Lambeth Safeguarding Children Partnership

7 Minute Briefing

Child Angela Safeguarding Practice Review

1. What is a Local Child Safeguarding Practice Review? The purpose of a LCSPR is to look at what happened and why, focusing on the systems that practitioners work within and what action we need to take to change those systems so that practice can be improved.

The agencies involved in this review were Lambeth Children's Social Care, Metropolitan Police Service, King's College NHS Trust, South East London CCG (Lambeth), Lambeth Violence Against Women & Girls Programme, Guy's & St Thomas' NHS Trust, Lambeth Education, a primary school in Lambeth and another in Kensington & Chelsea, Southwark Education Welfare Service. Angela's mother contributed her views. An Independent reviewer, Siobhan Burns, conducted the review on behalf of the LSCP.

7. Useful resources

Please visit the LSCP website for:

- Direct contacts for local experts, incl, Designated Doctor, VAWG; CSC
- Escalation process
- New Multiagency Neglect Strategy (from 1 April 2022)

6. What are we going to do next?

- Work with partners across London to develop mechanisms to better track children missing education
- The partnership's Performance & Quality Assurance Subgroup will monitor the improvement action plan and will audit and evaluate improvements over time
- Share the learning across the partnership through a series of briefings, trainings and communications.

5. What has changed already as a result of the learning?

- The hospital has developed a system to regularly review children's x-rays to ensure safeguarding experts can help identify any potential non-accidental injuries that may have been missed
- The LSCP has developed a Neglect Strategy and Toolkit which will be launched in April 2022
- Police and Education colleagues are improving the way Op Encompass works across the borough
- Children's Social Care have introduced operational audits to facilitate regular quality assurance and management overview for multiple contacts to ensure we are looking at incidents cumulatively
- The LSCP has updated its escalation processes to ensure that professionals come together as a multiagency group to share information and discuss professional difference for complex and perplexing situations
- Police have built their capability to audit domestic abuse contacts weekly to ensure appropriate referrals to the MARAC are being made
- Police are training all frontline AS-CU Police in professional curiosity, identifying neglect, domestic abuse and vulnerability. This uses Angela's story as a case study. By mid-March all 10 response teams, including 1st and 2nd responders, will be trained

2. What happened for Angela and her family? Angela, a little girl, disclosed serious sexual abuse perpetrated by her mother's partner, 'Joe' over the preceding two years. Eight months prior to this disclosure, Angela presented to a hospital emergency department with herpes. At the time, Angela was not enrolled in a school, having been off-rolled from her first school in a neighbouring borough 17 months prior. Angela was sleeping on a mattress in the kitchen of a property soon after declared unfit for human habitation. Angela's mother had reported to the Police, 7 domestic abuse incidents perpetrated by Joe. A Child & Family Assessment resulted in Angela being placed on a Child in Need Plan. Eight months before this presentation, Angela had attended the emergency department with a spiral fracture of her humerus. This information had not been shared with other services.

3. What have we learned about multi-agency practice?

- There was a heavy reliance on Angela disclosing her physical and sexual abuse, before action was taken.
- The Partnership does not have a neglect strategy which sets out how agencies will work together to identify and respond to neglect, governance to ensure the strategy drives practice improvement and a quality assurance framework to measure the impact of the strategy on frontline practice.
- When the property that Angela was living in was declared unfit for human habitation, she and her mother should have been offered immediate appropriate temporary accommodation, rather than being placed on the Band A Housing list
- When Angela stopped attending her first Primary School, attempts to contact Angela's mother were not successful. Following this, the school were advised by another local authority's Education Welfare Service to take Angela off their roll. There was no effective tracking system in place to monitor Angela from becoming out of sight. It is not uncommon for families to move between Boroughs and children missing education is a key vulnerability factor.
- There were many multi-agency opportunities for intervention in respect of the domestic abuse, controlling and violent behaviour that Angela was witnessing. Both the police and children's services response to the mother appear to lack professional curiosity. They accepted the mother's assurances that she would accept domestic abuse services, would seek an injunction and on several occasions that the relationship had ended. There was no real triangulation to offer social workers and officers insight into what the mother calls being "hijacked" in her own home and the limited resources she had to protect Angela.
- The second school Angela attended did not receive any notifications of domestic abuse incidents via Op Encompass.
- The powerlessness and frustration felt by the practitioners was linked to differing levels of confidence in the recognition of child sexual abuse. The Partnership needs to create the space and culture to facilitate multi-agency discussions to explore professional differences.
- Professionals did not call upon the expertise on child sexual abuse available from the Designated Doctor or Mary Sheridan Centre.
- Professionals did not consistently use high quality translation services to communicate with Angela's mother, who has limited English.

4. Key learning themes