at risk.

In addition, the Partnership should ask its other member agencies how practitioners (child or adult facing) are being supported to maintain the knowledge and skills to build effective working relationships with reluctant and harder to engage parents, to maintain professional curiosity, use appropriate challenge and to hold the needs and vulnerability of the child in mind. Audit Practice review week Annual conference

This will enable the Partnership and local agencies to decide what further actions, if any, are required to support this core and challenging area of practice that has been seen to underly a number of case reviews where children have been harmed.

[14] Evaluation: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/932367/Hertfordshire_Family_Safeguarding.pdf

[15] Family Safeguarding Model – Trial Evaluation - What Works for Children's Social Care (whatworks-csc.org.uk)

Learning from the coordination of the multi-agency assessments and support to safeguard the children and its possible implication for the wider local safeguarding system

6.66 The early work within Children's Social Care in relation to the family shows a lack of agency oversight of the needs of the children, which led to several assessments over a short period of time. Practice was not properly scrutinised and supported by management or any other Quality Assurance activity. Supervisors, managers and Child Protection Co-ordinators need to routinely raise practice issues with senior managers to help the organisation identify any concerns about practice. The Child Protection Co-ordinator has a particular role in ensuring that the Child Protection Plan is robust and is being implemented to keep children safe.

6.67 The Child Protection Plan was not fully developed and did not address the long-standing issues in the family, such as Ms A's own adverse childhood experiences and their possible impact on her current behaviour (including the possibility of alcohol and or drug use), the current influence of her family, her avoidant behaviour with professionals, and Mark's troubled presentation. An opportunity was missed to use the analysis in the good quality assessment presented at the Initial Child Protection Conference to formulate a more robust Child Protection Plan. There is a challenge for child protection co-ordinators to ensure that outline Child Protection Plans reflect and address all the safeguarding concerns, not just the immediate safety of a family. Also, when a crisis, such as the disclosure in the conference of the alleged level of domestic abuse, coercive control, and fear, diverts attention, it is important that someone in the system, such as a supervisor or child protection co-ordinator, holds the children in mind to ensure that the original presenting and identified problems are not lost. There is a risk that the social worker will be diverted by the time-consuming practical tasks of emergency rehousing and rebuilding a network of professionals rather than refining the Plan to meet all the concerns from the assessment. This is made more complex if the social worker is not the same person who led that assessment as they may not own the assessment as fully.

6.68 Supervision should be a place to support the workers with reflective thinking and that the risks are fully noted and translated into an effective plan.

6.69 The practitioners who attended the Learning Event / Focus Group, as part of this review, to contribute their own thinking made the following comments in relation to learning about the Coordination of Multi-Agency Assessments and Work to Safeguard Children.

- **Understanding relevant psycho-social history and other key information when undertaking assessments** There is a challenge to ensure that new agencies joining the network are aware of relevant history, especially if they do not have the reports and records of previous Child Protection Conferences. Practitioners noted the issue of consent to share – but that is more applicable to early help or child in need work, not child protection work. Mark's nursery in 2018 was surprised to learn, at this Review's Focus Group, about the complex and potentially damaging family history, which had been unknown to them while they were trying to engage with Ms A.

- A question was raised whether the **Signs of Safety Model**[16], in use at the time, gave sufficient weight to family history. Child Protection Conferences need to hold in mind relevant previous

[16] Signs of Safety https://www.signsofsafety.net/what-is-sofs/ *At the time of drafting this report the Wandsworth Multi-Disciplinary Model is shifting to a different model.*

family and parental psycho-social history and how it may affect the here and now functioning. This would help there to be more focus on the possible longer-term impacts on parenting. There was a view (in hindsight) that it is important to understand history and family dynamics as well as holding a focus on acute risk such as domestic abuse. There may need to be a greater understanding and use of ACEs (Adverse Childhood Experiences) and how they can affect parenting.[17] Wandsworth Social Care and partner agencies are adapting the Signs of Safety model as a core methodology to a revised Family Safeguarding Approach[18].

- **Sustaining effective change,** A Manager reported having noted at the time, that, given the long history of negative experiences and her short-term protection, containment and managing in the refuge that Ms A may be challenged to remain resilient on her own outside the refuge, without other supports being in place.

- **Information sharing** did not work well. Several practitioners noted that they did not have all the relevant information, particularly history, including recent history and recent events. Better handovers are needed as families move through the support and safeguarding systems, such as midwifery and health visiting and between teams when families move across local authority or service boundaries. Universal services were not aware at times that there was a social worker for the family.

- One Practitioner in universal services said that in their experience some social care workers seemed to believe that other council services had **access to the Social Care database** and to family records and could read about families there. This is not the case. This led them to question whether in child protection cases other council children's services providers should be able to see such records. It also raised the need for partner agencies' practitioners to be more assertive in seeking out information from social care keyworkers.

- **Effective networks** Key agencies were not invited to Core Groups. Strategy meetings are not helpful if they do not involve the professionals who know the family and child. *It was noted that recent use of online strategy meetings in 2020, because of Covid19, was securing the right people who know the family.*

- **Thresholds** After the family's first move to temporary housing the new Health Visiting team did not assess the family as needing additional support, but nothing had changed, and so the family had lower priority in large and busy caseloads. (This was prior to the Child Protection Threshold being seen to be met.)

- **Contributing to risk analysis in Child Protection Conferences and Plans** Practitioners questioned why some professionals will not take part in "scaling"[19] the likely/probable risk to children. These colleagues were seen to be from Domestic Abuse Services where their abstention was understood to by agency policy, of which other services were unaware.

- **Managing disagreements in the network with regard to threshold decisions** At the final Child Protection Conference there was disagreement between professionals about whether the children should remain on a plan. Professionals newer to the case were unhappy about the

[17] **Adverse Childhood Experiences ACEs.** A useful introduction and signpost to wider research to aid understanding the impact of Adverse Childhood Experiences on adults/parents and the pros and cons of using them in assessments is to be found in **Children & Young People Now October 2020** pages 35 – 46, Special Report: Policy, Adverse Childhood Experiences www.cypnow.co.uk

[18] **Family Safeguarding Approach** This is based on the **Family Safeguarding Model** introduced in Hertfordshire**.** Hertfordshire family safeguarding model | Hertfordshire County Council

[19] "Scaling" refers to an exercise in the Signs of Safety Model to grade the possible strengths and risks in family functioning. What Is Signs of Safety? - Signs of Safety

proposal and the decision to step-down to child in need. Although their dissension was minuted they did not discuss this with their own safeguarding managers to consider escalating the decision under the agreed local and London procedures[20]. They had subsequently learned of the need to inform and discuss with a manager or specialist the need to consider escalation, where this occurs.

- **Parental rather than child focus** Some practitioners believed that the plans focussed more on the mother than the children. There is no doubt that Ms A was at risk of domestic abuse, but this served to obscure other issues in the care of the children which were not specifically related to domestic abuse.

- **Venues of Child Protection Meetings** Practitioners were aware, beyond this case, of examples where meetings were sometimes held at a family home to support parents' attendance. The advantages and disadvantages of this had not been explored but it was felt that this was a way to engage some parent/s.

- **Family supporters in child protection meetings** It was noted by one practitioner, in hindsight, that there was a family supporter in one of the Child Protection Conferences who kept interjecting and disrupting the meeting.

Moves of home, their management and impact on the safeguarding system

6.70 The timeline shows that Ms A's moves, particularly those outside the home borough, disrupted the ability of the safeguarding systems to assess, support and monitor. As a result, Ms A had antenatal care, domestic abuse support, social care and health visiting and some little pre-school service for Mark from several boroughs. This meant that for those services which do not follow the family across boundaries, such as Midwifery, Health Visiting and Community Safety, the history and concern had to be transferred to new professionals. Wandsworth Social Care had difficulty over several months to trace Ms A when she first moved to Croydon. The Croydon MARAC referred her to the Lambeth MARAC, but she had by then been moved back to Wandsworth and we have found no evidence that she was then referred on to Wandsworth domestic abuse services. The Health Visiting Service for the refuge sought to transfer responsibility for her to the Croydon Health Visiting Team which could not find her as she had already moved again, back to Wandsworth.

6.71 This systemic problem, compounded by division of responsibilities within Housing Departments and by the range of housing providers, has potential to disrupt the safeguarding support from housing agencies and means changes in the working and therapeutic relationships with parents and children. With parents who are harder to engage it is important as much as possible to have continuity in the professionals and the multi-agency network, especially where this is a Team Around the Child or a Child Protection Core group.

[20] 11. Professional Conflict Resolution (londoncp.co.uk)

6.72 Practitioners must pass on their concerns and how they have been working to support the family, but they cannot always identify the relevant service or people, and there is a risk that they will get lost. The nursery which recognised the concerns of neglect about Mark in late 2018 told this review that they never discovered to whom they should transfer their records about his brief period with them after they referred him to Social Care and Ms A then withdrew him from nursery. This disruption can mean that the history of concern can be lost, thereby making it easier for distortion, or apparently compliant behaviour to be seen without a longer-term view of how genuine it may or may not be.

6.73 Temporary housing, eviction, re-housing for safety, availability of safe placements, unsuitable placements, and concern about the possible use of a temporarily vacated family home as an alleged base for the sale of drugs were key dynamics in this case. Housing agencies as assessors and providers need to be key stakeholders in the safeguarding network.

6.74 This Review discovered that practitioners and managers were unaware of the existence of the Priority Rehousing Protocol between the Wandsworth Housing Department and Wandsworth Children's Social Care. The Independent Reviewer was personally aware that historically Wandsworth Council had a Safeguarding Protocol whereby families with children subject of Child Protection Plans could be nominated by senior managers in Social Care for priority re-housing, as part of a safety plan. This cohort of children, assessed to be at risk of significant harm, is among a Local Authority's highest priority of families. The Wandsworth Safeguarding Children Partnership, as a result of this review agreed an interim recommendation to examine the need for and use of a Priority Housing Protocol to ensure that the whole system, including housing agencies, contributes to children's safeguarding. It may be necessary top update that Protocol in line with the new provisions of the Domestic Abuse Act 2021.21

6.75 The challenge systemically in this housing and safeguarding review will be to include key housing stakeholders such as Housing Providers from the private and voluntary sector. Such a Protocol should include clear expectations not only about housing responsibility but also the contribution to Child Protection Plans and Meetings.

6.76 Clearly, there will be times when a move of Local Authority Area is important for the safety of children or one of their parents, usually a mother. The London Procedures allow for this and when a move is permanent rather than temporary the case responsibility can also transfer permanently.

Recommendation 6 Wandsworth Council (Children's Social Care and Housing; with Adult Social Care for access to Refuge Provision) should undertake a review of the Protocol for Priority Rehousing and its use for re-housing families where children are subject of child protection plans to minimise moves away from the borough and key safeguarding networks, except where a move from the borough is essential to the safeguarding of the children or a parent.

Such a review will ensure safe housing as a key dynamic within a family's safeguarding system and should enable continuity of frontline practice from safeguarding agencies monitoring and for effective networks of key professionals, including housing providers, to support families and to protect children.

This recommendation was agreed during the period that the review was still being undertaken.

[21] The Domestic Abuse Act 2021 Part 4 section 57 deals specifically with the Local Authority's strategic duties with regard to the housing needs of survivors of domestic abuse.

6.77 A further overall systems and strategic dynamic to be considered arises from the diverse provision and management of social housing and the co-ordination of the safeguarding arrangements for assessing and supporting families in need of or in receipt of housing across Council Services and independent, social, and private landlords and associations. This also raises the question of the relationship of such independent or community housing assessors and providers with Local Safeguarding Children Partnerships and their role in safeguarding practice within a local authority area. Historically the strategic relationship would have been with a Local Authority's Housing Services, which fall under section 11 of the Children Act 2004. The safeguarding requirements on other large providers such as Housing Associations do not carry the same Section 11 mandate. This is a national issue.

The place of housing services within the overall strategic response to safeguarding children and mothers

6.78 This review has noted that the Housing Association responsible for Ms A's permanent tenancy had no direct relationship with the Wandsworth Safeguarding Children Board (and later Partnership).

6.79 A family's housing and its management can be crucial to safeguarding. The Social Worker contacted the Housing Association on at least two occasions but noted that it was difficult to know who to speak with about Ms A's case. The Housing Association has no record of invitations to Conferences or Core Groups; but notes that its recording may be incomplete.

6.80 The Housing Association referred Ms A back to Wandsworth Housing for an urgent management transfer on grounds of safeguarding as she could not return to the property, which was thought to be being used for drug dealing. From this point Ms A was a temporary tenant of the Housing Department. However, it seems no action was taken about the alleged drug-dealing from the property and the tenancy was not ended by the Housing Association until August even though Ms A had given it up in March. The Housing Association said it would usually work with the Police when a property had been identified as a source of drug-dealing. It is not clear that referrals were made to the Police or to Community Safety about these allegations.

Recommendation 7

The Wandsworth Safeguarding Children Partnership should review its relationship with local large Housing Providers to ensure that they are included both strategically in the Partnership's work and in the dissemination and training of best safeguarding practice.

This should include advice on best practice in local safeguarding arrangements and policies for Housing Providers.

In pursuing this recommendation, the Wandsworth Safeguarding Children Partnership should refer this issue to the Wandsworth Safeguarding Adults Board and involve the Wandsworth Housing Department in agreeing a way forward.

Practitioners' views to this Review on the systemic risks arising from families' moves

6.81 A Health Visitor manager noted the need to ensure that relevant information is passed on quickly to the new support team when families in need or at risk move across local authority boundaries. Such moves across Local Authority boundaries are disruptive to good working relationships with parents. A Social Care manager noted the need to build new networks quickly when families move. There was agreement that the disruptions from such moves could interrupt the work needed and the efficiency of multi-agency teams where some key practitioners had to change. Managers in a school and in universal services noted the systems risk that a service could be unaware of the concerns when a family moves to their resource, and they are not quickly brought into the Team Around the Child or Core Group and receive the relevant history.

6.82 Practitioners noted an intrinsic systems dynamic, in that, in a new case, when a child first becomes the subject of a Child Protection Plan there will most likely be an automatic change of social worker and supervisor to a new longer-term team at a crucial time. In this case, an additional systemic issue was that neither the new social worker or line-manager was able to attend the Initial Child Protection Conference; being present in the meeting makes it easier to own the history and the plan.

Responding to and preventing harm from Domestic Abuse

6.83 The risks and damage from domestic abuse, including coercive control to children and mothers are well known. Good examples were found in this review of practitioners seeking to work with Ms A about the abuse she had experienced. During antenatal care she was asked about risk of domestic abuse through routine enquiry. She did not say that she was at risk of such abuse. Following the serious assault in Croydon on Ms A by Mr B the Croydon Community Safety service responded appropriately. An Independent Domestic Abuse Advisor met with and advised Ms A, but Ms A did not continue in work with the advisor despite their attempts to engage with her. Ms A was advised about steps to take including Non-Molestation Orders. She said that she had used them, but it is not clear that this was checked.

6.84 Wandsworth Community Safety has an over-arching responsibility on behalf of the Community Safety Partnership (and the Safeguarding Children Partnership) for ensuring the effective working of the Domestic Abuse MARAC[22] to reduce the risk to victims of domestic abuse. Whilst Community Safety does not currently have responsibility for management of Emergency Accommodation services (such as refuges) it does have a key co-ordinating role and links with Adult Social Care which commissions the local Emergency Accommodation services for victims of domestic abuse. Community Safety holds the lead for co-ordination of the Violence against Women and Girls Strategy, inclusive of Domestic Abuse. It employs the Domestic Abuse MARAC Co-ordinators, and commissions local Independent Domestic Violence Advocates services.

[22] **MARAC** – Multi-Agency Risk Assessment Conference is a local multi-agency meeting with a primary focus on the safety of adult victims who are at high-risk of domestic abuse. - 12. Risk Management of Known Offenders (londoncp.co.uk)

The role of MARAC as a multi-agency system to co-ordinate responses to known cases of domestic abuse

6.85 **Inter-borough referrals** There are no records of any contact with the local Wandsworth MARAC about Ms A. Lambeth MARAC has no record of receiving a referral from Croydon MARAC. Good practice would have been to pass this on to the Wandsworth MARAC when it became known that Ms A had moved back to Wandsworth. Following this Child Safeguarding Review, Wandsworth Community Safety undertook a review (2021) of the local MARAC to MARAC Protocol to ensure that transfer issues are fully understood and used appropriately. *A revised Transfer Protocol became operational from 2022 and is included in MARAC Training.*

6.86 **Repeat incidents** Repeat domestic abuse incidents in this case were not referred to the **MARAC** by Police or other agencies (such as health visiting or social care). The current MARAC Protocol states, "In Wandsworth, where there have been three or more reported domestic violence police crime reports in a 12-month period the case will be referred to the MARAC." This is recognised best practice. Wandsworth Community Safety completed a review of the operation of the MARAC in 2021, including the escalation criteria for repeat incidences of domestic abuse to be referred to MARAC. Work after that review led to a 50% increase in referrals to MARAC by the end of 2021, with a better quality of referrals.

Incidence of domestic abuse impacting on mothers and children

6.87 An examination of national data for 2020-21 shows the larger number of referrals to MARACs in London (Metropolitan Police area) came from the Police (31.7%) or IDVAs (28.4%). The Wandsworth figures are April 2020 – March 2021: Police (30%) IDVAs (20%) and Children's Services (11%) with much lower numbers referred by other agencies. For January to December 2021 (part year) they were Police (39%), IDVA (20%) and Children's Services (5%), in Wandsworth. Given the high numbers of children in households referred to MARACs it could be argued that more referrals to MARAC, through the completion of DASH (or DARAC) could be anticipated from social care, health, and education agencies. It must be noted, however, that Domestic Abuse cases known to Children's Social Care should also be known to the Police which may explain lower referral numbers from children's services agencies. A key question for Wandsworth agencies, including health and schools, is: Are practitioners aware of how and when to refer cases to MARAC and are they doing so?

Use, competence, and confidence in using formal Domestic Abuse risk assessments by the wider workforce.

6.88 The Police were called to incidents/allegations of a domestic nature on several occasions. For most, but not all, of these the attending police officers completed a Safe Lives "DASH risk assessment". The DASH (Domestic Abuse, Stalking and Honour Based Violence), a risk assessment tool, is the nationally recognised and locally used means of assessing risk at a moment in time. [23] They provided evidence of a sequence of events that merited an automatic referral to a MARAC. Each of these risk assessments is shown as having been assessed as "Standard". In addition, there are examples in the timeline of other agency contacts with Ms A where a DASH was not completed when there were risk factors, such as pregnancy; children in household; abuse occurring more frequently; use of objects to cause injury; strangulation; sexual nature of assaults; presence of alcohol/drugs. This raises hindsight questions about professional curiosity and about opportunities to explore the degree of domestic abuse through completion of DASH risk assessments and assurance as to the levels of knowledge and training in respect of domestic abuse and DASH for frontline staff in other agencies as well as by police officers.

6.89 A DASH risk assessment was not completed following Ms A disclosing abuse, coercive control, and fear at the Initial Child Protection Conference in December 2018. The risk was determined as high enough to require a move to emergency safe accommodation. This was a missed opportunity to refer to the MARAC, the multi-agency panel for monitoring and supporting high risk domestic abuse cases.

6.90 There was a strong view from the Practice Learning Focus Group to this review (September 2020) that practitioners from different services were not confident in domestic abuse work and had insufficient training. Except for Domestic Abuse specialists, practitioners in other services were not confident in the use of the Safe Lives DASH Check List24. This Review was informed in January 2022 that since 2020 many practitioners across different services had received additional training in working with domestic abuse and the role of the MARAC. This had resulted in better understanding of domestic abuse and domestic abuse procedures by frontline practitioners. The training continues to be provided regularly to meet the challenge of staff turnover.

6.91 In 2021, The Children's Social Care Department completed a review of the use of the Barnardo's Domestic Abuse Risk Assessment for Children, DARAC, based on the earlier Barnardo's Domestic Violence Risk Identification Matrix for assessing the risks to children from domestic violence[25]. It is seen to be more child focussed and is in line with the London Child Protection Procedures approach to differentiate risk assessment tools for adults and children[26]. From March 2022, as part of the introduction of the Family Safeguarding Model (*see 6.61 above*) and the embedding of Domestic Abuse Coordinators within Family Safeguarding Teams there will be clarity about which assessment tool should be used; this will provide greater consistency and focus on the impact on children as well as adults.

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[23] Source: http://www.safelives.org.uk/sites/default/files/resources/Dash%20for%20IDVAs%20FINAL_0.pdf
[24] https://safelives.org.uk/practice-support/resources-identifying-risk-victims-face
[25] barnado_s_domestic_violence_risk_identification_matrix__dvrim_.pdf
[26] London Child Protection Procedures 28.10 Assessment and intervention (from domestic abuse) 28. Safeguarding children affected by domestic abuse (londoncp.co.uk)

Recommendation 8a
The Wandsworth Community Safety Partnership or the new Violence Against Women and Girls Strategic Group with the Wandsworth Safeguarding Children Partnership and Wandsworth Children's Services should clarify local procedures and guidance for all local agencies on the parallel use of formal and systematic tools for domestic abuse risk assessments (DASH and/or DARAC) upon all disclosures of domestic abuse, and their reporting to MARAC.

Recommendation 8b
In line with this the Community Safety Partnership or Violence Against Women and Girls Strategic Group with the Safeguarding Children Partnership should also seek assurance from local Agencies that relevant staff and officers have received sufficient training in respect of domestic abuse awareness and the use of tools such as the DASH *(for adult victims)* and/or DARAC *(for child victims)* risk assessments; and when to refer a case to MARAC.

Oversight and Governance of Local Multi-Agency Domestic Abuse Response Coordination

6.92 At the time of this case there was no local Strategic Group that oversaw the multi-agency response to Domestic Abuse in Wandsworth. A local Domestic Abuse Operational Group was introduced in the summer of 2019 that was used to inform and develop a local needs assessment in respect to Violence Against Women and Girls (VAWG). The operational group was in a formative stage and did not operate a scrutiny function in respect of the VAWG Agenda or MARAC. National best practice suggests that a MARAC Steering Group should oversee the activity of the local MARAC.[27] Frequently this sits as part of a work stream of an overarching Strategic Group for VAWG. It is noted that the Community Safety Plan has now adopted such a strategic approach.

6.93 In February 2022, a new Violence Against Women and Girls (VAWG) Strategy for Wandsworth for 2022-25 was agreed. This will ensure accountability for the local MARAC and the coordination of multi-agency responses to domestic abuse under the VAWG strategic partnership board. The Strategy Priority Workstreams will report regularly to a Strategic Partnership Board to ensure there is singular and central oversight of the workstreams and provides the link to the Community Safety Partnership and Greater London Authority[28]. This will provide co-ordinated leadership to the local delivery of the Statutory Guidance under the new Domestic Violence Act 2021[29].

[27] Source: http://www.safelives.org.uk/practice-support/resources-marac-meetings/resources-steering-groups (Accessed March 2020)
[28] https://wandsworth.gov.uk/media/10605/violence_against_women_and_girls_strategy_2022_25.pdf
[29] Domestic abuse: draft statutory guidance framework (accessible version) - GOV.UK (www.gov.uk) See:
Chapter 4 https://www.gov.uk/government/consultations/domestic-abuse-act-statutory-guidance/domestic-abuse-draft-statutory-guidance-framework#chapter-4--agency-response-to-domestic-abuse
Chapter 5 https://www.gov.uk/government/consultations/domestic-abuse-act-statutory-guidance/domestic-abuse-draft-statutory-guidance-framework#chapter-5--working-together-to-tackle-domestic-abuse
Chapter 6 https://www.gov.uk/government/consultations/domestic-abuse-act-statutory-guidance/domestic-abuse-draft-statutory-guidance-framework#chapter-6--commissioning-response-to-domestic-abuse

Recommendation 9
It is recommended that the new Violence Against Women and Girls Strategic Group formed in 2022 should ensure that an Annual Report is provided to the Wandsworth Safeguarding Children Partnership on the multi-agency work to tackle domestic abuse in the borough in relation to children and families, and on the progress of that work.

This is in line with the Domestic Abuse Act 2021, section 59, and will enable the Safeguarding Children Partnership to both scrutinise and contribute to local strategic responses to domestic abuse as it affects children and families at both a strategic and practice level.

Training and the competence of frontline practitioners in recognising and responding to domestic abuse

6.94 In 2020, the Community Safety Service noted the need to: Seek assurance that professionals are sufficiently well versed in the completion of DASH assessments and display the professional curiosity to explore the risk domestic abuse with service users. The Wandsworth Community Safety Partnership, as noted above, has since been providing regular domestic abuse training across the multi-disciplinary workforce, including MARAC training - through the Council's Learning and Development Team. This is multi-agency training and is conducted on a voluntary basis. In January 2022 a planned training needs analysis and review of the delivery of Domestic Abuse Training across services had not yet been completed and it was stated that responsibility for domestic abuse training was held in different places by Community Safety Services (Council's Learning and Development Team), Children's Services Social Work Academy and the Safeguarding Children Partnership.

Awareness of 'Clare's Law' in frontline practice

6.95 Clare's Law is the colloquial name for the Domestic Violence Disclosure Scheme[30] through which a person can make enquiry about possible risk from a prospective partner. Ms A was in a highly abusive and violent relationship with Mr B. Subsequently she was in a relationship with Mr C, father to Lloyd. There is no evidence that he was physically abusive to her, but it can be argued that he took advantage of her as he had no intention of a long-term relationship. In the summer of 2019 Ms A started a relationship with Mr D although this was unknown to practitioners at the time. It is not clear whether at any time any practitioners working with Ms A to support her advised her of her right under the scheme to seek information about a prospective partner. Informing women about their rights under Clare's Law could be a core tool with abused women to assist them in understanding possible risks and to empower them to be able to make informed decisions about future relationships.

[30] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha/request-information-under-clares-law/ and Domestic Violence Disclosure Scheme factsheet - GOV.UK (www.gov.uk)

6.96 Practitioners advised this review that they were not aware of or currently advising service users about Clare's Law. It was noted that this is not referred to in local Wandsworth procedures or training. Comment: It is explained in the London Child Protection Procedures, to which Wandsworth is subscribed, as a possible useful tool (with safeguards) for practitioners to use[31].

Recommendation 10
It is recommended that the new Violence Against Women and Girls Strategic Group should agree the overall governance of the different strands of commissioning and delivery of Domestic Abuse Training by local services and providers to ensure co-ordination of training needs analyses, delivery of cross-cutting priorities and evaluation and that within this the needs of vulnerable children are recognised and met. This should include:

- the recognition of domestic abuse in its various forms[32], including repeat incidents,
- the impact on children as well as mothers of domestic abuse,
- the use of appropriate assessment tools for adults and children (DASH/DARAC),
- the role of MARAC, and
- how local practitioners and services are supported regarding when and how to inform service users about Clare's Law (The Domestic Violence Disclosure Scheme) and its value.

It is understood that the Welsh Strategic Model may provide a good basis for this[33].

A public health approach and awareness raising about domestic abuse in the community

6.97 At the time of the original review this issue was not identified as specific learning from this case. At the further review in 2022, after the adults were charged with Lloyd's death it, was noted that in Wandsworth good progress had been made in this area and that the Council had been awarded White Ribbon status in November 2021.[34] There had been widespread training and Ambassadors had been appointed in schools, and colleges to promote community engagement. Awareness of Clare's Law could also feature under this approach. Also in 2021, Wandsworth Council's Housing and Regeneration Department was accredited with the Domestic Abuse Housing Alliance Chartermark for its robust response to domestic abuse.[35]

[31] https://www.londoncp.co.uk/chapters/sg_ch_dom_abuse.html?zoom_highlight=clare%27s+law
[32] See the revised definition of domestic abuse as set out in the Home Office draft Statutory Guidance Framework (Oct 2021) to be made final and published in 2022 under the Domestic Abuse Act 2021. Domestic abuse: draft statutory guidance framework (accessible version) - GOV.UK (www.gov.uk)
[33] Guidance-for-Local-Strategies.pdf (welshwomensaid.org.uk)
[34] https://www.wandsworth.gov.uk/news/2021-news/news-november-2021/white-ribbon-accreditation-for-wandsworth-as-it-prepares-for-16-days-of-action-against-domestic-violence/?dm_i=XWH,7MZOE,G70JHT,V42ML,1
[35] Accreditation for Wandsworth's response to domestic abuse - Wandsworth Borough Council

Parenting Education and the delivery of the NHS Healthy Child Programme

6.98 Ms A was a first-time parent, for Mark. The review of this case raises questions for Midwifery Services and perhaps for Public Health Services (as commissioners with lead responsibility for supporting parenting education) and the Health Visiting Service about how first-time parents are supported in the perinatal period to understand the needs of babies and the impacts they can have on parents, and then later the parenting of older children.

6.99 Given Ms A's own self-reported and known history, there were likely to be challenges for her in parenting. The NHS Healthy Child Programme sets out the range of support that is best practice. This case shows a particular challenge when parents, including fathers, do not engage with the universal antenatal and postnatal services for maternal and baby care, advice, and support.

6.100 Ms A did not engage well with Maternity Services in Croydon or Wandsworth. This raises a question about how Health Services are commissioned to respond in the Healthy Child Programme, given their high workloads and that the services are voluntary for parents, unless there are clear signs of possible future harm. A supplementary question is whether there has been an over-reliance on leaflets as a way to pass information on to parents. On their own, leaflets are known to be a less effective tool.

6.101 At the Initial Child Protection Conference in December 2018, it was agreed that Ms A (and Mr B) should participate in a Family Recovery Project Parenting Course. There is no evidence that this was followed up, including at subsequent Core Group meetings, perhaps because the response to the acute domestic abuse took priority. Later Ms A reported that she was having difficulty with Mark and his tantrums. She was given advice but admitted that she gave in to him rather than managing his behaviour.

6.102 Lloyd died from serious injuries, inflicted over time by an adult or adults. Such injuries can often be the result of parental or carer frustration or reaction to a child's crying or, in older children, their behaviour. This raises a question about how universal parenting education seeks to support parents, including fathers, in understanding children's behaviours and adults' reactions and how to anticipate and manage responses to children. At the time of this report the outcome of the criminal investigation into Lloyd's death was still awaited. This may reveal other reasons for the injuries. However, there is sufficient information in this case to question Ms A's preparedness and ability to manage day to day parenting. She had not engaged in prebirth parenting education and used very few parenting supports after the children's births.

6.103 From pregnancy to a child's second birthday are crucial[36]. A question for the Wandsworth Health and Well-being Board and the Safeguarding Children Partnership is how the provision of basic parenting education and parenting support at a population wide level fits in to the overall strategic plan for the delivery of services in Wandsworth and whether sufficient provision is included in perinatal and early years services to offer parenting education to new parents, including managing their own reactions to babies and toddlers. The recent Department of Health and Social Care report (March 2021) The Best Start for Life: A Vision for the 1,001 Critical Days, The Early Years Healthy Development Review Report[37].

[36] NHS England » 1,000 days to make a difference

[37] The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf (publishing.service.gov.uk)

Recommendation 11
The Wandsworth Safeguarding Children Partnership should request a review from the Commissioners of Health Services of the rationale for and provision of universal parenting education and parenting programmes by Midwifery Services and through the Healthy Child Programme within the borough and of any actions that may be required.

This may be as part of the national initiative and actions set out by the Government in The Best Start for Life.

Parental Drug and Alcohol Misuse

6.104 Ms A was known to have a history of alcohol and drug use. There was good routine enquiry by some practitioners about her alcohol and drug use, to which she replied that she was not currently using. She admitted to cannabis use and tested positive with the Midwifery Service during the pregnancy with Lloyd. This suggested that Mark may have been affected by parental drug use. There were also occasions when alcohol use was a cause of concern in relation to visitors to the household and the care of Mark. The nursery raised concern for Mark about smelling of cigarette smoke but there is also a suggestion that he may have smelled of cannabis; a suggestion which was reported to have angered Ms A. The Police also had soft intelligence that the family home may be being used for drug-dealing (after Ms A and the children had moved to the refuge). This was not shared with Children's Social Care, or with the Community Safety Partnership which also has a lead responsibility for tackling drug use in the borough.

6.105 Mr D had been a known serious drug user but there was no knowledge of him being associated with the household and so any risk from him could not be assessed.

6.106 After Lloyd's death tests showed that Mark had been exposed to drugs over some time.

6.107 This case serves as a reminder of the possible prevalence of drug use by parents and the need for practitioners to be vigilant and curious about this in their assessments. It is not clear how much this is a part of all Child and Family Assessments. Parental drug use is not only a concern in relation to children's possible direct or indirect exposure to drugs but also to the impacts of their use on the thinking, judgments and behaviour of parents and their reactions to children's behaviour. For women who are subject of domestic abuse, including through coercive control as Ms A was, there may also be a risk of further exploitation by use of their accommodation for drug using or dealing.

6.108 Workers were aware of the risks of drug use in this case and did ask Ms A about it. This was good safeguarding work and is a reminder of the need for services to support frontline staff in being competent and confident in asking about alcohol and drug use and assessing the responses. Information provided to this review suggested that in general front-line workers are not confident in this area and look to specialist drug workers. It was suggested that staff in some services are unaware of how to recognise possible drug use and its indicators.

6.109 The Wandsworth Safeguarding Children Partnership may wish to explore further with the Metropolitan Police what response may be appropriate when soft intelligence about drug misuse relates to a property associated with children. When should such, as yet unevidenced information be shared with other agencies as part of safeguarding assessments or child protection plans?

The Wandsworth Safeguarding Children Partnership may also wish to assure itself of the content of training in recognition and response to drug use by parents for frontline workers.

Use of written agreements

6.110 Ms A signed a written agreement following concern about a family member and others using her property, in her absence, placing Mark at risk. She agreed to exclude the family member. Such agreements have become common in child protection social work. There has been limited research into their use and efficacy. It is not uncommon for them to be unenforceable or for breaches not to be followed up. In this case the family member was later noted by a colleague from another agency to be present in the house despite the written agreement. The colleague was unaware of the written agreement. It is not clear whether subsequent social workers were aware of the existence of the agreement.

6.111 Practitioners outside social care told this review that they were unaware how such agreements are used by Social Care and asked how these are supported and enforced, especially if colleagues from partner agencies are unaware of them. It is important that where such a written agreement is used that colleagues from partner agencies are aware of it so that it can be enforced, if necessary.

Recommendation 12
Wandsworth Social Care is recommended to review its use of written agreements with families, when they are not part of agreed Child Protection Plans or a formal agreement reached as part of work under the Public Law Outline[38]. Guidance should include when to share information about the content of a written agreement with key partner agencies.

[38] **Public Law Outline** A process of legal work with families as part of pre-proceedings when a Local Authority is considering seeking a court order to protect a child under the Children Act 1989. Stages are described in Statutory Guidance: DFE_stat_guidance_template_(publishing.service.gov.uk) After negotiation with parents about the concerns and what must change, and usually with the parents' legal advisors, a letter is sent by the Local Authority setting out the agreed actions by all parties. This is effectively an agreement.

Managing multi-agency disagreements in the network with regard to threshold decisions

6.112 At the final Child Protection Conference there was disagreement between professionals about whether the children should remain on a lan. Professionals newer to the case were unhappy about the proposal and then decision to step-down from child protection to child in need. Although their dissension was minuted they did not later discuss their view that this was not the right decision with the safeguarding managers within their own agencies to consider escalating the decision under the agreed local Inter-Agency Escalation Policy[39] or London Child Protection Procedures[40].

6.113 Some professionals can feel disempowered and lack confidence in the face of decisions made by social care staff and need to understand that there are agreed arrangements for questioning and challenging such decisions where there are grounds to do so. This may need advice and support from a senior manager within their own agency. It is important that local agencies inform and support their staff to challenge such decisions, where there are grounds to do so.

6.114 All agencies should also ensure that this Escalation Policy is included in safeguarding training commissioning and delivery.

[39] https://wscp.org.uk/media/1329/inter_agency_escalation_policy-v2.docx
[40] London Child Protection Procedures section 4.11 4. Child Protection Conferences (londoncp.co.uk)

7 Recommendations

This Review makes the following recommendations and has also raised questions which the Safeguarding Children Partnership is asked to consider as possible areas for further work. If these are adopted by the Safeguarding Partners, they should be transformed into an Action Plan with clear achievable outcomes, timescales and areas of lead responsibility and monitored by the Safeguarding and Continuous Learning Subcommittee.

The effectiveness of local multi-agency safeguarding children thresholds and pathways

Recommendation 1 (See paragraphs 6.6 – 6.10 for context)

The Wandsworth Public Health Services, as Commissioners of local Health Visiting Services, with the Providers, and with consultation from the Clinical Commissioning Group, should commission an audit of a random sample of cases, across teams, at "targeted" level of service (Universal Plus) which, are not multi-agency child in need or child protection cases, to review how such cases are supported and monitored over time.

The purpose of this audit of frontline health visiting practice is to provide assurance that when families have been assessed to require a higher level of Health Visiting Service that cases continue to be monitored by the agreed method and frequency to ascertain if any change (particularly increase) in provision is required.

Wandsworth Public Health Services should report the outcome of this review to the Wandsworth Safeguarding Children Partnership.

The Child's Lived Experience – Seeing children and holding them in mind

Recommendation 2 (See paragraphs 6.11 – 6.13)

Services which assess children or parents, and their welfare or safety must take into account all the children who are usually resident in the household, or children in frequent contact, as their welfare may be an indicator of well-being or need for other household / family members.

Local children's agencies, Midwifery Services and Adult Services should review their practice guidance, information gathering and sharing arrangements and supervisory arrangements to ensure that when one child or parent is being seen and considered that there is curiosity about and consideration of the welfare of other household members or family members in regular contact, especially children under 5.

Recommendation 3 (See paragraphs 6.11 – 6.19)

The Wandsworth Safeguarding Children Partnership Safeguarding and Continuous Learning Subcommittee should commission agency and multi-agency practice audits to ascertain how services are assessing and recording the daily lived experience of children, including those in a household who are not the index child. These audits should consider how children's behaviour and appearance are recorded and taken into account when assessing their welfare and safeguarding needs, in addition to what children say, for those able to speak.

From this audit a decision can, be made whether additional practice guidance is needed. This review should include children who are identified as vulnerable but who are not seen as often as they should be.

Formulation of and Management of Child Protection Plans and Management of Core Groups

Recommendation 4 (See paragraphs 6.28 – 6.38)

Given the centrality of Child Protection Plans and Core Groups to multi-agency safeguarding systems the Wandsworth Safeguarding Children Partnership is recommended to monitor the progress of the local initiatives to focus and strengthen Child Protection Plans and Core Groups by requiring feedback from the Safeguarding and Continuous Learning Subgroup on the impact of Child Protection Plans and Core groups; initially at six months and then at least annually. Such quality assurance data should also include information about agency attendance at Core Group meetings**.**

Working with parents who are reluctant to engage – "disguised compliance"

Recommendation 5 (see paragraphs 6.56 – 6.66)

The Wandsworth Safeguarding Children Partnership should plan a review of how the Family Safeguarding Approach in Children's Social Care and Early Help is impacting on the delivery of safeguarding services to families identified to be at risk.

In addition, the Partnership should ask its other member agencies how practitioners (child or adult facing) are being supported to maintain the knowledge and skills to build effective working relationships with reluctant and harder to engage parents, to maintain professional curiosity, use appropriate challenge and to hold the needs and vulnerability of the child in mind.

This will enable the Partnership and local agencies to decide what further actions, if any, are required to support this core and challenging area of practice that has been seen to underly a number of case reviews where children have been harmed.

Moves of home, their management and impact on the safeguarding system

Recommendation 6 (Paragraphs 6.71 – 6.77) *Recommendation was agreed during the review.*

Wandsworth Council (Children's Social Care and Housing; with Adult Social Care for access to Refuge Provision) should undertake a review of the Protocol for Priority Rehousing and its use for re-housing families where children are subject of child protection plans to minimise moves away from the borough and key safeguarding networks, except where a move from the borough is essential to the safeguarding of the children or a parent.

Such a review will ensure safe housing as a key dynamic within a family's safeguarding system and enable continuity of monitoring and for effective networks of key professionals, including housing providers, to support families and to protect children.

Recommendation 7 (Paragraphs 6.79 – 6.81)

The Wandsworth Safeguarding Children Partnership should review its relationship with local large Housing Providers to ensure that they are included both strategically in the Partnership's work and in the dissemination and training of best safeguarding practice.

This should include advice on best practice in local safeguarding arrangements and policies for Housing Providers.

In pursuing this recommendation, the Wandsworth Safeguarding Children Partnership should refer this issue to the Wandsworth Safeguarding Adults Board and involve the Wandsworth Housing Department in agreeing a way forward.

Responses to domestic abuse

Recommendation 8 (See paragraphs 6.84 – 6.92)

Recommendation 8a

The Wandsworth Community Safety Partnership or the new Violence Against Women and Girls Strategic Group with the Wandsworth Safeguarding Children Partnership and Wandsworth Children's Services should clarify local procedures and guidance for all local agencies on the parallel use of formal and systematic tools for domestic abuse risk assessments (DASH and/or DARAC) upon all disclosures of domestic abuse, and their reporting to MARAC.

Recommendation 8b

In line with this the Community Safety Partnership or Violence Against Women and Girls Strategic Group with the Safeguarding Children Partnership should also seek assurance from local Agencies that relevant staff and officers have received sufficient training in respect of domestic abuse awareness and the use of tools such as the DASH *(for adult victims)* and/or DARAC *(for child victims)* risk assessments; and when to refer a case to MARAC.

Recommendation 9 (See paragraphs 6.93 – 6.94)

It is recommended that the new Violence Against Women and Girls Strategic Group being formed in early 2022 should ensure that an Annual Report is provided to the Wandsworth Safeguarding Children Partnership on the multi-agency work to tackle domestic abuse in the borough in relation to children and families, and on the progress of that work.

This is in line with the Domestic Abuse Act 2021, section 59, and will enable the Safeguarding Children Partnership to both scrutinise and contribute to local strategic responses to domestic abuse as it affects children and families at both a strategic and practice level.

Recommendation 10 (See paragraphs 6.95 – 6.97)

It is recommended that the new Violence Against Women and Girls Strategic Group should agree the overall governance of the different strands of commissioning and delivery of Domestic Abuse Training by local services and providers to ensure co-ordination of training needs analyses, delivery of cross-cutting priorities and evaluation and that within this the needs of vulnerable children are recognised and met. This should include:

- the recognition of domestic abuse in its various forms41, including repeat incidents,
- the impact on children as well as mothers of domestic abuse,
- the use of appropriate assessment tools for adults and children (DASH/DARAC),
- the role of MARAC, and

[41] See the revised definition of domestic abuse as set out in the Home Office draft Statutory Guidance Framework (Oct 2021) to be made final and published in 2022 under the Domestic Abuse Act 2021. Domestic abuse: draft statutory guidance framework (accessible version) - GOV.UK (www.gov.uk)

- how local practitioners and services are supported regarding when and how to inform service users about Clare's Law (The Domestic Violence Disclosure Scheme) and its value.

It is understood that the Welsh Strategic Model may provide a good basis for this[42].

Parenting education and the delivery of the Healthy Child Programme

Recommendation 11 (See paragraphs 6.99 – 6.104)

The Wandsworth Safeguarding Children Partnership should request a review from the Commissioners of Health Services of the rationale for and provision of universal parenting education and parenting programmes by Midwifery Services and through the Healthy Child Programme within the borough and of any actions that may be required.

This may be as part of the national initiative and actions set out by the Government in **The Best Start for Life.**

Use of written agreements

Recommendation 12 (See paragraphs 6.111 – 6.112)

Wandsworth Social Care is recommended to review its use of written agreements with families, when they are not part of agreed Child Protection Plans or a formal agreement reached as part of work under the **Public Law Outline**[43]. Guidance should include when to share information about the content of a written agreement with key partner agencies.

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Malcolm Ward B.Soc.Sc., Master of Social Work
Independent Lead Reviewer
May 2022

[42] Guidance-for-Local-Strategies.pdf (welshwomensaid.org.uk)

[43] **Public Law Outline** A process of legal work with families as part of pre-proceedings when a Local Authority is considering seeking a court order to protect a child under the Children Act 1989. Stages are described in Statutory Guidance: DFE_stat_guidance_template_(publishing.service.gov.uk) After negotiation with parents about the concerns and what must change, and usually with the parents' legal advisors, a letter is sent by the Local Authority setting out the agreed actions by all parties. This is effectively an agreement.

Panel Membership

Panel Members were independent of the management of the case and able to speak for their agency and professionally on applicable standards

Lead Reviewer: Malcolm Ward, Independent Social Worker, and Child Protection Consultant

Chair of the Panel: David Peplow, Independent Chair/Scrutineer WSCP

Panel Members

Central London Community Health Trust (CLCH):
Associate Director of Safeguarding
Named Nurse Safeguarding Children

Metropolitan Police:
Detective Sergeant, Specialist Crime Review Group, Metropolitan Police

NHS London South West Clinical Commissioning Group (CCG):
Head of Safeguarding / Designated Nurse
Named GP Wandsworth

St Georges Hospital NHS Trust:
Head of Safeguarding (for part of the Review)
Named Midwife for Safeguarding

Wandsworth Council:
Head of Safeguarding Standards - Children Social Care
Vulnerabilities Manager - Community Safety Partnership
Housing Policy and Performance Officer - Housing Services

Wandsworth Safeguarding Children Partnership:
Business Manager
Senior Business Support Officer

Malcolm Ward

May 2022