

1 Introduction

- 1.1 This Child Safeguarding Practice Review was commissioned by the Local Safeguarding Children Partnership (LSCP) for the local authority area, LA1. It was initiated following the deaths of two children in 2022 (referred to as Child K and Child L), both of whom were under the age of six at the time of the incident.
- 1.2 Although the family had recently been rehoused in temporary accommodation within LA1, they were primarily known to services operating across two other local authority areas. Consequently, this review has been conducted with the full collaboration and cooperation of multiple agencies and their respective LSCPs within LA2 and LA3.
- 1.3 The incident was notified to the LSCP in LA1, and a Rapid Review meeting took place. Members recommended a Child Safeguarding Practice Review which was agreed by the National Panel.
- 1.4 The review examines services to the children between 2019 and 2022. Panel members, practitioners and family members all contributed the findings in the review.
- 1.5 The children's mother was found guilty of their murder in 2025 and is serving a lengthy prison sentence.

2 Brief Background

- 2.1 This review involves a family of Mother, Father and two children. Mother grew up in the UK (in LA3) and has two other children (Child A and Child B) from a previous relationship. An acrimonious custody battle in private law led to public law proceedings some years earlier than the review period. During this time, Mother experienced a significant mental health crisis. There were concerns about drug misuse, sexual abuse and domestic abuse. Child A and Child B were ultimately placed with extended family.
- 2.2 Father lived in LA2, and Mother joined him there after the proceedings ended. Child K was born and became subject to statutory intervention in the form of a Supervision Order to LA2 which ended in 2018. Mother's mental health remained stable during this period, and no further symptoms of mental illness were evident. However, concerns about domestic abuse and limited engagement with health professionals persisted, leading to ongoing challenges in providing adequate support to the family.

3 Timeline of key events

2019	Mother was pregnant with Child L. Anonymous referral about alleged domestic abuse received by LA2. LA2 conducted network checks with other involved agencies. Mother denied the allegations, No formal assessment conducted.
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	The Midwifery service was asked to monitor and report any further concerns.
2020	Child L was born. Routine visits showed no concerns. When Child L was six weeks old, LA2 received a second anonymous referral about the children's safety in relation to alleged domestic abuse. LA2 conducted thorough network checks, and no additional concerns were raised. The case was allocated for a 'child in need' assessment under section 17 of the Children Act 1989. However, no assessment was completed. Mother was contacted, denied any domestic abuse and would not consent to an assessment. Father was not contacted. A management decision was made for the nursery and health visiting service to continue to monitor the children and report any safeguarding concerns. As for many families during the COVID-19 pandemic, engagement with health visiting services for this family was very sporadic. Health visitor had limited success with monthly phone contact and referred the family to LA2 due to parental non-engagement. Referral was not progressed by LA2, recommending universal services continue to monitor.
2021	Health visitor made a second referral to LA2 due to poor engagement in the context of the historical concerns about maternal mental health and domestic abuse. LA2's attempts to contact mother were unsuccessful. No assessment was initiated after positive nursery feedback for Child K. Child K started school, after a delay, and settled in well. No concerns raised by the school. Health visitor flagged Child K as vulnerable to school health services, but e-mail did not reach the school, so they were unaware of Child K's safeguarding history.
2022 Final Days	Mother requested medical records amended to remove her mental health diagnosis as she had been stable for a significant period. Mother applied to discharge court order for older children. Court application refused. Judge recommended children remain with extended family. Health visitor visited family to support mother and complete Child L's developmental check. Home conditions were noted as poor. Mother requested housing assistance but declined health visiting support. Parental relationship broke down. Mother moved, with Child K and Child L, to temporary accommodation in LA1. Most professionals appear to have been unaware of the move at the time. Mother was provided with utility vouchers and food vouchers in LA1. Mother attended GP visits in LA2 saying she was feeling stressed with the move and recent break-up but declined mental health referrals. The children died in LA1.

4 Lessons

Identification of risk and need for families

- 4.1 The review found that services initially had a strong understanding of the family, aided by effective communication between LA3 and LA2. In assessments and ongoing work however, key parental risk factors lacked clarity, including the extent of domestic abuse, substance misuse, and historical sexual abuse allegations. These gaps hampered further assessment, and concerns were frequently denied by both parents. Substance misuse appeared infrequently in the review, but it was raised as a concern during the subsequent police enquiries.
- 4.2 Mother's mental health was considered stable throughout the review period. While she reported stress, this was seen as a normal response to challenges such as financial struggles, reliance on foodbanks, and commuting between LA1 and LA2. These difficulties were not evident to those around her, as she appeared to be coping after the separation. Father had a positive relationship with school which he maintained after the incident.
- 4.3 Information about parental risk factors was sporadic and was not considered to meet the threshold for statutory intervention. While greater exploration of domestic abuse was identified as a learning point, the overall picture also suggested the family were facing struggles, particularly later in the review period. Early help services may have been of benefit, but as this is consent-based, the parents may have been unlikely to accept such support.
- 4.4 Contact with Father is not evident and **the recommendation below is made to strengthen practice in relation to working with males in families.**

The LSCP in LA2 should seek assurance from all agencies that their respective training strategies include awareness raising about the importance of including fathers and other male family members in assessments and ongoing work.

- 4.5 The limited information on the previous history, including the lived experiences of the children, impacted decision-making and the health visitors struggled to assess risks due to the family's disengagement from services. Professional disagreements arose but were not formally raised through the correct escalation processes. **The following recommendations are made to support practice in this area.**

The LSCPs in LA1 and LA2 should agree on specific actions to embed learning into practice regarding ways of working with parents who are perceived as 'difficult' or where practitioners struggle to find ways to engage them. This is intended to ensure a consistent approach in identifying the impact of parental behaviours on children, carers and the professional network.

The LSCPs in LA1 and LA2 should develop guidance for practitioners regarding the weight and consideration that should be given to historic child protection concerns (which impact on parenting). This is particularly relevant when assessing risk in vulnerable families who appear stable, yet decline consent to early help and demonstrate inconsistent engagement with universal services.

- 4.6 LA2 has since adopted a strategic approach to domestic abuse, focusing on forming alliances with non-abusing parents, holding perpetrators accountable, and addressing coercive control dynamics. **A recommendation is made for LA2's MASH to ensure robust decision-making at referral points.**

The LSCP in LA2 should seek assurance that responses to incidents of domestic abuse involving children under 5 are managed by the Multi-Agency Safeguarding Hub using a consistent and robust application of thresholds.

- 4.7 CAFCASS have introduced a *Domestic Abuse Practice Policy* (September 2024) which is currently being rolled out to their staff.

Information sharing for families who move across local authority boundaries and transition points.

- 4.8 There was a smooth transition of information between LA3 and LA2 which led to appropriate safeguarding action for Child K. This was supported by good information sharing and joint understanding of risk. The transfer of information from LA2 to LA1 did not go as smoothly, largely because there was little information to draw on that was known in the network. LA2 placed the family in temporary accommodation in LA1. Mother did not tell services (apart from her GP) that she had moved with the children, and services in LA1 were unaware of any history with the family. There was no cause for concern during this time, so no alarm bells were raised.
- 4.9 A gap that was identified at a crucial transition point was Child K's move to school health from health visiting. The intention by health visiting was to flag Child K as vulnerable so that school health was aware of his history. An email was sent with the relevant information but was overlooked and so the information for practitioners was never received or recorded on Child K's records. There needs to be an improved pathway of information sharing between health visiting and school nursing to ensure that vulnerable children are flagged and assessed accordingly in a timely manner. **A single agency recommendation is made to address this issue.**

LA2's Community Health Trust should review its information sharing pathway between Health Visiting and School Nursing services for vulnerable children.

- 4.10 The review noted that Housing services were missing from network checks, and a crucial notification (where housing notify local authorities when a family moves) was not made due to system disruption at that time. **A recommendation is made to strengthen multi agency information sharing where a family's housing is a significant factor.**

LA1's and LA2's LSCPs should oversee a review of Housing services' engagement in statutory processes for families where there are safeguarding issues, to ensure that they are a consistent partner in the family's professional network.

Issues arising from intersectionality.

- 4.11 Through the process of the review, the family's circumstances became clearer. As with all children, Child K and Child L's circumstances and their day to day lived experiences were unique. Assessing their journey through statutory services using the lens of

intersectionality¹ would have been a helpful framework to aid practitioners' understanding of their uniqueness. As global majority children they would have encountered multiple disadvantages. Whilst all of this was identified, assessment of the cumulative effects of these factors was not evident across the multi-agency network and these factors were not sufficiently explored and understood at the time.

- 4.12 In recent years all partnerships have developed frameworks to promote strong approaches to anti racist practice across all services. Workers consulted during the review reflected on how different their approach would be now.
- 4.13 This shift in practice should help practitioners to recognise that early experiences increase children's vulnerability and to take this into account. **A recommendation is made to reinforce this area of practice.**

Considering the findings in this review about children who experience multiple oppressions and disadvantage, practitioners across the partnerships in LA1 and LA2 should be equipped with the knowledge and understanding of intersectionality to properly identify and consider these factors when assessing and managing the risk to children.

Escalation and challenge in multi-agency networks

- 4.14 There were several points in the timeline where the health visiting team, and the GP had concerns about the family as they were unable to engage them in their services. Their referrals to LA2 did not result in services to the children and there was no use of formal escalation processes by health professionals.
- 4.15 Such processes can be used to good effect, and an effective learning organisation is one where inter-agency challenge and discussion is encouraged by managers and leaders. Outcomes for children and young people are improved when disagreements are aired and resolved. All Partnerships have clear escalation processes, which practitioners are encouraged to use. Deference to the views of others and barriers to effective challenge is a feature of other multi agency reviews over several years. **This is linked to a recommendation to review the partnerships' multi agency escalation processes**

The LSCPS in LA1 and LA2 should oversee an evaluation of the impact of the current process for inter-agency escalation where there is professional disagreement. This should include a consultation with partner agencies to explore the barriers to professional challenge and what would support good practice.

¹ Intersectionality is the interconnected nature of social categorisations such as ethnicity, race, class, and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.