Lambeth Safeguarding Children Partnership

Child Angela

Safeguarding Practice Review Report

November 2021

Independent Reviewer: Siobhan Burns

Contents

1. The Critical Incident That Triggered The Review

1.1 Angela was taken to hospital one night in June 2020. She was taken there by her mother and her mother's partner. The mother's partner was restricted from entering the ward due to Covid restrictions. At the hospital, Angela's mother told the doctor that Angela had been sexually assaulted. Angela went on to disclose multiple counts of rape and sexual assault, perpetrated by the mother's partner. He was arrested and charged for sexual harm, possession of indecent images and possession of cocaine. He has since been sentenced to 23 years imprisonment. Angela was safe at the point this report was written.

2. The Review Process

2.1 The background to the review, terms of reference and a description of how the review was carried out are shown in the Appendices to this report.

3. Family Composition

Family member	Relationship
Angela	Child concerned
Jane	Mother
Joe	Mother's partner
Alan	Angela's father

4. Background History

4.1 Angela was born in a European country. She was brought to the UK by her mother in 2013. The mother presented as homeless to Lambeth Housing service but was not provided with accommodation. She returned Angela to her birth country and placed her in the care of her maternal grandfather and aunt. Angela was reunited with her mother in 2015 when she returned to the UK. English is not the first language of any of the family members. Joe was known to have a better command of English than the mother.

4.2 Angela has no contact with her birth father, who does not reside in the UK. He has never taken an active role in Angela's life.

4.3 Joe lived with his mother until he commenced his relationship with Angela's mother, in March 2019. There is no record of him being in employment during the scope of this review. He was known to have perpetrated sexual abuse in his country of origin, although this only became apparent after the trigger incident.

4.4 The family had limited support and were isolated. Joe's mother and father lived locally, however, were not protective of Angela or the mother. The mother's family lived abroad.

4.5 The mother worked as a cleaner. When the mother went to work, Angela was left in the care of Joe.

5. Narrative Chronology

5.1 The first incident of note happened in November 2017 when Angela was a small child. Angela and her mother were living with the mother's friend in a nearby London Borough. Angela was found by police officers at 1 am in the morning. She was with a 14-year-old girl and a 15-year-old boy. The 14-year- old girl was described as having "snuck out" to meet her boyfriend and Angela was reported to have followed her. This was viewed as a "one-off" incident, children's services were informed, and no further action was taken.

5.2 In June 2018, whilst still living in the neighbouring borough, Angela's attendance at school dropped and she ceased attending school in June 2018. She did not attend school again until the end of November 2019. She missed 17 months of schooling, and this remained undetected.

5.3 In late November 2018, the first of 14 contacts were made from Angela's mother to the police. The first two contacts with the police, took place in November 2018 and December 2018. These calls were made from a mobile phone. On both occasions, it was not possible to establish the address of the domestic abuse incidents. The mother refused to name Joe or give an address. When the DASH[1] risk assessment was completed with the mother, over the telephone, she described having been assaulted by her boyfriend and that she was fearful of him.

5.4 December 2018 is the first note by children's services of Joe and the mother's relationship. They moved in together in January 2019 and began living in Lambeth.

5.5 In February 2019, Angela was taken to hospital by Joe and her mother. He waited outside while treatment was being sought for Angela. It was reported that she was found by Joe at home. Angela gave an account that she had slipped and fallen on her arm. She was initially seen by a junior doctor who identified that Angela had suffered a spiral fracture of the humerus. Angela was admitted overnight and then discharged, information about this hospital presentation was not shared with school nursing, a GP, police or children's services. Angela was not registered with a GP or attending a school at the time. Angela was not brought for her follow up orthopedic outpatient appointment. This was not followed up.

5.5 A further domestic abuse incident happened in March 2019. The mother made an abandoned call to the police, stating that she was being abused by someone she used to live with. A child could be heard crying in the background. Despite numerous attempts to reach the mother, including texts in her primary language and calls, the mother was not reached. No other agencies were made aware of this incident.

5.6 In April 2019, the landlord of the family's flat contacted the police due to concerns that Angela had been left at home alone with a large dog. This was at approximately 9 pm. When she arrived home, the mother told the attending officers that she had only left Angela for 10 minutes. Angela was not spoken to, although recorded to be 'safe and well'. The home conditions were noted as being poor and the officers were concerned that the flat would not pass basic safety standards. Children's services were informed of this incident. The social

[1] The Safelives DASH risk checklist is a standard tool used by the MET police. It is a tool to guide the assessment of risk to victims and also to inform decision making about referrals to domestic abuse services and MARAC.

worker attempted to speak to the mother about this incident, by telephoning her. When no contact was achieved, the case was closed. It would appear no information was sought from other agencies. Angela was not registered with a GP or attending school. The home was not seen, and Angela was not spoken to by a social worker.

5.7 In early June 2019 officers attended two domestic abuse incidents. One around midnight and the other at 05.45. Angela was known to have witnessed the early morning incident. She was not seen or spoken to on either occasion. A referral for a MARAC[2] meeting was considered, but this incident was not thought to have met the threshold for this. There was also consideration of a Domestic Violence Protection Order[3]. This was discounted as it was believed to be the second domestic abuse incident. It was in fact the fourth that Angela had witnessed. Angela was not spoken to at the incident at midnight but was spoken to in the morning following the second incident, after which she attended the police station with her mother.

5.8 A referral was made to children' services. When spoken to, the mother told the social worker that Angela was asleep during the argument. This appears to be unlikely given the size of the flat and Angela slept on a mattress in the kitchen. Angela was not spoken to as part of this assessment and the assessed risk was lowered 10 days later, as the mother had stated that she had ended the relationship with Joe.

5.9 The sixth call to the police happened in early July 2019. The mother called the police stating that she and Joe had argued, she wanted him to leave and she wanted to gain an injunction against him. She was spoken to on the telephone. Subsequent attempts by the police to complete a DASH risk assessment were unsuccessful as the mother did not answer her telephone. Joe and the mother shared a mobile phone.

5.10 There was a delay of a month before Angela was allocated her first social worker. Four attempts were made by the social worker to carry out a home visit. Angela was seen at home two weeks after she was allocated a social worker. When discussing the domestic abuse, the couple stated that they had resolved their difficulties. Angela's case was closed on the 14th of August 2019.

5.11 In August 2019 there was a further domestic abuse incident. The mother and Joe had been arguing and Joe had been throwing things around the flat. Angela was present. Angela was spoken to, but this was not done in a way to try to elicit the lived experience of the child. When children's services were notified of this, there appears to be no action taken.

5.12 In early November 2019 Angela was taken to hospital at approximately 8 pm in the evening. The mother reported that she had swollen upper gums and "lumps" on her vagina. The mother told the paediatric consultant that there was no history of cold sores or herpes. Clinical investigations found that she was positive for Herpes type 1. After consultation with the virologist, it was concluded that it was likely to be 'self-contamination' from her mouth

[2] MARAC – A Marac is a regular local meeting to discuss how to help victims at high risk of murder or serious harm. A domestic abuse specialist (Idva), police, children's social services, health and other relevant agencies all sit around the same table. They talk about the victim, the family and perpetrator, and share information.

[3] A DVPO can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency. The DVPO contain a condition prohibiting the perpetrator from molesting the victim.

to her vagina. A referral was made to children's services. The referral stated that there was no evidence to suggest that Angela's medical presentation was indicative of sexual abuse. Angela was spoken to by a female doctor. She did not disclose any abuse.

5.13 A child and family assessment was commenced by children's services. The children's services team manager, school nurse and the school designated safeguarding lead, all felt concerned that Angela had contracted Herpes as a result of sexual abuse. In her notes, the team manager also cited concerns about neglect, where Angela was not in school or registered with a GP.

5.14 The 8th domestic abuse incident took place in mid-November 2019. The mother called the police as her relationship with Joe was reported to have ended. She had asked him to leave but he had refused. On arrival of the police, Joe had left the scene. She described him as being controlling. The home address was described as "cramped and messy". Angela was seen but not spoken to.

5.15 A social worker visited the family home, 6 working days after the domestic abuse incident. Joe was home, the mother was out. Angela was observed to be lying in her bed in the kitchen area. Angela was spoken to and described what she will have for breakfast and that she was happy about starting school.

5.16 Angela started attending school again in late November 2019. On the same day at 08.47 hours, the 9th domestic abuse incident took place. The mother called the police as she had told Joe that their relationship had ended, he had left, and she feared he might return. The mother reported that she and Joe had not argued, and the mother refused to complete the DASH risk assessment. The social worker telephoned the mother 8 working days after this incident. The outcome or agreed next steps as a result of this discussion were not noted. The school were not aware of the domestic abuse incident, despite having signed up to Operation Encompass[4].

5.17 In December 2019 Angela had a health assessment with a school nurse. Speech and language needs were identified as well as the need for Angela to be taken to the optician and a referral to audiology. When spoken to about Angela's lisp her mother stated that this was because she was "lazy" with her words, "because she is a bit spoilt". Angela's mother was prompted to get Angela registered with a GP and the impact of domestic abuse was discussed. There were repeated prompts by the school nurse and social worker to get Angela registered with a GP, including physically taking the mother to the GP surgery. Angela remained unregistered with the GP until she came into the care of the local authority, in June 2020.

5.18 The school nurse raised concerns with Angela's mother about her "lack of inhibitions" and advised how Angela could be kept safe. Angela was presenting as overly friendly, for example, giving hugs to adults that she had just met. During the assessment Angela told the nurse that she had a sore, due to not washing her hands and then wiping her vagina.

5.19 Later that month, Angela was allocated a new social worker.

[4] Operation Encompass (or Op Encompass) is a means to share information about domestic abuse incidents with the school on the following working day after a domestic abuse incident has occurred.

5.20 On Christmas day in 2019 there was the 10th domestic abuse incident (however, this was the 7th incident known to the police and linked to Angela, as previously calls could not be traced to the mother's phone). On Christmas day, Angela, her mother and Joe had gone to Joe's parents' home. Officers attending were met at the door by Angela, who told them that her mother had been beaten up. She had been punched multiple times in the face. Joe was arrested for assault, damaging the mother's phone and possession of class A drugs. When the Safelives DASH Risk Checklist was completed, the mother described controlling behaviour and that he had threatened to kill her on one occasion, but that this was "off the cuff". Officers considered offering a panic alarm in her home. The mother told officers that she had been issued with an eviction notice so the panic alarm was not considered to be appropriate at that address. No other safety measures were considered at the time. Referrals were made to domestic abuse services and the mother stated that she did not want to press charges. The risk of eviction thereafter dominated the focus of the multi-agency intervention.

5.21 The social worker made a referral to the GAIA Centre[5] in early January 2020. The mother was contacted on the 3rd, 7th and 13th of January 2020. Contact attempts were made on the two telephone numbers provided. A further attempt was made by the GAIA centre to contact the mother, this was unsuccessful. An interpreter was used for each of these contacts.

5.22 On the 23rd January 2020 the police attended the family home. The mother had texted her friend asking her to call the police as Joe was refusing to leave the home. On arrival at the home, the police found the mother alone and she reported that nothing had happened.

5.23 In February 2020 Angela had a second health assessment. She had not been taken to the optician and spoke of not being able to see the 'board' in classes. This was shared with the mother who was prompted to take Angela to the opticians. She was also prompted to register Angela with a GP.

5.24 At a child in need meeting in March 2020, Angela was described as being two years behind her peers in school. She was often dropped off and picked up late for school. Angela continued not to be registered with a GP and had not been taken for an eye test. Angela ceased attending school on the 23rd of March 2020 due to school closures arising from the Covid 19 pandemic.

5.25 On 28th March 2020 the 12th domestic abuse incident occurred. The mother described that Joe had pushed her in the chest as they argued. She didn't want him to be arrested and declined to give his name or address. She declined referrals to services for victims of domestic abuse. When the DASH risk assessment was carried out she described that he was controlling, very jealous and had called her a 'whore'. A referral for a MARAC meeting and Domestic Violence Protection Notice was considered but not thought to be 'applicable'. Angela was present during this incident.

[5] A single point of contact for Lambeth residents experiencing any form of gender-based violence, including domestic abuse. They provide a range of support such as risk assessment, safety planning, independent advocacy, ways to improve home safety, and peer support.

5.26 Angela was allocated a different social worker in April 2020. This allocated worker was a student social worker. In the same month, the property was deemed to be unfit for human habitation by the council and the mother was given the highest housing priority level, to enable her to bid for a property. Whilst she was supported by email to undertake a bid, this did not enable her to commence bidding on properties.

5.27 On the 1st May 2020 the 13th domestic abuse incident happened. Joe was reported to have thrown items on the floor, during an argument. The Safelives DASH Risk Checklist and referral to MARAC were not completed on the same day. They managed to gain contact with the mother on the 25th of June, by which time Angela had fully disclosed the abuse she had suffered and Joe had been arrested.

5.28 Angela had another change of social worker on the 12th of May 2020.

5.29 On the 27th of May 2020 the 14th domestic abuse incident took place. Angela went to a neighbour at 23.29 hours for help due to her mother and Joe arguing. She had witnessed Joe punch her mother. The neighbour described how Angela was "really scared" and could hear Joe and her mother fighting. Upon police arrival, only the mother and Angela were present. The mother made no allegations of assault. She described that Joe was controlling and jealous, and had threatened to kill her, she considered this to be 'an empty threat'. After the police left, Joe returned to the flat and the argument continued. The police reattended, making this the 15th call out. Joe was advised to stay away from the flat until he had sobered up. Angela was present on both occasions, but not spoken to.

5.30 Angela recommenced attending school on the 1st June 2020, she attended one day a week and this gradually increased leading up to the date Angela disclosed.

5.31 On the 5th of June 2020, the mother returned home and found Angela with no clothing on her lower body. Angela told her mother that she had been assaulted by Joe. She later retracted this, and Angela's mother did not call the police, the social worker or seek medical attention for Angela.

5.32 On the 9th June 2020 Angela was taken to hospital at 22.30 by her mother and Joe. The mother shared her concern that Angela had been abused by her partner. Angela then made a full disclosure of the abuse she had suffered, perpetrated by Joe. Angela disclosed how she had been harmed by Joe and shared that she had not been able to speak out earlier as Joe had threatened to kill her mother.

6. The Views Of The Family

6.1 The author met with the mother, her support worker and an interpreter. This meeting took place almost a year after Angela had felt safe enough to disclose her abuse. The mother described having asked for help for housing in the past, due to being homeless and having a small child. She says that she was turned away and as a result of this and returned Angela to her country of birth for 3 years.

6.2 She described the harm that she experienced, perpetrated by Joe. She described being

'hijacked' in her home for years. She stated that this abuse prevented her from speaking out. Joe had reportedly threatened to harm her family in Spain if she spoke to anyone about the domestic abuse.

6.3 When she did reach out for help she described her disappointment that professionals could not see the 'fear in her eyes' at the hospital, when she didn't disclose about the abuse she was suffering. She did in fact contact the police directly or indirectly on 15 occasions.

6.4 Angela's mother was aware that Joe had broken Angela's arm when they took her to the hospital in March 2019. She was aware this injury had been caused by Joe, who told her that Angela had been naughty and tried pulling away from him when he was trying to hit Angela with a belt.

6.5 She had hoped that someone would 'notice' her fear and guess what was going on in the home. She felt too fearful to speak out and tell them that Joe had caused the broken arm.

6.6 She also felt it was "insulting" that the cause of Angela's herpes was meant to be due to hand hygiene and that she had relied on professionals to tell her what was happening, i.e. raising the question of sexual abuse.

6.7 She spoke of the extremely poor living conditions in the flat and did not recall ever being offered a place in a refuge. She described having gone to the housing 'one-stop shop' three times, asking for help and provided them with video evidence of the conditions she was living in. No help was provided.

6.8 The mother recalled sending Angela to school with visible bruising. Angela would tell professionals that she had fallen or was playing. Angela's mother questioned why this was never raised.

6.9 She felt that there were red flags everywhere that could or should have been spotted by professionals to trigger help for her and Angela. She said there were small things that, if picked up earlier could have prevented the harm to Angela.

6.10 She particularly recalled the domestic incident in December 2019, where the police were called to Joe's parent's home. She said she didn't want any problems and therefore did not agree to press charges. Her view was this showed just 'how scared she was'.

6.11 On another occasion, Joe had broken her nose. She attended Kings College Hospital and told 'them' she had hit her head on a door. This account was accepted at face value and no action was taken.

6.12 The mother described how difficult it had been to communicate. The use of interpreters had been inconsistent, both in their quality and availability. She recalled some documents being translated using google translate and this being done over the telephone. She described that this added to her continuing sense of 'impotence' in her situation.

7. Analysis

7.1 ***What can we learn from the incidents of professional differences? Were there barriers to raising professional differences and how might professionals be supported to navigate these differences?***

7.2 There were no professional differences with regards to the spiral fracture. This was erroneously dealt with as an accidental injury and notifications were not made to other services.

7.3 There was no evidence that there were any professional differences of assessment or opinion regarding the levels and severity of the domestic abuse. The impact of the domestic abuse was discussed with the mother by the school nurse and the social worker. The domestic abuse was also referred to in the child in need meetings[6]. There was no evidence of professional difference of opinion regarding the levels and severity of the domestic abuse. It seems that there was a group acceptance with regards the domestic abuse which hindered action, rather than there being a difference of opinion.

7.4 There was a considerable difference of opinion in the professional group working with Angela regarding the causation of Angela's viral infection. The social work manager, school nurse and designated school safeguarding lead all had concerns that Angela had been sexually abused and struggled with the diagnosis that the Herpes infection had resulted from cross-contamination from Angela's mouth to her vagina. They articulated this to each other, but this was never openly discussed in the child in need meetings or raised formally. Practitioners that took part in the review reflected that there is an unspoken "hierarchy" between acute and community health providers and hierarchy between doctors and nurses. Acute settings and hospital doctors were perceived to have superior knowledge than that of the community providers and nurses. Similarly, the children social care practitioners reflected that as a doctor had given a diagnosis, they did not feel equipped to challenge the knowledge of a doctor.

7.5 A further barrier for professionals was the lack of disclosure, until June 2020. Direct work was undertaken with Angela by the school nurse and a social worker. She was also seen by a female doctor when she attended the hospital with herpes. She presented as a happy, confident, talkative and lively girl and the fact that Angela showed such reliance, acted as a barrier to professionals taking decisive action. She was coached into her explanations of the cause of the spiral fracture and the Herpes infection. Following her disclosure on the 9th of June 2020, she shared that she had been threatened by Joe. He had told her if she told anyone about the abuse he would kill her mother. There is important learning in this review for professionals working with abused children. The protection of children should not rely solely on disclosures from children. As one author writes:

"The point, crudely stated, is this; children having witnessed the beating of their mothers', need no further reminder of the possible consequences of their resistance to the wishes of their fathers, or indeed, of older males in general.[7] "

[6] A child in need meeting is a multi-agency meeting whereby the progress against the child in need plans is considered and reviewed.

[7] Goddard and Hiller (1993) Exploring family violence: Links between child maltreatment and domestic violence | Child Family

7.6 The absence of a GP for Angela was a missed opportunity to safeguard Angela. Before Angela's diagnosis of Herpes, there had been a spiral fracture and multiple police attendances at the home address, due to domestic abuse incidents. There is a significant body of research that links domestic abuse and sexual abuse of children, which could have triggered action by a GP if the spiral fracture, the domestic abuse and the herpes diagnosis were considered together. The absence of a family GP was a significant feature for this child. At the time of writing this report the Partnership had already taken on the early learning from this case and had undertaken awareness raising and disseminated information on how to register children with GPs.

7.7 Practitioners in this review reflected that if the paediatric liaison was working well this could have offered an opportunity for some constructive challenge to the diagnosis. Similarly, the health visitor liaison service could have provided an opportunity to piece together all of the evidence of abuse that Angela was experiencing. As one health practitioner stated, the medical view of the source of the herpes infection was a "part of the puzzle, not the answer" – albeit a large part of the puzzle.

7.8 Community-based health and social care practitioners could have drawn on the specialist safeguarding expertise of the Designated Doctor for Safeguarding or colleagues at the Mary Sheridan Centre. This would have provided a platform to challenge the Herpes diagnosis and countered the sense of powerlessness and hierarchy, felt by the practitioners.

7.9 ***To what extent does the multi-agency partnership use single or multi-agency assessments to recognise, make decisions, and respond to sexual abuse, physical abuse, and domestic abuse?***

7.10 **Police:** The police used the Safelives DASH Risk Checklist as a single agency assessment to assess the risk of domestic abuse to Angela's mother. However, each assessment was carried out individually and did not fully take into account the previous call-outs made by the mother.

7.11 Referrals for a MARAC meeting and Domestic Violence Protection Order (DVPO) were considered, in June 2019 and March 2020. These considerations were not revisited in response to the incidents in July 2019, November 2019, December 2019 or January 2020. By the time the decision had been made that a referral to MARAC was acted upon, in June 2020, Joe had already been arrested for the harm he caused Angela.

7.12 The level of risk was not always appropriately assessed. In instances where victims refuse to answer questions contained in the DASH risk assessment, this should be graded as 'medium' risk. This was not applied consistently in the police response to the instances when the mother refused to answer questions. The perceived level of risk was also impacted by the view that the mother said she was willing to receive services from domestic abuse services and to seek an injunction. Officers accepted this at face value, without referring to records of previous call-outs. Had the history been reviewed, it would have become apparent that she had given these assurances before but not followed through with them. It is good practice that attending officers should seek information from the control centre, on what is

Community Australia (aifs.gov.au) accessed on 31.05.2021

already known about the victim, perpetrator and address, before attending any domestic incidents.

7.13 Not all of the domestic abuse incidents that were responded to by the police were reported to children's services. This meant that one of the domestic abuse incidents were not known by children's services. The aborted calls were never shared with children's services, which skewed their assessment of the risk.

7.14 Angela was not always spoken to by officers attending the scene. The police single agency response to the domestic abuse was not child focussed, did not capture the lived experience of Angela or recognise the impact on her of witnessing domestic abuse and being the victim of the controlling and violent environment.

7.15 Before the children's services assessment in July 2019 there was no multi-agency approach to the assessment of Angela's needs. The response to the referral when Angela was found in the street at 1 am was poor from children's services. No information was sought from other agencies and the case was closed after one failed attempt to contact the mother. Angela was not seen or spoken to.

7.16 **School nursing and the school single agency assessment:** The school nurse single agency assessment was of good quality. She saw Angela every term, she highlighted the impact of the domestic abuse on Angela, she was able to capture the lived experience of Angela, more so than any other agency. She regularly attended the child in need meetings and contributed her valuable observations and was also dogmatic in trying to get Angela's unmet health needs to be met.

7.17 It is clear that the school nurse was worried about Angela. However, she only formally discussed Angela in supervision four months after she had started to work with her. Unfortunately, the issue of sexual abuse and Angela's contraction of Herpes was not discussed. This would have been an opportunity to reflect on the general neglect that Angela was experiencing and also to explore the overly friendly nature that Angela was noted to show. This could have provided the mechanism to raise a challenge about the diagnosis being due to 'cross-contamination' and for this to have been escalated to the named nurse or doctor. Although the school nurse had been assured by her manager that safeguarding procedures had been followed. It has not been possible to establish why the school nurses' manager did not escalate Angela to the named nurse. However, this review has found that the school nurse was in the early stages of her career which would have likely impacted on her confidence to escalate her concerns above the safeguarding nurse.

7.18 The single agency assessment of the school was heavily reliant on the findings of the school nurse and the assurance given by the school nurse's manager that all safeguarding procedures had been followed. The school liaised closely with the social worker and attended the child in need meetings. The school also provided the family with food parcels when Angela was not in school. Speech and Language therapists were not going into schools during the school closures and therefore her speech and language needs remained unassessed until June 2021. It is not clear what actions were taken by the school to meet her speech and language needs and her delayed development. The amount of intervention offered by the school was impeded by Angela's late-term arrival as a new pupil with no handover from her previous school and also that Angela's mother did not send her to school

following the Covid school closures.

7.19 **Children's services:** A multi-agency children's services assessment commenced in July 2019, although there was a month delay from the referral to the allocation of a social worker. The assessment was commenced in response to the domestic abuse incident in June 2019, which was believed to have been the first domestic abuse incident to have happened. A managers review of the case in June 2019 lowered the assessed risk, due to assurances given by the mother that she had ended her relationship with Joe, which was untruthful. The acceptance of this assertion by the mother was unwise, given that the mother had not been spoken to directly or the child is seen. Research also shows that victims of domestic abuse on average, live with the risk for 2.3 years before getting help and victims often return to the abusive relationship multiple times before they feel able to leave[8].

7.20 Child and family assessments are designed to be multi-agency and should always be informed by information from other agencies. What is now clear is that by July 2019, Angela had witnessed 6 domestic abuse incidents, although it is not clear when the two aborted calls were successfully linked to the mother's mobile telephone number, on the police national computer.

7.21 The social worker tried on several occasions to gain access to Angela and saw her in early August 2019. When the social worker spoke to the mother and Joe, using language line[9], the adults both stated that they had resolved their difficulties. The social worker showed some awareness that this could not be taken at face value, but there is no evidence of further exploration of the domestic abuse. It is also noted that the family's flat was very small and so the social worker arranged for the family to come into the office so that Angela could be spoken to alone. There is no evidence to suggest this office appointment took place or that further efforts were made to speak to the mother alone about the domestic abuse.

7.22 Angela told the social worker that she was 'fine' and 'happy', the child and family assessment was completed and the case closed. The team manager at the time noted that if there were any further domestic abuse incidents, then child protection procedures should be initiated. This was never followed through.

7.23 This assessment lacked the insight that could have been gained from wider agency information, including:

- Information from neighbouring boroughs where Angela's poor school attendance was noted.
- Angela was not registered with a GP.
- Angela was not in school.

7.24 The assessment notes the small size of the family's home and it would have been observed that the child was sleeping on a mattress in the kitchen, next to the family dog. Angela was not seen alone as part of the assessment process and the direct work done, in the presence of Joe and her mother, did not elicit Angela's lived experience. Although, knowing how scared Angela was of Joe it is very unlikely that she would have been able to share any

[8] How long do people live with domestic abuse and when do they get help to stop it? Safelives. Accessed on 01.06.2021
Language line is an interpreter service delivered over the telephone.

of her trauma and harm, in the presence of Joe and her mother.

7.25 The following types of neglect were defined in 2007[9] by Jan Howarth. The table below shows what information was available at the time to establish that the threshold for services under a child in need plan was required as Angela was unlikely to "achieve or maintain or have the opportunity to achieve or maintain a reasonable standard of health or development without the provision of services"[10].

Type of neglect	Symptoms	Evidence in respect of the parenting of Angela
Medical neglect	This involves carers minimising or denying children's illness or health needs, and failing to seek appropriate medical attention or administer medication and treatments.	Angela was not registered with a GP and had not received any vaccinations in the UK. She was also not registered with a dentist. There was a delay in testing her eyesight and when it was tested her glasses were never provided.
Nutritional neglect	This typically involves a child being provided with inadequate calories for normal growth.	Not enough was known to rule out nutritional neglect as Angela's lived experience was not understood.
Emotional neglect	This involves a carer being unresponsive to a child's basic emotional needs, including failing to interact or provide affection, and failing to develop a child's self-esteem and sense of identity. Some authors distinguish it from emotional abuse by the intention of the parent.	The mother was a victim of domestic abuse but was also not able to meet Angela's emotional needs by protecting her from the domestic abuse. Angela is described as being asleep and not witnessing domestic abuse and/or being the victim of the controlling and violent environment, although the size of the family's flat would make this highly improbable.
Educational neglect	This involves a carer failing to provide a stimulating environment, show an interest in the child's education at school, support their learning, or respond to any special needs, as well as failing to complying with state requirements regarding school attendance	Angela was not in school for 17 months.
Physical neglect	This involves not providing appropriate clothing, food, cleanliness and living conditions. It can be difficult to assess due to the need to distinguish neglect from deprivation, and because of individual judgements about what constitutes standards of appropriate physical care.	Angela did not have a bed or bedroom. The conditions of the flat were observed by police in April 2019 to be poor, mouldy and not likely to pass environmental health safety standards. The family home was later deemed uninhabitable.
Lack of supervision and guidance	This involves a failure to provide an adequate level of guidance and supervision to ensure a child is physically safe and protected from harm. It may involve leaving a child to cope alone, abandoning them, leaving them with inappropriate carers, or failing to provide appropriate boundaries about behaviours such as underage sex or alcohol use. It can affect children of all ages.	In 2017 Angela was found by the police at 1am with two teenage children. In April 2019 there was also a referral about her being home unsupervised for long periods. When police attended, the mother reported that she had only been gone for 10 minutes.

[9] Howarth, J 2007 Child Neglect: Identification and Assessments, Basingstoke, Macmillan

[10] Definition of child in need set out in the Children Act 1989

7.26 The lack of health, education and basic living conditions such as having a bed and a bedroom, should have triggered the identification of the neglect, as well as the emotional harm she was experiencing as a result of witnessing the domestic abuse and being the victim of the controlling and violent environment.

7.27 Following the two domestic abuse incidents in August 2019 Angela's case was referred to the team that had been previously working with her. It is not clear what the outcome of this was as no action was taken. If the recommendation of the previous manager had been acted upon, this would have provided an opportunity to trigger a strategy discussion[12] with the police and health colleagues in the MASH. This would have given the basis for a multi-agency discussion and assessment which would have revealed the following:

- Joe was stopped and searched due to suspicions of cannabis use
- Poor home conditions
- 2 aborted calls to the police by the mother
- A referral about Angela being left at home alone
- 5 police call-outs to the home due to domestic abuse (as of 26.08.19)
- Angela not in school
- Angela not registered with a GP

7.28 The spiral fracture was not notified so would not have been available at this meeting from the health representative in the MASH, if a strategy meeting had been convened.

7.29 Angela was taken to the hospital regarding the Herpes infection in November 2019. It does not appear that a new multi-agency assessment was commenced at this point. This again was a missed opportunity to gather information from a range of agencies. It was noted that Angela was not in school, but the assessment activity focussed on the "unknown source of the infection"[13].

7.30 At this point the police were informed that the hospital safeguarding team had considered Angela's presentation and there were no safeguarding concerns noted.

7.31 Children's services got clarification from the safeguarding coordinator administrator and the consultant at the hospital, that Angela was suffering from Herpes and that tests for other sexually transmitted diseases had come back as negative. At this point, a further child and family assessment was commenced. It is clear that there were concerns about Angela's lived experience and the neglect of her health and education needs. Unfortunately, the assessment activity did not effectively pull together the family's history, the additional two domestic abuse incident in November 2019 and really grasp the evidenced neglect and emotional abuse Angela was experiencing. A decision was made that her needs could be met through a child in need plan and child protection enquiries were not triggered.

12 The purpose of the Strategy Discussion is to decide whether a Section 47 enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry. The social work assessment is the means by which the Section 47 Enquiry is recorded by Children's Services Social Care.

13 Referral received recording in the chronology of Lambeth Children's services.

7.32 From this point the multi-agency assessment process seemed to end and individual agencies expended time and energy in trying to respond to the ongoing unspoken concerns about sexual abuse. The child in need meetings would have been key opportunities to pull together all of the multi- agency information which by the 8th December 2019 would have shown:

- 2 aborted calls to the police by the mother.
- A referral about Angela being left at home alone.
- police call-outs to the home due to domestic abuse in the preceding 12 months.
- Angela not in school.
- Angela not registered with a GP.
- Angela diagnosed with Herpes.
- School nurse assessment showing unmet speech and language needs.

7.33 The police were not invited to any of the child in need meetings or invited to provide information.

7.34 A further child in need meeting was held on the 19th of December 2019. By this time further information had been elicited from the school nurse assessment. This included observations that Angela had a lack of inhibitions and could present as being over-friendly.

7.35 By the February 2020 child in need meeting further information was held in the system. This included:

- The serious domestic abuse incident on Xmas day in 2019 where Angela was visibly distressed by the assault on her mother.
- Angela continued to not have access to a GP.
- Angela had had another outbreak and had two open sores on her lips which remained untreated.
- Continuing concerns from the team manager about the contraction of Herpes in a young child and the impact of the domestic abuse on Angela.
- Evidence of lack of routine (going to bed at midnight).
- Sometimes sharing her bed with the dog in the kitchen.

7.36 Unfortunately not all of this information was considered in the children's services multi-agency assessment of risk and harm to Angela.

7.37 In March 2020 further information came to light including:

- Angela was 2 years behind her peers at school.
- Angela was not registered with a GP.
- Continued speech and language issues.
- Angela reported not being able to see the board at school and required bifocal glasses.
-

7.38 In April 2020 at the child in need meeting it was known that:

- Angela not in school due to Covid restrictions (even though Angela could have attended as a child in need, there was no statutory requirement to do so).
- A further domestic abuse incident had taken place.
- Angela not registered with a GP.

7.39 In the seven months that Angela was the subject of a child in need plan the deterioration in her care, the 13 in total domestic abuse incidents, her continued lack of access to a GP, dentist or optician were not pulled together to inform the multi-agency assessment of her needs. There continued to be concerns about sexual abuse that were not escalated or resolved to the team manager's satisfaction. The focus of the child in need meetings was largely on meeting the family's housing needs. Practitioners in the event described that Joe did not attend the meetings and that at times the mother appeared to be skilled in deflecting and avoiding issues. An example was the continued lack of registration with the GP. Practitioners reflected that the learning from Angela's case was that the child in need meetings provided an opportunity to 'ask difficult questions' and have 'difficult conversations'. However, this opportunity was not taken.

7.40 ***How effectively was information shared across agencies? How effectively did the MASH help to triangulate key pieces of information? How can we ensure that the full family history and information held by partners is accessed to inform assessments and decisions?***

7.41 Before the child in need meetings there were times that information sharing fell short of what is expected in practice. There was one occasion that the police responded to a domestic abuse incident, Angela was present, but the expected notification was not made to children's services.

7.42 The hospital did not recognise the spiral fracture as an abusive event and therefore did not share this information with other agencies. It has not been possible to establish why the explanation provided by the mother was accepted and not checked with the radiologist, or indeed what else should have happened at the time, to ensure effective recognition in the future. This was an important reachable moment where child protection enquiries could have been commenced.

7.43 Health practitioners reflected that the information about the Herpes diagnosis was an important part of the jigsaw. This led to a discussion about how health practitioners from a hospital setting could be included in the child in need meetings. The link between the acute setting and the community would have been difficult in the absence of an allocated paediatrician. However, practitioners felt that the strengthening of the role of the paediatric liaison or health visiting liaison could have offered an opportunity for information sharing to have been improved.

7.44 There was evidence of good information sharing between the school, social worker and school nurse. Unfortunately, this information was not analysed to enable the pieces of the jigsaw to be pulled together and for her neglect and abuse to have been detected and responded to earlier. This led to drift of 7 months under the auspices of the child in need plan and issues such as her medical needs, needs for protection against witnessing the domestic abuse, dental needs, visual needs and need to be registered with a GP, continued to be unmet. The focus of the child in need meetings centred on the mother's housing situation. The interventions became focused on the adults' needs. The fact that the mother's assurances to carry out actions were not followed through, didn't result in an escalation in the levels of intervention.

7.45 There are clear indicators that information was not triangulated by the police and children's services. The mother gave false reassurances that she would engage with domestic abuse

services, had ended her relationship with Joe, would seek an injunction, she was seeking a GP for Angela, had tried to get glasses for Angela – these assurances were not challenged or triangulated between the agencies. This resulted in Angela's continued exposure to domestic abuse and her basic needs not being met. If more professional curiosity had been exercised, it would have become evident that the mother was unable to extricate herself from that relationship and at times gave untruthful accounts of steps she agreed to take.

7.46 There are no current practice indications that the MASH did not collate or triangulate information in this case. Angela was allocated for assessment. Usually, MASH enquiries are used to establish threshold where is it difficult to judge if a child has met the threshold for services. In this case, the two allocations clearly indicated that Angela met the threshold for statutory services. Therefore, MASH enquiries were not undertaken.

7.47 **How well was Angela's lived experience understood?** ***To what extent did we capture Angela's lived experiences? When she was spoken to, how did practitioners consider how Angela understood the questions asked of her? What impact did context or gender have on how well we engaged with Angela?***

7.48 Angela was spoken to by the social worker, the school nurse and was spoken to alone by the female A&E consultant at hospital in November 2019.

7.49 The interaction between the social worker and Angela was limited. She was only seen at home, it is reported that Angela's mother was reluctant for her to be seen alone. It would be normal practice to see a child at school or even go out with a child. The purpose of this is to build a rapport with a child and allow them to talk about anything that may be worrying them and for this to happen away from the home environment. The fact that Angela's mother was reluctant for this to happen, should have registered as a concern to the social worker. It is also known now that Angela was extremely scared of Joe, as he had threatened to kill her mother if she told of the abuse she was experiencing. It is highly unlikely therefore that Angela would have felt safe enough to talk, in the context of this threat, in such a small flat.

7.50 That said, Angela's views were sought, for example, being excited about starting school and that she played games at the weekend. There is no evidence of structured direct work and in the absence of this, Angela's lived experience[14] was not understood. It is also of significance that Angela had three changes of the worker. Children have shared their frustration at having to repeat themselves and also the impact of changes of the worker on their levels of trust in their social workers.

7.51 The school nurse did see Angela away from the home environment. She told the nurse about her sore and explained that this was due to not washing her hands. The school nurse had some insight into her lived experience. In February 2020 Angela was known to be sleeping in the kitchen and shared with the school nurse that she sometimes went to bed as late as midnight and that she sometimes shared her bed with the dog. The school nurse did undertake structured direct work using tools such as the NSPCC's Talking Pants in response to the perceived 'lack of inhibitions' observed in Angela's behaviours. She also used the 'safe and unsafe secrets' direct work tool. Unfortunately, Angela did not feel safe enough to use these opportunities to talk about what was happening to her.

[14] A child's lived experience is what a child sees, hears, thinks, and experiences on a daily basis that impacts on their personal development and wellbeing. This includes physical and emotional wellbeing.

7.52 It is clear that Angela found school to be a safe place. She became visibly upset when sent home from school due to tooth pain. The school were not notified of each of the domestic abuse incidents, in line with the local commitment by the police in Op Encompass.

7.53 The A&E female consultant tried to gain a view about Angela's lived experience when she attended the hospital in November. It is good practice that Angela was seen alone and by a female consultant, given the concerns about sexual abuse. It is not realistic to expect that the full lived experience of a child can be gained in the context of a time-limited consultation in an Emergency Department setting.

7.54 There is no evidence that Angela was spoken to by attending police officers. It appeared from practitioner feedback that the perceived primary purpose of speaking to Angela would have been as a witness. It is also apparent from the records that when police did attend the family home and knew of Angela's existence, they were assured by Joe and her mother, that Angela had not witnessed anything. This appears to be unrealistic given the size of the family home and seems indicative of a lack of awareness of the impact on children, of directly or indirectly witnessing domestic abuse and being the victim of the controlling and violent environment. The police neither sought Angela's views nor were able to consider her lived experience of living with domestic abuse. In one instance the police attended the home address but did not enter the address. Officers must enter family homes, where children have been cited in previous risk assessments and children services notifications. Attempts to engage victims of domestic abuse on the street also seems an improbable method to build trust and protect confidentiality, which are key elements to ensuring that adult victims feel safe enough to disclose about domestic abuse.

7.55 ***To what extent do A&E treatment pathways ensure that children receive the best possible service, safeguarding concerns are identified and responded to and the most appropriate professional responds to safeguarding concerns in the most effective and skilled way?***

7.56 The hospital assessment of Angela's fracture failed to identify that fracture was the result of physical abuse. A spiral or oblique fracture of the shaft of the humerus is more likely to be due to abuse, than accidental, in young children (NSPCC 2012) [15]. A study published by the Royal College of Paediatricians and Child Health in September 2020 showed that of 14 children with fractures to the humerus, 10 were caused by abuse[16]. Both historical and current research indicates that a spiral fracture of the humerus is a strong indicator of abuse. This was not detected by the treating staff and Angela's account of how she incurred this injury was accepted. The treating doctor did not seek advice from the paediatric consultant or the safeguarding children team and also did not test out the veracity of the accounts given by the mother and Angela, with the radiologist. This would appear to be due to a lack of a safeguarding awareness in injuries that are more ambiguous.

7.57 As a result, the abusive way in which this injury was received was not detected and other agencies were not notified. This resulted in a missed opportunity to consider all of the information held by the agencies. This could have included a review of the fracture, the two previous aborted calls to the police, the referral in November 2017, where Angela was found at 1 am with 14 and 15-year-old children and the information that Angela was not in school or registered with a GP.

7.58 The hospital assessment in response to Angela being taken to the hospital with oral and

genital herpes was limited to focussing on a purely medical diagnosis, based on Angela's presentation, the account provided by her mother and the coached account given by Angela. The treating Accident and Emergency consultant sought information from colleagues in dermatology and general paediatrics. Angela was spoken to alone by a female doctor, using an interpreter. It is known now that she was too scared to tell about the abuse she was experiencing, as her abuser had threatened to kill her mother if she told.

7.59 There were concerns about potential sexual abuse. Angela's case was discussed in the safeguarding peer review meeting. A safeguarding nurse and the emergency room safeguarding lead were present at the meeting. It would appear that there was no clear pathway or route map of actions to be taken in presentations such as Angela's. Due to the treating consultant's concern about Angela, a referral was made to children's services, despite Angela not having been able to share her experience of abuse. To allay the remaining 'niggle' about sexual abuse, Angela's mother was asked to attend her GP for a swab, to rule out sexual transmission. The mother never attended for a swab and in the absence of a GP for the family, there was no means to follow this up. This demonstrates the critical role of GPs in coordinating community health needs and ensuring that follow up appointments and actions are carried out.

7.60 The referral to children's services stated that the source of the viral infection was cross-contamination from Angela's mouth to her hands. On reflection, practitioners felt that when making referrals to children's services, care and attention should be paid to ensure that the language used is universally understood. Practitioners felt that language such as "we cannot rule out sexual abuse" may have been more helpful in the referral to children's services, than a reference to cross- contamination. Health professionals felt that more professional curiosity could have been exercised and it was observed that some professionals have differing safeguarding 'barometers' meaning that some professionals are more attuned to safeguarding issues than others. The presence of the safeguarding team in the hospital meant that some departments felt that safeguarding children isn't their role.

7.61 It is interesting that even in the practitioner event there was a challenge about the level of certainty that could have been held about the source of the Herpes infection. This comment was made in the knowledge that there has been a successful prosecution of the perpetrator and the child has made full disclosure of the harm she suffered. As the independent author, I couldn't help but wonder where there continued to be a difference of views, how this might play out in the clinical setting for other children with infections that may be due to sexual abuse and act as a potential barrier to clear and decisive actions on the part of clinicians.

7.62 ***What was the impact of the fact that English wasn't the family's first language?***

7.63 The use of interpreters was inconsistent. There are only very few entries where an interpreter has been used with Angela. These were by the hospital in November 2019 and the subsequent health assessments undertaken by the school nurse. Unfortunately, the earlier entry, where Angela experienced the spiral fracture, was not supported by an interpreter.

7.64 The limited use of any interpreter for Angela was indicative of Angela's increasing grasp of the English language. The table below shows the number of contacts between the family and agencies and when an interpreter was used.

[15] NSPCC 2012 *Fractures in children (CORE-INFO leaflet) (nspcc.org.uk) accessed on 30.05.2021
[16] Cited from *Chapter Fractures_Update_280920.pdf (rcpch.ac.uk). p 12 accessed on 31.05.2021

Agency	Number of contacts	Number of times an interpreter used	Comments
Police	14	3	On a further 3 occasions, officers who spoke the family's primary language were used to translate, either in situ or back at the police station
Hospital setting	2	1	Joe took Angela to the hospital on this occasion
Children's services	9	4	Interpreters were provided for all child in need meetings
School nurses	6	3	The earlier contacts with the family were supported by an interpreter

7.65 Steps were taken by children's services to ensure that the mother and Joe understood the concerns and were able to contribute to assessments. However, at times this has been limited to using a telephone interpretation service and google translate. Angela was spoken to by the first social worker, in the family home. The completed assessments were not translated into their first language. The outcome of the assessment and the agreed next steps would not have been known to the mother or Joe. It has been remarked upon by children's services practitioners that at times, the mother was avoidant and would block questions, for example why Angela did not have an allocated GP. The mother's perspective was that this was due to fear and intimidation on her part. Any barriers to her ability to work in partnership with professionals would have likely been exacerbated by communication issues.

7.66 Efforts by the police to engage the mother were infrequently supported by officially recognised interpreters. Again, this will have exacerbated her ability to share how safe or not she was feeling. The use of officers who could speak the family's primary language to communicate with the mother and Joe is not acceptable. Formal translation requires a greater deal of skill than a 'primary-language speaker'. It is not known whether this was an officer that had conversational speaking skills or this was his or her native language. In any event, it is important that official translators are used in interactions with victims.

7.67 Practitioners in the event also highlighted the cultural differences between the European country of Angela's birth and her family's country of origin. While the language spoken in both these places is the same, there are significant variations in vocabulary and dialect. In an area as diverse as Lambeth it would have been good practice to gain an interpreter from

the specific country, where available.

7.68 ***Did any other practice issues, either single or multi-agency, have any bearing on the serious harm inflicted upon Angela?***

7.69 There were multiple points at which the threshold for a MARAC meeting was met. There were 11 recorded attendances at the home address or to the mother between June 2019 and June 2020. The threshold, in this case, was met in two ways. Through the severity of the abuse e.g. the incident at Christmas 2019 when the mother was assaulted by Joe in his parents' home and or the frequency of the mother's need to resort to calling to police to protect herself. The local threshold for the police service in this borough before this review was set at 7 attendances. That threshold had been met following the domestic abuse incident on Xmas day 2019.

7.70 Inclusion in the MARAC process would have allowed the multi-agency group to risk assess the domestic abuse, consider the impact on Angela and develop a coordinated action plan. There are multiple entries where attending officers' supervisors considered a referral to MARAC but decided not to. It seems that the mother's reassurance that she would seek an injunction, end the relationship and engage with services, impacted on the perceived assessment of risk.

7.71 However, any professional can refer to the MARAC process. A referral could have been made by the social worker, designated school lead or school nurse, where it was felt that the adult victim or young person as being at high risk of harm, either by using the SafeLives DASH Risk Identification Checklist or by using professional judgement. It will be important that the Partnership ensure that all those signed up to the MARAC protocol are aware of their ability to make referrals. Typical actions that can arise from a MARAC meeting include:

- Placing a victims' home on 'cocoon watch' and offering panic alarms and providing other safety devices in the home.
- Ensuring that professionals meet with the victim alone for example in hospitals and other health settings.
- IDVA[17] support to secure new housing, communication and coordination between agencies, assisting victims with seeking legal assistance.

7.72 Although it is good practice for the victim to be made aware of and consent to a referral to MARAC, where the perceived risk is high enough, a referral can be made without the victim's knowledge.

7.73 The effectiveness of the single agency and multi-agency assessment and interventions under the child in need plan are referred to above in detail. There was drift and the practitioners felt frustrated that the plan was not bringing about the required change. This highlights the importance of reflective supervision for practitioners in identifying trends, the impact of events on children and identifying when interventions need to escalate from supportive to protection status. The evident drift in the child in need planning points to the need to review what opportunities were available for the social workers to really reflect on the lived experience of Angela.

7.74 The need for reflective supervision is not restricted to the role of the social workers. The school nurse was clearly worried about Angela. However, Angela was not discussed in supervision until she had been working with the child for four months. This supervision did not appear to promote reflection on the impact of the domestic abuse, neglect, concerns about some of Angela's behaviours and the worry in the 'system' about sexual abuse. This could have provided a reachable moment for the harm that Angela was experiencing to have been crystalised, which in turn could have shaped a challenge to the multi-agency team around Angela. Practitioners commented that multi-agency supervision would have offered a safe opportunity to pull all of the pieces of the jigsaw together – providing an effective mechanism to focus on the harm that Angela was experiencing as well as triggering a review of the cross-contamination diagnosis.

7.75 Angela's absence from school was not detected when she moved from one borough to another. As a result, she missed 17 months of schooling. This contributed to her isolation and reduced her contact with safe adults in the school environment. Not least, being in school would have provided Angela with a safe place away from home. The lack of a system to track children moving from one area to another, where parents have reported having made applications to multiple schools, is a national issue. A recommendation linked to this issue is set out later in this report.

7.76 It would appear in this case that Angela's school were not notified about the domestic abuse incidents, despite being signed up to Op Encompass. As a result, they were not informed of 6 domestic abuse incidents. This would have provided an opportunity for professional

8. Identified Good Practice

8.1 The direct work by the school nurse showed examples of good practice in eliciting the lived experience of Angela. She used a variety of recognised tools in her structured direct work with Angela. She also spoke to the mother about how to keep herself safe from harm by Joe and the importance of protecting Angela from witnessing domestic abuse and being the victim of the controlling and violent environment. She discussed ways in which the mother could keep Angela safe from sexual harm. She was dogmatic in trying to establish the harm Angela had suffered and highlighted the ongoing neglect of Angela's health needs in the child in need meetings.

8.2 The hospital consultant that met Angela when she was diagnosed with Herpes, was sensitive to the prospect that this could have been caused by sexual transmission. In her attempts to address her worries she spoke to Angela alone, using an interpreter.

8.3 A referral was made to children's services by a clinician. This wasn't clear in the concern about sexual abuse, but it did trigger some activity in the safeguarding system around Angela.

8.4 The GAIA Centre responded swiftly to the referral for the mother in January 2020. They were persistent in trying to speak to the mother and only closed their interventions after attempts had been made to gain contact.

9. Lessons Learnt

9.1 The purpose of a child safeguarding practice review is to establish whether there are lessons to be learnt about how local professionals and organisations work together, to safeguard and promote the welfare of children and to identify any good practice.

9.2 This review has highlighted some good practice by the school nurse, the hospital consultant and the GAIA centre. The school nurse and consultant took time in their roles to listen to Angela and try to understand what life was like for her. This is critical to not only eliciting the voice of the child but most importantly to understand the lived experience of the child. The two are different from each other.

9.3 The school nurse undertook some focused direct work with Angela, which were designed to promote disclosures and explore any adults that a child may not feel safe with. However, Angela was understandably frightened that by speaking out, Joe would kill her mother. The physical harm she experienced and control and the violence that she witnessed in the home, would have only reaffirmed this threat for Angela.

9.4 Perhaps the most saddening learning from this review was the professional reliance on a disclosure to trigger action. Both in respect to Angela and her mother.

9.5 There was a heavy reliance on Angela disclosing her physical and sexual abuse, before action was taken. Professionals that took part in this review described Angela as a 'friendly, lively child'. Her levels of resilience were not considered to be conducive to the collective view of what an abused child 'looks like' or 'acts like'.

9.6 There was a sense of powerlessness felt by the professionals from November 2019 onward, when trying to make sense of the diagnosis of herpes and to a lesser extent, the domestic abuse. This powerlessness and lack of clarity played out again in the practitioner event.

9.7 **The recognition and response to physical abuse:**

Angela's fracture on the 1st of February 2019 is the earliest reachable moment for Angela. She was taken to hospital by both her mother and Joe. The mother has described how in her 'desperation' she just wanted Angela to be checked and for there to be "no problems". She was being threatened by Joe and living in a house that was "falling down around them". The mother has articulated how she did not have the resources to take action at this point and colluded with Joe. Had this injury have been recognised as a non-accidental injury this would have triggered a strategy discussion and child protection enquiries. This could have been a critical point whereby the mother could have been offered and empowered to accept services and secure their immediate safety from Joe and take the protective steps that could have been taken to ensure that Angela was safe.

Linked Recommendation:

Kings College Hospital to provide assurance to the Lambeth Safeguarding Children Partnership that the actions set out in their Learning review dated February 2021 is making changes to practice and improving the identification and response to physical abuse.

9.8 **Angela's experience of neglect:**

Angela experienced neglect, physical harm, emotional harm and sexual harm. It is clear that Angela did not feel safe enough to talk about the physical abuse or the sexual abuse. It was therefore incumbent on the professionals, to identify the neglect she was experiencing and take action.

9.9 Practitioners in this event spoke about Angela being 'perfectly presented', having a pristine uniform, clean and styled hair and 'lots of toys'. The professionals that saw where Angela lived, would have known that the property was unfit for human habitation and the poverty that Angela was living in. Information was in the professional domain about her poor school attendance, late arrivals and pickups by the mother, Angela sleeping in the kitchen, not being registered with a GP, unmet visual needs and not being protected from emotional harm due to the exposure to the domestic abuse.

9.10 Angela was very scared and her responses to professionals were highly suggestive of her being coached. This does not detract from the lack of grasp by professionals on her lived experience which resulted in a lack of purposeful intervention about the neglect she was experiencing.

Linked recommendation:
The Partnership to consider the development of a multi-agency neglect strategy which sets out how agencies will work together to identify and respond to neglect, governance to ensure the strategy drives practice improvement and a quality assurance framework to measure the impact of the strategy on frontline practice.

9.11 It was known that Angela was living in housing that was not considered to be fit for human habitation. The Housing Department was notified of this in March 2020 by Environmental Health. In response, the housing department awarded the mother with the highest priority for rehousing (Band A). However, the family was essentially homeless as it was unreasonable for them to remain at the property as a result of the prohibition notice. They should have been provided with suitable temporary accommodation in March 2020. The family's safety was paramount and they should not have remained in a property unfit for human habitation.

Linked recommendation:
The Housing Department to consider amending practice to ensure that any individuals or families living in property deemed to be unfit for human habitation are offered suitable temporary accommodation without delay.

9.12 Angela had been out of education for 17 months. She was in school in a neighbouring borough to Lambeth. When she left this school, the school reported that they had difficulty in getting in touch with the mother. They did refer for early help support and the education welfare service made attempts to visit the family at home. These attempts were not successful. Following this, the school were advised to take Angela off their roll. It is normally good practice to ensure a child is 'on roll' or enlisted with another school before taking a child off the previous school's roll. This did not happen as there was no effective tracking system in place to monitor Angela from becoming out of sight. It is not uncommon for

families to move between Boroughs and children missing education is a key vulnerability factor.

Linked recommendation:
For the London Child Safeguarding Partnership to consider collaborative work with London Partnerships to devise a pan London protocol about children missing education that move between boroughs.

9.13 **The impact of domestic abuse:** Angela's mother was also a victim. She spoke of being 'hijacked' in her own home, asking for help repeatedly from the police, but the extent of the harm she suffered was not recognised. She spoke of fearing for her family who lived abroad and how he had threatened to hurt them if she spoke out about the domestic abuse. Angela's mother did not have the resources to take protective steps for Angela. There were organisational steps that could have been taken to enable Angela's mother to be made safe, these were not taken.

9.14 Angela's mother reports having presented at the hospital with a broken nose and she said this was an attempt to get some help. She repeatedly called for police assistance but then retracted allegations of harm, declined to make a statement and or gave assurances that she would take steps to protect herself and Angela. The mother was not able to do this. Her view is, this was due to fear of reprisal from Joe.

9.15 It is important where women repeatedly call for help and then retract allegations or give assurances that they will take action, when action is not taken by the victim this should not be seen as a 'failure' but interpreted as potential fear.

9.16 There were many multi-agency opportunities for intervention in respect of the domestic abuse, controlling and violent behaviour that Angela was witnessing. Had a MARAC meeting been held following the domestic abuse incident in December 2019 after there had been 7 call outs, this would have offered an opportunity to pull together the information known about the domestic abuse perpetrated by Joe and develop a plan to support Angela and her mother.

Linked recommendation:
The partnership to seek assurance from the police, via audit and data analysis, that referrals to MARAC are being made appropriately.

9.17 That said, a MARAC meeting can be requested by any professional[18]. The fact that children's social care, the school or school nurse did not raise as a potential action suggests that the function and purpose of the MARAC is not as well understood across the partnership as it should be. In addition, there is a single pathway, through the GAIA Centre, for specialist support – and advice – regarding domestic abuse. The fact that this provision was only referred to, and no professional used the service for specialist consultation to aid their reflection and safety planning, suggests a need to promote the available resource.

Linked recommendation:
Partner agencies to be reminded of the function and purpose of the MARAC and the range of specialist Domestic Abuse services that are available to offer advice, consultations and services.

9.18 The child in need meetings were other multi-agency mechanisms by which the impact of the domestic abuse could have been analysed and understood in a more purposeful way. Angela's case transferred to the Family Support and Protection team in children's services in December 2019. A child in need meeting was held where the family history was noted including 4 domestic abuse incidents. Following this, there was a significant domestic abuse incident at Christmas 2019. Domestic abuse had been a feature in this family for an extensive period of time and the fact that this did not escalate to a child protection threshold is indicative that there was a lack of awareness of the impact of domestic abuse in the safeguarding system.

The police attended the home address on several occasions and also saw Angela and her mother at the police station. There is evidence that Angela was spoken to by officers, but no evidence that she was spoken to ascertain how safe she felt or what she had witnessed. This is suggestive of a lack of awareness of the impact of domestic abuse on children.

9.19 Both the police and children's services response to the mother appear to lack professional curiosity. They accepted the mother's assurances that she would accept domestic abuse services, would seek an injunction and on a number of occasions that the relationship had ended. There was no real triangulation to offer social workers and officers insight into what the mother calls being "hijacked" in her own home and the limited resources she had to protect Angela.

Linked recommendations:
The Partnership to ensure that the learning from this review informs the implementation plan of Lambeth's refreshed multiagency Violence Against Women and Girls Strategy and that partners are regularly cited on the impact of the strategy for children.

Children services to consider introducing a practice standard that requires a strategy meeting or management overview where there have been 3 or more referrals of children involved in domestic abuse incidents.

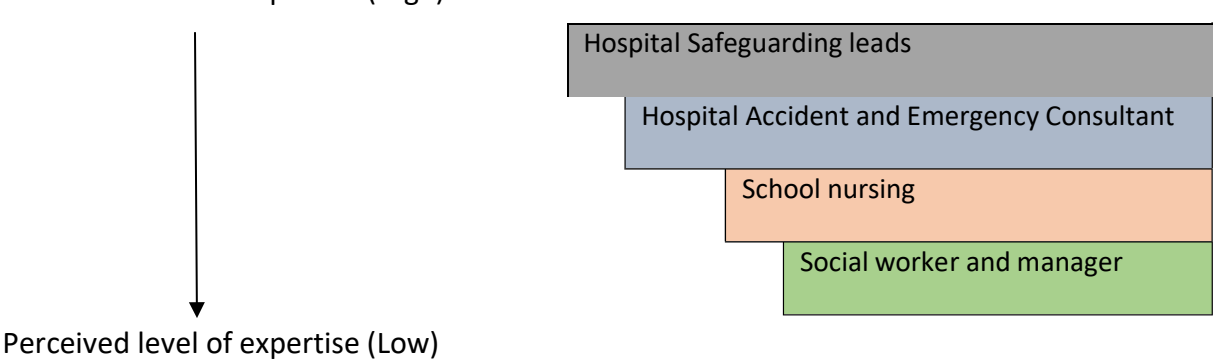
9.20 During this review, it has also become apparent that the school were not informed of the domestic abuse incidents between November and June 2020.

Linked recommendation:
For the Partnership to receive assurance from the police that Operation Encompass is effectively sharing information with all schools that have signed up to the project.

9.21 **The recognition and response to sexual abuse.**

The powerlessness and frustration felt by the practitioners was linked to differing levels of confidence in the recognition of child sexual abuse, which resulted in a referral from the hospital to children's services which 'muted' concerns about sexual abuse. This led to professionals deferring to unseen and unspoken hierarchies shown in Figure 2 :

Fig 2:



9.22 In this case, the least experienced member of staff was the most concerned that Angela had been sexually abused. Although this concern was shared amongst the network of professionals, this never escalated to senior members of safeguarding specialist personnel. This is remarkable given the levels of concerns seen in notes and observed indirect feedback from practitioners.

9.23 This also offers some important learning for agencies about the need to support professional curiosity and ensures that local escalation policies are in place, well understood and effective.

9.24 It will also be important going forward that Emergency Department Consultants, community nursing and social workers and managers know who they can talk to when they have ongoing concerns about diagnosis, in cases such as Angela's.

Linked recommendations:

The Partnership to ensure that practitioners and managers are aware of child sexual abuse expertise available in Lambeth. E.g. Named Doctor for Safeguarding and colleagues in the MarySheridan Centre.

The Partnership to emphasise the importance of professional difference and to support a culture of difference by developing the escalation process to create space for a multi-agency professionals meeting to explore perplexing cases. Specifically, the key areas of risk, the information each agency holds, to examine what that information is telling the network and to determine what more information is needed and who is responsible for gathering this.

Individual agencies and the Partnership to ensure that their escalation procedures are in place, well understood and effective to ensure that concerns such as those held by professionals about Angela, get escalated.

9.25 **Communication with parents whose first language is not English:**

Angela's mother is not fluent in English. Even for parents whose first language is not English, who appear to have a good grasp of the English language, it must be recognised that the language used by police, nurses, teachers and police is more complex than conversational language. Only qualified and skilled translators should be used for these important conversations. Angela's mother was communicated with using google translate, members of staff who spoke the family's primary language and at times she was supported by translators that were of poor quality. There needs to be a commitment from organisations that good communication is supported by the use of good quality translators and that any quality issues raised in this review are actioned with providers.

Linked recommendation:
The Partnership to gain assurance of the availability and quality of interpreters used for children and parents who are or have experienced abuse or neglect and whose first language is not English.

[18] Taken from the Lambeth Guidance on MARAC found at Multi-Agency Risk Assessment Conference (MARAC) | Lambeth Council

Appendix 1

Practitioner Input To The Review

One virtual practitioner event took place involving professionals from hospital, school nursing, the school, police officers, and children's services.

A virtual recall event took place and comments received by email where some practitioners were not able to attend.

There were also follow up meetings with key agency representatives to clarify individual aspects of learning for this review.

Finally, a draft copy was sent to all the practitioners that contributed to the review for their comments and observations.

PARALLEL PROCESSES

Criminal proceedings had concluded at the time of this review and Joe was sentenced to in excess of 20 years in prison. Care proceedings had not yet concluded at the time of this report being written.

Family Input To The Review

Angela's mother was met (virtually) using an interpreter and with the support of her emotional support worker. She was invited to share her view of events, what learning needed to be taken by the Partnership and her thoughts on how services could be improved. The report was then translated and shared with her and her emotional support worker, where she was invited to comment.