# 1 Introduction

1.1 This Child Safeguarding Practice Review (CSPR) is being conducted in response to the death of two children Child C and Child D who died as a result of a house fire in March 2021. The fire is believed to have been started by their mother who also died. Children C and D were known to several services in Greenwich - Child C had an Education Health and Care Plan (EHCP) due to his additional needs. Child D was being assessed for an EHCP at the time of his death.

1.2 The deaths were notified to the Greenwich Safeguarding Children Partnership (GSCP) and a Rapid Review meeting took place a few days later. Members felt that there was learning for the Partnership from the circumstances of this family and recommended a Child Safeguarding Practice Review. They notified the National Panel who agreed with the recommendation.

1.3 At the time of writing, police enquiries had concluded (having established the cause of the fire) and the coroner's inquest into all three deaths was in train. This had been substantially delayed due to issues caused by the global C-19 pandemic.

# 2 Terms of Reference

2.1 The Terms of Reference were agreed by the panel. Agencies involved with the family were asked to analyse their involvement via a brief written submission. To ensure that the review was proportionate, the period covered is the preceding year i.e., from March 2020 up to the date of the incident in March 2021. However, agencies first became aware of the family in 2009 and, with help from the family, the panel used this early history to help build a picture of them. The review period coincides with the first and subsequent national lockdowns imposed by the government as the impact of the Covid-19 pandemic hit. Agencies were therefore asked to comment on how this had disrupted services.

2.2 The report is based on the agencies' submissions and a practitioner event with key staff that had worked with the family and knew them. Meetings were held with members of the family and their contribution is summarised at Section 6.

2.3 The broad areas included in the Terms of Reference that the panel agreed were the most important to look at were:

- The quality of information sharing across agencies about the needs of the children and their mother
- Exploration of family relationships including Mother's extended family and the children's father
- Were needs identified swiftly, thresholds applied correctly, and services provided in a timely manner. If not, what were the barriers to this? Were opportunities missed to identify risk at any stage?
- How were issues arising from diversity addressed e.g., were ethnicity, culture and background of the family considered during assessments? If so, were any issues or barriers identified?

- What impact did Covid-19 have on how professionals worked with this family and on the family stressors?
- The support for the family to try and minimise the impact of the challenges presented by the children and their additional needs
- What was understood, assessed, and shared by agencies about Mother's mental health and physical health (i.e., Mother's diagnosis of MS) and how these impacted on her capacity to parent?
- How much priority was given to understanding the lived experiences of the children?
- Examples of strong multi agency practice as well as lessons to learn across the Partnership.

# 3 The children

3.1 Before detailing the contact professionals had with this family it is important to pause and reflect on both children who are subjects of the review. It has been evident throughout the process that the children were popular, engaging and loved by those around them. These profiles have been collated from family members and from practitioners who knew the children well.

### Child C

3.2 Child C was a unique funny, kind, and sweet young man who brightened up everyone's day. He smiled a lot and would put on funny voices, acting out different characters and being a comedian. He was a cheeky individual and everyone who knew him loved him. He loved all things 'tech' and was a great older brother. He would cook every day and was planning to take food tech as a subject in GCSE. Child C's family described him as clever, witty, energetic, and very helpful. In the time he spent with them he made jokes and was mischievous but always made time to help. He liked to play with his phone and watch television and liked to look after his little brother. He enjoyed working with his grandmother and was happy chatting to the people he met there. In short, he was a total joy to have around, and he is very sadly missed by everyone.

### Child D

3.3 Child D was a well-loved member of the school, he always made his friends and adults smile. He was a quiet member of class, but he was always included in the children's chatter. He quite often sang to himself throughout the day, and he loved listening to stories and being read to. He could also be mischievous and one time he hid some maths resources from his teacher because he didn't want to do the activity! Each day he helped to collect a group of children together to lead them around a sensory circuit and this was one of his favourite things. In doing that he showed that he cared for others. Child D's family described him as a 'wonderful' boy. He had little speech but often would speak when he decided to. MGM has fond memories of him reading words such as 'swimming', 'dad', 'mum'. He loved home made food and wanted to help in the kitchen and taste everything. He was great at shopping enjoyed bus journeys. His family said he was 'just lovely'. When he saw his uncle and brother playing, he wanted to join in and sometimes complained that they were not including him. Child D enjoyed watching his IPAD and laughing at what was going on. He is also very sorely missed.

# 4 Agencies contact with the family

4.1 The agencies' submissions as part of the review process have been co-ordinated into a combined chronology and briefly summarised here. Further information is provided in subsequent sections to add context where relevant. This is not intended to be an exhaustive list of day-to-day contacts but highlights the main interactions.

## Background information

4.2 The family (Mother and the two children) lived and received services in Greenwich. Mother was separated from the Children's father, and he lived in another borough with his new family. There was a history of domestic abuse from father towards mother, dating back to 2009, and he received a community order for assaults against her. The children's contact with him was sporadic, particularly once he had other children. The parents' relationship remained difficult. Mother had another relationship which professionals were aware of, but she kept this very private, and he was not part of the children's lives.

4.3 Both children had additional needs and their behaviour could be very challenging. Child C had an Education Health and Care Plan (EHCP) due to his diagnosis of autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD). He received a high level of support in school. Child D was in the process of being assessed for an EHCP which was submitted in January 2021. He also received support in school. Of particular concern for him (aged 5) was that he had very limited speech.

4.4 Prior to and throughout the period under review there was a high level of contact with the ASD Outreach Team to support the family and this continued as much as possible through the national lockdowns. The children received other services such as Speech and Language Therapy (SALT) and music therapy, to try and support them with their associated communication difficulties. Agencies worked closely together throughout this period via a series of Team Around the Child (TAC) meetings, particularly around the boys' education and offering the family support during the lockdowns. Mother and other members of the family such as Maternal Grandmother (MGM) engaged in the meetings.

## Events in 2020

4.5 At the beginning of the first national lockdown (due to the C-19 pandemic) in March and April of 2020, schools were closed to try to contain the virus. Mother became overwhelmed with the demands of looking after both children at home. In addition, Mother reported the impact of the children's father telling her that if she couldn't cope, she 'should kill herself'. This was very upsetting and on top of everything else, this had got her down.

4.6 To try and support her, Child D's Music Therapist made a referral to Children's Social Care in Greenwich. It was agreed that the school would assist her further and a plan for daily contact with them was made. Mother found the contact helpful and although many services had to be delivered online, rather than in person, the children received a package of support.

4.7 In the autumn of 2020, Mother received a diagnosis of Multiple Sclerosis (MS). She had been experiencing symptoms for some time, but the diagnosis came as a shock. Mother reported that she had balance issues, found walking difficult and was suffering with

fatigue. There were additional symptoms she struggled with, including loss of sense in the fingers, and being unable to grip. This caused challenges to simple day to day activities e.g., buttoning her or the boys' clothes, cooking, writing etc. In addition, she also told her family that she had started suffering from memory loss.

4.8 She undertook treatment in the following months and reported some improvement in her symptoms, but she understood that this was a long-term condition. She was understandably worried about the future and the impact of this on her ability to care for her children.

4.9 The primary school made a further referral to Children's Social Care in Greenwich. The family were allocated to the Early Help Service to assist with co-ordinating services. A referral was made almost immediately for assistance from Health and Adult Services in Greenwich, but no services were offered as they assessed that Mother was not eligible. She was reluctant in any case to receive any practical help at that stage.

4.10 In the autumn of 2020, Mother's brother and MGM were babysitting the children but Mother did not return at the agreed time. A family member reported her missing to the police and they commenced an investigation into her whereabouts. She returned the following day, saying that she had needed some respite and space to process everything that was happening.

4.11 The referral to Health and Adult Services (HAS) was revisited when Mother was feeling more positive about accepting services. They were unable to contact Mother to explore what services would be helpful and referred back to Children's Services.

4.12 Mother took up the offer of counselling from Greenwich Time to Talk[1] and had several sessions. She engaged well with these and when the allotted amount came to an end, the counsellor recommended that the sessions continue.

4.13 At the beginning of 2021, the UK again experienced a national lockdown to try and contain the spread of C-19 virus. Both children were allocated places in school and attended as normal. The Team around the Child meetings continued as a school-based plan, as the family were closed to Early Help services in early February. Early Help had put a sustainability plan in place in case the family needed help and they were also able to link in with the school.

**Week leading to the tragedy**

4.14 In the first week of March 2021 there were several contacts with the professional network. Mother had a counselling session with 'Time to Talk' where she disclosed that Child C had unwittingly seen her, and her partner in bed. The exact details of this are not known but Mother disclosed that she had spent money on Child C to try and appease him. Mother was tearful and low in this session and sought advice about how to deal with the situation. **NB** Mother's partner did not live in the family home and was not well known to the children.

[1] Greenwich Time to Talk is part of a national programme of Improving Access to Psychological Therapies (IAPT). It is for people with mild problems of anxiety or depression who are motivated to work to change the problem.

4.15 There was a Team Around the Child meeting in the same week where Mother initially presented as being very subdued and tearful. She was reported to be more positive at the end of the meeting. After this, MGM contacted the Early Help team as she was worried that her daughter's mental health was deteriorating and wanted to see what other support could be offered. MGM was unaware that this team were no longer involved. Mother contacted Early Help services later to apologise for her mother's contact with them saying that she would use QWELL[2] as per the sustainability plan.

4.16 On the same day Mother reported to her MS consultant that there had been an overall improvement in her condition after her treatment, but she still had walking and balance issues. This was recorded by the service as a positive interaction.

4.17 The primary school also referred to the Multi Agency Safeguarding Hub (MASH) concerned that mother was becoming overwhelmed. Her mental health was deteriorating, and the referral noted she was very tearful in the recent TAC meeting. MASH and Early Help services communicated about this and MGM's contact to services.

4.18 On Friday (the day before the fire), Child C arrived at school saying that his bag had been stolen on the way to school. Police and MASH were informed, and school staff contacted Mother. This was being dealt with by MASH but had not yet been uploaded to the system. Mother did not seem concerned about this and was happy to see Child C when she collected him. **NB** this turned out to be untrue and he had left his bag at home.

4.19 The following day the events leading to this CSPR unfolded. Mother and both children died as a result of the house fire.

# 5 Findings

### The Team around the Child/Think Family

5.1 The Team around the Child for this family was well established, having been started in both the children's schools and then brought together by the Early Help team during the review period. Strong plans were established to help the children with their communication difficulties and to try and support Mother in caring for them. Mother was very engaged with the process and professionals had good relationships with her. Professionals noted that Mother's anxiety presented itself by talking at length to them about her issues and she seemed 'lighter' at the end of these sessions.

5.2 The review has highlighted however that some services could have adopted a stronger 'think family' approach. The children's needs were the focus of the Team around the Child and support to Mother in relation to their needs was evident. However, Mother had needs in her own right which also impacted on her ability to care for the children. Not least, these were around her physical deterioration due to her MS, coupled with the worries and anxiety this had understandably provoked in her.

5.3 It was evident through the review that Mother was troubled about a number of things in

[2] QWELL is a free anonymous, online counselling and emotional wellbeing service for adults

her life E.g. being a victim of domestic abuse from the children's father, the ongoing difficulties in that relationship, and her disappointment and possibly shame in her current relationship that she conveyed to practitioners. Very little is known about him and was worthy of further exploration. Whilst there is no suggestion that their association was anything other than consensual it seems that this also contributed to her anxiety and having low self-esteem.

5.4 In addition to these factors, it is not unusual for parents of disabled children to feel grief and depression at the loss of the type of life they had imagined their children living and the achievements they wished for them. The family also noted Mother's struggles with the demands of her children, and more is said about this in Section 6. In relation to her own life changing condition, Mother was extremely fatigued and day to day life was becoming more difficult in terms of managing routine tasks. Mother's family noticed that these all became more pronounced during the C-19 pandemic as the restrictions meant that access to her coping mechanisms such as exercising at the gym were not available.

5.5 There was some liaison between children's services and adults' services, but these were limited. Adult focused practitioners such as the MS nurse did not attend the Team around the Child meetings. She was invited to at least one but was unable to attend. The information gleaned through this process states that she was able to feed in information to the meetings through the EH practitioners, but it lacked continuity. Attendance at the meetings would have given her a more holistic view of the family and what Mother needed in terms of her own care.

5.6 In consultation with practitioners, they reflected on the reasons for this. They were clear that Mother's emphasis in these meetings was the children and there was some resistance from her to mix the two sets of services. Whilst this was understandable from Mother's perspective, the lack of co-ordination meant that there was a mismatch between the needs of the children, Mother's needs in terms of being able to care for the children and Mother's needs in her own right. The hospital based MS service (Queen Elizabeth Hospital), Health and Adult Services (HAS) and Greenwich Time to Talk all had information to contribute. This would have given a more rounded picture of Mother's difficulties and would have informed the assessment of need. Instead, the assessment of Mother and her needs was piecemeal.

5.7 Whilst it would not have been appropriate for Mother's counsellor to join meetings as such, the information from Oxleas during the review makes the point that there is merit in counsellors contacting other services e.g., children's services, to exchange information. This would have been especially beneficial around Mother's mental health and mood which fluctuated between sessions. Opening this channel of communication would also have been advantageous when dealing with the issue of Child C and the complexities of those dynamics. There was a missed opportunity for the practitioner and the organisation to seek safeguarding advice and supervision outside of their own organisation. Had Children's Services been made aware of this issue, statutory intervention may have been offered at an earlier stage.

5.8 In families such as this one, where there are complex needs for both the adults and the children, services need to work in partnership with each other as well as in partnership with the family, to ensure that all members of the family's needs are met effectively. Adult

health services and the family GP who were providing support to Mother in relation to her MS, had very limited knowledge of the family as a whole.

5.9 An avenue that could have gone some way to bridging this gap may have been a formal Parent Carers Assessment under the Children and Families Act 2014[3]. It was not utilised and there is a question about whether the pathway in Greenwich is clear to practitioners about when this can and should be used. Mother's physical deterioration and fluctuating mental health was a major factor in finding the demands of caring for her children overwhelming. This is unsurprising given their additional needs and the fact that she was a single parent. Meeting her needs under the auspices of this legislation may have opened up more resources to be help her. Mother never requested this, but it was unlikely that she was aware of her right to ask for such an assessment. **Recommendations are made at 8.2 and 8.3 to ensure practitioners are aware of this legislation and obligation to assess carers and that carers are aware of their rights.**

5.10 Although no formal assessment of her caring needs was completed, good practice was demonstrated by offers of respite care, child minding and after school clubs for Child C. It seemed however, that there were multiple barriers for Mother as to why these were not utilised and opportunity for a more detailed exploration of what these barriers were, may have been more evident through this formal assessment. Information from Early Help services usefully identified that a possible barrier for Mother was the sheer number of services offered, which may have felt overwhelming.

5.11 Professionals were aware of the children's extended family on Mother's side and knew that they were supportive and close as a family unit. An organised pattern of respite through a Family Group Conference would have been an avenue to explore this further. It is not clear if Mother would have followed through with any such plans given information gleaned from family and professionals alike which acknowledged that when services were offered, they were rarely taken up.

5.12 Health and Adult Services (HAS) also offered services which Mother declined on the first occasion. A further referral was made, and this was not followed up by them when they were unable to contact her. Learning identified is again about the need for adult focused services and child focused services to better comprehend each other's worlds. There was no doubt that Mother did have eligible needs under the Care Act 2014, but the information was shared between agencies in a fragmented way resulting in limited understanding of Mother's needs.

5.13 Since this review and because of learning from it, Greenwich have updated their existing joint protocol between the Greenwich Safeguarding Children Partnership and Safeguarding Adult's Board. This is due to be launched in spring 2022 to help practitioners identify and respond to concerns about a vulnerable child or adult at risk. The protocol will help to ensure effective and timely referrals between all adult's and children's services and promote good practice in multi-agency working. This guidance for staff will be invaluable to Greenwich in how to provide better joined up services between adults and children. **A recommendation is made at 8.1 to ensure that this is**

[3] The Children and Families Act 2014 amended some sections of the Children Act 1989. Under this legislation local authorities must assess parent carers if it appears that the parent carer may have support needs, or they receive a request from the parent carer to assess their support needs.

**embedded into practice**

**Responding to fluctuating mental health needs**

5.14 It was well known to the network that Mother struggled with her mental well-being. To this end services were in place to try and support her with trying to improve her mood. Mother was given a choice of services and opted for counselling provided by Greenwich Time to Talk. This was her main mental health support. Mother also confided in other professionals and many of them reported lengthy sessions with her where she would talk freely and often feel more positive after these. Family members also offered their ongoing support both in terms of helping her and the children. As the outcome in this instance was so tragic, it is necessary to examine some of the practices and factors that led to her mental health crisis going unrecognised. Significantly during the period under review, Mother was never assessed formally under the Mental Health Act, nor did she seek mental health support from her GP. i.e., she was never considered to be high risk of harming herself or others.

5.15 Prior to Mother being supported by Greenwich Time to Talk, Early Help Services recognised that Mother's mental health was an issue. What this looked like for her and how it impacted on her day-to-day functioning was not explored sufficiently. In terms of initial safety planning i.e., whilst waiting for counselling, Mother was advised to seek alternative support such as the Samaritans or present herself to A&E. The reasons that these suggestions were made is not explored with her (or at least not recorded). The information gleaned during the review identified learning for Early Help practitioners in being equipped to identify mental health struggles on a person's ability to parent and to ensure that the reasons for referral are re-visited. Since this incident, the Early Help Service in Greenwich are developing practice guidance for their staff specifically about how to approach assessing risk thoroughly where parents are experiencing intrusive thoughts.

5.16 A referral was made to Greenwich Time to Talk, and they provided a service to Mother between December 2020 and March 2021. The sessions were led by Mother as per their practice model and the therapist worked with what she brought to each session. Much of the work was focused on her personal issues but Greenwich Time to Talk used screening tools to assess risk as per their usual practice. Learning was identified in relation to how risk is assessed using their standard patient questionnaire. The questionnaire is based on a series of questions answered by the client in relation to their day to day lives and how they are feeling. In this instance, the overall scores in terms of Mother's well-being were getting better but this does not tell the whole story. There were times when Mother's response to the specific question about intrusive thoughts should have triggered more in-depth assessment of risk.

5.17 Practitioners expressed (and was confirmed by managers) that there was limited time to check individual scores. Custom and practice in that service was that counsellors only looked at the individual scores more closely if there is a reason to e.g., serious concerns expressed in the sessions. OXLEAS acknowledged this learning and made a recommendation to alter their practice. This is a systemic issue that needs to be addressed and new practice has been embedded whereby practitioners are asked to check the individual scores and not just the overall score. Quality assurance mechanisms

to ensure compliance with this are in train.

5.18 Due to COVID, the sessions were also delivered via the internet or the telephone and in these circumstances, subtle nuances of body language and other cues may have been missed. There is a view from Mother's family that this approach was not helpful to her, and this is expended on by them in Section 6. This is a systemic issue as practitioners were directed by their employers to work online, in line with government instruction and were not permitted to meet clients in person. It is nevertheless an important point. Now that agencies have experienced service delivery through a pandemic, how services are offered and how risk is managed for individuals will be an important feature for major disruption to services in the future. **A recommendation is made at 8.7 to put in place contingency plans for any future interruption to services**

5.19 A challenge for practitioners working with the family was not just Mother's poor mental health but also the fluctuating nature of it. It is likely that this was, at least in part, connected to her physical health also being up and down. As we have seen, Mother responded well to agencies and really appreciated the support. She was very verbal about this and often wrote to agencies to thank them for their help. In her darker moments she would express how down she felt but practitioners observed that she was frequently visibly more positive at the end of an interaction. As outlined, there are lessons to learn but this may go some way to explaining how this was missed. Mother was able to mask her true feelings and intentions, perhaps as a coping mechanism. The day before the fire, despite being 'down' earlier in the week, school staff had a conversation with Mother (ostensibly about Child C's bag being stolen) where outwardly she appeared to be fine. She was supportive to Child C, pleased to see him and did not show any signs of distress. **Individual agencies recognised this issue in their submissions to the review. They have plans in place to address these practice shortfalls so although this is identified learning, there is no recommendation for the Partnership.**

**The legacy of domestic abuse**

5.20 It was very positive that services (Early Help in particular), tried very hard to engage the children's father with their work. He was resistant to being directly involved but did agree that the practitioners would keep him up to date as he did not want to attend Team around the Child meetings. His contact with the children was sporadic and became more so when he had a new family in the autumn of 2020. The relationship between the parents was complex and mother found the legacy of the domestic abuse difficult to deal with. Little is said by agencies about the impact of this on the children. It is not therefore known how the children viewed their father and how keenly they felt his absence in favour of his other children.

5.21 An important lesson from this review is about domestic abuse between partners who have separated but where there is ongoing contact with children. This is a complex dynamic; the power imbalance is likely to be still present and practitioners need to consider how this should be assessed. Research tells us that parental separation does not guarantee an end to domestic abuse and that for many women who separate from violent partners, the domestic abuse continues beyond this. The Domestic Abuse Act 2021 recognises

that separated women are at particularly high risk and so therefore are their children.[4] The new legislation extends the controlling and coercive behaviour offence to cover post separation abuse.

5.22 For many families, contact between fathers and their children provides a context for domestic abuse to continue.[5] Notably in this instance, Mother had reported that Father made her feel uncomfortable. She found him controlling and verbally abusive and if he did come to the house to collect the children, she stayed upstairs. It is likely that this added to Mother's poor self-esteem and her feelings of shame. Although by no means the only issue Mother faced, it was an important one to assess. **A recommendation is made at 8.4 to try and address this.**

**Understanding the Family's lived experience**

**Children C and D**

5.23 Understanding of the children's needs and lived experiences in this family was mixed. From the information provided it is evident that many services were geared towards the children. These were both in terms of maximising their education opportunities but also improving their emotional well-being. Both schools (primary and secondary) had a good relationship with the children and provided them with a huge amount of support. Unfortunately, there was a long lead in time to submitting the EHCP application for Child D, due largely to the amount of evidence needed for this and it was inevitably delayed further due to COVID. This was not however outside of usual waiting times and the school followed the process of gathering the substantial evidence needed to progress the application. School funded support was made available to Child D prior to the EHCP being in place. Consultations with Mother were child focused and she contributed to developing plans for both children in and out of school.

5.24 During the lockdowns, schools were under an immense amount of pressure, and it would be reasonable to assume that services faltered whilst they got to grips with the demands that lockdown brought. That said, as soon as they were able to provide more services, they did so as Mother was finding it very difficult to manage the two children at home. During the first lockdown the children were not allocated school places as they did not meet the very specific criteria. In any event, Child D would have struggled to cope with the daily staff changes that were a feature of how the school managed their timetable in that period. With Mother's agreement, extra support was put in at home, and this was a mixture of face to face and virtual contact. During subsequent lockdowns when schools were able to exercise their discretion and allocate places according to need, both children attended as normal.

5.25 From the information provided, no agency had an in depth understanding of what day to day life was like for these children when they were at home. Their voices are not strong in the information submitted by agencies. Mother's physical deterioration would have

[4] The Domestic Abuse Act 2021 came into effect in 2022.

[5] Children Experiencing Domestic Violence: A Research Review (Stanley 2011). Children's health and well-being, and service responses. www.rip.org.uk/publications

meant changes for the children in how they were cared for and there are reports of Child C stepping in to help Child D get ready for school. Those who knew him well felt that this would be a great expectation on him which he would have found difficult. It is understandable in this context, how Mother might have come to rely on his help, but it is by no means clear to what extent Child C was providing support to his mother.

5.26 Assessments and subsequent work with children will always be unique to the individual features of that family. Multi agency services are aware of the impact of specific factors such as race, religion, and family background. It is disappointing therefore that there was insufficient exploration of the children and their identity, e.g., their relationships and extended family. A genogram would have enabled further exploration of the nuances of the family. Whilst it is unlikely that this would not have impacted on the outcome, it would have provided a more complete picture and enable further understanding of the children and their lived experience. This resonates with other reviews that have been carried out in Greenwich. **A recommendation is made at 8.5 to ensure that practitioners are equipped to be able to carry out this work competently.**

5.27 It is likely that the contacts and referrals to MASH in the days just prior to the incident would have led to a more formal statutory assessment, and more information (such as the extent of Child C's help) may have been captured then through a safeguarding lens. The lack of emphasis on Mother's deteriorating parenting capacity in the Team around the Child is an area for practice development within that structure. This was exacerbated by adult services not being involved in meetings and a holistic understanding, shared by all the professionals involved with the family, would have been valuable. The Early Help service identified that the practice was more focused towards supporting parenting. Where this is the case, there are now quality assurance mechanisms in place to ensure the impact on the children in the family is also sufficiently considered.

**Mother**

5.28 Throughout the review, Mother's circumstances have been highlighted. As in all families, circumstances in relation to their day to day lived experiences were unique. Viewing this family through the lens of intersectionality[6] would have been a helpful framework to aid practitioners' understanding of their uniqueness and therefore their needs. Mother encountered multiple disadvantages, the combination of which meant that she faced multiple barriers to accessing services. Mother was a Black African single mother to two children with additional needs. She struggled with her mental health, was a victim of domestic abuse, and she had a debilitating, life limiting condition. Whilst all of this was identified and acknowledged, assessment of the cumulative effects of these factors was not evident across the multi-agency network.

5.29 One vital aspect of Mother's life that was missing from assessments was the support she got from church members. It is significant to note that Mother's faith did not feature in any of the information provided to the review and it was the extended family who brought this to the panel's attention.

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

5.30 Mother had a rich spiritual life and a strong faith. The church had been a very important feature of her life since childhood and she had known some church members since then. She had always drawn spiritual guidance from the church and in times of need she was supported by different members. She attended services and various other activities both in person (prior to lockdowns) and online.

5.31 During the many lockdowns during this period, she had at least weekly contact with a mentor who encouraged her and prayed with her. Mother was able to confide in the people from the church that she trusted, and they formed a huge part of her support network. Much of this was done online as the situation allowed, but feedback from members of the church was that she gained great comfort from their contact. Whilst the focus of the support was Mother, the children also had a relationship with the church, particularly Child C who was able to communicate more ably through the internet.

5.32 The bringing of all the information together in assessments, plans and direct service delivery would have been beneficial. Its absence is a stark reminder that issues of practitioners being culturally competent and addressing the discrimination experienced by some communities, is still some way to being fully embedded in practice. Mother's spiritual life and her faith were central to her being and very important to the rest of her family, yet it was not known about throughout the work being done. It is not clear if the question about the family and religion was specifically explored but the conclusion reached here is that this, and other multiple factors were not sufficiently assessed or understood. **A recommendation is made at 8.6 to try and address this within the Partnership**

# 6 Family Contribution

6.1 The author had the privilege of meeting and liaising with family members during the review. It is to the family's credit that they were able to contribute as thoughtfully as they did, considering the devastation they felt at the loss of their family members. The report is a richer piece of work for this, and the author and panel are grateful to the family for taking the time to do this at such a painful time.

6.2 The family spoke freely about what they considered the strengths and weaknesses of services offered to them. Where these were triangulated with other material from the review, these are referenced in the body of the report. Otherwise, the following is a summary of what was discussed and reflects how the family viewed things at the time.

6.3 In essence, the family wanted to emphasise that they feel that services for Mother did the bare minimum. Throughout the last few months of her life, the lack of face-to-face interactions with her and particularly throughout Covid, contributed to Mother's deterioration and perhaps even the actions that followed. The family think there was a lack of contingency planning for when clients could not be seen, and that services did not talk to each other. To them it feels like Covid will be used as a "reason" rather than an excuse as to the level of service that was received. They did not want this to detract from how let down they feel as a family, regarding Mother's care from the services she was involved with. More aspects of why the family thought this are detailed in the next few paragraphs.

6.4 The family had a good understanding of the process of this review and appreciated that it was focused on learning lessons to improve practice, but they were frustrated by how long everything was taking, especially the inquest. At the time of speaking to them, there was no date for the inquest and several of Mother's personal effects had not been returned to them. Although they understood that everything had been delayed by the C-19 pandemic, this was causing them some distress knowing that the inquest was still outstanding and would be a difficult thing to go through. The Police Family Liaison Office was keeping in touch as much as they could but frequently there was no update to give. To date the police still have not contacted the family.

6.5 The family did not understand or realise the extent of how low Mother was feeling and wondered why this was not picked up by professionals who knew her. As family members they felt that they were not trained to do this but that professionals who were should have explored this more. They reported that Mother found the children's needs very overwhelming, and they helped as much as they could. They offered much support – e.g., for the children to spend the day with them - MGM even offered for Child C to go and live with her. Mother would always agree but then often this would not happen. They felt that this was because she did not want to be a burden and reflected that the reason for this may have been that she had already planned the deaths. Mother was always very good at covering up how she really felt, and this had always been the case.

6.6 The situation deteriorated as Mother's MS symptoms became worse and her ability to perform practical tasks lessened. MGM noted how much more difficult Mother found it to do housework and this was very upsetting for her as she was very house proud. Issues such as being able to claim benefits such as Personal Independence Payment (PIP) became important to her, but this was turned down, nor was she entitled to Mobility Allowance to enable her to travel more easily.

6.7 As it got worse – particularly in those final days before the fire, MGM had contacted Early Help Services to see if they could provide more assistance as she could see that Mother's mental health was deteriorating. In discussion about this, the family agreed that a conversation with Mother about contacting her GP or more formal mental health services may have been beneficial to see if they could provide further support. MGM thought that Mother had a good relationship with her GP so this may have been an avenue to explore. They believed that the GP had prescribed sleeping pills, but there is no record of this.

6.8 The family could see that COVID had influenced how services were being delivered, particularly when face to face services were replaced by online services. They felt that this was not good for Mother or the children and that in future if circumstances such as a pandemic should reoccur, consideration should be given to keeping some face-to-face appointments open. Mother used her sessions to the full but also found them distressing as she talked about deep and painful experiences. She was then left in her own space, in her own home and was isolated with her 'heavy' thoughts with just the children to look after. They felt this 'blanket approach' to delivering services virtually was not helpful to her. In addition, Mother had lost access to all her coping mechanisms such as the gym, spa days and being able to swim. These things were always important to her but especially so in these circumstances.

6.9 The family explored the notion of help from adult services and wondered why this had not

been pursued more vigorously. They understood that Mother was reluctant to accept help but were unsure about at what point services should be obligatory when it was clear that someone was really struggling. The question of mental capacity came up for them and although they knew that Mother always had capacity, they questioned why it was that services could be refused so easily.

6.10 All in all, the family felt that Mother's mind and character had changed immensely since her diagnosis of MS. She felt that life had treated her very unfairly and she was angry and upset. She struggled with her children's challenges and would sometimes say she wanted them to be 'more like other children'. She was able to see that Child D had some profound needs and that these would get more difficult to manage for her and him, as he got older. MGM said that the schools had offered a lot of support and that they and Mother were very grateful for that. MGM did question however the length of time that the EHCP for Child D was taking when it was so obvious that his needs were very great. Child D had no speech and was very delayed compared to his peers.

# 7 Conclusion

7.1 There is learning from this tragedy for the partnership which may require some strengthening of practice for agencies. The learning is captured in the body of the report but can be summarised by the following points.

- The need for practitioners to think more holistically about families and consider all the presenting needs, including those of the adults in the family.
- A recognition of practitioners' role and responsibilities for parents caring for children with disabilities and how legislation and guidance can support their work
- Assessment of the impact of domestic abuse whether current or historic and the emotional effects of that on family members.
- The need for practitioners to be cognisant of the impact of intrusive thoughts and for those to be risk assessed at an early stage.
- The importance of grasping children's day to day lived experiences and how their history, identity, and individual struggles shape this.
- The support that families receive from their faith and from their church should be assessed as a vital part of their support network.
- Issues of intersectionality and the impact of multiple oppressions experienced by this family needed to be explored and understood.
- The disruption to services caused by COVID meant that Mother's needs in relation to her own support were not adequately met.

7.2 The review has also identified good practice. E.g., despite the restrictions imposed by COVID the children were well supported in their schools and a variety of services were offered to support Mother's care of the children. There was a co-ordinated Team around the Child in place and strong plans in place that were reviewed regularly.

# 8 Recommendations

8.1 The Safeguarding Families Joint Protocol which requires practitioners to 'think family' to

be launched in Spring 2022. This should include awareness raising of the revisions to the existing protocol with front-line practitioner events, audits of practice, visual aids etc. The Greenwich Safeguarding Children Partnership should ensure that this continues to remain a primary focus for safeguarding partners as a result of the learning from this review.

8.2 Greenwich Safeguarding Children Partnership should ensure that the learning from this review i.e., the need to assess parents as carers when caring for children with additional needs, is embedded in practice. This is to ensure that carer's needs are sufficiently considered and assessed in line with the expectations of Parent Carers Assessments in the Children and Families Act 2014.

8.3 In addition to the recommendation above, the provision of information available in Greenwich about Parent Carers Assessments needs to be reviewed so that it is clearer to carers what their entitlement is, how to request it, who can access it and what to expect as a result of such an assessment.

8.4 Greenwich Safeguarding Children Partnership to review their training strategy to ensure that all partners equip their practitioners to be confident when dealing with families where domestic abuse is (or has been) a factor. This should include the importance of professional curiosity about all relationships, exploring potential ongoing risks, when parents separate and the need for ongoing contact arrangements to be kept under review.

8.5 Greenwich Safeguarding Children Partnership should ensure through its learning and development programme, that all agencies have arrangements in place to ensure assessments and ongoing work includes the child's experience and emotional impact of these experiences as well as the child's voice.

8.6 In line with the above and in light of the findings in this review about families who experience multiple oppressions and disadvantage, professionals in the Partnership should also be equipped with cultural competency together with an understanding of intersectionality to properly identify and consider these factors when assessing and managing the risk to children.

8.7 Greenwich Safeguarding Children Partnership should oversee partner agencies have sufficient contingency plans to provide nuanced, child centred services in the event of a major disruption to services such as experienced during the C-19 pandemic services.

8.8 The learning from this review should be shared with the Greenwich Adult Safeguarding Board.

**Jane Doherty**
**Independent Social Work Consultant**
**December 2022**