Safeguarding Adult Review "Annabel", commissioned by Merton Safeguarding Partnership

Reviewers:

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1 Introduction

1.1 WHO WAS ANNABEL?

1.1.1 "*Being a mum was Annabel's life and the most important thing to her. She was vibrant, colourful, and full of life... She would be the heart and soul of the party and would make everyone laugh – she got that from her gran. She was a girly girl. She loved to help people and collected a lot of things for people who were in great need. At the anniversary of … [a tragedy causing deaths and homelessness in a London community] the residents contacted Annabel's mum in order to arrange for pins with the names of Annabel's children on them. Annabel also helped people with Domestic Violence and donated lots of clothing and push chairs to Children's Services."* (Annabel's mother in the meeting with lead reviewers on 13/06/2022)

1.2 WHY WAS ANNABEL CHOSEN FOR A SAFEGUARDING ADULT REVIEW?

1.2.1 The Care Act (S. 44) states as follows:

> ***44 Safeguarding Adults' Reviews (SAR)***
>
> (1) A SAB (Safeguarding Adult Board) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
>
> (b) Condition 1 or 2 is met.
>
> (2) Condition 1 is met if—
>
> (a) the adult has died, and
>
> (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).
>
> (3) Condition 2 is met if—
>
> (a) the adult is still alive, and
>
> (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.
>
> (4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.2.2 The Merton Safeguarding Adult Review (SAR) subgroup received the referral for a young woman who had taken her life and decided that it met the criteria for a SAR under condition 1, as outlined in the Care Act and it was therefore accepted as a mandatory SAR. The referral was initially considered for a "Review in Rapid Time" approach but due to the number of agencies involved, the complex circumstances, and the absence of any recent SAR within Merton where similar aspects featured, it was decided that a more in-depth approach was needed. The SCIE Learning Together methodology was therefore chosen.

1.2.3 The adult will be referred to as Annabel in this report.

1.3 SUCCINCT SUMMARY OF THE ANNABEL'S STORY

TIME PERIOD UNDER REVIEW: MARCH 2020 TO 05TH MARCH 2021

1.3.1 Annabel was a mother to several children from different relationships. She was White British. At the time of her death, she was still considered a permanent resident in LB Merton but had been living in temporary accommodation in Brighton & Hove since January 2021. Annabel's mother played an important role throughout her life and offered extensive support in relation to the children, some of whom were in her care at the time of Annabel's death, and some continue living with her.

1.3.2 In her short life, Annabel had experienced multiple trauma through rape as a teenager, significant domestic violence and abuse in several relationships, multiple miscarriages and the separation from her children due to care proceedings.

1.3.3 During the time under review Annabel and her family had been known to several agencies within and outside of Merton due to incidents of domestic abuse leading her to seek emergency accommodation outside of Merton. During the time period under review, Merton Children's Services escalated their involvement to child protection and subsequently issued care proceedings in relation to four of Annabel's children, which was an enormous shock to the whole family and devastating for Annabel. Annabel experienced crises of physical and mental ill health, including several attempts to take her life.

1.3.4 In December 2020, a road traffic collision left Annabel temporarily paralysed and with care and support needs.

1.3.5 The children's care proceedings concluded with the judge ordering for the children to live with extended family members and limited contact was granted to Annabel.

1.3.6 Annabel sadly took her own life on 5th March 2021 by taking an overdose. She was 34 years old.

1.4 METHODOLOGY

1.4.1 The purpose of a SAR is to provide findings of practical value to organisations and professionals for improving the reliability of safeguarding practice within and across agencies (Care Act Guidance Para 14.178), in order to reduce the likelihood of future harm linked to abuse or neglect, including self-neglect.

- To promote effective learning and improvement to services and how they work together;
- To learn lessons about how the local safeguarding system works that will help to reduce the likelihood of future harm;
- To understand what happened and why;

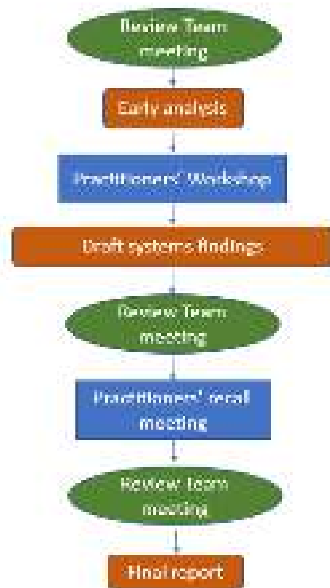
1.4.2 Merton Safeguarding Partnership decided to use SCIE's tried and tested *Learning Together* model for reviews to conduct this SAR (Fish, Munro & Bairstow 2010). It provides the analytic tools to support both, rigour, and transparency to the analysis of practice with the individual and identification of systems learning.

A PROPORTIONATE APPROACH

1.4.3 Learning Together allows a proportionate approach that builds on any internal agency investigations that have already been completed. It uses data and learning from Annabel's story to create the findings.

1.4.4 It revolved around 2 half-day workshops with practitioners and their direct managers, and three meetings with the "Review Team" (Senior Managers representing the agencies involved with Annabel).

1.4.5 The process of the approach is summarized in the graph below:



A COLLABORATIVE, SYSTEMS-FOCUSED WORKSHOP

1.4.6 Information and insights from key documentation related to Annabel was used to produce an early analysis report. This created a structure for the workshop with the practitioners. It identified Key Practice Episodes (KPEs) and raised questions where input from participants was needed. Participants were involved through the workshop in evaluating what went well and where there could have been improvements in practice with Annabel through each episode. Crucially, they were also involved in identifying from a range of different social and organisational factors, what helped and what hindered them in their work at the time.

1.4.7 From that basis, the lead reviewers supported the group to move from thinking about their work with Annabel, to identify if there are any generalizable issues that impacted on practice with Annabel and impact on their practice more widely. By this means they drew out underlying systemic issues that help or hinder good practice beyond the practice Annabel who is subject of this SAR.

BUILDING SENIOR LEVEL OWNERSHIP OF SAR SYSTEMS FINDINGS THROUGH THE PROCESS

1.4.8 To support the identification of systems learning, the Learning Together approach requires three meetings (including the introduction meeting) with senior representatives from the agencies who were involved with Annabel. This "review team" plays an important role in bringing wider intelligence to the SAR process in order to ascertain which issues are case specific only, and which represent wider trends locally. Their ownership of the review findings is crucial.

TIME PERIOD AND FOCUS OF THIS SAR

1.4.9 It was agreed that SAR Annabel would focus on responses to Annabel and her family during the final year of year life: from March 2020 to 5th March 2021.

1.4.10 As Annabel was considered a permanent resident of LB Merton at the time of her death (whilst temporary living in Brighton & Hove), the Merton Safeguarding Partnership considered the referral and commissioned this SAR. The focus of this review is therefore on the work and practice by agencies within Merton and it is this practice that will be appraised in the report. Information that was provided by agencies outside of Merton was considered to provide important context.

1.4.11 The Review Team has used their discretion to share any specific concerns relating to the practice of a particular agency outside of Merton with the agency directly in relation to their specific work with Annabel and her family.

1.4.12 A list of agencies within and outside Merton that participated in or contributed to this review can be found in the appendix.

RESEARCH QUESTIONS

1.4.13 The use of research questions in a 'Learning Together' systems review is equivalent to Terms of Reference but focuses on the generalizable systems learning that is sought. The research questions identify the key lines of enquiry that the Safeguarding Partnership want the review to pursue and are framed in such a way that make them applicable to practice more generally, as is the nature of systems findings. The research questions provide a systemic focus for the review, seeking generalizable learning from the single individual. The research questions agreed for this SAR Annabel were as follows.

1.4.14 What can we learn from Annabel's story about what is helping or hindering…

- … the timely and effective engagement of Merton partners with women with multiple disadvantages, such as chronic trauma and risks linked to domestic abuse, mental health issues, child protection concerns and substance dependency who move frequently in and out of Merton?
- … the effective communication by multi-agency partners in Merton with relevant agencies across borders concerning women in those circumstances?

INVOLVEMENT AND PERSPECTIVES OF THE FAMILY AND SIGNIFICANT OTHERS

1.4.15 We also sought to engage with family members to gain their perspectives and to talk through the analysis and findings and to answer any queries.

1.4.16 Annabel's mother played an important role throughout her life and offered extensive support in relation to the children, some of whom were in her care at the time of Annabel's death, and some continue living with her.

1.4.17 Annabel's mother wished to meet with the Lead Reviewers. The meeting was face-to face, and she invited a professional along to offer her support.

- Annabel's mother shared with the reviewers that Annabel was a vibrant colourful woman whose children meant the world to her. She loved being a mother and not being with her children was desperately hard for her. Annabel helped people who had experienced domestic violence. Her mother described the time when Annabel donated four double buggies to people who needed it. She described Annabel as being mousy and the heart and soul of the party.

Annabel would make everyone laugh; she got that from her maternal grandmother. Annabel at the time had just completed a degree and had hopes of becoming a police officer. Annabel was described as being such a girly girl and family was so important to her.

- Annabel's mother spoke about a situation that highlighted her and Annabel's difficulties in understanding the reasons why Annabel was seen to be a risk all of a sudden: when the family were celebrating one of Annabel's children's birthdays together in early 2021, Annabel was contacted by the police to say that the children could not be with her and needed to return to the care of her mother. Her mother said that from then on, it went downhill for Annabel.
- When Annabel's mother was talking about Annabel's frequent moves, she said they were due to Annabel believing that the social worker had compromised Annabel's and her children's safety, as she believed that the social worker had shared her address with her ex-husband and father of two of her children. She described Annabel as being absolutely petrified of him.
- Annabel's mother still wishes to know why Annabel's safety plan was not implemented, although she had overdosed four times. She also queried why Annabel was not admitted to hospital due to her increasingly poor mental health. Annabel had a hospital passport that detailed her needs, and Annabel's mother strongly felt that Annabel needed to be seen by the psychiatric team.
- Annabel's mother shared that when the police came to break the news of Annabel's passing to her, there was no one from Children's Services who made contact until the following day and Annabel's mother shared that they did not help or advise her how to break the news to the children. She felt that at the time when she and her family needed the support from Children's Services the most, it was not offered to them, and they felt being left alone.
- Annabel's mother said that she appreciated the opportunity to participate in the review because she did not want any other family to go through what they had to go through as a family.

1.4.18 Annabel's oldest son also wished to meet with the Lead Reviewer and this meeting took place virtually.

- Annabel's son described his mother as an amazing woman who did her best. She also did a lot for the community, and he feels that she did not get enough credit for this work.
- Annabel's son shared that there was involvement by Children's Services throughout most of his life and he felt that this involvement mostly caused pressures and stress for the family.
- Annabel's son told us that he remembers a time period when his mother would not allow him and his siblings to go out and play freely, as she was worried that something might happen that would cause Children's Services to intervene. He felt "robbed" of his childhood in some way.
- He also spoke about his mother being in constant fear more generally of doing things wrong with the children that could lead Children's Services to take the children away from her and he felt strongly that this constant pressure on his mother was not fair. He described the approach of some Social Workers as non-caring, without real interest in finding out what was going on for his mother and how it was impacting on her, i.e., her miscarriages, or the plan of Children's Services for the children to no longer live with her. He said that

particularly the latter caused a lot of upset and stress for his mother, especially as she was also in constant physical pain because of the car crash that she was involved in just before, in December 2020.

- Annabel's son spoke of his mother experiencing a real crisis when she was told by the Social Worker in January 2021 that she could no longer be with her children unsupervised. It was on the birthday of one of his siblings and Annabel, who was with the children at the time, then brought them to her mother where she broke down and stated that she had now lost her children. He quoted his mother saying: "my children are my world, and my world is literally ripped away from me". He described the last three months of his mother's life the worst and cannot, nor wishes to, imagine what it must have been like for her.
- Annabel's son was and still is upset that following his mother's suicide, Children's Services went quiet for at least a month or two and nobody was in contact with the family.
- Annabel's son still has questions about the safety plan that he understands was put in place for his mother just before she took her life, and he queries why this does not seem to have been implemented.
- Having had the experience that he had, Annabel's son shared that wishes for professionals to be more sensitive and kinder when working with people like his mother. He wants them to be more sensitive to the situation that the person could be going through and to try their best to understand what is going on for the person.
- Annabel's son does not wish for any other family to go through what they have gone through as a family. He appreciates that a SAR is undertaken and that a report is written and shared with agencies.

1.4.19 Annabel's partner at the time (on and off during the time period under review) was also contacted but did not respond to the offer of a meeting.

REVIEWING EXPERTISE AND INDEPENDENCE

1.4.20 The review was led by Anna Muller, Principal Auditor and Reviewer at SCIE, together with Lorraine Henry, Safeguarding and DOLS Team Manager in Adult Social Care in LB Merton. Lorraine has completed the SCIE LT Together training: the full approach as well as the "review in rapid time approach. SAR Annabel was Lorraine's first SAR using the LT methodology. One time during the period under review, Lorraine gave advice in relation to an adult safeguarding referral that was made in respect of Annabel; therefore, Anna led on the appraisal of practice for this aspect. Anna is totally independent of all services in Merton. She is an accredited SCIE Learning Together Reviewer with a Social Work background, having worked in several local authorities.

METHODOLOGICAL COMMENT AND LIMITATIONS

1.4.21 This is the first time that Merton has commissioned a review using the Learning Together methodology. Efforts to identify all the right operational staff to contribute to the Case Group were hampered by the time that had passed since the trigger incident which meant that some people had changed roles and moved agencies and were not able to contribute to or participate in this SAR. This placed a level of limitations to the comprehensive understanding of contextual factors of specific events from the practitioners' perspectives.

1.4.22 It was also necessary for the lead reviewers to seek some follow-up conversations with individual practitioners/ managers who were unable to attend the workshop.

1.4.23 The collaborative process and Learning Together tools, including feedback loops, nonetheless worked well to enable operational staff to check factual inaccuracies, explain the rational for actions and inactions, and help the reviewers understand some of the contributory factors. Review Team members also made every effort to fill arising gaps.

1.5 STRUCTURE OF THE REPORT

1.5.1 Throughout the writing of the report the Review Team has been mindful to the need for the family's anonymity.

1.5.2 There are two main sections to the report. The Appraisal of Practice Synopsis is presented first. This gives a summary evaluation of the timeliness and effectiveness of responses to Annabel and her family. It captures the case findings, detailing where practice was below or above expected standards and, where possible, explaining why.

1.5.3 The second part of the report draws out the wider learning. Systems findings are presented that impacted on practice with Annabel and hold true more broadly and continue to impact on wider practice today. Each finding also lays out the evidence identified by the Review Team that indicates that these are not one-off issues. Evidence is provided to show how each finding creates risks to other adults in the future, because they undermine the reliability with which professionals can do their jobs.

2 Appraisal of professional practice in relation to Annabel

2.1 BRIEF TIMELINE OF THE PERIOD UNDER REVIEW

April 2020
- Incident of domestic abuse against Annabel by her partner at the time - Attempts by Annabel to seek emergency accommodation in Brighton - Strategy Discussion between Children's Social Care and police – threshold for an Initial Child Protection Conference (ICPC) is agreed
May to 1st September 2020
- ICPC: child protection plan under "emotional abuse" - MARAC meeting/ Merton - Annabel added to waiting list for trauma work - Disclosure by Annabel of historic domestic abuse, and other offences in relation to her partner at the time - Annabel's ongoing refusal to cooperate with the police investigation unless she is re-housed outside Merton - Annabel's 1st miscarriage during the time under review - Review Child Protection Conference: ongoing CP plan - Family's short stay (one night) in emergency accommodation in Gravesend/ Kent - MARAC meeting/ Merton: "repeat" referral
2nd September to 2nd October 2020
- Early stages of pregnancy and need for medical attention several times - Family's move to Greenwich - Annabel's threats to kill herself if police pursue investigation against her partner - Safeguarding Adult Referral: Referral to Mental Health Team
3rd to 13th October 2020
- MARAC meeting/ Greenwich - Annabel's second miscarriage during the time under review and medical complications
14th to 19th October 2020
- Arrest of Annabel's partner by police in relation to Annabel's earlier disclosures - Insufficient evidence to refer case to Crown Prosecution Service; no charges brought against Annabel's partner
October to 31st December 2020
- Need for emergency medical attention following the recent miscarriage - Annabel's intermittent and limited engagement with various agencies - Road traffic collision leaves Annabel temporarily paralyzed and with care and support needs - Family's move to Brighton into emergency accommodation

January 2021 to 5th March 2021
- Care proceedings in relation to Annabel's children: orders for children to live with extended family members - Several attempts to take her life and self-harm by Annabel - Goodbye letter written by Annabel - Annabel starts therapy sessions - Annabel's death

2.2 APPRAISAL SYNOPSIS

2.2.1 The following section provides an appraisal of the professional practice undertaken during the period under review. We do not claim to have covered every aspect of practice and instead focused on identified key periods and events and professional responses by Merton agencies. The need for the protection of the family's anonymity has been taken into consideration.

SHORT SUMMARY OF WIDER HISTORICAL BACKGROUND

2.2.2 We were told that over the years, Annabel and her family had been supported by Children's Services on and off, mostly under S. 17 as well as S47 of the Children's Act 1989, as "children in need" and "Children at risk of significant harm". This included involvement by various local authorities, depending on where the family was living at the time. Reasons for the involvement included concerns around domestic abuse and its impact on the children including several moves, Annabel's mental health, challenging family dynamics and the children's specific individual needs, particularly around their education. Annabel was known to have a long-standing history of mental health issues, such as anxiety and depression. Her repeat prescription for antidepressants was managed through her GP. She also suffered multiple trauma as the result of significant domestic abuse (which warranted a number of safety measures having been installed in the home), rape and several miscarriages. The Review Team was told that Annabel was introduced to cocaine by her latest partner and was using it, on and off, during the time period under review, but less so towards the end.

APPRAISAL OF PRACTICE

2.2.3 Following an incident of domestic abuse in the home at the beginning of 2020, Annabel reported to the police that the physical altercation with her partner at the time, who had left the home by then, and his threats to kill had caused her to have a panic attack, exacerbated by her existing and long-standing mental health issues of depression and anxiety. Annabel did not wish to provide a statement to the police. It was good practice that professionals worked together with Annabel and extended family members to agree on a range of temporary safeguarding measures for her and her children.

2.2.4 In the following two weeks, Annabel attempted to seek temporary accommodation in Brighton on two occasions, citing domestic violence: once together with some of her children when Annabel was offered accommodation which she turned down as she felt it was too small; the second time, Annabel's partner at the time (who Annabel had reported to have made threats to kill her only a couple of weeks earlier) sought to be housed with Annabel as her carer but this request was refused. Annabel and her children returned to their home in Merton. During this

time, Annabel was supported by an IDVA (Independent Domestic Violence Advocate) and whilst disclosing fear and threats by one of her ex-partners, she denied any domestic violence from her current partner. The focus by the IDVA on immediate safety planning, including support around housing, was good practice and acknowledged Annabel's recent experience and situation. We also heard that Annabel was referred to Westminster Drug Project (WDP) in relation to substance use. The quick response by the service enabled Annabel to start her engagement with the practitioner.

2.2.5 In a professionals meeting towards the end of April 2020, Merton Children's Services, who were involved with Annabel and her children under S17 Children's Act ("children in need") at the time, as well as other professionals involved, shared their increasing concerns about the impact of Annabel's current relationship and recent experiences on the children. In a strategy discussion between Children's Services and police shortly after, it was decided that the threshold was met to proceed to an Initial Child Protection Conference due to concerns of the children suffering, or likely suffering significant harm as a consequence of the situation at home. We heard that it was rather unusual for the discussion not to include any other partner agencies such as health and education, or for a strategy meeting to be arranged for a fuller discussion amongst the multi-agency network that was already in place through the children's "child in need" plans. However, this discussion occurred at the height of the global COVID 19 pandemic and took place just over one week into the national lockdown that caused challenges to established working practices and new ways of working were just being established. Participants also shared that there was a consensus in the professionals' meeting a week prior that the threshold for child protection clearly had been met, therefore it was felt that the conference would offer a forum for a discussion and information sharing with the family and the multi-agency partners.

2.2.6 Mid-June 2020, the Initial Child Protection Conference decided that Annabel's children needed to be made subject to child protection plans under the category of emotional abuse. There was good representation from the multi-agency network, including support services for Annabel, such as the IDVA and WDP, and an appropriate focus on the children's needs and their need for protection. However, the way Annabel's needs and decisions were articulated were problematic, raising questions about how her situation was actually understood by professionals. In particular, there was insufficient attention on the ongoing challenges around domestic abuse as well as Annabel's experience as a victim of domestic abuse in her own right. The Reviewers would have expected others present in the conference to have challenged the presentation of and wording used about Annabel's 'decision' and 'choices'. Too high a level of responsibility was placed on Annabel without equivalent consideration of the responsibility on the perpetrator. **Limitations to a "Think Family" approach locally are discussed in more detail in Finding 2.**

2.2.7 Around this time, Annabel's allocated practitioner in the Westminster Drug Project (WDP) recognized the need for Annabel to receive a specialist assessment of, and treatment for, her multi-faceted mental health issues and therefore referred Annabel to Merton Mental Health Services (Primary Care Recovery Service). This was appropriate and in her best interest and what she needed at the time. Their response was timely, and the initial assessment identified the need for trauma work by Merton Uplift. However, we heard that their strict criteria of being able to start

working with an individual only once they are abstinent and sober can place real challenges on people who use substances to self-medicate, particularly in the absence of any other support. Due to increased pressures on services by COVID 19 at the time, in addition to existing challenges such as high staff turnover and insufficiently robust care pathway management, Annabel needed to be added to their waiting list to receive trauma-focused Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), both of which are recommended in the NICE guidance in treating Post-Traumatic Stress Disorder. Being placed on the waiting list started to create a delay for Annabel and meant that she was left without specialist mental health input when she needed it. **The lack of options and approaches to risk management as well as for therapeutic support for women in Merton is discussed in more detail in Finding 1.**

2.2.8 When Annabel then made disclosures to the IDVA about serious history domestic abuse against her by her partner at the time, including threats to her using a firearm and his involvement with a drug gang, the IDVA shared this with police in a timely manner. It was taken seriously, and a thorough investigation of the different allegations was started, but the police did not take a statement from the IDVA which could have been helpful particularly in light of Annabel's unwillingness to provide a statement to police directly. Annabel repeated the disclosures to various professionals, shared her fear of possible repercussions from her partner and therefore requested to be re-housed outside of Merton. Annabel's vulnerability at the time was heightened due to being pregnant with her partner's child that she unfortunately miscarried shortly after. The decision by police to delay the arrest of Annabel's partner therefore showed acknowledgement of her situation and took her fears seriously, although Annabel remained unhappy about the police's decision to pursue an evidence-led investigation. The IDVA remained dedicated to and involved with Annabel around safety planning and her wish to be re-housed, also fueled by her fear of being stalked by an ex-partner. This resulted in a couple of moves outside Merton in quick succession. Annabel had wished to move outside of Merton, however it was not in her desired area (Brighton) and professionals also grew concerned about the instability this was causing to the children, in addition to growing concerns about Annabel's mental health. Particularly the practitioner from WDP continued to offer ongoing check-ins and support around Annabel's emotional state which Annabel engaged with, however, she was unable to offer the specific input that Annabel needed for her mental health. **This is discussed in more detail in Finding 1.**

2.2.9 In September, Annabel was accepted as a "repeat referral" (first referral in May 2020) by Merton MARAC (Multi Agency Risk Assessment Conference) and was discussed in the meeting. This offered an opportunity for the multi-agency network to discuss their concerns about the most recent events and the risk that these posed to Annabel and her children. In their contributions to this SAR, practitioners shared that the logistics and timing posed real challenges at the time: partner agencies were still identifying the best possible way of conducting the meetings virtually in light of COVID 19, including the sharing of information prior. The MARAC chair and coordinator both noted a good and mutually supportive working relationship which helped the running of the meeting, but they also both acknowledged that the high number of cases being referred impacted on the ability for thorough discussions. The absence of a dedicated minute taker at the time was evident in the minutes that were less comprehensive than desired, particularly in

relation to the actions. This increased the potential that the risks to Annabel and the children, discussed in the meeting, were not accurately reflected, and therefore possibly not understood in the same way by all partner agencies. As Annabel was living outside of Merton at the time of the discussion, it was good practice that a swift MARAC to MARAC referral into the other area was identified necessary and made by the MARAC coordinator.

2.2.10 At that time, Annabel also started to experience physical health issues related to her recent pregnancy and miscarriage. When seeking medical attention in several hospitals outside Merton (there is no acute NHS hospital within LB Merton), she openly shared her experiences of domestic abuse and several miscarriages, and how this impacted on her overall. The Review Team was unclear if this was always followed up appropriately, but as the hospitals are outside Merton, this falls outside the scope of this SAR and was not explored further.

2.2.11 Additionally, Annabel's emotional and psychological wellbeing deteriorated further towards the end of September, and she grew increasingly concerned about the police investigation into her earlier disclosure against her partner and the possible repercussions to her from him. Annabel informed professionals that she was pregnant again, from this partner, and she had decided to move back to her home in Merton to be close the hospitals that she knew as she was deemed a high-risk pregnancy. This should have triggered and automatic MARAC to MARAC referral back to Merton which did not happen and unfortunately none of the professionals involved with Annabel in Merton alerted MARAC either. This was a missed opportunity to continue the sharing of information through this particular forum.

2.2.12 Annabel also withdrew her allegations in one of the core group meetings that were held regularly in respect of her children who continued to be subject to child protection plans. The IDVA told us that Annabel was angry with her for having shared information in the recent MARAC meeting and felt her trust had been breached. Annabel's contact with the IDVA became sporadic from this point onwards and it meant that Annabel had lost an important source of support. The IDVA remained involved indirectly however and continued to offer advice to the Social Worker of Annabel's children when this was needed, which was a necessary means of keeping the issue of Annabel's experience of domestic abuse part of the discussions by professionals. Participants shared as part of this SAR process that this was a time when Annabel overall had less contact with professionals and specifically also asked her children's schools, for example, not to share her phone number, which she had recently changed, with anybody else.

2.2.13 The situation escalated and, on several occasions, Annabel shared with police as well as with her children's Social Worker threats to kill herself if the partner was arrested, and the GP was also alerted. Her threat seemed to have been understood differently by different professionals without any formal risk assessment being conducted or specific tools being used to support this process. This was insufficiently robust and appropriate, given her circumstances. Annabel's threat was also sent to the Adult Safeguarding Team for review who assessed that the threshold for a safeguarding duty had been met. As Annabel was open to Merton Uplift, waiting to start therapy, and the children's Social Worker had confirmed that they would request Annabel to be assessed under S.135 Mental Health Act (1983). The Adult Safeguarding Team Manager understood that Annabel was allocated to the Social Worker for Safeguarding within the Primary Care Service, where Merton Uplift sits, but the Review Team Member for Mental

Health shared that this had not been the case and no work or consultation had taken place. This might have been influenced by the fact that the Social Work position within their team was a newly created post at the time. This continued to leave Annabel without the support she required in a situation of increasing psychological and emotional challenges. **This is discussed in more detail in Finding 1.**

2.2.14 When Annabel experienced the second miscarriage during the time under review in early October, she shared further details about the circumstances around previous miscarriages as well as the trauma of rape when she was much younger. The children's Social Worker appropriately identified the need for emotional support, and Annabel herself shared the information with Merton Uplift whose assessment acknowledged the clinical history, however the Review Team was told that additional information regarding past trauma would not necessarily move individuals to a higher priority on the waiting list but the current presentation and goals for treatment are crucial to therapy. This meant that Annabel remained on the waiting list for the trauma work, with her mental health needs continuing to increase which was not in her best interest. **This is discussed in more detail in Finding 1.**

2.2.15 The police, after investigation and intelligence gathering into Annabel's different disclosures against the partner, finally arrested him in October for interviewing and he denied all offences. Annabel's continuous refusal to engage in the police investigation meant that they relied on evidence only and the Evidential Reviewing Officer concluded that the threshold set by the Crown Prosecution Service (CPS) could not be met. As part of the SAR, the police's Review Team member reviewed the investigation and the final report by the Evidential Reviewing Officer and concluded that it had been a thorough investigation, albeit the absence of seeking to obtain a statement from the IDVA, to whom Annabel had made the initial disclosure, with the decision not to refer to the CPR being considered and detailed. She also highlighted the clear statement within the report that such decision did not mean that Annabel was not believed. This highlighted the challenges around the high criminal threshold, particularly in evidence-led investigations, and the need for this to be clearly explained to partners with sufficient detail. This was not explored further as part of this SAR.

2.2.16 Following Annabel's second miscarriage, she required further medical attention for physical health needs, and she continued to struggle with her mental health. The Primary Care Recovery Service (PCRS, Merton Mental Health) was alerted, and referrals were made by the GP, but Annabel was assessed as not meeting the threshold for an assessment. It is very commendable that the WDP practitioner had stayed in contact with Annabel all that time, focusing on supporting Annabel to stay abstinent and attempting to keep her engaged whilst awaiting to start the trauma work with Merton Uplift. Annabel's relationship with the WDP practitioner was of particular importance as we were told that she had lost trust in Children's Services as well as the IDVA. At this point, Annabel's deteriorating mental health needed re-assessing urgently to determine what support and therapy she required. **The lack of adequate resources is discussed in more detail in Finding 1.**

2.2.17 This was followed by a key event on 10th December when Annabel was involved in a road traffic accident that left her temporarily paralyzed and with care and support needs. She was given the diagnosis of Functional Neurological Disorder. Annabel's mother shared with the lead reviewers that the period that followed from

there was the most difficult time for Annabel. Her mother emphasized that Annabel had asked repeatedly for help for her mental health but did not feel listened to or taken seriously by professionals. Annabel therefore took the decision to self-discharge herself from hospital and the family stepped in to help out with the care arrangements of the children, as they had done so many times before when it was needed, whilst Annabel was recovering. Although Children's Services were not involved in making those arrangements for the children who were still supported through child protection plans, they were aware of them and did not object.

2.2.18 It was good practice by Children's Services to make a referral to Merton Adult Social Care to request a Care Act Assessment for Annabel, particularly in the absence of a referral having been made by the hospital following Annabel's self-discharge. The response to the referral by the relevant teams (First Response, Hospital Discharge and Reablement) was swift, especially in light of the time of the year (close to Christmas) and another national lockdown due to the COVID 19 pandemic. The focus of the assessment was on the task in hand, without consideration for Annabel's wider circumstances and vulnerabilities, and she was assessed as requiring a package of care of two daily visits to help her with personal care whilst being in her home and a referral to Occupational Health was made to assess the need for additional aids within the home. Annabel's mother told us that from the beginning Annabel struggled with the support offered and felt that it did not work for her. She mentioned that whilst the carers were meant to come in the morning and evening, they only arrived mid-morning by which time Annabel had somehow managed to get herself up and ready. Annabel therefore did not make use of the package of care and in fact spent most of the time with her mother over the Christmas period where most of her children were also staying at the time.

2.2.19 On 31st December 2020, Annabel moved to Brighton into council accommodation. Annabel's mother was concerned how Annabel would be able to manage and look after herself whilst recovering from her injuries and she was also worried about her emotional wellbeing, being at a distance from her and her children. But nevertheless, Annabel moved to the area which had been her long-standing wish and she was preparing the home for her children to join her long-term.

2.2.20 Children's Services, however, grew increasingly concerned about the situation and how the children's long-term needs could be met sufficiently and safely long-term by Annabel. At that point, a review of the family's history was undertaken, including seeking information and chronologies from local authorities where the family had lived before. The focus seemed to have been on the cumulative impact of Annabel's long-standing mental health issues, historic substance abuse, impact of domestic abuse, frequent moves and relocations, previous involvement by Children's Social Care, and the decision to remove the children from a stable arrangement to Brighton in an area that was close to her partner and his family where there were significant concerns of domestic abuse including disclosures of weapons. Children's Services arranged a Legal Planning Meeting on 6th January 2021 which decided to initiate care proceedings in respect of Annabel's younger children. When Annabel was informed about this decision, she was understandably shocked. We also found no evidence that Annabel was offered support in understanding this development, i.e., through an advocate, or that her right to information was advocated for by a professional known to her and with whom she shared her worries about this escalation. Annabel already had legal representation. Annabel's children meant everything to her, and this had a

significant impact on Annabel . The Social Worker and Team Manager at the time no longer work in Merton and did not participate in this SAR which has restricted how much the SAR has been able to understand the decision making at the time. **This is discussed in more detail in Finding 2.**

2.2.21 A few days later after being told about the plan by Children's Services, on 10th January 2021, paramedics attended Annabel's home in Brighton following her attempt to take her life. She did not require any further medical attention and was advised of local mental health services, but it seemed that she did not contact them and the agencies in Merton, who were still involved with her, such as GP, Merton Uplift (albeit on the waiting list), WDP, IDVA, and Children's Services, were not made aware of this significant event. This meant Annabel's significant mental health crisis at the time was not flagged and did not allow them to review their level of involvement and support in line with the newly escalated risk. **This is discussed in more detail in Finding 1.**

2.2.22 In the context of a significant change of stance by Children's Social Care, and Annabel's attempt to take her own life shortly after being informed of the escalation, extreme care was needed in how preparation for the court case was handled. Despite the national lockdown, professional discretion could have been used to manage the situation differently in an attempt to offer the support to Annabel that she required at the time, particularly when looking at her multiple vulnerabilities and trauma.

2.2.23 The initial contact with Annabel by the manager of the children's Social Worker, in preparation for the court hearing in relation to Annabel's children, was around one month after Annabel's attempt to take her life and this was a telephone conversation with Annabel around two weeks before the actual hearing. The national lockdown was still in place which most likely impacted on the ability to have a face-to-face meeting with Annabel, in addition to the distance between Merton and Annabel's new home in Brighton. The Review Team reflected that this conversation had great importance and significance for Annabel as well as for the professional network as it presented as an opportunity to explain the rationale of Children's Services decision to initiate care proceedings, to outline the proposed plan and to assess the likely impact of those on Annabel and what support she might require during that time. We heard from Annabel's son and mother as well as from various professionals throughout this SAR process that the importance of the children to Annabel was huge and any proposal for the children not to live with her, even if the plan was for them to still remain within the extended family network, would have been very difficult for Annabel to understand and accept. A phone call was therefore not appropriate. Unfortunately, we were unable to speak to the Team Manager who had this conversation and the records of it are limited.

2.2.24 The lack of sensitivity or appreciation of the risks continued in the way that access to the court papers was facilitated. The record of the conversation informed the SAR that consideration was given to the potential impact on Annabel in reading the court documents that had been sent to her, however, this did not prevent Annabel being sent the papers by post and left to read them unaccompanied and without ready support. Review Team members shared that good practice would have been for the Social Worker, or Team Manager, to go through the documents with Annabel, whether in a virtual call or in a face-to-face meeting. **This is discussed in more detail in Finding 1.**

2.2.25 On 18th February 2021, nine months after the first referral to Merton Mental Health,

Annabel was assessed and had her first treatment session with a therapist. This was a video call, rather than a telephone call, and considering the ongoing lockdown, this was usual practice and would have allowed the therapist to also use some observation to inform their assessment of Annabel's state of mind. Merton Uplift shared that all therapists hold qualification and experience for the treatment that is recommended for the individual. In Annabel's case this was in relation to trauma-focused CBT and EMDR. Whilst the service endeavors to allocate therapists according to their strengths, they consider it also important that all therapists work with a range of difficulties/ presenting challenges in order to sustain and improve their knowledge and abilities. The therapist who saw Annabel had left the service and did not participate in this SAR. The Review Team was left with questions as to the therapist's particular experience of working with women of children for whom the local authority proposes long-term care arrangements away from them and of their specific understanding of the process of care proceedings. **This is discussed in more detail in Finding 1.**

2.2.26 In the session, Annabel was described as tearful, particularly when talking about her children and the care proceedings, with the hearing scheduled for less than a week later on 24th February. She also shared with the therapist that she had written a goodbye letter to her children earlier in the year. The focus of the session was on managing risks and completing a safety plan of what to do if she was in crisis. It was shared with Annabel's mother and Annabel's GP, in agreement with Annabel. There does not appear to have been consideration or discussion with Annabel about sharing it with children's services; this gap in communication is explored more in Finding 2. It was agreed for the first of 16 sessions of EMDR intervention to start on 25th February. What was missing as part of the immediate safety planning, was support for Annabel and a plan in place for her specifically to manage the day of the court hearing, including the possible outcome of an order for the children not to live with her and how she would be able to deal with this. This was a significant oversight and **is discussed in more detail in Finding 1.**

2.2.27 It was good practice that the therapist called Annabel's GP in Merton, where she was still registered and who had good knowledge of her and her history. This was done timely on the same day and offered the opportunity to share the concerns and observations, as well as the agreed safety plan. Furthermore, the GP with the added lead role for vulnerable adults and safeguarding adults within the practice was alerted to the situation and contacted Annabel the following day to check in and assess the risk. This offered another opportunity for Annabel to share her worries and concerns and for the GP to rehearse and embed the safety planning with Annabel which was necessary at that point of crisis. This situation would have also offered an opportunity for the therapist and the GP to consider getting in contact with the Social Worker of Annabel's children to share their concerns and presenting risks and to discuss a multiagency approach to safety planning for the entirety. It is problematic practice that this was not considered or followed up. Children's Service therefore appear to have been left unaware of how badly Annabel had been impacted by the prospect of court proceedings about her children, including that she had written a farewell letter to them. This could have supported their planning with the family and engendered a more compassionate stance. **This is discussed in more detail in Finding 2.**

2.2.28 The court hearing on 24th February 2021 ordered for Annabel's younger children to live continue living with other family members on Child Arrangement Orders,

with an Interim Supervision Order granted to the local authority. Annabel's therapist had agreed another session with her for 25th February, but she did not attend. This should have triggered an emergency response but instead only a standard reminder for her for her following session for 4th March was issued. We mentioned the lack of planning for the day of the court hearing already and **this is discussed in more detail in Finding 1 and 2.**

2.2.29 Annabel's son and mother both described the time just before and straight after the court hearing as very challenging for the entire family. They felt that the restrictions placed on Annabel and her children around contact impacted very negatively on all of them. **This is discussed in more detail in Finding 1.**

2.2.30 Annabel attended her next session with the therapist on 4th March and spoke openly about recent self-harm. The therapist appropriately focused on the risks and protective factors together with Annabel and they agreed on practical steps for Annabel to follow in a situation of crisis. Annabel did not share any thoughts on self-harm or taking her life and practitioners felt that it would have therefore been in line with expected practice not to escalate or share this with any other agencies. It was also felt that it was good practice that the safety plan in place was reviewed together with Annabel in light of her recent behaviours. The challenges around appropriate support for vulnerable women in similar situations to Annabel **is discussed in more detail in Finding 1.**

2.2.31 Annabel sadly took her own life on 5th March 2021.

3 Systems Findings

3.1 IN WHAT WAYS DOES ANNABEL'S STORY PROVIDE A USEFUL WINDOW ON OUR SYSTEM?

Two systems findings have been prioritised from Annabel's story for the Safeguarding Partnership to consider. These are:

	Findings
1.	FINDING 1: **MANAGING RISK FOR VULNERABLE MOTHERS IF THE LOCAL AUTHORITY PROPOSES CARE ARRANGEMENTS FOR THEIR CHILDREN OUTSIDE THE FAMILY HOME** Approaches and options for risk management and therapeutic support in Merton are inadequate for women whose children the Local Authority is proposing to remove/ not to return to their care, even when those women have known long-standing mental health issues, and a known history of self-harm and attempts to take their own life. This increases the risk that potential tragedies are not averted, and intra-familial cycles of trauma are exacerbated. (Management system issues)
2.	FINDING 2: **"THINK FAMILY" APPROACH** In circumstances where children's services are initiating court proceedings, a think family approach is not adequately embedded. This means there is little chance that input from a range of adult services who know the mother feeds into planning at this stage of child protection processes. It decreases the chances of adequate compassion being shown to mothers or vital information being shared about risks of self-harm or suicide linked to their despair, so support can be provided. (Professional norms and cultures of communication and collaboration in longer term work)

3.2 FINDING 1: MANAGING RISK FOR VULNERABLE MOTHERS IF THE LOCAL AUTHORITY PROPOSES CARE ARRANGEMENTS FOR THEIR CHILDREN OUTSIDE THE FAMILY HOME

FINDING 1: **Approaches and options for risk management and therapeutic support in Merton are inadequate for women whose children the Local Authority is proposing to remove/ not to return to their care, even when those women have known long-standing mental health issues, and a known history of self-harm and attempts to take their own life. This increases the risk that potential tragedies are not averted, and intra-familial cycles of trauma are exacerbated. (Management system issues)**

3.3 CONTEXT

Multiple disadvantage: The term multiple disadvantage refers to those people who face multiple and intersecting inequalities including gender based violence and abuse, substance use, mental ill health, homelessness, being involved in the criminal justice system and the removal of children.[1]

Care Proceedings: This is the legal process where children's services apply to the family court to become involved in a child's care. They may do this if they are concerned that a child has suffered or is at risk of suffering significant harm. Children's services can ask the court to make an order to protect the child. This includes an emergency protection order or a care order. These orders give children's services shared parental responsibility for a child, together with their parent/s. Children's services must seek the parents' views when making decisions relating to the child. However, children's services will have the final say in the recommendation made to the court. They may also ask the court to make a supervision order (including an interim supervision order). This order does not give parental responsibility to children's services, and the child is not placed into care. A supervision order places a duty on children's services to 'advise, assist and befriend' the family. This means that children's services will 'supervise' and support the parent in caring for the child. [2]

3.4 HOW DID THE FINDING MANIFEST IN ANNABEL'S STORY?

Annabel had experienced multiple trauma, that she had told professionals about

- Domestic abuse by previous partners that required various safety measures in the home to be put in place; Annabel was very concerned that an ex-partner had found out her address in April 2020 and she believed he had come to the home
- Domestic abuse by the man who was her partner (on and off) during the time under review: physical attack and threats to kill; she also disclosed significant historic abuse against her by this man which made her leave her home and led her to seek

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[1] Against Violence & Abuse (AVA) project: **https://avaproject.org.uk/ava-services-2/multiple-disadvantage/#:~:text=The%20term%20multiple%20disadvantage%20refers,and%20the%20removal%20of%20children**, accessed on 23/06/2022

[2] Family Rights Group, **https://frg.org.uk/get-help-and-advice/a-z-of-terms/care-proceedings/**, accessed on22/06/22

emergency housing outside of Merton, together with some of her children, on various occasions during the time under review

- She had a history of multiple miscarriages, two alone during the time under review
- In October 2020, she disclosed having been raped at the age of 12
- Long standing history of anxiety and depression, she had been prescribed medication for the latter by her GP
- She had a known history of attempts to take her life as well as a history of self-harm: 10th January she took an overdose that required paramedics' attendance; end of February 2020 she poured two bottles of superglue on her hands and ripped it off – she disclosed this to the therapist on 4th March 2021
- Period of substance misuse for which WDP were involved.

Annabel was referred for therapy with Merton Uplift in April 2020 and was accepted as requiring trauma work, she was not seen by a therapist until 18th February 2021, despite the multiple trauma and mental health issues that she had been experiencing. When she finally had the first session with the therapist, she was experiencing a significant additional crisis due to the prospect of the children not returning to her care.

The Review Team learned through the conversation with Annabel's son and mother as well as from the representative of Children's Social Care that her children meant everything to her, therefore it was to be expected that Annabel would become very upset and distressed when she learned about the plan by Children's Social Care that the children should not return to Annabel's care (after an informal arrangement by the family for the children to temporarily stay with other family members until Annabel had recovered from her injuries sustained in the road traffic accident). Annabel shared her anxiety and distress on several occasions to several different professionals in February and March.

On 18th February in Annabel's first session with the therapist she presented as and shared that she was very anxious about the upcoming court hearing one week later. The focus of the session was on managing risk, which was assessed as being at a non-urgent level, and as a result, a safety plan was developed to support Annabel with strategies to manage any arising risks or triggers. This was shared with Annabel's GP the same day, but no discussions seemed to have taken place with any other professionals, i.e., the children's Social Worker, particularly around safety planning for safety planning at the day of the court hearing. The safety plan was a practical document aimed at helping Annabel anticipate times of crises and plan what to do to keep herself safe. At the same time a long-term plan of 16 sessions of EMDR (Eye Movement Desensitisation and Reprocessing) therapy was agreed to start the following week, on 25th February.

The court hearing took place on 24th February which decided for the children to remain with family members and not to return to Annabel's care. No evidence was provided to the Review Team that a plan was considered/ made to check in with Annabel on that day. When Annabel did not attend the scheduled session on 25th, the therapist followed due process and called Annabel during the time of her appointment. As she did not answer her phone, a text message was sent with the details of the next session and cancellation policy. This raises serious questions about the appropriateness of the service's standard approach being applied to all clients, regardless of their current state of mind, their particular circumstances and the risks resulting from this.

The Review Team learned that in the session that Annabel had with the therapist on 4th March 2021, she disclosed self-harm a week earlier (pouring superglue on her hands and

ripping it off) as she felt she need to punish herself. She shared that she had no intent for self-harm or attempt to take her life, and the safety plan was discussed, including discussion around some strategies that Annabel could use to manage thoughts of self-harm. Only the safety plan was updated as a result of this, and the Review Team was not provided with any evidence that any other professional, such as Annabel's GP, was informed about the updated safety plan.

Annabel took her life the day after, on 5th March 2021.

3.5 HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE-OFF?

When we explored this issue in more detail with the case group and the review team, participants shared that the finding was fair and resonated with their experience, and it was sadly not a one-off in Annabel's story.

Representatives from Children's Services acknowledged the lack of specialist support services for mothers, and parents more generally, when care proceedings are issued for their children, particularly when the plan is for care arrangements outside the family home, in order to help them to understand the reasons and support them with their grief. They felt it was a really important area that requires consideration, particularly as those mothers and parents will all have been experiencing very challenging situations, most of them with pre-existing mental health issues, by virtue of the local authority seeing the need to issue care proceedings.

Other participants also shared their difficulties when referring adults to Mental Health Services, particularly around long waiting times and the strict criteria that requires the adult to be sober/ abstinent before being able to receive treatment. Yet, in their experience a lot of those adults use substances to self-medicate, particularly in the absence of any support offered for their mental health needs. Practitioners felt that this made the accessibility of the scarce support even more difficult.

Additionally, the Review Team heard from a number of practitioners that the thresholds regarding primary and secondary care were, and still are, not routinely understood. In the practitioners' view this can mean that those vulnerable women are either supported inadequately or fall into the gap between the two.

Input from the Case Group and the Review Team also highlighted that the particular circumstances at the time around the global COVID 19 pandemic and the national lockdown exacerbated not only the existing strain on services, but also increased the need for those services at the same time, which increased the pressure two-fold.

3.6 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

The Review Team Member representing Merton Mental Health informed that they currently do not collate data in relation to the number of mothers they are supporting in their service who had children removed from their care. This therefore may represent a gap for the service to better understand the specific needs of these vulnerable women.

The Review Team Member of Children's Services shared that between April 2021 to March 2022, the local authority issued care proceedings in relation to the children of 13 mothers, 8 of whom were noted to have multiple disadvantages. Numbers of people

actually or potentially affected by this finding are therefore small compared to the total number of children open to statutory Children's Services (approximately 559), but their vulnerability is potentially high.

In terms of how wide-spread this systems finding is, the Review Team Member from Children's Services shared her current involvement in a piece of work with West London Family Court and various partner agencies that is looking at how to support parents in care proceedings. It is therefore an issue that has been recognised by Merton Children's Services and is relevant beyond Merton.

Additionally, the Family Rights Group has been campaigning for reforms to improve the lives of children and families, including "A duty on local authorities to offer therapeutic support and counselling to mothers and fathers whose children are removed, to help them deal with their grief and to address the reasons why their child was removed."[3] This finding therefore also holds relevance on a national level, and is not unique to Merton.

3.7 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

The pressure on mental health services, such as historical under resourcing and poor pay, leading to long waiting lists, large numbers of vacancies and significant staff turnover, in combination with a lack of specialist therapeutic provision for women who are multiply disadvantaged means that women in those circumstances are left to be supported by practitioners of other services who are not sufficiently trained and skilled to manage the complex risks. This increases the risk that even when the woman's mental health needs are obviously deteriorating and she is asking for support, the increasing risks to her wellbeing cannot be assessed and managed by the services involved. Without specialist and responsive mental health and therapeutic provision for those women who, in additional to being multiply disadvantaged, are then also faced with the traumatic prospect of being separated from their children through care proceedings, professionals from partner agencies who are already involved with the person run the risk, despite best efforts and commitment, to continue to offer support that is less than adequate for the complex needs of the woman.

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[3] Family Rights Group; **Family Rights Group's Campaign Goals - Family Rights Group (frg.org.uk)**; accessed on 01/07/2022

FINDING 1: MANAGING RISK FOR VULNERABLE MOTHERS IF THE LOCAL AUTHORITY PROPOSES CARE ARRANGEMENTS FOR THEIR CHILDREN OUTSIDE THE FAMILY HOME

Approaches and options for risk management and therapeutic support in Merton are inadequate for women whose children the Local Authority is proposing to remove/ not to return to their care, even when those women have known long-standing mental health issues, and a known history of self-harm and attempts to take their own life. This increases the risk that potential tragedies are not averted, and intra-familial cycles of trauma are exacerbated. (Management system issue)

SUMMARY OF SYSTEMIC RISKS

For most mothers, state intervention that sees their children removed from their care is devastating, layering further trauma on multiple disadvantages that they have often already faced. Yet, the lack of a specialist therapeutic provision for women who are multiply disadvantaged, combined with a fragmented understanding of thresholds in primary and secondary mental health services, means that practitioners from other agencies, who are not necessarily sufficiently trained and skilled are required to continue their support to these women. Such commitment is commendable but risks delaying or even preventing necessary treatment and intervention and can also risk scarce resources being diverted. A safe system manages these risks by the provision of a therapeutic service that is accessible and whose thresholds are agreed and understood by partner agencies in order to support these women. This finding highlights the gap in the specialist therapeutic provision for this small, but significant group of women and it increases the risk that those women who are already multiply disadvantaged will be further disadvantaged by not being offered timely support when they need it most, which can lead to further trauma for them and their families, and additional pressure on agencies.

3.8 QUESTIONS FOR THE PARTNERSHIP TO CONSIDER:

3.8.1 Do partners understand the complex needs of women such as Annabel who experienced multiple disadvantage? How confident are they in their workforce's abilities to support this group of women adequately?

3.8.2 How can partner agencies support each other in a robust multi-agency risk assessment for these women and explore what "good practice" should look like?

3.8.3 A number of cases do not meet the high threshold of existing "high-risk" forums, i.e., MARAC; therefore, how are partner agencies assured that risk is nevertheless recognised and assessed robustly by involved partners, when the case falls outside of any such forum?

3.8.4 Are there any existing local and/ or national networks that Merton partners can use to support the national campaign for specialist support for parents whose children have been removed from their care?

3.8.5 How will the partnership know if and how progress has been made in this area?

3.9 FINDING 2: “THINK FAMILY” APPROACH

FINDING 2: **In circumstances where children’s services are initiating court proceedings, a think family approach is not adequately embedded. This means there is little chance that input from a range of adult services who know the mother feeds into planning at this stage of child protection processes. It decreases the chances of adequate compassion being shown to mothers or vital information being shared about risks of self-harm or suicide linked to their despair, so support can be provided. (Professional norms and cultures of communication and collaboration in longer term work)**

3.10 CONTEXT

“Think Family”: Think Family is an initiative that was introduced by the Department for Children, Schools and Families (DCSF) in 2008 following the Cabinet Office’s ‘Families at Risk Review’. The term ‘at risk’ is used to describe families who are experiencing multiple and complex problems, which frequently lead to poor outcomes for children within those families. “A system that ‘thinks family’ has no ‘wrong door’: contact with any one service gives access to a wider system of support. Individual needs are looked at in the context of the whole family, so clients are seen not just as individuals but as parents or other family members... Support is tailored to meet need so that families with the most complex needs receive the most intensive support.”[4]

A ”Think Family” approach therefore aims to support practitioners in all agencies who work with children, adults and families to consider a family and their support network as a system whose members interact and impact on each other. This also includes the practitioners’ duty to safeguard children and adults at risk, regardless of the agency they work in, and to be aware and confident when they need to make referrals to the relevant partner agencies.

“Think Family” has the potential to strengthen working relationships between agencies and to increase practitioners’ understanding of relative roles. It can therefore foster practitioners’ confidence and ability for professional and respectful challenge of professionals from partner agencies who work with the same family and to advocate for the family as a whole and/ or for the particular member of the family who the practitioner works with.

Public Law Outline (PLO): The Public Law Outline is a legal framework put in place by the Ministry of Justice in 2008. It aims to provide guidance for the family court on how to manage cases involving care proceedings. The PLO is also set out in practice guidance for the family court. It includes timescales for the courts to follow for each stage of the process, up to the final hearing. Guidance for children’s services requires Children’s Social Care to go through the pre-proceedings process with a family before starting court proceedings (except in an emergency). The PLO says the court must check at the first hearing that this ‘pre-proceedings’ work has been done.[5]

Pre-proceedings: This refers to the procedures that children’s services must follow if

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[4] Social Exclusion Taskforce: *Think Family – Improving the life chances of families at risk,* Cabinet Office (2008), p.5

[5] Family Rights Group, **https://frg.org.uk/get-help-and-advice/a-z-of-terms/public-law-outline-plo/**; accessed on 22/06/2022

they are thinking about initiating care proceedings. These procedures are set in the Public Law Outline (PLO). The first step that Children's Services should take is to send a letter before proceedings to the parents (and anyone else who has parental responsibility) to invite them to a 'pre-proceedings meeting'. The pre-proceedings process is a chance for parents and Children's Services to work together. The aim is to get to a point where Children's Services are satisfied that the parents can care for their child safely. If the concerns are around the child or young person being beyond parental control, then the process will focus on how to ensure their safety. During the pre-proceedings process, the parents will be assessed (for example through a parenting assessment, if that has not already happened). This should also be an opportunity for Children's Services to put in place support for the family, where needed.[6]

Two of the principles that are highlighted in Best Practice Guidance when working with families prior to court proceedings are that of partnership working with the child(ren), their family and significant others and that of using a multidisciplinary approach that uses, wherever possible, the existing skills, shared knowledge and resources of all partners and agencies involved with the child(ren) and their family to effect positive change.[7]

3.11 HOW DID THE FINDING MANIFEST IN ANNABEL'S STORY?

Annabel's plans to move to Brighton, were significant in Children's Services progressing to a Legal Planning Meeting, where the decision was taken to issue care proceedings with the plan for the children to remain with other family members, and not to return to Annabel, due to the potential cumulative impact on the children of Annabel's parenting on the children over the years, together with the impact of domestic abuse and her mental health and the loss of stability and support networks if she moved. The Review Team understood that Annabel's response to this decision was one of confusion and not being able to understand the reasons of this quick escalation as well as significantly increased anxiety and distress. We did not hear any evidence that Annabel was provided with any support or signposting at that point, whether in relation to her emotional needs (as outlined in Finding 1 already), or in terms of practical support for her rights, i.e., through a professional advocate, in addition to her solicitor. In this finding we want to highlight that there was also no evidence provided to the Review Team that Children's Social Care sought to consult with and include agencies in working with Annabel or to whom Annabel was known at the time (her GP, WDP, the IDVA) as part of their initiation of care proceedings. This was not in spirit of a "Think Family" approach and meant that other agencies did not have the opportunity to share the significantly heightened risks to Annabel in the time leading up to and after the court proceedings.

Conversely, responses by adult agencies to Annabel's disclosures of anxiety and distress, also including a lack of information sharing with children's services to enable a think family approach (or escalation). Annabel made numerous disclosures of anxiety and distress prior to and following the court hearing on 24th February which granted Child Arrangement Orders to extended family members in relation to her four younger children with an Interim Supervision Order to the local authority. Annabel clearly voiced and showed her confusion, distress and anxiety, to a number of professionals during this time

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[6] Family Rights Group, **https://frg.org.uk/get-help-and-advice/a-z-of-terms/pre-proceedings-process/**, accessed on 22/06/2022

[7] Public Law Working Group: "Best practice guidance: Support for and work with families prior to court proceedings", March 2021

period:

- On 10th February during her conversation with the Team Manager in Children's Social Care when she was informed about the Local Authority's proposed care plan for her children to live with other family members
- On 18th February during her first session with the therapist from Merton Uplift
- On 19th February during a telephone conversation with her named GP and Adult Safeguarding Lead of her GP surgery
- On 4th March when attending an outpatient follow-up appointment at Croydon Health Services (as this agency is outside of Merton, their practice has not been in focus of this SAR)
- On 4th March during her second session with the therapist from Merton Uplift

We did not hear any information or evidence that any of the agencies sought to speak to Children's Social Care, as part of their response to Annabel, to share their observations and concerns and enable this information to inform planning and support to the whole family in the lead up to, through and after court proceedings..

3.12 HOW DO WE KNOW IT IS UNDERLYING AND NOT A ONE-OFF?

Discussion with the case group and review team about progress with taking a think family approach locally surfaced areas of strength and areas for development. Review Team members felt that, although 'think family' has been recognized as an area requiring work, and progress has been made, it continues to be an important aspect within their agencies. This is summarised below.

Due to late information related to this finding, the reviewers have not had the opportunity to test specifically the extent to which a think family approach is routine once children's services have initiated care proceedings. Children's services confirmed that it is not their standard practice to consult other agencies when they initiate care proceedings. Only later, as part of the care proceedings, there are expert assessments identified that would clearly consider the parenting and the parent's needs that has an impact on children.

Participants, particularly from Victim Support/ IDVA, WDP and the children's social work team felt that "Think Family", in the sense of considering every member in the family and working with relevant agencies, is a routine approach. Whilst this aspect of "Think Family" was also echoed by the MARAC representatives, they also shared that that there is still a general expectation of a mother, when she is victim of domestic abuse, to keep the children safe and to put the responsibility on her, and there is less consideration by the professional network on what necessary work needs to be done with the perpetrator. One practice example of how this challenge can be approached differently is the Drive Project[8]. As the MARAC is a multi-agency forum, this feedback would potentially relate to the approach of many agencies who are members of MARAC.

In relation to offering advocacy support routinely to parents of children for whom professionals have child protection concerns or initiate care proceedings in order to help them understand the process and their rights, participants shared that this is not usual practice. This tends to be considered and offered only when parents have very particular

[8] www.driveproject.org.uk; accessed on 14/07/2022

needs, such as learning disabilities.

Discussions with the Review Team confirmed that here was no ‘live’ policy around “Think Family” routinely embedded in all agencies. However, Children’s services described their Multi Agency Safeguarding Hub that includes partners from across Police, Health, Education, Housing, IDVA as well as links with Probation and Adult Services. This is designed to enable a Think Family Approach within the Local Authority from the outset of a referral being made. Review Team members for the Clinical Commissioning Group and Mental Health emphasised their agencies’ usual approach in their practice to see a family holistically and consider all family members and significant others and their impact on each other in their assessments and work. The Review Team member for IDVA/ Victim Support shared that they also did not have a specific policy, but they take a holistic approach to supporting families and will ensure that the children are supported. They work with other services and also advocate on behalf of survivors for their needs, experience and risks to be recognized and their rights to be upheld.

Since Annabel’s death, agencies have done work around “Think Family”. Westminster Drug Project have started making arrangement with relevant partner agencies for co-location of practitioners to facilitate stronger working relationships between agencies and to reduce the need for people using services of several partner agencies to attend different locations. Representatives from Adult Social Care shared that there is now a Think Family policy in place in relation to their partnership working with Children’s Services and this required further work around its implementation and embedding. Within the Metropolitan Police there continue to be discussions around their ability to share appropriate and relevant information in relation to family members during meetings and discussions with partner agencies, whilst adhering to the legal requirements.

A Task and Finishing Group led by Adult Social Care oversees the further ongoing development of a Think Family approach across the partnership. Review Team members shared that this continues to be work in progress. This builds on work initiated in 2018[9].

3.13 HOW WIDESPREAD IS THIS SYSTEMS FINDING AND HOW MANY PEOPLE ARE ACTUALLY OR POTENTIALLY AFFECTED?

As described in Finding 1, the numbers of families involved where Children’s Services initiate care proceedings is small in Merton, but potentially high risk. Annabel’s case underlines how vital a think family approach is in these circumstances.

3.14 SO WHAT? WHY SHOULD THIS FINDING BE A PRIORITY FOR THE SAFEGUARDING PARTNERSHIP AND PARTNERS?

The current varied interpretation and level of implementation of a “Think Family” approach

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[9] See: Young Merton Together - (mertonpartnership.org.uk)

Reflections on the MSCP/MSAB Joint Conference by Aileen Buckton, Independent Chair of MSCP - Merton Safeguarding Children Partnership (mertonscp.org.uk)

across partner agencies means that partner agencies, whether currently involved with the same family or not, are not always contacted and do not always seek contact across the adults and children's services divide, when children's services decide to initiate care proceedings in respect of children in the family. Without an agreed and embedded understanding of a "Think Family" approach for these particular circumstances, individual practitioners are ill equipped to acknowledge and recognize when there is a need to make contact with relevant partner agencies to share relevant information, to enable effective support and risk management for all members of the family.

FINDING 2 – “THINK FAMILY” APPROACH

In circumstances where children’s services are initiating court proceedings, a think family approach is not adequately embedded. This means there is little chance that input from a range of adult services who know the mother feeds into planning at this stage of child protection processes. It decreases the chances of adequate compassion being shown to mothers or vital information being shared about risks of self-harm or suicide linked to their despair, so support can be provided. (Professional norms and cultures of communication and collaboration in longer term work)

SUMMARY OF SYSTEMIC RISKS

A lack of clarity about the need for a “Think Family” approach across agencies including circumstances where children’s services initiate care proceedings, fosters working practices that do not adequately focus on the mothers and other adult carers in such evidently distressing times.. This leaves us without having an embedded knowledge of the roles and responsibilities of partner agencies that could be relevant to and necessary for the person and their family and it increases the risk of missing situations where a mother’s distress has escalated so significantly reflected in the degree of her self-harm and that she has considered taking her own life. A safe system manages these risks by embracing and routinely advocating a well understood approach within agencies across the partnership. This finding highlights the gap in the opportunities across agencies to foster stronger working relationships with partners, that increase the understanding of respective roles and responsibilities, allow appropriate information sharing to support planning. This increases the risk that the support provided particularly to those people and their families with whom a number of agencies are involved fails to consider a balanced approach to the needs of all family members.

3.15 QUESTIONS FOR THE PARTNERSHIP TO CONSIDER:

3.15.1 Is the SAB aware of how the “Think Family” approach is understood and/or currently implemented and embraced by each partner agency, , including in respect of care proceedings?

3.15.2 Is there a common understanding of the general approach as well as the different aspects, particularly in circumstances where chidlren’s services have initiated care proceedings? If not, how could partner agencies work towards a commonly agreed understanding? What role might the SAB have to support this?

3.15.3 What are the ways in which partner agencies could support each other in the implementation of an agreed “Think Family” approach, particularly offering support to those agencies where implementation has not started, is at the early stages and is proving challenging?

3.15.4 Are the examples of good practice of a “Think Family” approach available in other London boroughs that the SAB can identify and learn from?

3.15.5 How would the SAB know if practice in this area has improved?

4 Appendix

4.1 AGENCIES WITHIN MERTON INVOLVED IN SAR ANNABEL

LONDON BOROUGH OF MERTON

- **Adult Social Care**
  - **Reablement Team** – supports residents for a period of one day up to 6 weeks who need care and support, usually following being discharged from hospital.
  - **Adult Safeguarding Team** – undertake safeguarding enquiries for residents in Merton who have care and support needs and are unable to protect themselves from the abuse. The team work collaboratively with partner agencies.
  - **First Response Team** – Offer Care Act Assessments if the resident meets the national eligibility threshold.
  - **Hospital to Home Team** – Supports residents who are in hospital but require assessment and support to ensure that their care and support needs are met.
- **Children's Social Care**
  - **Child Protection Chair** – they chair any child protection conference and ensure that child protection plans are robustly implemented, reviewed and progressed to ensure timely outcomes for children, young people and their families.
  - **Safeguarding and Care Planning Team** – Social Workers within the team works with children and families who are supported through a child in need or child protection plan. Additionally, they work with families for whom care proceedings are being considered or have been initiated.
- **Community Safety and Merton MARAC (Multi-Agency Risk Assessment Conference)** – MARAC is a multi-agency meeting attended by statutory and voluntary agencies in respect of highest risk domestic abuse cases; the aim is to share information and to increase the safety, health and wellbeing of victims/ survivors, adults and their children.

FROM OTHER AGENCIES/ORGANISATIONS:

- **Westminster Drug Project** – Deliver safe and effective and innovative services for people who are affected by drug and alcohol misuse.
- **Victim Support** – includes the Independent Domestic Violence Advisor (IDVA): the purpose is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children.
- **Clinical Commissioning Group (CCG)** – represent the GP practices
- **Metropolitan Police**
- **South-West London and St George's Mental Health NHS Trust**: Offer support via different approaches to get residents back on the path of mental health wellness.
  - Merton Uplift: is a free integrated primary care mental health service for adult residents in Merton and supports anyone who has a wellbeing need whether this is due to emotional difficulties or life stressors. It has three key elements:

Primary Care Recovery Service, Talking Therapy or Improving Access to Psychological Therapies (IAPT), and wellbeing.

- Merton Primary Care Recovery Service (PCRS): is an integral of Merton Uplift and utilizes the principles of partnership working and co-production supporting individuals with complex and severe and enduring mental illness.

4.2 AGENCIES OUTSIDE MERTON THAT WERE INVOLVED WITH ANNABEL AND PROVIDED INFORMATION/ DOCUMENTATION FOR CONTEXT PURPOSES

- **St Georges Hospital/ LB Wandsworth**
- **Epsom & St Helier Hospital Trust**
- **Croydon NHS Trust**
- **Sussex Partnership NHS Foundation Trust**
- **Greenwich MARAC**
- **Kent Police**
- **Brighton & Hove City Council**

4.3 GLOSSARY

Acronym	Meaning
ASC	Adult Social Care
CP	Child Protection
CSC	Children’s Social Services
EMDR	Eye Movement Desensitisation and Reprocessing
ICPC	Initial Child Protection Conference
IDVA	Independent Domestic Violence Advocate
LA	Local Authority
MARAC	Multi-Agency Risk Assessment Conference
MH	Mental Health
PCRS	Primary Care Recovery Service
PLO	Public Law Outline
RCPC	Review Child Protection Conference
SAB	Safeguarding Adult Board
SAR	Safeguarding Adult Review
WDP	Westminster Drug Project