Lambeth and Bromley Safeguarding Children Boards

Serious Case Review

Child K

April 2019

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Independent Lead Reviewers

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Foreword

In November 2016 Child K was assaulted by his mother's partner, Mr C, and later died as a result of the injuries he sustained.

Mr C was convicted of the murder of K in July 2017, and is presently serving a life sentence in prison.

This Serious Case Review was commissioned jointly by the Lambeth and Bromley Children's Safeguarding Boards, with a view to:

(i) gaining a better understanding of the events that led up to the death of K, and of any involvement of professionals and agencies with responsibilities for safeguarding, and

(ii) identifying any opportunities for learning coming from the tragic death of K, which might serve to improve services, and better protect children in future.

The joint LSCBs commissioned Malcolm Ward and Ghislaine Millar, respectively as Independent Chair and Author of this Serious Case Review. We appreciate the very considerable work that they undertaken for this report.

First and foremost it is important to stress that only K's mother's partner, Mr C, was responsible for his murder. Whilst this Serious Case Review rightly takes a wider focus, to include K's family and also the professionals who knew about him, or had contact with him, there is no implication that the action or inaction of any other person contributed materially to his death. Indeed, I would like to thank all the professionals and agencies who gave considerable time to the production of this review, and especially K's family, through what must have been an unimaginably difficult time for them.

This Serious Case Review raises specific concerns with regard to the release of offenders from prison who, like Mr C, are known to pose serious risk to both adults and children. It also raises issues about the manner in which they are supported and supervised by the National Probation Service when returned to the community. These matters will be dealt with by a separate review, as it is not appropriate for me to comment further here, other than to say had the bail conditions set for Mr C been communicated appropriately at the right time, the wider partnership of safeguarding professionals would likely have had better insight into the potential risks posed by Mr C to both K and his mother Ms A.

What is clear from the content of the Serious Case review, however, is that there are a number of learning points, identified by the reviewers and accepted here without reservation. We are committed to making sure that we use these to improve safeguarding in future, and so that we all learn from the tragic circumstances leading up to K's murder by his mother's boyfriend.

The completion of a Serious Case Review such as this is inevitably an endeavour requiring considerable time and the timescale for such Reviews are often extended by a requirement for this process not to prejudice any judicial matters.

We have made sure, however, that much of the necessary learning emanating from this work has already been put into action. In this light, actions with regard to audit and joint training suggested by the reviewers have already been taken forward.

This Serious Case Review raises important issues about the support provided to adults with no recourse to public funds. This has potential implications not just in Lambeth and Bromley, but also for the children of adults in similar circumstances across the country as a whole.

The review confirms that child K's mother, Ms A, had no recourse to public funds, having overstayed her student visa in the United Kingdom. This was, however, not the case for K who was born here and held full rights as a UK citizen.

There is no implication that the services received by Ms A as an adult with no recourse to public funds were in any way deficient, but the principle enshrined in the Children Act (1989) that the rights of a child are paramount, does bear some additional consideration. As it may be that too rigid a focus on the circumstances of adults who have no recourse to public funds, can inadvertently take attention away from their children and from the paramountcy of their rights.

For K as a UK citizen, born in this Country, and who clearly could have been assessed as a 'child in need,' there should have been no question that his needs were in any way secondary or subsumed by the lack of status of his principal adult carer Ms A.

Steps will be taken in Lambeth (and I will recommend the same to the Independent Chair of the Bromley Safeguarding Children Board) to raise this matter with the appropriate professionals to ensure that the individual needs and rights of such children are prioritised.

I will, in addition, raise this matter with the newly appointed National Panel for Serious Case reviews across the transitional period to September 2019, and also with the appropriate Secretary of State to raise this issue nationally.

In conclusion, I would like to thank all those directly involved in the production of this Serious Case review, with particular mention of the individuals involved in the multi-agency partnerships and were members of the review panel.

Finally, and importantly we are wholly committed to taking forward the lessons from the tragic death of K and from this Serious Case Review. This may not provide K's parents with any solace or comfort but it is very important that, in acknowledgement of K's life and memory that we make sure that necessary changes are made to practice and policy.

On behalf of the Lambeth and Bromley Safeguarding Boards, I would like to dedicate this Serious Case review to K, and to his memory.

Dr Mark Peel
Independent Chair LSCB
November 2018.

1. Why This Case Was Reviewed

1.1 On 21st July 2017 Mr. C was found guilty of murder. He was sentenced to life in prison following an assault on K, then aged five and a half, after K lost one of his trainers in the park. It was late afternoon at the end of November 2016 and it was dark. Mr. C, K's mother's boyfriend, failed to call for ambulance assistance when K was unresponsive. On returning home to Ms. A's accommodation, with Mr. C carrying K over his shoulder, Mr. C allegedly assaulted Ms. A, who was attempting to call an ambulance for K. She succeeded in calling 999 and K was taken to hospital. Mr. C was arrested. K suffered severe damage to his brain, had abdominal bleeding and bruises to his face. He died two days later.

1.2 Although K lived with his mother in Bromley at the time of the murder they were not and had not been known to any Bromley agencies. It was agreed by the Chairs of Bromley and Lambeth Safeguarding Children Boards that the case met the criteria for conducting a Serious Case Review (SCR) as outlined in statutory guidance.[1] It was agreed by the two Independent LSCB Chairs that Lambeth LSCB would lead the review. Contributions were also to be requested from Nottinghamshire LSCB, as Ms. A and K had lived there briefly during the period under review.

1.3 Child K

1.3.1 K was an able, mixed-race child. Professionals who knew him at nursery and later at school, for over 18 months, saw him as well-cared for and to have a good relationship with his mother. His father, Mr. B, collected him from school sometimes and it was believed that K also had a good relationship with him. The nursery said "*K started nursery as a quiet, unassuming child who blossomed during his time with us. He was at his happiest when learning outdoors and could easily become absorbed in a task. He was artistic and loved reading and was very proud of his handwriting. Everyone remembers his sense of humour and cheerful smile".*

1.3.2 Ms. A was very engaged with his learning and supported him with activities at home. He was always clean, well dressed and well groomed. Mother was described as an attentive parent who responded to K's needs and encouraged him to learn and develop. This strong bond was commented on by the Social Worker in the assessment in October 2014.

1.3.3 K was meeting his developmental milestones, apart from his speech. He spoke English and Russian (this was his mother's first language as she was from the Ukraine) but had difficulty putting sentences together and was receiving help at school for this. Otherwise, he was making steady progress at school and had good peer relationships, although his speech delay did sometimes make him frustrated and angry. He was described as responding well to positive encouragement from his mother. Staff at the school, who knew K well, had no worries about him or his care during the period under review.

[1] Working Together to Safeguard Children 2015

2. The Review Team.

2.1 A Review Team was established to undertake the SCR. It was agreed that the review would cover the period **3rd October 2013 to 19th November 2016.** Malcolm Ward, Independent Children's Safeguarding Consultant, was appointed to chair the Review Team meetings and Ghislaine Miller, also an Independent Children's Safeguarding Consultant, was appointed to write the report. As such, they were Lead Reviewers of the Review Team, made up of representatives from the agencies involved with K, his parents, Ms. A and Mr. B and Ms. A's boyfriend, Mr. C. Details of the terms of reference and methodology agreed by the LSCB Independent Chairs can be found in the Appendix. The Panel met on six occasions.

3. History of Professional Involvement & Significant Events: A Summary

3.1 The review sought to understand K's murder by Mr. C in the context of agency involvement with K and his family, including Mr. C, up to the time of his death.

3.2 The family first came to the attention of safeguarding services in Lambeth in 2013, when there were concerns about K's welfare. In 2014 Ms. A and Mr. B separated and from this point onwards Ms. A and K received support from Lambeth Children's Social Care (CSC) in relation to domestic abuse and Ms. A's immigration status. K continued to have some contact with Mr. B. The focus of the work by Lambeth CSC shifted from responding to domestic abuse to assisting Ms. A with her immigration problems. When this was achieved Lambeth CSC closed the case. Ms. A and K had moved to Bromley by this time. Lambeth CSC had no concerns about Ms. A's care of K at the time the case was closed in June 2016 and did not know that Ms. A had begun a relationship with Mr. C, who later murdered Child K. Bromley CSC had no knowledge at all of Ms. A, until K's death.

3.3 Mr. B was not involved in or responsible for K's death, which happened at a time when Mr. B was not seeing K. The chair of the Lambeth Children Safeguarding Board took advice from the national panel on the content of this report. The panel was of the view that the report included information about the parents that was not relevant to the death of Child K. The final report has consequently been revised in response to the advice given by the national panel. However some of the lessons that have arisen as a result of multiagency involvement with the parents have been retained in the report to promote practice improvement.

3.4 The timeline of the review falls into 6 phases:

Phase 1: Background information and the period when K and his parents Ms. A and Mr. (3rd October 2013 to 26th August 2014).

Phase 2: Ms. A separating from Mr. B and seeking accommodation and support from agencies in Lambeth. (From 27th August 2014).

Phase 3: The move to Nottinghamshire. (September 2014).

Phase 4: The return to London and increasing pressure re Immigration Issues and referral to No Recourse to Public Funds Team (NRTPF).
(October 2014-23rd February 2015).

Phase 5: The relationship between Ms. A and Mr. C. (March 2016-November 2016).

Phase 6: Mr. C's past criminality, supervision on licence and the work of the probation service. (October 2013-November 2016).

Text in italics below includes comments and information from, or views of the parents about the services provided to them; or information from practitioners or records, which has only become known during the course of the review and is therefore hindsight. It is included to help make sense of what was happening for K but was not known to practitioners at the time that decisions were being made or services were being provided.

3.5 **Phase 1: Background information and the period when K and his parents were living together, and the anonymous referrals made about neglect and drug use.**

(3rd October 2013 - 26th August 2014).

3.5.1 Ms. A came from the Ukraine to live in the UK in 2006. She was granted a one-year student visa, but when this expired she remained in the UK as an "overstayer". The terms of her visa stated that she had "no recourse to public funds". This meant that she was unable to claim benefits.

3.5.2 Mr. B is a British Citizen of African heritage, who grew up in the U.K.

3.5.3 Ms. A met Mr. B in 2008. Ms. A later became pregnant and following a normal pregnancy gave birth to K in a London hospital in May 2011, when she was 24 and Mr. B was 36. She registered herself and K with a G.P. practice in Lambeth in May 2011. Mr. B was also registered at this practice.

3.5.4 K lived with his parents at various addresses in Lambeth. K was a UK citizen by birth. Mr. B claimed Child Benefit for K, as Ms. A, a Ukraine citizen with no recourse to public funds in the UK, could not.

3.5.5 The allocated Health Visitor (HV1) gave advice on breastfeeding to Ms. A. Attempts to visit her and the baby at home proved difficult as Ms. A was, in HV1's opinion, "quite elusive", not answering telephone calls, and not being at home when HV1 called. In September 2011, HV1 signposted Ms. A to the local children's centre.

3.5.6 On 3rd October 2013, when K was 2 years 5 months old the NSPCC received an anonymous telephone call expressing concerns about K. The NSPCC wrongly referred this to the Southwark Multi-Agency Safeguarding Hub (MASH). On 9th October 2013 Southwark passed the referral to Lambeth CSC, which was the correct destination. On 13th October 2013 Lambeth MASH completed checks and concluded that there was no historical evidence to substantiate the current concerns of neglect/drug use. The same day a family member telephoned Lambeth CSC to express further concerns. The caller asked for a Social Worker to visit the family. A Health Visitor (HV2), based in the Lambeth MASH team, asked the locality Health Visitor (HV3) to visit the family.

3.5.7 HV3 visited with the nursery nurse on 15th October 2013 and saw Ms. A and K. The property was a 2-bedroom flat in Lambeth rented in Mr. B's name. They reported no concerns. The Nursery Nurse (NN1) completed a developmental review of K during the visit. His immunisations were up to date and his speech was appropriate for his age. Ms. A was encouraged to take him to a local children's centre but Ms. A said that she did not want K to go to a nursery yet.

3.5.8 On 21st October 2013 HV3 telephoned HV2 who was based in the Lambeth MASH, to give feedback from the home visit. HV2 recommended that mother be referred to a children's centre for outreach work. HV2 also stressed that mother should be "strongly advised" to take up the offer of K attending the local nursery. The same day, the Lambeth Social Worker, SW1, telephoned HV3 for feedback on the visit. It was agreed that there was no further action needed in respect of the concerns raised in the two 'anonymous' telephone calls. On 13th November 2013 K began attending "Stay and Play" and "Wriggle and Rhyme" at the local children's centre and continued to attend until 10th February 2014.

3.5.9 Ms. A. took K to the Health Clinic on 20th November and 2nd December 2013. He refused to be weighed on both occasions. Ms. A declined the offer of taking K to the nursery, as he was already going to the Children's Centre twice a week. She was urged by HV3 to take K to "Chattertime" speech and language group (at a different Children's Centre), as he appeared to be quiet. (His speech had been assessed as appropriate for his age by a nursery nurse a few weeks prior to this). K began attending "Chattertime" sessions.

3.6 Phase 2: Ms. A separating from Mr. B and seeking accommodation and support from agencies in Lambeth.

(27 August 2014 - end of September 2014).

3.6.1 Ms. A separated from Mr. B following an incident in late August 2014 (Child K 3 years 3 months old). She told a Social Worker of her immigration status (being an overstayer with no recourse to public funds) and said she wanted to leave Mr. B as she had experienced domestic violence. She was wrongly advised to go to Southwark Housing department and ask for help. Lambeth CSC records contain a decision to carry out a full assessment on this case given that Ms. A was the victim of DV and wanted help to leave Mr. B. Later that day, Ms. A went to see her G.P., as recommended by the Lambeth Social Worker.

3.6.2 The following day the Gaia Centre contacted Ms. A who said she had already seen someone from Solace Women's Aid in Southwark. The Gaia Centre offered to support her application for housing. Solace Women's Aid in Southwark telephoned Lambeth CSC and told them they would refer Ms A to MARAC[2] (a Multi-Agency Risk Assessment Conference, where information is shared on the highest risk domestic abuse cases between representatives of local police, probation, health, child protection and housing practitioners, and Independent Domestic Violence Advisers). Lambeth CSC told the Solace Women's Aid worker that they would be carrying out a full Child and Family Assessment. This commenced in October 2014 and was completed in December 2014. The related Child in Need plan was completed with agreement with Ms. A on 7 January 2015, with a review date of 18th February 2015, and the case was then assigned to a different Social Worker.

3.7 Phase 3: The move to Mansfield, Nottinghamshire.

(September 2014).

3.7.1 On Monday 1st September 2014, Ms. A told the Gaia Centre worker that she had been forced to sleep in the park until 1am one night over the weekend, as she was homeless. (It is not clear if K was with her or not). She was advised to go back to Lambeth CSC. She did so and told the Lambeth Social Worker that she could not go to the family home and had no money. Lambeth CSC agreed to pay for accommodation for her and K away from Lambeth and she was placed in Bed & Breakfast in Bexley. *Ms. A told the Lead Reviewers that she felt unsafe in this accommodation and reported this at the time, although there is no record of such a report.*

3.7.2 Lambeth CSC agreed to offer help and support to Ms. A and K under Section 17, Child in Need (CIN), to help her regularise her immigration status and to provide accommodation until her immigration status had been resolved.

[2] MARAC, Multi-Agency Risk Assessment Conference is a local multi agency, victim-based process/ meeting for sharing information and assessing risk management of cases where the victim of domestic violence is at medium to high risk from the offender. The aim is to enable an action plan to be implemented, to reduce risk to the victim and increase public safety.

The following day a conversation took place between the Gaia Centre worker and the Lambeth Social Worker, who said that the longer-term temporary accommodation Lambeth CSC could provide was in Nottinghamshire, not Notting Hill, as Ms. A had thought. The Gaia Centre worker called Ms. A and clarified matters. The records state "Ms. A could not provide a good reason why she would not be able to leave London". She was given the number of Women's Aid in Mansfield, Nottinghamshire. The Gaia Centre then closed her case.

3.7.3 When Mr. B was seen by the Lambeth Social Worker (SW2) he agreed to bring money for K into the office.

3.7.4 It is not clear exactly when Ms. A and K moved to Mansfield, Nottinghamshire, but she was contacted by a local Social Worker there on 2nd October 2014, after a referral by Women's Aid in Nottinghamshire. Ms. A told the Nottinghamshire Social Worker that she "feels like she has been dumped in the middle of nowhere", and it was much harder for her to try and resolve her immigration status, as she was now away from London. The Nottinghamshire Social Worker telephoned Lambeth CSC as it seemed that Ms. A needed more support from Lambeth. The Social Worker was told that Ms. A's Social Worker in Lambeth was on holiday.

3.8 Phase 4: The return to London and Increasing pressure about immigration Issues. The transfer of the case to the No Recourse to Public Funds Team (NRTPF).

(21st October 2014-31st May 2016)

3.8.1 On 21st October 2014, Ms. A. and K travelled back to London to try and resolve her immigration status. She was applying for a passport for K and she had asked the Lambeth Social Worker to obtain Mr. B's signature on the application form, as his name was on K's birth certificate. She collected the signed form from the Social Worker on 29th October 2014. She told the Social Worker that she had contacted 'Rights to Women' to support her application to remain in the UK. Two days later, Ms. A telephoned SW4 in Lambeth and asked for help in resolving her immigration status. SW3 from Lambeth agreed to help with this. Ms. A said she was now living back in London. Ms. A had told professionals in Nottinghamshire that she was leaving. A Multi Agency Risk Assessment Conference (MARAC) in Nottinghamshire had considered her case on 23rd October 2014 and agreed to offer her "floating support". *Ms. A also told the Lead Reviewers that she had felt unsafe in the temporary accommodation in Nottinghamshire. She said she was concerned about the behaviour of other tenants and visitors to the property.*

3.8.2 On 5th November 2014, Ms. A took K to the Child Health Clinic in Lambeth where he was seen by HV3, who noted he was "clean and suitably dressed" and "very active". The following day, 6th November 2014, Lambeth HV3 telephoned SW1, who said that Lambeth CSC were supporting Ms. A's return to London with K. The same day the police visited Ms. A to carry out a

"welfare check"[3] following an anonymous telephone allegation against the parents. They went to the family address, which was in Mr. B's name, and saw Mr. B and K, who was in the care of Mr. B. at the time. They reported "no concerns". They completed a MERLIN recording details of Ms. A, K's mother, and that Mr. B had told them they had separated. The MERLIN was sent by e-mail to Lambeth CSC on 11th November 2014. Mr. B was not allowed to have direct contact with Ms. A at this time, but there was no restriction on him having contact with K.

3.8.3 On 12th November 2014, Ms. A told SW1 that she had sought legal advice about her immigration status. She said that she and K were currently staying with K's paternal aunt and paternal grandmother, but she said she planned to return to Nottinghamshire. The same day Ms. A and K were seen by G.P.4, in Lambeth. Ms. A said she was now living in London. She discussed Mr. B having contact with K with the G.P. GP4 advised her to discuss the matter with her Social Worker. On 13th November G.P.4 spoke to the Lambeth Social Worker and recorded in her notes that the Social Worker had told her that K was not considered to be at risk from Mr. B.

3.8.4 On 6th November 2014, HV3 discussed the case with the Safeguarding Nurse Specialist, who advised her to find out the address where Ms. A and K were sometimes staying in London.

3.8.5 On 1st December 2014, HV3 spoke to Ms. A, who said that she was looking into K spending a few days with Mr. B.

3.8.6 On 5th December 2014, SW3 from Lambeth CSC had supervision with her team manager and was advised to transfer the case to the Lambeth No Recourse to Public Funds Team (NRTPF). On 8th December 2014, Ms. A was seen in the Lambeth office by SW3. She said that, *"*All is well*".* She said that K was due to start at nursery in Lambeth in the New Year.

3.8.7 On 9th December 2014, HV2 had supervision with the Safeguarding Nurse Specialist and they discussed the possible impact of the frequent moves on K, including any difficulties accessing services, such as nursery. It was agreed HV3 would transfer the case to Nottinghamshire and send them the records. The case was transferred to HV4 in Nottinghamshire two days later, on 11th December 2014, and the records sent recorded delivery.

3.8.8 On 12th December 2014, Lambeth SW3 visited Ms. A at a house in Lambeth where she and K were said to be staying with a friend. Ms. A said that K was having contact with his father, Mr. B, and was enjoying it.

3.8.9 On 15th December 2014, Mr. B told G.P.3 that he was looking after K "5 days a week", and that he was receiving counselling through a programme called Building Better Relationships. Mr. B said that he would never hurt his

[3] This is a check (also known as "safe and well" checks) conducted by the police in response to a notification from a member of the public/family that someone may be at risk of serious and imminent harm and as such, is an emergency response

children. Lambeth CSC confirmed in a call from G.P.3 that Mr. B was not allowed contact with Ms. A, but there was no restriction relating to his contact with K.

3.8.10 K started at nursery in January 2015*. The nursery was unaware that K had been assessed as a child in need, that Lambeth CSC was involved, or that there had been a history of concern. Mr. B occasionally collected K from nursery. The nursery had no concerns about him collecting K, which had been agreed with Ms. A.*

3.8.11 On 13th January 2015, Mr. B told the G.P. that he was enjoying looking after K and taking him to nursery.

3.8.12 On 23rd February 2015, the case was transferred from the Lambeth CSC Child in Need team to the Lambeth No Recourse to Public Funds Team (NRTPF team) as the assessment had now been completed. On 13th March 2015 Lambeth CSC provided Ms. A and K with temporary accommodation within the borough. *(The nursery and later the school were unaware of this change of address.)*

3.8.13 On 7th May 2015, Ms. A applied to the Home Office for Leave to Remain in the UK under the Family and Private Life criteria. Her application was refused. Ms. A saw Lambeth SW4 on 30th July 2015 and was upset about the refusal. The Social Worker noted a strong bond between Ms. A and her son, K. The following day Ms. A telephoned Lambeth SW4 to say that she had received a letter from the Home Office, advising her to seek legal advice, as she was likely to be 'detained'.

3.8.14 On 8th August 2015 Ms. A was due to take K for a Speech and Language Therapy (SALT) appointment but did not attend. Two previous appointments had been postponed due to staff sickness. (Ms. A had referred K to the SALT service, as she was concerned about his speech). *(Ms. A told this review that K found it difficult to speak in sentences, the school has confirmed this).* On 11th August SALT2 contacted the outreach worker from the Children's Centre. OW1 had seen K with his father the previous day. OW1 agreed to remind mother of the SALT appointment on 17th August. They did not attend this appointment.

3.8.15 On 14th September 2015 Ms. A visited the Lambeth CSC offices to see the Social Worker (SW4) for a support letter to be taken to her appointment with the Home Office. K was seen to be "clean and well presented".

3.8.16 On 26 October 2015, Ms. A applied to the Home Office again for Leave to Remain. She obtained letters of support from G.P.4 and Lambeth SW4. Her application was successful. On 5th January 2016, Ms. A was granted Leave to Remain in the U.K. until 5 July 2018.

3.8.17 On 20th April 2016 Ms. A told Lambeth SW5 that she had been to the Job Centre to look for work, so she could support herself and K financially. She was offered and accepted a job in a retail fashion shop.

3.8.18 On 11th May 2016 Ms. A started receiving benefits for herself and K. Lambeth CSC planned to close the case as immigration and financial matters had been resolved. Ms. A and K were assisted by Lambeth Housing to move to privately rented accommodation in Bromley. K started in Year 1 at school in September 2016. The school was unaware that K was now living in Bromley as Ms. A had not informed them. *Ms. A said that she continued to use the nursery and school in Lambeth for K as she did not want to uproot K and felt that her support network and all her friends were in Lambeth.*

3.8.19 On 12th May 2016 Ms. A saw G.P.9 and said she was in a new relationship.

3.9 Phase 5: The relationship between Ms. A and Mr. C.

(March 2016 onwards)

3.9.1 *When the Lead Reviewers met Ms. A she described how she met Mr. C.* (this was not known to agencies). *She said she was encouraged to meet him by a neighbour when she was living in the temporary accommodation in Lambeth, in March 2016. The neighbour's boyfriend was a friend of Mr. C. Ms. A stated that Mr. C initiated contact with her in a handwritten letter from prison. The neighbour had told her not to pre-judge him because he was in prison. Ms. A said she was impressed by him writing to her and she wrote back. They exchanged several letters.* (The Prison Service has no evidence to suggest written contact with Ms. A. However, his calls and letters were only monitored for the first month of his stay in prison.) *Ms. A said that Mr. C "begged" her to go and see him.* Ms. A visited Mr. C in prison at the beginning of April 2016. She visited him 4 times before his release on 31st May 2016.

3.9.2 On 6 June 2016, SW5 from Lambeth NRTPF team made a final home visit to the flat in Bromley where Ms. A and K were living. Ms. A was happy with the accommodation and said she would think about moving K to a local school once they were more settled. *She told the Lead Reviewers that she wanted K to remain at school in Lambeth and hoped to be offered accommodation there by the Housing Department, as she thought her name was still on the Housing List. (It had in fact been removed once she moved to the privately rented accommodation in Bromley).* Lambeth SW5 was of the view that any risks to K were minimal now and the case was closed. Lambeth SW5 was unaware of Ms. A's relationship with Mr. C, as Ms. A was not asked, or counselled, about new relationships and Ms. A had not mentioned the relationship with Mr. C, or that he stayed with her and K on occasions.

3.10 Phase 6: Mr. C's past criminality, and the Involvement of the National Probation Service.

(October 2013 onwards)

3.10.1 Mr. C was born in the U.K. 1978. He is of African heritage. His parents took him to Nigeria at the age of 3. The family later moved back to the UK. He

had a history of violent behaviour, with 21 convictions: between 1998 and 2016 for offences of assault, including assaults relating to domestic abuse against previous partners, and between 1994 and 2009 for offences of theft, robbery and offences relating to bail. He had one adult caution for possession of cannabis.

3.10.2. On 4th October 2013, Mr. C was released from prison. Whilst on release under supervision he was sentenced to 30 months imprisonment for GBH and ABH against a female partner. He was in prison from 8th January 2014 until 5th January 2015. A probation officer, PO2, visited Mr. C in prison on 15th May 2014, in preparation for his release on 5th January 2015. At that time Mr. C was still denying the conviction. PO2 assessed him as high risk; made a referral for Approved Premises[4]; (this was received on 6th June 2014, and a place was allocated to him upon release) and made follow up enquiries with several London boroughs to try and locate the whereabouts of the two women he had been violent towards. In one case, this entailed PO2 having to make a re-referral to CSC in another borough. Risk assessments were carried out on the women and children involved, and this enabled an exclusion zone to be added to his licence, which had been agreed at the local Multi-Agency Public Protection Arrangements[5] (MAPPA) meeting. In November 2014, PO2 and PO3 visited Mr. C in prison. They discussed the Thinking Skills Programme he had completed in custody, as well as his impending release and CSC involvement in relation to the areas where his previous partners lived.

3.10.3 When Mr. C was released from prison on 5th January 2015, a senior probation officer, SPO1, saw him. Mr. C maintained that he was not required to live in Approved Premises (AP), but SPO1 challenged him, saying he must live there. He was allocated a keyworker at the AP (to monitor him and ensure he kept the curfew he had been given) as well as a probation officer.

3.10.4 By February 2015 the AP keyworker was ready to issue a first warning letter, which would result in no further late-night passes as Mr. C was failing to comply with curfew conditions. However, this was not done as the AP Keyworker *"*Thinks Mr. C is going through a tough time at the moment*"* as his father had just died.

3.10.5 On 24th March 2015, PO3 reduced the frequency of Mr. C's reporting arrangements from weekly to monthly. On 20th April 2015, SPO2 had management oversight of the case and was concerned that the reporting had been reduced to monthly, as Mr. C posed a high risk and should have continued to report weekly. It was SPO2's view that there was *"*no justification for this decision made by PO3*"*. PO3 had left the probation service by this time, and PO4 was asked to co-work the case with PO2. The case was being co-worked as PO4 was a trainee and this was in line with probation policy.

[4] Approved Premises are accommodation supervised by the Probation Services

[5] Multi-Agency Public Protection Arrangements. MAPPA agrees the arrangements to assess and manage the risks posed by sexual and violent offenders in the community.

3.10.6 By August 2015, there had been no improvement in Mr. C's behaviour in the AP. On one occasion, he was 45 minutes late for the curfew. He had an altercation with his keyworker over this and pushed him/her aside. PO5 notified AP staff that Mr. C would be given a warning and be issued with an eviction notice. This triggered the need to find other accommodation for him. Three days later, on 3th August 2015, a probation officer telephoned Mr. C's sister, who said she would be happy for Mr. C to live with them. PO5 made an appointment to visit her on 12th August 2015. The AP Manager expressed concern to PO5, about Mr. C living with his sister, given that he had recently failed a drugs test, and that it would be difficult to monitor him there.

3.10.7 On 12th August 2015 Mr. C was arrested for ABH and witness intimidation regarding a previous partner who he had assaulted again since his release from prison. He was re-called to prison on 14th August 2015 as a result of this arrest. On 4th March 2016 he was sentenced to 23 weeks further imprisonment for a common assault against his previous partner. He was released on 31st May 2016.The pre-sentence report completed by his probation officer, PO6, had assessed Mr. C as *"*high risk of harm to previous and future partners*".* No restrictions were put on visits or letters to him in prison. *Ms. A started her relationship with him whilst he was serving this sentence in prison.*

3.10.8 On 13th May 2016, Mr. C was at Wormwood Scrubs, and was found with a mobile phone in his possession. He was now being supervised by PO7. Mr. C telephoned PO7 to say that he wanted to live with his sister when released. PO7 visited Mr. C's sister on 27th May 2016 and discovered that she had 4 children. PO7 advised her that the local CSC in west London would have to carry out safeguarding checks, to risk assess Mr. C living in a home with his 4 nephews/nieces. The probation officer was unaware of the visits by Ms. A to Mr. C in prison and thus neither Lambeth nor Bromley CSC were alerted to undertake similar checks, in relation to Ms. A and K.

3.10.9 Mr. C was released from Wormwood Scrubs prison on 31st May 2016. He was on licence to the National Probation Service until 11th August 2016, followed by Post Sentence supervision. There were seven standard conditions; and four additional bespoke conditions attached to his licence, namely:

- Not to seek or communicate with the victim of the offence for which he had been imprisoned;
- Not to have unsupervised contact with children under 16 without the prior approval of the supervising officer and social services;
- To attend an offending behaviour programme including a domestic abuse programme, as directed by the supervising officer;
- To notify the supervising officer of any developing relationships with women/men.

3.10.10 On his release from prison Mr. C was met by a previous girlfriend. Later that day he met with PO7. He said his girlfriend had driven him there. This girlfriend was a previous partner he was seeing before his time in prison. Mr. C asked PO7 if he could go to visit his brother and this was agreed. The same

day the girlfriend telephoned PO7 to say they would be away for 2 more days. Later that day PO7 contacted the west London CSC to see whether they knew Mr. C's sister.

3.10.11 On 16th June Ms. A telephoned PO7 on behalf of Mr. C to say that he was "running late" for his appointment with her. Five days later, on 21st June 2016 Mr. C kept his appointment with PO7. He stated that his relationship with his girlfriend was over and that he now had a new girlfriend (Ms. A). He gave PO7 the names, Ms. A, and her son, K. but not their address or dates of birth.

3.10.12 On 27th July 2016, Mr. C failed to attend an appointment with PO7. He telephoned to say he had no money and refused to say where he was staying, but PO7 "suspects it is with his girlfriend" (Ms. A).

3.10.13 In September 2016, PO7 sought managerial advice from ACO1 and they discussed Mr. C's failed appointments, risk assessments, Mr. C's partner and children and CSC. PO7 also discussed the case with SPO1. PO7 discussed the fact that Mr. C refused to give an address where he was living, that there was a *"*high risk of DV*"* (to Ms. A) and the suspicion that he was living with his partner and her child (K). At this point he could not be recalled to prison. Mr. C was now the subject of Post Sentence Supervision as the licence period had ended. It was agreed that he should be returned to court for failing to attend appointments. This was not proceeded with as he later produced medical certificates for the absences.

3.10.14 Mr. C continued to meet with PO7. PO7 stressed the need for him to attend these appointments, *"*so that they can do some focused work on Domestic Violence*".* PO7 recorded that Mr. C "had shown some insight*",* but that "his motivation is not completely genuine". On 16th November 2016, Mr. C failed to attend his appointment with PO7. PO7 decided not to send him a warning letter as PO7 *"f*eels they have developed a working relationship now, and a warning letter might damage this*".*

3.10.15 Four days later on 20th November 2016, Mr. C assaulted K. K was taken to hospital, but died two days later.

4 The Views of Family Members.

4.1 Ms. A and Mr. B (K's parents) and Mr. C (Ms. A's boyfriend and responsible for K's death) were notified that a Serious Case Review was taking place and were invited to meet with the independent lead reviewers to share their views on the services they were offered up to K's death. No response to the invitation was received from Mr. C.

4.2 The purpose of both meetings was to listen to K's parents' views and to seek to learn from them about how services were provided, what was helpful and what could be improved in similar situations in the future. The parents' statements were not challenged although a footnote is added where the Lead Reviewers comment on statements made about one service as it seems that Ms. A was confused about who was actually providing the service. Where the

parents' information or comment is appropriate in assisting with understanding gaps in the timeline above in section 3 the text is in italics to emphasise that it was not known to professionals at the time.

4.3 The Lead Reviewers met Ms. A in August 2017. She had been receiving support from Victim Support since the death of K and her support worker was present.

4.4 It was not possible to meet with Mr. B until December 2017. He had been unwell prior to and after K's death. Mr. B told the Lead Reviewers that he had been badly affected mentally by K's murder and the subsequent trial and had no memory of being advised about or invited to contribute to the serious case review. His twin sister, Ms D, as his advocate, and a Victim Liaison Officer were present in the meeting with the Lead Reviewers.

4.5 Both parents were offered a meetings in to discuss the findings of the Review, prior to publication.

4.6 Mother's view of services provided to her and K.

4.6.1 Ms. A said that she was shocked to learn in the trial about Mr. C's violent history and that no-one had told her about it or about 'Clare's Law'[6]; which she said would have enabled her to make enquiries about Mr. C's background.

4.6.2 The Probation Officer who was supervising Mr. C on release had spoken to Ms. A on the telephone. Ms. A says she told the PO all about herself. She thinks that the Probation Officer should have told her about Mr. C's criminal history and that he was high risk, but Ms. A was not told anything. She said she would have finished the relationship if she had known the truth about him. Ms. A said Mr. C had a good relationship with his Probation Officer and they would laugh and joke during telephone conversations and she felt "no-one was forcing him to go to probation".

4.6.3 After leaving Mr. B in August 2014 Ms. A was helped by Solace Women's Aid, she and K were placed in a property in Bexley. She was unhappy with this and said she felt unsafe. She stayed there for three weeks, before being moved to Nottinghamshire.[7] She thought it was going to be Notting Hill.

4.6.4 Ms. A said that the worker from Solace Women's Aid took her and Child K to the accommodation in Nottinghamshire and "Left her there". *(*This was temporary accommodation for the homeless arranged by Lambeth council.) The property was damp and cold. A man sent to collect the property of previous residents "behaved inappropriately towards her". She says she complained to CSC in Lambeth, but nothing happened.

4.6.5 Ms. A said that she was given no support or advice about domestic violence except a card with a number to ring if she was at risk. Ms. A returned to London occasionally and then decided, "Enough was enough" and returned

[6] Clare's Law: The Domestic Violence Disclosure Scheme https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/clares-law/

[7] **Reviewers' comment:** The property in Bexley was not a Solace Women's Aid Property or arranged or staffed by a Solace worker. The accommodation was private bed and breakfast arranged by Lambeth CSC.

to London with Child K, staying with friends. She approached Lambeth CSC and was allocated a Social Worker who organised temporary hostel accommodation in Brixton.

4.6.6 Once back in London, Ms. A started working again. In response to the question of Child K staying with Mr. B five days a week reported by Mr B to his GP she replied "It's not true." He did stay with his father most weekends, until she stopped him seeing Child K some time later (August 2016) because he (Mr. B) was very unwell.

4.6.7 Ms. A said that she used friends or family members as intermediaries when K was seeing his father, such as the paternal grandmother. She was not afraid of Mr. B and did not think he would harm K.

4.6.8 Ms. A was asked about the different services she received, and whether anyone had given her advice about how to protect herself in future relationships. She said she had not been given any advice like this, by any agency. The Police gave her a "victim card" but did not do any keep safe work about her future safety or relationships.

4.6.9 Ms. A was very positive about the support she received from Lambeth Social Workers over immigration, and help from people from the Children's Centre, nursery and the school, including the Speech and Language Therapist at the school. She was very positive about the school, *"It's the best school. I was very happy with it".* People asked her how she was and showed concern for her. K was very happy at school. He was starting to make friends and was very popular with the other children, a *"superstar".* She was determined that he would stay at the school after they moved to Bromley, and described the daily journey to and from school, saying *"although we lived far away, we were always the first at the school gates'.*

4.6.10 Ms. A was also positive about the service she had from her GP (she always saw the same one) who had known K since he was born. The GP always asked her how she was.

4.7 Father's view of services provided to him

4.7.1 Ms. D acted as Mr. B's advocate as he did not think he could express himself due to his grief. He said that he was still very seriously affected by what had happened. Mr. B said he had not received the original letter about the Serious Case Review and he had only learned of it recently from the Victim Liaison Officer.

4.7.2 Ms. D told the Lead Reviewers that Ms. A and Mr. B had lived with her and her children from when Ms. A was 8 months pregnant with K (2011). However, Ms. D asked them to leave the house in the summer of 2013.

4.7.3 In September 2013, after Ms. A and Mr. B had moved out with K, Ms. D telephoned the NSPCC and Lambeth CSC to make anonymous allegations about the neglect of K, and saying, both Ms. A and Mr. B were taking drugs.

She did not tell her brother about this at the time.

4.7.4 Mr. B said that he and Ms. A occasionally argued, usually without physical violence. He said that when K and Ms. A were in Nottinghamshire, he gave her the train fare to return to London. He gained the impression and hoped that they were going to get back together.

4.7.5 When Mr. B was involved in the Child and Family Assessment, the Social Worker said it would take 3 weeks to complete. At the end the Social Worker read it out to him as he could not read, but he did not understand what he was being told and was not given a copy. Mr. B was worried, as he was stopped from seeing K until the assessment had been completed. He said this was hard, because he missed K and K missed him. After the assessment was completed the Social Worker said Mr. B could see and have K to stay. He said this was monitored by Lambeth CSC. Mr. B would sign a paper every time he had K. *(The Lead Reviewers have found no evidence of such signed documents).* Mr. B said that he was seeing K and Ms. A, throughout this time, and at times they were both staying with him, when she came back to London. *(Ms. A said that she did not stay with him.)*

4.7.6 Mr. B said that after Ms. A and K were rehoused into the hostel in Lambeth he had K to stay every weekend. He would pick him up from nursery on Friday and take him back there on Monday, when Ms. A would then collect him at the end of the day. *(The nursery and school have subsequently confirmed that Mr. B would have had to identify himself and be approved by Ms. A initially but after that he would be allowed to collect K and would not have to sign each time as he was known and approved. He would sometimes come to the school and collect K. Mr. B was also known to some of the school staff through the local community. The nursery and school had no concerns about Mr. B and were unaware of Children's Social Care involvement.*

4.7.7 When asked, Mr. B said that he had not been told of his 'rights' as a parent by anyone, regarding access to and care of K. Mr. B said that he had asked social services to give him a paper to let him have contact and care of K.

4.7.8 With regard to Mr. C, Mr. B and Ms. D were aware that Ms. A had met Mr. C while he was in prison. Mr. B was worried about K having contact with Mr. C as he thought he was dangerous.

4.7.9 Mr. B said that whilst he still having contact with K, he thought that K feared Mr. C, who he called "*daddy C" and that K "cried most of the time"* because of this. Mr. B said K had bruises given to him by Mr. C. He said that K was *"nervous and wary of people who looked like Mr. C".* Mr. B told the Lead Reviewers that he did not tell the authorities about these things as he was scared that Ms. A would stop him seeing K.

4.7.10 Mr. B also told the Lead Reviewers that Ms. A stopped him seeing K in the summer of 2016 and stopped answering the phone calls from him. This coincided with the time when Mr. B's health was deteriorating and followed Mr. C being released from prison.

4.7.11 Both Mr. B and Ms. D told the Lead Reviewers that their mental health had been badly affected by K's death.

5. Analysis and Appraisal of practice: identifying key learning issues.

5.1 The key areas to be explored in this Serious Case Review were agreed by the Independent Chairs of the LSCBs and can be found in Appendix 1. This part of the report highlights examples of good practice from the agencies involved and discusses examples where practice could have been better. In such examples, it is important to highlight if systemic issues have impacted on practice. It is also important, in such cases, to outline what good practice would have looked like.

5.2 There are two main areas to the learning. The most important lessons relate to the assessment and management of risk to K and Ms. A from Mr. C, a known violent offender, who went on to kill K after he formed a relationship with Ms. A on his discharge from prison. Mr. C and his relationship to Ms. A were unknown to children's safeguarding agencies in Lambeth and Bromley with agencies also unaware that K and his mother were living in their area. The second area of lessons is about working with cases of domestic abuse more generally based on the work done while Ms. A was in Lambeth (and later Bromley). Although Mr. B was in no way responsible for K's death a number of systems lessons are included here to improve understanding of multi-disciplinary work to safeguard children where a domestically abusive relationship exists between the parental adults.

5.3 The phrase *"Safeguarding is everyone's responsibility"*, lies at the heart of statutory guidance, and practice, dictating how children are safeguarded. Working Together 2015, The Munro Review of Child Protection[8], and various serious case reviews, research and associated literature, repeat that children can only be safeguarded within a multi-agency partnership characterised by shared responsibility. These collective responsibilities include a shared multi-agency ownership of assessments, analysis, plans and outcomes, and include exercising professional challenge and debate across multi- agency partners and across management hierarchies.

5.4. The management of convicted domestic violence offenders released from prison on licence: safeguarding children where there is domestic violence and abuse between adults.

5.4.1 **Assessment of risk from Mr. C:** The National Probation Service (NPS) had known of Mr. C since 4th October 2013, when he was released from prison for a previous sentence. NPS gathered a great deal of information about Mr. C during his three periods in custody, for violence against women, theft, robbery, breach of bail and use of cannabis. They had responsibility for supervising him during the two periods when he was released on licence, and the one period of

[8] Munro review of child protection: final report-a child-centred system, May 2011, ISBN9780101806220

post sentence supervision from 11th August 2016, when his licence had ceased.

5.4.2 Mr. C was known to be dangerous and a risk assessment by PO5 in July 2015 deemed that he was "high risk". The terms of his licence, when he had the prior release on 5th January 2015, included a condition that he was not allowed to have contact with children under 16. He was recalled to prison on 14th August 2015, following an assault on a previous partner. (He was unlawfully at large, until 22nd September 2015, when he handed himself into the police).

5.4.3 Attempts were made by some probation officers to assess where there was likely to be contact with children. For example, in April 2015, Mr. C gave PO2 the details of his sister and 4 children, as he wanted to stay with them upon his release. He also gave PO2 details of a woman he had been having a relationship with for the previous month. It was recorded that she "had some knowledge" of Mr. C's offences, and she stated that when he loses his temper *"he controls this by going away or making a cup of tea"*. PO2 contacted a West London CSC asking whether the woman in question was known to them as they wanted to assess the situation before Mr. C was allowed to reside there (this was good practice). That CSC did not know this person, but they were prepared to carry out an assessment if PO2 provided them with a risk assessment of Mr. C. It is not clear that this information was provided.

5.4.4 By August 2015, the Approved Premises were struggling to cope with Mr. C. The new probation officer, PO5, contacted his sister who said that she would be happy to have him there. The Manager of the Approved Premises expressed concern about Mr. C living with his sister and children, given that he had tested positive in a drugs test in May 2015 and that it would be difficult to supervise him there. In fact, Mr. C had already been living with her but moved on.

5.4.5 In August 2015 a previous partner of Mr. C contacted the police to say that she had been assaulted by Mr. C. He was arrested and charged with ABH, witness intimidation and breach of licence and remanded back to prison. (In March 2016 he was sentenced to 23 weeks imprisonment for this offence). Mr. C's risk to previous partners was now clear.

5.4.6 There had been discussion between Mr. C and PO7 at the beginning of May 2016, when he was still in prison, about where he would stay once released. He had given PO7 the details of his sister who lived in London with her four children. Checks were made with the police, and it transpired that the accommodation may not be suitable. Checks were made with the local CSC department but the outcome of this was not clear. PO7 visited the home and spoke to Mr. C's sister, and subsequently approved this as the place where he would reside once released.

5.4.7 This would then have been in violation of condition 2 of his bespoke licence condition that he was *"not to have unsupervised contact with children under 16 without the prior approval of the supervising officer and social*

services." In agreeing that Mr. C could reside with his sister and her children it is not clear what arrangements were put in place to ensure that there was always an adult present and that Mr. C did not have unsupervised access to the children, as his licence conditions required. Information from Ms. A to this review suggests that Mr. C occasionally baby-sat his sister's children, presumably alone.

Learning Point 1: When offenders are known to have been domestically violent to adults and or children full assessments must be made of their accommodation arrangements following their release from prison to ensure that these do not pose a risk to previous or new partners or children.

The possible risk to Mr. C's sister's children was not fully assessed and proper arrangements made to ensure that Mr. C did not have unsupervised access to the children. Given that Mr. C was deemed to be a high risk, would Approved Premises (AP) have been a better option despite previous difficulties with this?

5.4.8 When he was released on licence, from 31st May 2016 to 11th August 2016, there were 7 standard licence conditions and 4 bespoke conditions, one of which was "Not to have unsupervised contact with children under 16, without the prior approval of the supervising officer and Social Services". On 21st June 2016 Mr. C told PO7 that his relationship with his previous "girlfriend" was over and that he now had a new girlfriend. He gave PO7 the name of his girlfriend, Ms. A and her son, K, but not their address. This left PO in the position of not being able to make checks with the relevant CSC (Bromley) and the police. When an offender refuses to co-operate with a licence, enforcement action should be taken, including, ultimately, recall to prison.

5.4.9 Less than a month after his release Ms. A telephoned the probation officer (PO7) on 16th June 2016, to say that Mr. C had been delayed and was going to be late for his supervision appointment. During a later supervision appointment on 21st June 2016 he told PO7 of the relationship and gave Ms. A's name and K's name. He withheld their address on this and subsequent occasions and was continually "evasive" about the address, maintaining that he was homeless and "sofa surfing". Mr. C's refusal to divulge Ms. A's address prevented any assessment of risk to them. Information about this relationship was not, therefore, shared with local child safeguarding agencies, even though it was suspected that Mr. C probably stayed with her. There was no multi-agency discussion about this.

5.4.10 No CSC or other children's agency was aware of Mr. C's relationship with Ms. A until the fatal assault on K in November 2016. The case was closed to Lambeth CSC following a last visit by a Social Worker to Ms. A in Bromley in June 2016. This visit was after Mr. C's release from prison and he had already started a relationship with Ms. A. The probation officer (PO7) suspected he was staying with Ms. A and her son but did not know where and so did not inform the relevant CSC. Ms. A did not mention this new relationship to the Lambeth Social Worker. Bromley CSC was unaware that Ms. A and K were

living in their area.

5.4.11 Mr. C's relationship with Ms. A should have been referred by probation to the local CSC department (Bromley) for a safeguarding assessment for K to be undertaken, but this was not possible as Mr. C refused to divulge her address. He should have been referred to the local MAPPA arrangements, prior to release, or later, given the concerns, and the fact that he was not co-operating with his probation officer and the conditions of the licence.

Learning Point 2: When an offender is released on licence from prison and breaches his licence conditions, consideration should be given to enforcement action, including recall to custody. This decision should be agreed at a senior level.

The National Probation Service were aware that Mr. C was having a relationship with Ms. A and he had given his probation officer her name and K's name. It was thought that he was living with them. This was in breach of his licence conditions. An ultimatum should have been given to Mr. C to provide full details of Ms. A and K and to re-iterate that it was not an approved address and so he should have been directed not to stay there. If this ultimatum was not complied with it would have been sufficient to recall him to prison.

Learning Point 3: An assessment of any future risk of known violent offenders to possible identifiable victims should be a multi-agency process. In summary, risk assessment and the management of an offender's risk in relation to adult female victims of domestic abuse and children should be robust, and good links forged with relevant partner agencies, to ensure that safeguarding women or children who may be vulnerable is seen to be a high priority. MAPPA is the multi-agency system to manage this process for high risk offenders. This also applies to non-custodial sentences.

5.5. Management of future domestic abuse risk by offenders in prisons

5.5.1 No restrictions were placed on visits or letters to and from Mr. C in prison after the first month, yet he was known to be a risk to previous partners and children. As noted above, conditions on contacts with children, previous partners and new relationships were a part of his subsequent licence on discharge.

5.5.2 He was able to initiate his relationship with Ms. A from prison, initially by letters that were not screened or assessed for risk. He also had a visit from a child, although this was supervised.

5.5.3 Men who are domestically violent, or who use coercive control, may seek to initiate and possibly groom (new) relationships from prison; as was the case with Mr. C and Ms. A.

Learning Point 4: The Prison Rules on letters and visits do not contain a duty to establish the identity of people, or consider the welfare and protection of people, who have contact with or visit prisoners who are known to be domestically violent. This raises a challenge about how prospective partners can be identified and risk assessments could be done to protect those who are not aware of an offender's violent history.

5.6 Assessment of parental domestic violence in the community

5.6.1 K's father, Mr. B, did not kill K. In seeking to understand the whole systems context of the multi-agency work done with K and his parents lessons have come to light with regard to work to assess and protect Ms. A and K from domestic violence. This is separate to the analysis of the work with Mr. C described above.

5.6.2 There were four incidents that resulted in referrals to Lambeth CSC which gave them the opportunity to risk assess K's situation and needs:

5.6.3 The serious case review was of the view that the anonymous allegation in October 2013 expressing concerns should have resulted in a s47 strategy discussion between the police and Lambeth CSC, but this did not happen. A Health Visitor was asked to visit the home. HV3 visited along with a nursery nurse (NN1) and they reported no concerns and the referral resulted in no further action (NFA) from Children's Social Care. Given the available history it is surprising that a strategy discussion did not take place, and this was a missed opportunity. There is also a question about whether it was appropriate for a health visitor to be asked to undertake a health assessment following this allegation. Health representatives on the review team would say that it was not appropriate, but this view was not expressed at the time. Given that family had no Lambeth CSC history and no concerns were raised by any other agency through the MASH, Lambeth CSC believed it was proportionate to gather more information through partner agencies. As the feedback from the health visitor following her visit did not substantiate and/or raise any CP concerns, Lambeth CSC's view was that the threshold for a Section 47 was not met. It would have been best practice to give feedback to the referrer or question them further about their concerns, which did not happen.

5.6.4 Following Ms. A's separation from Mr. B in August 2014, the Police carried out a Domestic Abuse, Stalking and Harassment Risk Assessment (DASH), which concluded that the threshold for calling a s47 Strategy Discussion with Lambeth CSC had not been met. They did, however, send a police notification to Lambeth CSC. The Review Panel's view is that there should have been a multi-agency s47 Strategy Discussion between the police, Lambeth CSC and possibly other partner agencies in Lambeth, such as the Children's Centre. However given that Ms. A agreed to be moved it was understood that they were safe.

5.6.5 Solace Women's Aid (Southwark) planned to discuss the case at the local

MARAC meeting. However, Ms. A was not rehoused in Southwark and was placed in a different borough (Bexley) before being transferred, by Lambeth CSC, to temporary accommodation in Mansfield, Nottinghamshire. The local MARAC in Nottinghamshire did review the case and agreed to offer "floating support" to Ms. A. However, Ms. A was only there for a short time. When Ms. A moved back to London the case should have been transferred to Lambeth MARAC to re-consider what support Ms. A might need, but it was not. The Nottinghamshire MARAC has acknowledged this as a learning point for them.

5.6.6 A Child and Family Assessment was started by SW3 from the Lambeth CSC Assessment/Child in Need team at the end of August 2014, it was completed on 5th December 2014, out of timescale, following Ms. A's return from Nottinghamshire. Ms. A was given a copy of the assessment on 8th December 2014. (Mr. B said that he was not given a copy). The assessment concluded that Ms. A needed help with accommodation in London and also support in resolving her immigration status (this immigration issue was completed on 5th January 2016, when Ms. A was granted leave to remain after Lambeth CSC and the G.P provided letters of support to the Home Office). The December 2014 assessment is the only recorded assessment completed by Lambeth CSC during the three-year period under review. There was no in-depth or multi-agency re- assessment of the nature of the parental relationship over the previous 18 months and any risk to K of possible emotional or physical abuse. The view was formed over time that Mr. B was not a risk to K, that he showed understanding of the reasons for his recent behaviour (the allegations about his behaviour over several years do not appear to have been put to him) and he was co-operating with treatment. Lambeth CSC was not informed that Mr. B had ceased to attend the counselling or sessions as part of his Community Order.

5.6.7 After Ms. A returned to Lambeth from Nottinghamshire in October 2014 K resumed contact with his father, Mr. B. The serious case panel was of the view that a further risk assessment should have been completed at this time.

5.6.8 The panel was also of the view that when an anonymous allegation of possible harm to K was made to the Police in Lambeth in November 2014 it was insufficient to rely to the police welfare check. A social worker should also have undertaken an unannounced visit to inform their ongoing assessment. Lambeth CSC's Independent Management Review report also expressed the view that it would have been best practice to carry out a timely, unannounced Social Work visit, but this did not happen at the time, as they believe that they did not receive information from the Police about the anonymous referral. Police records evidence that a MERLIN was sent to Lambeth CSC.

5.6.9 The G.P later sought safeguarding advice from CSC about Mr. B having contact with and possible overnight care of K but was advised that this was allowed.

5.6.09 K's nursery and later schools were also aware of ongoing contact between K and his father but had never been advised of any concerns or CSC involvement. In August 2016 there was a further opportunity to respond to concerns expressed by others when Mr B's mental health had deteriorated.

Mr. B told A&E health professionals that he had a son (K) who he had contact with. A practitioner from A&E contacted Lambeth CSC out of hours Emergency Duty Team to raise concerns about K having contact with his father, given the serious state Mr. B was in. This was good safeguarding practice. They were told the case was now closed to Lambeth CSC. This was true: the case had been closed two months earlier in June 2016, but the person from A&E was not given the full picture, that Ms. A and K now lived in Bromley. Lambeth CSC stated that there were *"no immediate risks to K"* and there was no further action. The health professional then made a written referral to Lambeth CSC. It should have been made clear to the referrer that the case was closed in June 2016 to Lambeth CSC and that any concerns should have been referred to Bromley Children's Social Care. On receiving the written referral from the hospital, Lambeth CSC should have referred the matter to Bromley CSC who could have considered whether a risk assessment was necessary.

5.6.10 These examples of concerns relating to parental health or behaviour may be a possible source of harm to a child and where multi-disciplinary strategy discussions and information sharing with other key agencies did not take place may indicate a wider, systemic issue, whereby the significance of multi-agency strategy discussions or information sharing is not fully understood by agencies. This is a feature noted in the 2011 two yearly national analysis of Serious Case Reviews by the University of East Anglia. *"Given their centrality to the (child protection) process, strategy discussions were conspicuously absent from the SCR reports we reviewed. Where they were mentioned, it was often to highlight inconsistencies in the conduct of these discussions, delays in holding the discussions, inadequate representation or poor decision-making. This suggests that strategy discussions may not be given the priority they deserve and therefore do not feature as a central point in critical thinking about the case and appropriate planning*"[9]. It is the authors' view that it was not obvious or transparent that any joined up, multi-agency critical thinking was taking place about the risks to K.

Learning Point 5: The Brandon 2011 research raises the question of whether multi-agency strategy discussions are taking place appropriately nationally.

This SCR raises the question about Lambeth over this period and whether there was clarity amongst professionals about the purpose and effectiveness of multi-agency strategy discussions and information sharing, including key agencies that know the child and family. It may be helpful to undertake an audit to test this out.

5.7 Multi-Agency Understanding about the powers and use of Police or Court bail to protect victims

[9] New learning from serious case reviews: a two year report for 2009-2011, Marian Brandon et al, UEA, 2011

5.7.1 An assumption was made by professionals that the lack of bail conditions, with regard to potential contact between Mr. B and K, meant that this had been assessed, and found to pose no risk. We would suggest children's safeguarding workers should take a wider view when considering the safety of children, and should not rely on bail conditions for guidance.

Learning Point 6: The absence of specific bail conditions pertaining to contact with children can engender a false re-assurance that such contact does not pose a risk. An assessment of risk, led by CSC, should be completed wherever possible, and take into account the wishes and feelings of the individual child.

5.8 Multi-disciplinary working with cases where there is a history of abusive behaviour between parents and assessing any inherent on-going risk or impact to children.

5.8.1 This case highlights the difficulties that professionals face in their efforts to safeguard and protect children in situations where there is or has been abuse between parents. Research evidences a connection between DV and child abuse. In Stark and Flitcraft's study[10] in 40-70% of cases where women were being abused, the children were being directly physically abused themselves. Brandon[11] noted "the mention of DV permeated all types of (SCRs) Reviews concerning babies, children and adolescents. Over 50% of the children studied (21) lived with current or past DV. Eleven children were living with families with DV and parents and carers who had criminal convictions".

5.8.2 It may appear relatively straightforward in cases where the perpetrator admits the violence and the abused partner wants to separate from them with a clean break. However, when Ms. A returned to London not long after, it was then not the clean break that had been planned, as K renewed his unsupervised contact with his father. Due consideration was not given by professionals to the risks K might be exposed to, given what we know from research about the link between the "toxic trio" (domestic violence, mental ill health and substance/alcohol misuse) and child abuse[12].

[10] Women at risk: domestic violence and women's health, Stark and Flitcraft, 1996; On the Relationship between Wife Beating and Child Abuse, Bowker et al, 1998

[11] Understanding Serious Case Reviews and their impact 2005-2007 Brandon, M, UEA, Published 2009

Learning Point 7: When a child has been safeguarded by removal from a parent by the 'protective' parent it should not be assumed that the child is safe to have contact with or care by that parent until a proper assessment has been completed, even if there was no previous evidence of direct harm to the child. The assessment should include risk of emotional abuse, including witnessing parental violent behaviour, as well as physical abuse.

5.9 A systems impact of moving families away from their networks, locality and services to separate them from the perpetrator of domestic violence

5.9.1 Ms. A and K were assisted by Lambeth CSC to move away from London.. However, Ms. A felt socially isolated there and felt unable to progress immigration matters when she was so far away from London. She returned to London of her own accord and Lambeth CSC agreed to support her in London. This was good practice. However, further work could have been undertaken with Ms A to develop an understanding of abusive behaviour in partner relationships. (see 5.11 below).

5.10 The particular vulnerability of victims of domestic violence whose immigration status is not secure.

5.10.1 Moving Ms. A and K to Nottinghamshire was based on the understanding that she did not meet the criteria for funding to be placed in a refuge in Lambeth, because she had 'no recourse to public funds'. However, part of the learning from this serious case review is that, domestic abuse services, including payment for a refuge for K and his mother in Lambeth or as near as possible could have been provided by CSC from section 17 funds. It should also be noted that K was a British citizen and was thus entitled to services in his own right and not subject to 'no recourse to public funds'.

5.10.2 Ms. A was vulnerable, as she had overstayed in the UK, after her student visa had expired. She was unable to work or claim benefits and was therefore fully dependent on Mr. B for financial support.

Learning Point 8: Women and children who have no recourse to public funds and who are at risk of domestic violence face more barriers in funding refuge provision. However, CSC have the power to make such payments from the section 17 Child in Need budget and should consider doing so.

Women who do not have residence rights may be at greater risk of ongoing domestic abuse for fear of revealing their immigration status. Financial circumstances or childcare worries may push them to continue or renew abusive relationships.

5.11 Working with women who have experienced domestic abuse to reduce future risk.

5.11.1 Ms. A was viewed by professionals as a good carer and protective factor for her son. This assessment was based on the observed closeness between her and K and for Lambeth CSC, on the basis of the Child and Family Assessment, completed in December 2014.

5.11.2 Ms. A entered into a relationship with Mr. C whilst he was in prison for crimes of assault against women. Mr. C posed a risk to Ms. A and K. *Ms. A told the Lead Reviewers that she was not aware of the convictions of violence that had resulted in Mr. C being in custody and he claimed he was innocent and had been wrongly imprisoned, and she believed him. During their relationship, she said that, Mr. C was employed and financially independent. and the relationship was positive - there was no domestic violence from Mr. C towards her.* It poses the question of what work was done or could or should have been done after Ms. A separated from Mr. B to help her become more aware of the possibility of such risk in future relationships, such as that subsequently posed by Mr. C.

5.11.3 Ms. A received appropriate but emergency short-term contact and advice from Solace Women's Aid (Southwark), the Gaia Centre in Lambeth; and the offer of support from Women's Aid Integrated Services in Nottinghamshire. Her moves from and back to London did however prevent more in-depth work on domestic abuse and its dynamics and this was unfortunate.

5.11.4 The Lambeth CSC summary report for this review refers to this issue and states *"with the benefit of hindsight, based on recent evidence that was not present at the time, it is now apparent that Mother had a very poor understanding of dangerous men with a history of domestic violence towards former partners. It is possible that had Mother been engaged in initiatives such as the Freedom Project by GAIA[13] she may have desisted from seeking out a relationship with the boyfriend who was in prison".*

Learning Point 9: When a person has been the subject of domestic violence consideration should be given to how they can be supported to understand the dynamics of abusive and controlling relationships to better equip them in the future. See also Section 5.12 below on the **Domestic Violence Disclosure Scheme**

5.11.5 If Ms. A and K had been placed in a Women's Refuge in August 2014, rather than in B&B accommodation in SE London and then in the general hostel in Nottinghamshire, which were not specialist resources for women who had experienced domestic abuse, it may have enabled more specialist support or advice to have been offered on the nature of abusive relationships in general. There is no guarantee, however, that a local Refuge would have been available and so Ms. A may still have had to move away from Lambeth.

5.11.6 It is in the nature of domestic violence that the victim may return to a violent partner, through attachment, fear, ambivalence, and/or conflicting

[13] The Freedom Programme is delivered by Home Start in Lambeth and not the Gaia Centre

loyalties toward their children and the partner. Pragmatic, social and cultural issues also influence the victim's decisions, in particular, when they are dependent on their partner for the chance to remain in the UK and for financial support.

5.11.7 The Lambeth LSCB Child H SCR, (2014) pointed out that *"Despite the threat of future violence, there may be other benefits to returning to the relationship: avoidance of the stigma from family and the community; an attempt to integrate in the community; the need for social companionship; and financial and practical support. Understanding these competing priorities and conflicting loyalties adequately to assess the risk of potential harm to the children involved is a complex and challenging task for professionals. It is one made more difficult by the uncertainty about risk and danger that characterises this field of work. The available research evidence base provides indicators but is not able to underpin absolute predictions of which partners will go on to harm their children".*

5.12 Information Sharing.

5.12.1 There are many examples that demonstrate that the GPs, and hospital professionals were very aware of their children's safeguarding responsibilities, towards K, which is excellent. GPs telephoned Lambeth CSC to clarify arrangements for Mr. B's care of, or contact with K, to ensure that what Mr. B was telling them was true. It is noteworthy that the G.P.s working in the local Lambeth practice were particularly good at sharing information with each other and other professionals and had a clear understanding of children's safeguarding issues. The G.Ps from this practice had attended the training events in 2014 following the Lambeth LSCB Child H SCR and this appears to have had a positive impact on practice, particularly information sharing.

5.12.2 There was also evidence of good safeguarding awareness by the A&E medical professional who dealt with Mr. B in August 2016. Mr. B had spoken about having contact with his son and had given the names of Ms. A and K. The A&E health practitioner telephoned Lambeth EDT to see if there were any safeguarding concerns about K having contact with his father. They were told by EDT that K was 'not at risk' from his father. The hospital was not told that Ms. A and K had moved to Bromley. The health professional followed up this telephone call with a written referral to Lambeth CSC, which was good practice. Lambeth CSC should have passed this information to Bromley MASH to re-assess, given that the view that K was safe with his father was historic and that Lambeth CSC had been unaware until then of the serious decline in Mr. B's health; but this did not happen.

5.12.3 A striking feature of this case is the number of professionals who were involved during the 3 years and 1 month covered by the serious case review.: there were 7 Probation Officers and 3 Senior Probation Officers plus prison staff involved with Mr. C during his periods in prison, and when he was in the community on licence or on post sentence supervision. There was also his keyworker (and other staff) when he was living in Approved Premises. Separately, there were 5 Social Workers and several managers from Lambeth CSC involved with Ms. A and K, and Mr. B, some from the MASH team, some

from the Child in Need team, and some from NRTPF team. There were 11 G.P.s from one G.P. practice, where Ms. A, Mr. B and K were all registered. There were also 2 Health Visitors in Lambeth, working with Mr. A and K plus Children Centre, nursery and school staff. There were also workers from the GAIA Centre, Solace Women's Aid workers. In Nottinghamshire there was a Women's Aid worker a G.P. and Health Visitor.

5.12.4 Different borough boundaries made information sharing more difficult. Knowing who to share it with was problematic and caused unnecessary delay. For example, the NSPCC had originally contacted Southwark CSC when they had received an anonymous allegation before the matter "made its way" to Lambeth. Additionally, when Ms. A was homeless after leaving Mr. B she was sent to Southwark housing, which was an error. Although she was temporarily residing there after she left Mr. B, her main residence had been in Lambeth.

5.12.5 There was also an issue about health records from Lambeth being sent to Nottinghamshire, when in fact Ms. A had returned to London. The health department expressing concern for possible risk to K that may arise from Mr. B's deterioration in health was not advised that K and Ms. A were now residents of Bromley.

5.12.6 There was a systems problem de-registering K from the GP practice in Nottinghamshire on his return to London. This was despite a 'deduction request' being submitted by the Nottinghamshire GP and K's mother seeking to re-register K in London. There had also been communication from the new GP practice to request additional information to inform the registration process. It is unclear why the registration and deduction process were not completed. This was escalated to NHS England as a registration issue and they were investigating this. Such an administrative and IT systems issue has the potential to hamper information sharing in safeguarding as the NHS Spine records will not be accurate.

5.12.7 K's nursery and school reported to this review that they had had no contact from or with Lambeth CSC while Ms. A and K were an open case to Lambeth CSC. A nursery or school where a child attends is a key place for the safeguarding of children.

5.12.8 The National Probation Service should have shared information about Mr. C with the local CSC where Ms. A and K were living to ensure that there was a proper assessment of any risk to them. This did not happen as they had not obtained full details or an address.

Learning Point 10: Research and previous SCRs have shown the importance of multi-agency information sharing when there are concerns about the welfare and safety of children. Clearly there are issues of consent where a case does not appear to meet a child protection threshold. However, without appropriate sharing of information through multi-agency strategy discussions, multi-agency child in need discussions, MARAC or MAPPA there is a risk that single agencies will not have sufficient information to make a decision about thresholds for intervention.

5.13 Domestic Violence Disclosure Scheme (also known as 'Clare's Law') and sharing information about known violent offenders.

5.13.1 The DVDS arrangement, which came into effect from March 2014, has two functions: firstly, the "right to ask" which enables someone to ask the police about a partner's previous history of domestic violence or violent acts; and secondly, the "right to know" gives the police the power to proactively disclose information in prescribed circumstances[14]. Ms. A told the Lead Reviewers that she was not told about this process by any of the professionals from the various agencies she was involved with. She is clear that if she had been informed of the "right to know" she would definitely have asked for information on Mr. C when she first met him and would have immediately ended the relationship.

5.13.2 Even though the Probation Officer had spoken to Ms. A briefly over the telephone, the officer would not have been allowed to disclose any information about Mr. C's convictions in that call. However, if the case had been referred to MAPPA by PO7, as it should have been, the matter of disclosure to Ms. A could have been discussed and agreed. Disclosure can be complex and can often put victims at more risk, which the MAPPA would have assessed.

5.13.3 Usual practice would have been to assess the risk and consider informing the offender that a partner would be assessed and may be told of his criminal history in relation to any risk he posed, so that he could tell the partner himself. Failing that, the partner could be advised by the Police or Probation Service through the MAPPA arrangements. This was not considered in this case as it was not referred to MAPPA, as it should have been, when any risk posed by Mr. C to Ms. A and K would have been formally considered in a multi-agency process, including children's services.

[14] https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/clares-law/

Learning Point 11: It is important that consideration is given to when to share confidential information about known offenders of domestic violence with partners or potential victims, including those entering into new relationships, without consent.

There is a question about how knowledgeable frontline practitioners are about the Domestic Violence Disclosure Scheme, and its possible benefits and drawbacks (such as false-reassurance or increased risk), and when to advise women about its availability.

When it is assessed that an offender poses a risk of violence to (future) partners, steps must be taken to ensure that whether and how to disclose are considered through the MAPPA or DVDS arrangements.

5.14 Professional Curiosity.

5.14.1 As a general point, it is clear with hindsight that Mr. C misled professionals. It remains important that professionals do not take things said to them at face value, but maintain a critical gaze, and seek to evidence and challenge things wherever possible; keeping an open mind to the possibility of disguised compliance.

5.14.2 Professional curiosity was demonstrated by the G.P. about Mr. B's increasing contact with K after he returned to London with his mother. The GP contacted Lambeth CSC to check on this arrangement, which was good practice.

5.14.3 Lambeth CSC could have shown more professional curiosity about the contact arrangements for K with his father once Ms. A returned to London.

5.14.4 The Police should have been more curious when they did a welfare check in November 2014, following anonymous allegations that K was being neglected. They saw K, who was in the care of Mr. B at his home address and "reported no concerns".

5.14.5 In December 2014, HV3 spoke to Ms. A who said that she was trying to clarify whether K could spend a few days with Mr. B. *(In fact, K was already having staying contact with his father.)* HV3 was aware of previous allegations about K's welfare and had visited Ms. A and K at their address in London in October 2013. This was an opportunity to clarify the situation with the Social Worker or HV2 (working in the MASH team) to assure herself that K would not be at risk staying with his father.

5.14.6 In January 2015, Mr. B told the G.P. that he was enjoying looking after K and taking him to nursery. He commented that Ms. A "had not told her Social Worker that K was staying overnight with him". It would have been good practice if the G.P. had followed this up with a telephone call to the Social Worker to clarify the situation.

Learning Point 12: Practitioners and their supervisors need to maintain professional curiosity, not taking things at face value, but taking an inquisitive stance, seeking corroborating evidence and challenging where appropriate.

5.15 Police: Welfare Checks

5.15.1 Police officers who undertake "welfare checks" are not specifically trained in children's safeguarding as their colleagues in the Child Abuse Investigation Teams (CAIT) are. They did not obtain a search warrant to look for drugs, as there was insufficient evidence under the Misuse of Drugs Act. These two issues limited what could be achieved from the visit to Mr. B following the anonymous allegation in November 2014. Welfare checks by the Police have been custom and practice for many years and a wide range of professionals have historically looked to the Police to respond on their behalf. Various SCRs have discussed the merit of these, as there is a danger that they are perceived by professionals as replacing s47 single agency or joint agency visits. For example, in the Baby F SCR in Harrow in 2015, the author identified that there was a *"repeated misunderstanding within CSC of the function of Police welfare checks as opposed to the CSC responsibility to investigate allegations and concerns. Within LCSC there was an assumption that when Police visited a home and concluded the children were safe and well, there was no need for further investigation of referrals. This demonstrated a basic misunderstanding of the Police role to establish if the children were at immediate risk of harm at that point in time, as opposed to the role of CSC to undertake the wider and in-depth assessment of the allegations"*[15].

5.15.2 There should have been a strategy discussion between Police and Children's Social Care to consider if further action was needed, given the recent family history. Lambeth CSC has said that a Social Work home visit should have been arranged but CSC was unaware of the Police visit, even though a notification had been sent.

Learning Point 13: Previous SCRs have raised questions about the over-reliance on Police welfare checks without further multi-agency enquiries when there are questions about a child's safety.
Is there confusion within Lambeth CSC and the police about the status of police welfare checks and the need for a Social Worker to undertake an assessment of the situation? These assessments must include speaking to the child, alone where possible, and liaison with other services to ensure that the welfare of the child is paramount.

5.16 'Anonymous' Referrals and referrals from family members

[15] Baby F SCR, Edi Carmi author, Harrow LSCB 2015

5.16.1 Anonymous referrals are noted in a number of SCRs. They can easily be downplayed, but research has shown that family members or community members who have a legitimate concern often make them.

5.16.2 Anonymous referrals feature in the Kent LSCB Ashley SCR in 2012[16] which involved the death of a 4-month-old baby, where there was domestic abuse between the adults involved. There had been three anonymous referrals expressing concern about the welfare of a sibling, and the review questioned the response to these referrals that were deemed to have not met the threshold for assessment. An audit on anonymous referrals conducted by Kent CSC found that *"the second largest source of referrals was from relations or neighbours (deemed to be anonymous as the caller did not want to give their name) comprised 21% of the sample audited and they were a high proportion of the referrals that did not progress to initial assessment. There was some evidence that some Kent Social Workers, if they deemed the referral to be malicious, did not undertake a full assessment. To some degree this was because they were aware of the distress that such an investigation could cause families, if the motivation of the referrer was suspect. There is however, significant evidence from serious case reviews nationally to show that relatives and friends are often aware of issues of concern sooner than professionals and any such referrals should always be investigated fully".*

5.16.3 In this case of K, with hindsight, the two 'anonymous' referrals to the Police and one to Lambeth CSC. Both referrals were acted on. The first resulted in visits from the HV and Police, which determined that there were no immediate concerns, but there was "no further action" and no fuller assessments took place. However, there was no further exploration with the referrer (who had become known) about their evidence for the concerns. The second anonymous referral (to the Police in November 2014) coincided with the return of Ms. A and K from Nottinghamshire and K having increased and possibly staying contact with his father. If the anonymous referral had resulted in a strategy discussion between the Police and Lambeth CSC a more thorough re-assessment could have been completed.

Learning Point 14: Anonymous referrals should be considered as legitimate expressions of concern and multi-disciplinary assessments should consider whether there is substance in the concerns raised. Consideration should be given to going back to the referrer, if they become known, to seek more evidence to support the allegations or ascertain if they are malicious or misguided, if required.

5.17 The Voice of the Child: adult/child focus

5.17.1 There are instances where K was not the main focus and interventions were adult focused. For example, the Police response on 27th August 2014.

[16] Kent LSCB Ashley SCR published 2012.

On such occasions K's voice was not sought. There was no focus by Lambeth CSC or the Police about the impact of the parental circumstances on him, physically or emotionally.

Learning Point 15: The missing voice of the child regularly occurs as an issue in SCRs.
It is not clear what direct work was done with K, given his age and understanding, as part of the assessments into his welfare. How are the views of younger children considered as part of domestic violence assessments? Is this an area which Lambeth SCB should review?

5.18 Management Oversight and Supervision

5.18.1 *"This national analysis[17]s again highlights the importance of challenging and reflective supervision, which pays attention to the impact of the case and the work on the practitioner and goes beyond procedures and processes. Supervision should foster professional development, encourage practitioners to keep their knowledge up to date and prioritise the time needed to get to know children and families. Strong support and constructive challenge of front line practitioners will not be possible if the agency context is one of overwhelming workloads with a limited capacity, or lack of permission to invest in relationship building or critical reflection".*

5.18.2 There was a lack of appropriate supervision for staff in Probation, particularly PO7, who recently qualified as a Probation Officer. PO3 reduced Mr. C's reporting frequency from weekly to monthly on 24th March 2015, when he was on licence. This was picked up in supervision on 20th April 2015, which was good practice, but PO3 had left the service by this time and the case was re-allocated to PO2 and PO4. The supervising officer was concerned that Mr. C was high risk but was reporting monthly and PO2 was asked to re-assess this. There is no evidence that this was done, and Mr. C remained on monthly reporting until his arrest for ABH and witness intimidation and breach of bail conditions.

5.18.3 Mr. C used disguised compliance as a tactic with his Probation Officers. He tested the boundaries of every rule and condition placed on him. Probation became aware of this and should have been firmer with him and enforced the licence, including ultimate recall to prison. More robust and frequent supervision and regular management oversight would have provided a more robust and challenging approach to him by the frontline staff. The report by the National Probation Service for this review concludes that in relation to multi-agency working, *"the sharing of information and joined up risk management was lacking in this case. MAPPA and MARAC would have been the obvious avenue to have undertaken this*."

5.18.4 There were several instances in Lambeth CSC of management oversight

[17] Marion Brandon. 2011

of the case, which is expected practice, but overall, there remains a question mark over the frequency and quality of supervision, as the various Social Workers involved never assessed the possible risks to K, and their focus was mainly on the adults, with the priority of immigration issues, after Ms. A had left Mr. B.

5.18.5 Learning Point summary

Learning Point 1: When offenders are known to have been domestically violent to adults and or children full assessments must be made of their accommodation arrangements following their release from prison to ensure that these do not pose a risk to previous or new partners or children.

The possible risk to Mr. C's sister's children was not fully assessed and proper arrangements made to ensure that Mr. C did not have unsupervised access to the children. Given that Mr. C was deemed to be a high risk, would Approved Premises (AP) have been a better option despite previous difficulties with this?

Learning Point 2: When an offender is released on licence from prison and breaches his licence conditions, consideration should be given to enforcement action, including recall to custody. This decision should be agreed at a senior level.

The National Probation Service were aware that Mr. C was having a relationship with Ms. A and he had given his probation officer her name and K's name. It was thought that he was living with them. This was in breach of his licence conditions. An ultimatum should have been given to Mr. C to provide full details of Ms. A and K and to re-iterate that it was not an approved address and so he should have been directed not to stay there. If this ultimatum was not complied with it would have been sufficient to recall him to prison.

Learning Point 3: An assessment of any future risk of known violent offenders to possible identifiable victims should be a multi-agency process. In summary, risk assessment and the management of an offender's risk in relation to adult female victims of domestic abuse and children should be robust, and good links forged with relevant partner agencies, to ensure that safeguarding women or children who may be vulnerable is seen to be a high priority. MAPPA is the multi-agency system to manage this process for high risk offenders. This also applies to non-custodial sentences.

Learning Point 4: The Prison Rules on letters and visits do not contain a duty to establish the identity of people, or consider the welfare and protection of people, who have contact with or visit prisoners who are known to be domestically violent. This raises a challenge about how prospective partners can be identified and risk assessments could be done to protect those who are not aware of an offender's violent history.

Learning Point 5: The Brandon 2011 research raises the question of whether multi-agency strategy discussions are taking place appropriately

nationally.

This SCR raises the question about Lambeth over this period and whether there was clarity amongst professionals about the purpose and effectiveness of multi-agency strategy discussions and information sharing, including key agencies that know the child and family. It may be helpful to undertake an audit to test this out.

Learning Point 6: The absence of specific bail conditions pertaining to contact with children can engender a false re-assurance that such contact does not pose a risk. An assessment of risk, led by CSC, should be completed wherever possible, and take into account the wishes and feelings of the individual child.

Learning Point 7: When a child has been safeguarded by removal from a parent by the 'protective' parent it should not be assumed that the child is safe to have contact with or care by that parent until a proper assessment has been completed, even if there was no previous evidence of direct harm to the child. The assessment should include risk of emotional abuse, including witnessing parental violent behaviour, as well as physical abuse.

Learning Point 8: Women and children who have no recourse to public funds and who are at risk of domestic violence face more barriers in funding refuge provision. However, CSC have the power to make such payments from the section 17 Child in Need budget and should consider doing so.

Women who do not have residence rights may be at greater risk of ongoing domestic abuse for fear of revealing their immigration status. Financial circumstances or childcare worries may push them to continue or renew abusive relationships.

Learning Point 9: When a person has been the subject of domestic violence consideration should be given to how they can be supported to understand the dynamics of abusive and controlling relationships to better equip them in the future. See also Section 5.12 on the **Domestic Violence Disclosure Scheme**

Learning Point 10: Research and previous SCRs have shown the importance of multi-agency information sharing when there are concerns about the welfare and safety of children. Clearly there are issues of consent where a case does not appear to meet a child protection threshold. However, without appropriate sharing of information through multi-agency strategy discussions, multi-agency child in need discussions, MARAC or MAPPA there is a risk that single agencies will not have sufficient information to make a decision about thresholds for intervention.

Learning Point 11: It is important that consideration is given to when to share confidential information about known offenders of domestic violence with partners or potential victims, including those entering into new relationships, without consent.

There is a question about how knowledgeable frontline practitioners are about the Domestic Violence Disclosure Scheme, and its possible benefits and drawbacks (such as false-reassurance or increased risk), and when to advise women about its availability.

When it is assessed that an offender poses a risk of violence to (future) partners, steps must be taken to ensure that whether and how to disclose are considered through the MAPPA or DVDS arrangements.

Learning Point 12: Practitioners and their supervisors need to maintain professional curiosity, not taking things at face value, but taking an inquisitive stance, seeking corroborating evidence and challenging where appropriate.

Learning Point 13: Previous SCRs have raised questions about the over-reliance on Police welfare checks without further multi-agency enquiries when there are questions about a child's safety.
Is there confusion within Lambeth CSC and the police about the status of police welfare checks and the need for a Social Worker to undertake an assessment of the situation? These assessments must include speaking to the child, alone where possible, and liaison with other services to ensure that the welfare of the child is paramount.

Learning Point 14: Anonymous referrals should be considered as legitimate expressions of concern and multi-disciplinary assessments should consider whether there is substance in the concerns raised. Consideration should be given to going back to the referrer, if they become known, to seek more evidence to support the allegations or ascertain if they are malicious or misguided, if required.

Learning Point 15: The missing voice of the child regularly occurs as an issue in SCRs.
It is not clear what direct work was done with K, given his age and understanding, as part of the assessments into his welfare. How are the views of younger children considered as part of domestic violence assessments? Is this an area which Lambeth SCB should review?

6 Recommendations.

6.1 Recommendation 1: The National Probation Service, London should audit a sample of licence cases to ascertain whether the guidance is followed or whether non-compliance with guidance is a wider systemic issue or was unique to this case. The audit should include compliance with the need to undertake full assessments of the suitability of the accommodation and any risk to adults or children living in the household when the offenders' circumstances change. This audit should involve liaison with appropriate local agencies.

It is understood that the Community Rehabilitation Company also supervises offenders on licence. They should also be asked to respond to this recommendation.

Outcome: This will give assurance to the National Probation Service and its Partners that Offenders who may pose a risk of violence and who do not adhere to their licence conditions are properly assessed and managed and will provide assurance to the Probation Service and its Partners that Offenders who pose a risk of violence and who do not adhere to their licence conditions are properly imposed and managed.

6.2 Recommendation 2: Her Majesty's Prison & Probation Service should be asked review the Prison Rules relating to visits with and letters to and from domestic violence offenders and offenders convicted of offences against children to consider how potential victims of grooming or coercive control can be protected, including potential new victims; and to assess whether the guidance on exchange of information about such contacts with relevant safeguarding agencies is sufficient. There should be liaison with the local (Brixton) prison with regard to these findings.

Outcome: This action will enable consideration to be given to any risk, including risk of grooming or coercive control conducted through contacts with known domestically violent prisoners.

Her Majesty's Prison & Probation Service should inform the Lambeth Safeguarding Children Board of the response and actions taken as a result of this review and the recommendations made.

6.3 Recommendation 3: The Lambeth Safeguarding Children Board should seek reassurance from its partners that relevant frontline staff and their managers involved in the assessment and management of cases where there is domestic abuse are aware of the arrangements for sharing information about offenders through the Domestic Violence Disclosure Scheme and the MAPPA arrangements (as set out in the London Child Protection procedures Section B3/28).

Outcome: Information about a history of violence will be properly considered and shared by the partner agencies, to improve the quality of assessments and interventions.

6.4 Recommendation 4: The Lambeth Safeguarding Children Board should review how families which are supported by the NRTPF team that are experiencing domestic abuse are helped and supported. Lambeth Children's Services should assure the Lambeth Safeguarding Children Board that relevant staff are aware that when families that are victims of domestic abuse have no recourse to public funds and need the support of a Refuge that consideration will be given to accessing funds to secure such a placement.

Outcome: These actions will provide assurance that a mother and child/ren can be considered for a place in a Refuge where they have no access to benefits, and where that is considered the appropriate means of support.

6.5 Recommendation 5 The Lambeth Safeguarding Children Board should seek assurance from its partner agencies that when assessing incidents of alleged domestic abuse, the risks to children, including emotional abuse, are fully assessed as set out in section B3/28 of the London Child Protection Procedures. 'Safeguarding children affected by domestic abuse and violence'. Advice should be provided to staff about the importance of thinking about the welfare of children when considering the application of bail conditions relating to adults in cases of domestic abuse. Advice should also be provided to staff about considering the emotional impact of witnessing domestic abuse and good practice intervention. The Lambeth LSCB should undertake a multi-agency audit of domestic abuse cases, including of families supported by the NRTPF team.

Outcome: This action will provide assurance that children in domestically abusive situations are fully assessed and their needs are taken into account, as well as the safety of adults who are the victims of domestic abuse.

Appendix 1: Terms of Reference for the SCR

1. The Purpose of the Review

1.1 Working Together (2015) states a serious case review should:

- Provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- Be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- Be suitable for publication without needing to be amended or redacted.

In response the LSCB should:

"Oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions"[21].

1.2 Lambeth and Bromley Safeguarding Children Boards have adopted the principles of the SCIE NSPCC SCR Quality Markers[22] that confirm the purpose of the SCR should be organisational learning and improvement and, where relevant, the prevention of the reoccurrence of similar incidents. The framework accepts that errors are inevitable and, where they are identified, they become the starting point of an investigation. Individual and organisational accountability is manifest through being open and transparent about any problems identified in the way the case was handled and demonstrating a commitment to seek to address the causes.

1.3 LSCBs and their partner organisations should translate the findings from Serious Case Reviews into programmes of action that will lead to sustainable improvements and the prevention of death, serious injury or harm to children.
SCRs and other case reviews should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children (using a Systems Analysis);
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;

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21 Working Together 2015

[22] SCIE NSPCC Serious Case Review Quality Markers 2016

- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

1.4 Serious Case Reviews should:

- Be proportionate;
- Involve the professionals fully and invite them to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Involve families, including children, where possible. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process;

2. Methodology

2.1 The methodology used for this Serious Case Review is based on the Welsh Child Practice Review Guidance[23]. It is a nationally recognised model that features the following components:

- The establishment of a Review Panel;
- A practitioners Learning Event;
- A Child Practice Review Report.

2.2 It is a model that takes a multi-agency collaborative approach, with a focus on systemic strengths and weaknesses. The goal is to move beyond the specifics of the case (what happened and why) to identify the deeper, underlying issues that are influencing practice more widely. It is these generic patterns that count as lessons from a case and changing them should contribute to improving practice more widely.

2.3 Data came from reviewing a range of single and multi-agency documents, meetings with the Review Team, with the practitioners involved in the case, and with family members.

3. Process

3.1 This SCR involved Bromley (where Child K and his mother were living at the time of his death, but unknown by agencies there) and Lambeth, where the case had been open firstly to the Assessment Team and later transferred to the No Recourse to Public Funds Team (NRTPFT) in Children's Social Care, until 6 June 2016. It was agreed that Lambeth would lead the SCR, and that the two boroughs would fund the SCR jointly.

3.2 The review is made up of a number of interconnected activities described below, all of which contribute to the rigor of the process and to the learning drawn from the case being reviewed;

- A Review Panel manages the review and independent reviewers are appointed to work with the Review Panel. The review engages directly with children and family members, as they wish and is appropriate, so their perspectives are included, and it involves practitioners and their managers who have been working with the child and family. A planned and facilitated practitioner- focused Learning Event is a key element of the review, conducted by two reviewers independent of the case management, to examine current case practice within a limited timeline and using a systems approach.

- A draft anonymised review report and an outline action plan are produced and presented to the LSCB. Members of the LSCB consider, challenge and contribute to the conclusions of the review, and identify the strategic implications for improving practice and systems to be included in the action plan.

- The final report is approved by the LSCB and submitted to the National Panel and then published by the LSCB. The process will be completed as soon as possible but no more than six months from the date of a referral from the LSCB to the Review Sub-Group.

- The action plan is finalised within four weeks of the final report and approved by the LSCB. The implementation of the action plan is regularly reviewed, and progress reported to the LSCB.

- Action plans should lead to improvements in child protection practice and the LSCB needs to ensure they are carefully audited to see whether actions are being carried out and with what effect, and whether they are making a difference.

The Review Panel

Malcolm Ward, Independent Chair/Lead Reviewer
Ghislaine Miller, Independent Author/Lead Reviewer

Assistant Chief Officer, National Probation Service,
Acting Designated Doctor, Lambeth CCG,
Designated Nurse. Lambeth CCG
Senior Schools & Educational Improvement Adviser, Education, Learning & Skills Lambeth.
Quality Assurance Service Manager, Lambeth CSC
Head of Safeguarding Children, Guy's and St Thomas's Hospital Trust
Violence Against Women & Girls Project Officer, Lambeth
Metropolitan Police (Serious Case Review Group)
Business Manager, Bromley SCB
Business Manager, Lambeth SCB
Administration Officer, Lambeth SCB

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