

Mark & Lloyd 7 Minute Briefing

1. Introduction

Ms A had a troubled history, was subject to domestic abuse, & had her own problems with alcohol & drug use due to childhood & adult trauma.

Lloyd born April 2018. Ms A & her family were in receipt of universal service provisions around the births of Mark & Lloyd, and services because of domestic abuse.

The Community Midwife referred the family to Children's Social Care (CSC) as Lloyd was living in a chaotic household & at risk of neglect. Mark's nursery also referred with concerns about Ms A's parenting abilities, engagement & neglect. Mark was hungry & dirty, he smelled strongly of cigarette smoke.

Police received anonymous & unverified information that drug dealing was happening from the family home. There were concerns about parenting, the children's development, housing, & later education.

The pathways of support from universal to child protection services & step down to Early Help were adversely affected by the family moving across different boroughs. December 2018 both children subject to Child Protection Plans for emotional abuse.

Lloyd died from a significant non-accidental injury in August 2019, and had significant injuries caused over several episodes.

After Lloyds death it was discovered that Ms A had started a new relationship, which she had previously denied, with Mr D who had a history of drug misuse & violence.

Mark, then aged 4, experienced significant harm over time & was removed & placed in foster care, he is reportedly doing well.

2. Areas of concern

Mark & Lloyd not seen for significant periods

- Staff changes leading to lack of consistency
- Agencies not being aware of family history & triangulating information
- Miss A avoiding services/evading professionals
- Children's voices not heard/ nor their daily lived experience identified
- Mark's presentation and behaviour
- Lack of professional curiosity regarding the males in the family's life
- Lack of curiosity of Miss A's own traumatic childhood & ability to care for her children
- Children not brought to appointments
- Parental rather than child focus
- Damage to parent from domestic abuse & coercive behaviour

3. Missed opportunities

- Considering a Child Protection approach before Mark's birth as Ms A rehoused several times for her own safety
- Police not alerting children's services & share information on a call out to check on a baby's welfare
- Agencies not aware of Ms A's relationship with Mr D
- Mark's needs & potential neglect identified but not translated into CP plan or acted on
- Review of family history to gain overall picture
- CP plan should have referred Ms A to MARAC for monitoring & supporting high risk domestic abuse cases
- To use the analysis in the good quality assessment presented at ICPC to formulate a robust CP plan

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4. Actions taken

- Health Trust has adopted the London Level of Need to monitor family's ongoing needs for services
- MASH triages all referrals and undertakes mapping to consider all information
- Develop outcome focussed CP plans including a new contemporaneous template for summarising the conference & plan
- Core groups to meet four weeks prior to each CPC & Practice Guidance produced
- Introduction of systemic practice in CSC & Early Help
- Introduction of Family Safeguarding in Children's Services
- Introduction of multi agency group supervision
- Developed a new brief Family History Guidance
- Introduction of a Priority Housing Protocol
- A revised MARAC Transfer protocol became operational from 2022 & included in MARAC Training
- Introduction of Local Domestic Abuse Operational Group in Children Services
- February 2022: new Violence Against Women & Girls Strategy
- Community Safety Partnership delivering multi agency domestic abuse training
- Widespread training & promote community engagement.
- Awareness of Clare's Law Ambassadors had been appointed in schools, and colleges to promote community engagement

5. Key areas for learning

- The need for better monitoring of family support at the Universal Plus level
- Curiosity about under 5's who are not seen in pre-school services & parents don't cooperate
- CP plans to address children's underlying needs
- Core Groups to monitor progress & change plans if outcomes/interventions are making insufficient progress
- Key agencies to be represented at core groups
- Moving families across Local Authority boundaries disrupts professional networks & relationships
- Priority re-housing systems need to be understood by frontline staff & managers
- Need better understanding of the complex mixed economy of housing provision & impact on child safeguarding
- Need for better co-ordination of domestic abuse responses across agencies
- Workers to challenge when parents avoid & agree actions & not follow through
- Workers to be supported in working with parents who have suffered Adverse Childhood Experiences (ACE)
- Need to ensure parenting education & support to young and/or first-time parents

6. Key areas of good practice

- Good attempts by SW's to do some direct work with Mark & assessment that analysed family history, previous involvement & risks & take immediate protective action
- Nursery staff concerned about Mark's welfare & potential neglect & referred to social care
- CP chair overruling recommendations to step down to Child in Need
- Ms A being challenged & confronted regarding her children's safety
- Conference split in its management so that Ms A & Mr D could attend separately
- Council awarded White Ribbon status Nov 21 due to Public Health approach & awareness raising about domestic abuse in the community
- 2021: Wandsworth Council's Housing & Regeneration Dept was accredited with the Domestic Abuse Housing Alliance Chartermark for its robust response to domestic abuse.

Please consider these 3 questions alongside the briefings:

What are your key thoughts and reflections?

How can we ensure the learning is embedded and how will we know this?

How can we integrate the learning into team or service improvement plans?