LONDON BOROUGH OF WANDSWORTH

COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW
AND JOINT
LESSONS LEARNED REVIEW

OVERVIEW REPORT

FLEUR AGED 21

MURDERED IN SEPTEMBER 2017 IN WANDSWORTH

CHILD A AGED 9 AND CHILD B AGED 5
EMOTIONALLY ABUSED IN THE SAME HOUSEHOLD

REVIEW PANEL CHAIR AND AUTHOR
BILL GRIFFITHS CBE BEM QPM
2 OCTOBER 2020

Domestic Homicide Review Panel – LB Wandsworth CSP
'Fleur' found murdered in September 2017 in Wandsworth

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INTRODUCTION

1. This report of a domestic homicide review (DHR) with joint Serious Case Review (SCR) examines agency responses and support given to 'Fleur' (not her real name), a French National and resident of the London Borough (LB) of Wandsworth prior to the discovery of her murder. She was the family au-pair/nanny to children, aged 8 and 2, and the review will also examine agency responses and support given to them on a 'lessons learned' basis.

2. In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before the homicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

3. In January 2016, a few days after her 20th birthday, Fleur left France to work as an au-pair for the two children, then aged 8 and 3, of 'Danielle' at a house in the LB of Wandsworth. Also living there was Danielle's partner, 'Pierre'. They are both French Nationals with Algerian heritage.

4. Within a few months, Fleur had become the subject of abuse and exploitation, led by Danielle with Pierre a willing collaborator. The trail of abuse degenerated to the point of starvation and torture, culminating in her death shortly before its discovery in September 2017. Following their joint trial at the Central Criminal Court, in June 2018 they were each sentenced to life imprisonment for murder and perverting the course of justice by attempting to cremate her body.

5. The review will consider agencies contact/involvement with Fleur, Danielle, her two children (Child A and Child B) and Pierre from when first known to agencies in November 2007 and the day of the discovery of the homicide in September 2017. Some contact with 'Luke', the putative father of Child B, will also feature. Any relevant fact from their earlier lives will be included in background information.

6. The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed because of domestic violence and abuse. For these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change to reduce the risk of such tragedies happening in the future.

7. The victim was not related to the perpetrators, nor in an intimate relationship with them as is usually the case with such reviews. However, she was in their employ and under their financial control living in the same household, thus necessitating a DHR within Home Office guidance. Latterly, she was a virtual prisoner in the home and suffered a mounting campaign of extraordinary physical and psychological abuse that resulted in her death.

8. On behalf of the Panel, the Chair has offered Fleur's parents heartfelt condolences on the loss of their daughter.

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TIMESCALES

9. The review began with a Panel meeting in June 2018, formed of representatives from the agencies (see table 1 below) that had relevant contact with Fleur and the family. Terms of Reference were agreed, and Individual Management Reviews (IMR) commissioned (chronologies of contact had already been gathered). At the second meeting on October, a timeline of events prepared by the Chair from the IMRs received was reviewed and eleven clarification questions he had identified were discussed.

10. A third meeting in November reviewed and debated the second draft of an overview report. There was then a delay due to the provision of the local GP Practice IMR which was made available in February. The fourth meeting in April 2019 considered the fourth version of the overview report. The fifth meeting on 21 August considered a sixth version of the overview report. The final version was presented to the CSP on 9 September and the finally agreed action plan has been incorporated in version 8.

CONFIDENTIALITY

11. The findings of each review are confidential. Information is available only to participating officers/professionals and their line managers.

12. For ease of reference, all terms suitable for acronym will appear once in full and there is also a glossary at the end of the report. Random pseudonyms have been allocated to the four adults involved and sequential letters to the two children. Pairs of letters will be used to refer to others that feature in the chronology and these are included in the glossary for reference.

13. The Government Protective Marking Scheme (GPMS) was adopted throughout with a rating of ''Official-Sensitive' for shared material. Either secure networks were in place (gsi, pnn) and adopted (cjsm) or papers shared with password protection. A copy of IMRs was provided to all Panel members for review and discussion. The Panel were satisfied as to the independence of the IMR authors.

TERMS OF REFERENCE

14. Following discussion of a draft in the first Panel meeting, Terms of Reference (ToR) were issued on the same day with an IMR template for completion by agencies reporting contact with Fleur and the family, and subsequently updated (appendix 1).

METHODOLOGY

15. Under s9 Domestic Violence, Crime and Victims Act 2004, a Domestic Homicide Review (DHR) was commissioned by the LB Wandsworth Community Safety Partnership and the Wandsworth Children's Safeguarding Partnership (WCSP) agreed a parallel 'Lessons Learned Review' under Working Together to Safeguard the Child 2015. In April 2018, Bill Griffiths CBE BEM QPM was appointed Independent Chair of the Panel. Tony Hester has supported him throughout in the role of Manager and Secretary to the Panel. The reason for the six-month delay between the homicide in September 2017 and this appointment is,

firstly, that the CSP was taking advice on whether the unusual circumstances met the definition of a domestic homicide (Fleur was not a family member or involved in an intimate relationship), secondly, the multi-Borough complexity meant that time was needed to identify key partners.

16. This review was commissioned under Home Office Guidance issued in December 2016 and Working Together to Safeguard Children Guidance 2015-18. Attention was paid to the cross-government definition of domestic violence and abuse and is included in appendix 1.

17. The following policies, initiatives and research papers have also been scrutinised and considered:

    HM Government strategy for Ending Violence against Women and Girls 2016-2020
    Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews published by the Home Office December 2016
    Domestic Homicide Reviews: Key Findings from analysis of domestic homicide reviews published by Home Office December 2016
    London multi-agency safeguarding adults and child protection policies and procedures 2015
    Working Together to Safeguard Children 2015/2018/Children Acts 1989 and 2004
    Wandsworth Council website: Domestic Violence and Abuse
    Modern slavery national protocols

18. In addition, the Chair has taken account of four prior DHR reports by Wandsworth Council for any parallel learning or repeat lessons to be learned.

INVOLVEMENT OF FAMILY, FRIENDS, WORK COLLEAGUES, NEIGHBOURS AND WIDER COMMUNITY

19. With the assistance of the police family liaison officer and a French language interpreter, Fleur's mother and stepfather were interviewed by the Chair when at the Central Criminal Court for the trial. A French version of the Home Office explanatory leaflet was also provided and the advocacy section highlighted. The draft Terms of Reference were explained and their input invited. They and Fleur's father were also seen at the sentence hearing and comment invited. They kindly provided respective permission for access to their witness and impact statements. Attempts to contact them through the French Embassy and share a draft copy of the overview for comment were not successful.

20. The perpetrators were located within the prison system. Requests for interview with the Chair were not responded to.

21. A local shopkeeper who gave food to Fleur and a witness who was a friend of Danielle who got to know Fleur were contacted and declined the opportunity to be interviewed by the chair but gave consent for their witness statements to be shared.

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CONTRIBUTORS TO THE REVIEW

22. This review report is an anthology of information and facts from the organisations represented on the Panel, most of which were potential support agencies for Fleur and the family. Each agency provided an Individual Management Review (IMR) containing their record of contact, their analysis of what happened, identification of good practice as well as any lessons to be learned with recommendations for improvements to the system for safeguarding. IMRs are conducted by a senior manager not connected with the events. The Chair was assured of the independence of Panel members. The French Embassy were consulted and briefed on the draft overview in January 2019 and expressed interest on what information they could provide to aspirant nannies and au-pairs and their families. This will be taken up at the conclusion of the process.

23. The agencies listed below provided a chronology of contact followed by an Individual Management Review (IMR) completed by a senior manager not connected with the events:
    Metropolitan Police Service (MPS)
    London Ambulance Service NHS Trust (LAS)
    City of Westminster Children's Services (CWCS)
    Wandsworth Children's Services (WCS)
    Local GP Practice for Danielle[1] and the children (Fleur and Pierre were not registered for GP services)
    South West London and St Georges Mental Health NHS Trust (SWLSTG)
    School 1 attended by Child A from entry until February 2015
    School 2 attended by Child B from entry and Child A until July 2017

THE REVIEW PANEL MEMBERS

24. *Table 1 - Names of the Panel members, their agency, roles and job titles*

Name	Agency/Role
Robyn Thomas	LB Wandsworth (LBW) Head of Community Safety
Mick Allen (to 11/18)	LBW Violence Against Women and Girls Strategic Manager
Mark Wolski (from 06/19)	LBW Violence Against Women and Girls Strategic Manager
Ruth Lacey	LBW Children's Services
Patrick Bull	South West London and St Georges Hospital (SWL&STG) Mental Health Trust
Dr Claire Taylor	Named GP for Wandsworth Clinical Commissioning Group (CCC)
Deidre Nunes	School 2

[1] Danielle used a version of her middle name when registered with her GP practice from 2014

John Snelgrove	London Fire and Rescue Service
Emma Bond	MPS Safeguarding Wandsworth Borough
Janice Cawley	Detective Inspector, MPS Specialist Crime Review Group and IMR author
Dina Sahmanovic	Victim Support, specialist adviser on modern slavery
Bill Griffiths	Independent Chair and Author of report
Tony Hester	Independent Manager and Panel Secretary

AUTHOR OF THE OVERVIEW REPORT

25. Set out in appendix 2 are the respective background and 'independence statements' for Bill Griffiths as Chair and author and Tony Hester who managed the review process and liaison with the CSP and Panel.

PARALLEL REVIEWS

26. When the DHR Panel was convened in April 2018, the criminal trial was ongoing and concluded in June. There are no misconduct allegations. Following the conclusion of the criminal trial, the Coroner closed the Inquest. Wandsworth Children's Safeguarding Board considered and decided against commissioning a joint Serious Case Review (SCR), instead opting for a parallel Lessons Learned Review. This decision was endorsed by the National Panel of Independent Experts in February 2018. WCSB was represented by Ruth Lacey on the DHR Panel.

EQUALITY AND DIVERSITY

27. Consideration has been given to the nine protected characteristics under the Equality Act in evaluating the various services provided. Fleur was female and White French and, given the circumstances of her life in London, was vulnerable and a victim of modern slavery. Had this had become known to services she should have been considered 'an adult with care and support needs' under the Care Act. Danielle and Pierre are French Algerian and of Muslim faith. Danielle claimed to have been disabled following a fall from a building when in France (not clinically confirmed) and this manifest at times with reduced mobility requiring the assistance of walking supports. She also suggested that Luke had used 'black magic' to control her. Danielle's children are White with dual French/British nationality. Luke is White Irish. The Panel have carefully considered protected characteristics, including their complexity and the intersection of multiple disadvantage revealed in this review, in concluding that a fair and professional service was provided.

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DISSEMINATION

28. The intended recipients of copies of this report, once approved by the Home Office Quality Assurance Panel, are listed at the end of the review after the glossary.

BACKGROUND INFORMATION (THE FACTS)

Fleur

29. Fleur was born in January 1996, the only child of a rural family in North East France. Her parents separated after a few years; her mother re-married and had another daughter and a son, half-siblings to Fleur. Her mother describes Fleur as placid, shy and naïve. She enjoyed ice skating and playing her guitar. She had a keen interest in the Jewish peoples plight during the war and her visit on a school trip to Auschwitz was her only one outside of France prior to her starting work as a nanny in London. Her treasured book was: *The Diary of Anne Frank*.

30. Her father has lost his only child whom he described as kind, quiet and reserved. She was very nurturing and liked animals and children. When she told him she wanted to go to England as an au-pair, he encouraged her as he thought it would help her to become more independent, mature and confident. He felt she would be happy working with children as it was her 'life goal'. She had studied a vocational training course in child-care.

31. Fleur was introduced through a friend of Danielle's brother and, following a two-week trial period in December 2015, she left France to work full time for the family aged just 20. The reality of her au-pair life from January 2016 was to be paid £50 a month (for the first few months, anyway) and to share a bedroom with the two boys, given the upper bunk bed. Her mother and father never saw her again.

Danielle and Pierre

32. Very little is known about Danielle and Pierre's early life which was spent in France. A Core Assessment by Westminster Children's Services conducted in 2008 noted that Danielle had attempted suicide by jumping[2] from a building in 2000 when aged 18 and living in Paris. She suffered a back injury and she reported mobility and back pain issues in the years that followed.

33. They met in 2001 when, aged 18, she was working at a fairground outside Paris and their relationship appears to have turbulent from the outset, with stories that family members did not approve and of Danielle ending the relationship by seeing other men. Despite that tendency, Pierre has appeared to be constantly in the background and has never really disappeared from Danielle's life. Pierre is not the father of either of her two children. AB, a French national, is the father of Child A and now has custody.

34. Danielle and Pierre first came to notice in November 2007 when living in rented accommodation (address 1) in a block of flats in Westminster City Council (WCC) area. In

[2] She later claimed the injury was sustained when thrown from a 3rd floor window

August 2013, they were known to have rented the ground floor garden flat at address 2 in LB Wandsworth. The police investigation has shown that they were in significant rent arrears within about 12 months of moving in.

35. In the timeline below (from paragraph 57), it can be noted that Pierre was seen on occasions and variously described by Danielle as: a cousin, brother, boyfriend, uncle, godfather, taxi driver and business partner, as well as 'partner' in the implied sense that they were a couple. He did have business interests in France, but he was plainly living in plain sight with Danielle and her children at the rented house in Wandsworth. It was assumed by agencies that he was the father or stepfather of Danielle's children.

36. Danielle claimed at her trial to have business interests in fashion and design and to have met many famous people involved in fashion and the music industry. The reality was that she worked from home and had very little success in fashion and design. At one point her main activity was to run a French *crepe* stall by arrangement with the owner of a local shop, but that too was not successful.

Luke

37. Luke was a musician and band member and has since been working as a producer in the music industry, living in the USA. It is not known how he met Danielle but they lived together, with Child A, for a period at the Westminster flat and then separated while he returned to Ireland, followed by work in the USA. When Danielle became pregnant with his Child B, she 'disappeared' apparently to travel, including to join Luke in the United States. Child B was born in St Mary's Hospital, London. When Danielle returned to live in Wandsworth, Luke paid for the first month's rent and deposit, a total of over £4,000. He subsequently paid for another six months, after which Danielle became personally liable for the rent.

38. As will be seen in the timeline of events, Danielle developed an obsession with Luke and, often through manipulation of Child A, made a number of serious allegations of Child Sexual Abuse (CSA) which Luke has consistently and firmly denied. He did not know and had never met Fleur. He had not spoken to Danielle for about three years prior to the fatal incident. He had settled in the US and did not visit the UK at all in 2017.

Overview of Fleur's treatment at the hands of the perpetrators[3]

39. To understand the relevance of the timeline, which starts in 2007, to what happened to Fleur in September 2017, it is felt that an overview of her treatment at the hands of the perpetrators would be helpful to the reader. Greater detail will be available in the section that sets out the facts uncovered by the homicide investigation.

40. The life Fleur led in Wandsworth was at times bizarre and oppressive. She was financially exploited, in that she was hardly paid for her work as a nanny, but Fleur thought that that

[3] Drawn from the prosecuting barrister's opening of the case to the Jury and the evidence from the tape recordings of Fleur being 'interrogated' by Danielle and Pierre

was acceptable because she believed that Danielle could not afford to pay her. Fleur had a big heart but was not worldly wise and it was easy to take advantage of her.

41. There were times that Fleur was happy, she had wanted to work with children, but as the months passed there was a marked deterioration in her circumstances and health. At other times she appeared scared and hungry. She complained to witnesses that she was being beaten and that she was not allowed to return to her home in France. They could only comment from what they saw and heard, mainly outside of the house. What took place behind closed doors when no independent witness was present is likely to have been very much worse.

42. One of those witnesses was CD, the owner of the local shop where, with his permission based on their friendship, Danielle had set up a *crepe* stall outside his shop and he had got to know Fleur. The edifice of relative calm and respectability began to break down one night in early 2017 when Fleur had a few glasses of wine in the shop. It did not take much to get her drunk. For the first time Fleur said that she was not happy but could not return home. The shop owner decided not to become involved.

43. Fleur became a more regular visitor to the shop and she would sit down in a corner and be given food to eat. What surprised the shopkeeper was the speed at which she ate her food, as if she was very hungry. She also made a sad sight because she was often dressed in the same clothes. One night she was tearful and said that her mother was unwell and that she wanted to go home to France to see her but said that she was not allowed to go home and that "they" beat her. She described one occasion when Danielle beat her because of food which the children had dropped on the floor. Fleur often appeared scared and he offered her help to find alternative accommodation and another job but the offer was not taken.

44. In about August 2017, Danielle came into the shop with Fleur and started to yell at the owner in a high-pitched voice. She accused him of interfering and later called Fleur "a bitch" for wanting to leave. Fleur did not say a word. As the result of Danielle's bad-tempered intervention, Fleur stopped visiting the shop and the friendship between the owner and the perpetrators terminated.

45. Another witness EF, had got to know Danielle through her child being in the same class at school as Child A. Danielle's obsession with Luke was very evident and she complained that he was stalking her; that he had hacked into her computer; that he stalked Child A at school; and that he was acting against her interests in collusion with Fleur.

46. The prosecuting barrister highlighted four examples in opening the case to the Jury:
    a. During a WhatsApp video call when Danielle accused Fleur of having stolen a diamond earing and EF could see Danielle's going through Fleur's suitcase but was unable to find the earring
    b. Danielle once telephoned the friend at 3am and screamed down the phone accusing Fleur of having digitally penetrated Child A's anus. When asked how she knew, Danielle replied that she had smelt Fleur's finger
    c. In the summer of 2017, the friend was present when Fleur was cooking some rice. The rice and a few vegetables did not make a sufficiently nutritious meal for Fleur and so the

friend asked if she could take some chicken from the fridge to give to Fleur. Danielle screamed at the friend, accusing Fleur of always playing the victim and of always looking for sympathy. The friend continued to help prepare the meal and the next thing she knew, Fleur was on the floor, holding her head and crying. She had obviously been assaulted. Danielle "was in a total rage". All the while, Pierre was present and simply stood by. Although Danielle said that Fleur had to leave immediately, Fleur, of course, did not

d. Fleur had been asked to leave the home and went to stay with EF for two nights in early August. Danielle then arrived and shouted at Fleur and took her back. Fleur looked lost and unsure of herself.

47. As is apparent from the only two independent witnesses, Danielle had begun to make a series of accusations against Fleur, but there is substantially more evidence available from a series of audio and video recordings made by the perpetrators in their interrogations of Fleur. Danielle alleged, for example, that Fleur had stolen a diamond pendant and although Fleur denied the charge, that did not stop it from being repeated. These allegations were a way of intimidating and controlling Fleur.

48. Then, Fleur was accused of taking Child B to a house where his putative father, Luke, had arranged to be and where his father told him that he would shoot dead his family. This allegation was first reported to the police by Danielle in August 2017. She said that the threat had been made three months before, in May. Fleur was present when Danielle went to the police and Fleur denied the accusation. Child B's father had also denied it. The police took no further action because, apart from anything else, the allegation made no sense and, if true, why continue to employ the same nanny; and why wait three months to report it?

49. But Danielle's allegations continued, and her suspicions concerning Fleur's activities and her supposed collusion with Luke was developed, extended and taken to new extremes. Danielle began to accuse Fleur of working together with Luke to sexually abuse the entire family. The accusations developed to the stage where it was alleged that Fleur had let Luke into the Wandsworth home, where he had drugged the family and sexually abused them. The purported activities included taking semen from Pierre, after he had been rendered unconscious. The semen was required to frame him for a charge of child sexual abuse. The fact that Fleur continued to be employed as the nanny and continued to sleep in the children's bedroom seemed unimportant. The allegations did not match reality.

50. Precisely what was in Danielle's mind may be difficult to determine but it seems that the more outlandish the allegations, the more she pursued them, despite the fact that they were denied and despite the fact that there was no evidence to support them. And her allegations appear to have been contagious because Pierre was clearly beguiled by Danielle with her obsessions and delusions and he began to adopt them himself.

51. Eventually, the two perpetrators confronted Fleur and wanted her to confess to conduct and crimes she had not committed. The allegations were untrue but a number of factors must have begun to operate on Fleur's will. Fleur became a prisoner in the home.

52. Together they mistreated and intimidated Fleur in a manner that is way beyond anything that could be considered normal or rational – their actions, at times, difficult to comprehend. Fleur had a great desire to please, even in adversity, and if she did not have the strength to walk out of this horrendous household, as she plainly did not, she must have found this situation wholly outside her experience and ability to manage. The perpetrators not only held her prisoner in their home, but occasionally had succeeded in removing her will to fight the allegations made against her.

53. At times Fleur made confessions to please her oppressors and then would withdraw them, or she would make a confession in terms that were unacceptable to the demands of the perpetrators. As the pressure increased so did the violence against her. The last days and hours of Fleur's life must have been truly wretched. She was subjected, at times, to a brutal and oppressive inquisition and to significant violence: there were fractures to her sternum; to four of her ribs; and to her jawbone. She also had bruising to her left arm, back and chest. Whilst in the custody of Danielle and Pierre, Fleur died.

54. Just as the full extent of her injuries are unknown, so is the precise cause of her death. That is because having murdered Fleur, they burnt her body in the garden of their home in the hope that no one would ever discover her remains. Their plan was to dispose of Fleur's body and to explain her disappearance by inventing a story that she had left their employment under something of a cloud and as far as they knew had returned to France. Another missing person, no longer their responsibility, her disappearance nothing to do with them.

55. Their plan was frustrated by the combination of a neighbour and inquisitive fire fighters. The neighbour became concerned about the fire which had been started to cremate Fleur's body. The fire was in a residential area and it seemed to last for an unnaturally long time. The neighbour became so concerned that she rang 999. The firefighters who attended were troubled by a number of factors and eventually they discovered Fleur's remains under the ash of the fire. Without such vigilance the two perpetrators might well have got away with murder - which was, of course, their aim.

56. With this overview in mind of what happened to Fleur at the hands of her employers from January 2016 to September 2017, it will be insightful to now turn back the clock to examine the extraordinary and complex trail of events and interactions by Danielle with agencies, that Fleur had unwittingly joined. There is a risk that, through this extensive examination, Danielle becomes 'the loudest voice' in this review, but it is felt necessary and proportionate to set out the full narrative of what is known about the perpetrators in order to understand the lessons to be learned from the suffering that Fleur endured in her relatively short time in this country.

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Timeline of relevant events and reported contacts with safeguarding agencies

2007

57. In November, police were called to a verbal argument between Danielle and Pierre at the Westminster address and a record made with no action required.

2008

58. In April, when pregnant with Child A, Danielle's GP referred her to Family Services due to concerns about a history of mental health issues and lack of preparation for the baby. It was recorded that she and the father (referred to as Pierre) had separated. Initial assessment noted her low mood and suicide ideation and a Core Assessment commenced in May. Pierre (not the actual father, AF) returned and was 'reunited' with Danielle just prior to the birth of Child A in June.

59. Due to high level of concerns, Danielle and Child A were placed at Coombe Wood Psychiatric Unit for Mothers and Babies for a 6-week period of parenting mental health assessment. The Local Authority had initiated legal proceedings but no order was required as Danielle agreed to the assessment. The outcome was positive, with the Consultant Psychiatrist stating that the Unit could find no evidence to support a diagnosis of Borderline Personality Disorder or Personality Disorder.

60. Attachment between mother and baby was described as 'strong' and care as 'good'. Danielle and Child A were discharged to home with 'father' (Pierre), legal proceedings were ceased and a plan of support to the family agreed. The case was closed in March 2009.

2010

61. In October, Danielle reported to police that Pierre was missing, whereas it was speedily ascertained that he was merely late home from work and the battery on his phone had lost its charge.

2012

62. In July, Danielle called police to request assistance in removing her 'partner', Luke, from their flat. She was six weeks pregnant with his Child B, had found photographs of another woman on his phone and suspected he was having an affair which he had denied before leaving. He had not assaulted or harmed her in any way but she wanted a divorce. He had refused. The Initial Investigating Officer (IIO) completed a Domestic Abuse Stalking and Harassment Risk Identification Checklist (DASH RIC) and Danielle provided negative responses (except that regarding pregnancy) and the risk was graded STANDARD[4]. In line with policy, the IIO also completed a MERLIN[5] Pre-Assessment Check (PAC) regarding Child A for the information of City of Westminster Children's Services (CWCS).

[4] The options are High, Medium and Standard

[5] The police form for sharing with and alerting other agencies of safeguarding concerns

63. Danielle made two more calls to police that evening. She first claimed that Luke returned and she was frightened. There was no response from within on arrival of police. Whilst they were investigating, Danielle made a second call and said she was going to stay with her sister but did not want police to see her there, instead, she would attend Notting Hill police station the following day. She did not attend and a text message was sent to her phone requesting contact. She called in to say she would attend but did not do so. A week after that a Community Safety Unit (CSU) Detective Sergeant (DS) contacted Danielle to check on her welfare. Danielle said that she and Luke were back together and claimed the argument was due to "*pregnancy hormones*".

64. In August, when at the Hyde Park Lido with Luke and Child A, Danielle called police to a dispute between her and another parent. Child A was observed by the other parent wandering around and then defecating. Out of concern for the child's welfare, she picked him up and walked around trying to find his parents. Danielle approached the other parent and asked why she had picked up her child and was walking around with him. An argument ensued, police attended and spoke with both parties to resolve any misunderstandings. A MERLIN PAC was shared with CWCS.

65. In September Danielle called police to report another argument with Luke. This was because Luke allowed Child A to take a wooden toy into the bath, which Luke confirmed was accurate. The row descended into name calling but there was no violence. Luke left the address for the night to stay with a friend. A DASH RIC was completed and assessed as STANDARD. A MERLIN PAC was completed and shared with CWCS and a single assessment recommended. A CSU officer completed a follow up call with Danielle a few days later and she said that she and Luke had resumed their relationship. She added that Luke had recently stopped migraine medication and that had made him irritable. He had apologised and no further issues were reported.

66. In early October, the Westminster Child Abuse Investigation Team (CAIT) received a referral from local Children's Services. Danielle had reported to the Access Team by telephone that, the day before, she was in the kitchen while Luke, was giving Child A a bath when she heard the sound of a slap, then her son crying. When asked what had happened, Luke claimed that Child A had slapped him on the face. Danielle asked Child A and his account was that he: "*touched daddy's hair then daddy smacked him across the legs".* Danielle noticed a red mark across her sons' legs and she told Luke to leave.

67. The incident did not meet the CAIT threshold for further investigation at that time. A CAIT officer held a strategy discussion with Children's Services and concluded that the matter was suitable for single agency investigation by CWCS. The discussion was closed with CWCS agreeing to conduct assessment and feed back to police. When seen on the home visit, Child A did not have a visible injury and Danielle reported no mental health concerns. A MERLIN PAC was completed and the matter was closed with no further police action.

68. In late October, Danielle contacted police and alleged Luke was harassing her since they had split up four weeks earlier. They had been in a relationship for eight months but she said she thought things had not been right from the start. She believed he had mental health issues and she alleged he took illegal drugs to manage pain. She added that he had been violent to her on three occasions.

69. The first was sometime in July when they were arguing and she tried to call police. Luke tried to grab the phone from her and put his hands around her throat to choke her leaving marks on her throat (no longer visible). Some two weeks later, he pushed her whilst they were in the lift despite knowing she was pregnant with his child. The last occasion was the incident above with Child A that was reported to CWCS. She had told him to leave and she tried to call police whereupon he took the phone from her, threw her on the sofa in the hallway, grabbed her around the throat and scratched her face.

70. The IIO noted that there was no reference in the CWCS referral to an assault on Danielle so it was not recorded on the Crime Report Information System (CRIS) in that way. Danielle added that, since they split up, Luke had texted and called her on a number of occasions asking her to get back with him. She thought he had also come to the flat and pressed the buzzer but she had not answered the door so could not confirm this.

71. The IIO completed a DASH RIC and she answered "yes" to more than half the questions so the risk was graded MEDIUM. Danielle did not know where Luke was living. The IIO discussed personal safety planning with her and she said she wished to stay in her flat. The officer completed a MERLIN PAC for the attention of CWCS. The allegation was assigned to a CSU investigating officer (IO) who tried to contact Danielle without success. The IO recorded on the CRIS that Luke would be circulated as 'wanted' for questioning in relation to the assaults.

72. The action by the CWCS Assessment Team, who noted that Danielle was 'stressed and staying with friends' was to source a Women's Refuge placement which was done on 12 November but not taken up. No further contact was possible until late December as Danielle had changed her phone without letting them know.

73. In early November Danielle called police as she believed Luke had entered her flat whilst she was out and had taken a pair of his own shoes. Police attended, noted there was no sign of forced entry to the flat and completed a DASH RIC which was again assessed as MEDIUM. This was recorded as a non-crime domestic incident and allocated to an officer in the CSU to make contact and discuss options for safety planning. Coincidentally and apparently unaware of this latest allegation against Luke, the IO for the common assault allegations made on 30 October tried without success to contact Danielle. The IO then posted Luke as 'wanted' on the Police National Computer (PNC) for the common assault.

74. In mid-November Danielle visited Notting Hill police station (in a different Borough to her residence) to ask about having a panic alarm installed. The Station Reception Officer (SRO) who dealt with her request updated the CRIS. The next day, Danielle called police to inquire why the alarm had not been fitted. She added that Luke was in Paris and had tried to bribe her younger brother; she wanted to know if he could be arrested while in Paris. Arrest enquiries to locate Luke continued and his flatmate and former business partner stated he believed Luke had gone back to Ireland. Contact details were provided.

75. In early December Danielle again visited Notting Hill police station claiming that Luke was still calling her almost every day. She had bought a new phone to avoid his calls but had retained her old one. She said she had gone to stay with her friend (probably Pierre) while

his wife was travelling but wanted an alarm so she could return home. The IO provided her with a hand-held alarm on 5 December.

76. The IO listened to the messages left by Luke and noted that they were not threatening in nature, however, was concerned by the persistence in the contact. Whilst the IO was speaking with Danielle Luke called again. The IO spoke with him and confirmed he was in Ireland, with no intention to return to the UK. The IO then secured a first instance arrest warrant to ensure that he could be arrested after the six months statutory time limit for prosecution, which was good practice. On 19 March 2013 (shortly after the birth of Child B), Danielle informed the IO by email that she was no longer in the UK and did not plan to return. Given that Luke was still living in Ireland, the IO withdrew the warrant and no further action was taken on the common assault allegation of 30 October.

2013

77. One early evening in mid-January Danielle called police to report her son, Child A then aged 4 and her 'cousin' (thought to be Pierre) had not returned from a day out. Within 30 minutes, she called again to report their safe return.

78. Later in January, Danielle had been examined at St Mary's Hospital and all was well with the unborn baby. She said she might return to France and on 4 March notified them that she was in France and was uncertain if she would return to the UK. She did return at some point because, in mid-March Danielle gave birth to a son, Child B at St Mary's Hospital. There were no further concerns registered at Westminster CSC because it was understood that the family has returned to France and their case was closed in early June.

79. In August, Danielle visited School 1 in Wandsworth, having been offered a place for Child A with her proposed move to LB Wandsworth. She made it clear that she did not wish to be allocated this school as it was too far to walk[6]. She claimed disability and was using two walking sticks at the time. When it was pointed out that pupil services would need to know more information in order to assist, Danielle said that they were not resident in the UK at the time and did not know when they would be. It was left that she would contact the school upon return.

80. In September, Danielle became involved in a dispute with her landlord at the Westminster flat. The rent was in arrears and a Possession Order had been implemented on the 1st. On the 5th, police were called because she, in company of a male and a child, were trying to gain entry with a crowbar. She had left before police arrived and there was an investigation into the damage caused, culminating in an interview in late September. The relevance is that she blamed Luke for not paying the rent and that the officer noted concerns about the state of her mental health. The matter was resolved as a civil dispute.

81. In November, by now living at Wandsworth, Danielle was seen by the local practice nurse for a new patient check and a week after that by the GP. She was walking with the aid of two crutches. She said this was due to a fall from a 4th floor in 1999 in which she had fractured two lower vertebrae that were then joined with a bone graft. She declined to discuss what happened. Her main issue was that she wanted help with a move of her

[6] A check with Google Maps indicates that school 1 is a 6-minute walk from the new home

son's school as it was too far to walk. A letter was provided for the school and the medical notes from her last practice requested. When they arrived, the notes were incomplete and follow-up requests did not yield any further medical history.

2014

82. In late February, Danielle started Child A at School 1. She reiterated her displeasure at this allocation, explaining that she was disabled, needing the aid of two walking sticks, having been thrown from a 3rd floor window by a former partner. She was still using the two walking sticks.

83. Two days later, Danielle attended an appointment with police to report harassment by her ex-partner Luke. She referred to her allegations in October 2012 and that she was not happy with the outcome. She went on to say that she and Luke had separately returned to live in the United Kingdom and they had met up because Luke wanted to see his son, Child B.

84. They met at Kings Cross station to discuss access and also a potential job opportunity but the meeting did not go well. Subsequently, he had sent her a large number of abusive emails accusing her of seeing other men. The IIO completed a DASH Risk Identification Checklist (RIC) assessed as STANDARD. Danielle was given safety planning advice and the IIO completed a MERLIN PAC with respect to Children A and B that was shared with Wandsworth Children's Services (WCS).

85. The allegation was reviewed by a DS who noted the messages sent were "rambling" in nature and were not offensive. It was not felt that there was sufficient evidence to prove a course of conduct amounting to harassment and the case was closed with no further action. This conclusion was shared with WCS and, there being no concerns regarding the children, their file was closed.

86. In early March, Luke emailed Danielle that he had made a dinner reservation for them. Danielle contacted police and suggested they attend the restaurant to arrest Luke for harassment. When told police would attend her house for more information, Danielle said she was not at home and wanted an appointment instead. The number provided was incorrect and an alternative one was not answered. The next day, Danielle called again and complained vociferously about the perceived lack of response. The call operator noted a difficult conversation and that Danielle appeared not to listen. An appointment was arranged for that afternoon.

87. When seen, Danielle again alleged she had received abusive and threatening messages from Luke. The officer examined the messages, assessed them as referring to child contact and were not threatening, so had a legitimate purpose that did not amount to harassment. Danielle also claimed Luke had hacked her Facebook account and deleted messages, however, there was no evidence of this. She voiced an intention to seek an order to prevent him contacting her but did not know where he lived; nor did he know where she lived. Finally, she claimed Luke had threatened to kill her in the past but could provide no further detail. Safety planning advice was provided and a DASH RIC completed with the assessment as 'STANDARD'. The IIO completed MERLIN PAC reports for Children A and

B that were shared with WCS. The CRIS report was reviewed by an Inspector to assess if the matter should be dealt with as a threat to life. The threat was assessed to be historic and had already been recorded when Danielle made the allegation Luke had slapped Child A. The rationale for the decision not to treat the allegation as a threat to life was recorded and is compliant with extant guidance.

88. A follow-up appointment led to further allegations of harassment by Luke. When asked for details, Danielle became agitated, accused the officers of failing to act and refused to answer their questions. A male present at the address, who claimed to be Danielle's brother, joined the criticism of police lack of action. Following advice from the CSU the matter was closed with no further action. The WCS came to the same conclusion.

89. During March, staff at School 1 began expressing concerns about Danielle's volatile behaviour towards them. Child A was unable to remember where he had placed his belongings such as his coat or folder at the end of each day and staff would have to gather his belongings. He was receiving extra support in school as he was so far behind his classmates and found concentrating very difficult. Frequently, Danielle would be late and very angry when bringing or collecting him. She often shouted at staff and Child A was observed to stand still with a blank expression. Danielle would sometimes be using walking sticks; sometimes she was observed walking freely, and at speed.

90. She was offered and declined a free breakfast club place to assist her difficulties. Then a member of staff was employed to collect Child A from home and return him each day. The support had to be withdrawn at the end of March as the member of staff was left feeling "scared and anxious" about Danielle's behaviour towards her. Occasionally, Pierre would accompany the boy and it was noted that Child A was happier in his presence; also that Pierre was more respectful to staff. Danielle referred to him variously as: the taxi driver, her boyfriend, Child A's godfather or uncle.

91. Such was the concern about Danielle's practical care of the children due to depression and physical disabilities that the EWO (Educational Welfare Officer) at School 1 made a referral to Wandsworth Children's Services and a Team Around the Child (TAC) meeting was set for late March. The school identified that Child A was not able to concentrate or follow instructions, his speech and language needs were not being met and was missing uniform. Danielle countered that the school had lost two jackets and had withdrawn the staff support for the school journey. The WCS social worker agreed to an Early Help Plan and additional supports services. A Health Visitor added concerns that Child B had not had requisite health checks.

92. On the day of that meeting Danielle called police to report that Luke had left a threatening message on her voicemail, reiterated her belief that he had hacked into her emails and added her concern he might know where she lived. Danielle was seen by appointment the next day and the voicemail listened to. It was more than two minutes long and a male could be heard aggressively saying that he was going to tell Danielle's parents that she was a "*bad Muslim girl*" and that she "*hadn't seen the worst of him yet*" but the message was not otherwise abusive or threatening in content. She was advised to change her email and Facebook password and to call 999 if Luke came to the address. The IIO completed a DASH RIC as STANDARD and completed MERLIN PAC reports regarding the children.

93. In the CSU follow-up investigation, it was established that the DASH RIC responses referred to the incident in October 2012 and there was nothing fresh apart from the voicemail. It was assessed that the message left was not offensive and did not constitute a threat to harm. The threat by Luke in the recording to tell Danielle's parents was religion-based abuse but this was not recorded as a hate crime as it should have been. Danielle requested a panic alarm and a camera outside her address. The IO explained that it would not be possible to authorise camera surveillance as there was no reason to believe that Luke knew her address and reiterated the 'call 999' advice. She was provided with the contact details for the One Stop Shop at Battersea which offers advice and support for victims of domestic abuse. The IO closed the CRIS report because the offence of sending a malicious communication had not been made out. It was noted that Danielle had decided not to apply for a civil injunction.

94. Near the end of March police received a call from School 1 to report concerns for Danielle and Child A, following a disturbance at the school. This was said to have started with a misunderstanding between Danielle and staff regarding the arrangement put in place to assist her because she was "on crutches" due to an injury, by collecting and returning Child A from and to home. Danielle had been rude to staff this day, accusing them of hiding Child A's clothing and various other complaints, so the arrangement was removed.

95. When she learned of the decision, Danielle attended the school, shouted at staff and demanded to see the head teacher. When the head teacher explained the decision to remove the special arrangement, Danielle lashed out at her and said she was evil and colluding against her. It was noted that the children did not flinch or show emotion at the outburst. The staff did not make a specific complaint against Danielle but wanted police to check on the welfare of the younger Child B. They reported he was safe and well and the house was clean and tidy. Danielle said she was going to report the school to her MP.

96. In response to this call from the school, the IIO completed a MERLIN PAC which was forwarded via the newly-formed Borough MASH (Multi Agency Safeguarding Hub) to WCS. The MASH supervisor gave the report a BRAG[7] rating of GREEN but did register concern about the impact of Danielle's behaviour on her children.

97. In mid-April, Danielle was referred by the School 1 Education Welfare Officer (EWO) to 'Brighter Futures', a funded project supporting DA victims locally with accredited Independent Domestic Abuse Advocates (IDVA). She chose to provide her middle name. The worker completed a DASH RIC, in which Danielle named Luke as the perpetrator, for the information of the next scheduled Wandsworth Borough Multi-Agency Risk Assessment Conference (MARAC) to be held in May. The minutes of that meeting have been provided and will be dealt with later in the timeline.

98. One afternoon in late April, the London Ambulance Service (LAS) sent a Fast Response Unit (FRU) and ambulance to the Wandsworth home to attend an 'unresponsive female' with two young children in the house. The eldest had wandered onto the street and asked a member of the public for help as their mother was not responding. Danielle was found

[7] London Continuum Of Need / BRAG: Blue, Red, Amber and Green. Red being the highest risk where there is a serious safeguarding concern requiring immediate action. A Green rating would be a low risk

slumped on a sofa, hyperventilating, with a consciousness score of 7/15. It was possibly a panic attack. There was evidence of cannabis in the home. Danielle was conveyed to St George's Hospital (SGH).

99. Police were called in by the LAS to ensure the welfare of Children A and B. They contacted Pierre, believed to be Child B's father who was on business in Paris, but could only make his way back by car within four hours. He knew of no friends or family nearby who could look after the children but suggested approaching the corner shop owner whom he could pay for their time. This was deemed to be not suitable and arrangements started with children's services.

100. Then Pierre called back with arrangements for a baby-sitter to attend who was known to the children. It was noted both children seemed happy with her and had toys to play with. There was plenty of food within the house. Child A was described as 'very bright' and able to communicate well for his age, with the initiative to have left the house for help.

101. About two hours after Danielle's arrival at SGH, a doctor called police to report a disclosure from Danielle that her ex-partner had sexually abused Child A, aged 5. Danielle was about to be admitted to hospital, so the allegation had been passed on in order to safeguard the children. Officers went to SGH and interviewed Danielle who named Luke as responsible. On the previous Friday after the children's bath, Danielle caught Child A touching Child B's bottom and penis. When she challenged Child A that it was wrong, he retorted that it was behaviour Luke did to him about three years before.

102. When probed, she was vague and the dates did not tie in or make sense. When asked why she did not inform police at the time, she said she was waiting until the next day to go to a central Family Court (it has not been possible to establish the nature of proceedings) with her 'business partner' and report it there. She repeated allegations she made previously about phone and computer hacking. She then claimed Luke used 'black magic' to control her and she had been placed in a house where cameras watched her but could not recall the details. The IIO noted that she became fixated on talking about Luke and phone hacking rather than the alleged incident with her son. The officer identified a propensity for exaggeration from the school incident in March. The circumstances of this matter were recorded on a MERLIN FOUND report.

103. The IMR author has commented that this was correct use to record details of Danielle's admission to hospital. However, the IIO should have completed a MERLIN PAC to record the allegations against Luke and a CRIS record should have been created. Concern about the veracity of the claim could have been recorded on CRIS as a Crime Related Incident (CRI) pending investigation.

104. The Psychiatric Liaison Nurse at SGH noted anxiety symptoms and depressive symptoms. Danielle had 'odd ideas' about her ex-partner: black magic, him hacking her phone, Facebook and emails. Danielle reported she had found out he had sexually abused her son and became anxious when preparing her case to apply for an injunction. It was noted that:

> *She may have delusional paranoia given that she said she has attended the police several times and they did not believe her. Also reported that one of the police who*

interviewed her in A and E had seen her in the past and not believed her. She said she believes the police are in partnership with Luke.

105. The assessed risk was low to self, children or others with the caveat that it was her emotional reaction that led to Child A seeking help for his unresponsive sick mother. Later in the day (now late April), prior to discharge to the Home Treatment Team (HTT), the following conclusions were noted by the Psychiatric Liaison Service (PLS):
    1. *Acute stress reaction secondary to discovery of her son's sexual abuse. Is experiencing physical symptoms of anxiety/panic attacks (chest tightness, dizziness, palpitations)*
    2. *The beliefs about black magic may be more prominent due to the stress she is currently experiencing. They may be part of a psychotic illness but this will require further review and assessment*

106. The IMR author has commented that there could have been further exploration in the PLS for key salient points of the alleged Child Sexual Abuse (CSA), there was no mention of how in practice she would look after the children and no assessment of the risk of emotional abuse

107. An 'out of hours' referral [WCS 'Referral 1'] of the same allegation was made by SGH staff to WCS who referred the matter directly on to the CAIT. A strategy discussion was held between WCS and a CAIT DS and it was noted that the children were in Pierre's care. He had advised that he was not father to either child, but was their godfather. It was accepted that it was not appropriate to speak to Child A without further information from Danielle who was awaiting psychiatric assessment. It was agreed that WCS would conduct a Section 47 enquiry[8] and would update the CAIT should evidence of an offence be suspected. A MERLIN PAC was created to record the discussion.

108. The day after that, SGH staff submitted a report to the imminent MARAC in relation to Danielle and the alleged abuse from her ex-partner. This reiterated Danielle's belief that Luke was using 'Black Magic' as a means of controlling her. The view taken by the hospital staff was that her allegations should be taken seriously until proven otherwise. The SGH report also highlighted concerns regarding the safety of Danielle's children. The allegations were recorded by police on CRIS.

109. After Danielle left hospital, she called police to complain that officers had searched through her things when they attended her house to report this incident. Nothing was missing but she thought it was wrong. Shortly after that she made another call to allege sexual abuse in relation to Child A. She made another call on the next morning repeating her complaints of the previous two calls. The call operator noted that the female was rambling. The call records were linked and brought to the attention of Wandsworth Borough Grip and Pace Centre (GPC). The IMR author has commented that, given Danielle had recently been in hospital for a potential mental health episode, it would have been prudent to despatch officers to complete a welfare check on Danielle and her children.

[8] Where a child is suspected to be suffering, or likely to suffer, significant harm, the local authority is required by s47 of the Children Act 1989 to make enquiries, to enable it to decide whether it should take any action to safeguard and promote the welfare of the child

110. Also in late April, Child A disclosed, to the teaching assistant who had been taking him to and from school in March, that Danielle was cross with him at home, put him in the corner and left him there all night. He said he could see she "had crazy eyes when she is really angry". He drew a picture depicting that image with what he identified as blood on the floor. He said that he had called his "Dad in France" (presumably Pierre) who told him to go out into the street to get an adult to help him. This disclosure was referred to children's services.

111. At its meeting in early May, the MARAC considered the RIC that had been referred by the Brighter Futures worker (an IDVA) on the basis of 'professional judgement'. The RIC noted she had a physical disability with mobility issues and recorded 17/24 confirmations that the risk factors had been experienced. The relevant free text comments were:

> The last injury was in June 2012[9] (Q1)
> Since moving to Wandsworth, Luke had made contact to let her know he knows where she lives and a number of anonymous silent calls have been made to the house. In addition: "Made threats to damage my face so nobody else can touch me" and "If he sees me with anybody else he will kill me" (Q2)
> He stole things from the family home and blamed it on her friends. He contacted her family in France causing them to be estranged from her for a year (Q4)
> She had tried separating from him many times before (Q6)
> Luke has stated he wants to see his son [Child B] (Q7)
> He has hacked her Twitter, Facebook and email accounts; she is concerned he uses this capability to track the family; he has sent emails stating: "I've found you and I'm coming"; he has turned up unannounced at the Westminster home (Q8)
> She had a miscarriage as the result of an altercation and this was reported to police[10] (Q11)
> He has attempted to strangle her[11] (Q15)
> He had previously spiked her drinks; forced her to have sex against her will (Q16)
> He had controlled her finances and forced her to end her job in PR. He employed her in his music production company and did not pay her appropriately, falsifying a contract (Q20)
> He said he would end his life if she ended the relationship (Q22)
> When they separated, Westminster children's services suggested no further contact with the children, yet he turned up unannounced (Q23)

112. Danielle's priorities were noted as; (1) an order in place to stop Luke contacting the family and (2) for her and the children to be safe. The meeting was well attended by 15 professionals with six attendees sharing contact information in line with the timeline of events since the family moved to Wandsworth in August 2013. The first agreed action was for Brighter Futures and a health visitor to visit the family for a Section 47 assessment and this was carried out that day, with both children seen. The reason for involvement was cited as Danielle's mental health. She was diagnosed with depression and borderline personality disorder with a history of self-harming. The second action was for a TAC

[9] There is no record in IMRs of this being reported
[10] There is no record in the police chronology of contact
[11] This may be a reference to the incident in July 2012 reported to the MPS in October 2012

(Team Around the Child) meeting later in May (see below). The case was not brought back to the MARAC because the agreed actions had been completed.

113. The police investigator spoke to Danielle the next day (regarding her complaint above) and advised that police searches had been completed in order to locate details of someone who could care for the children following her collapse. She was also given the CRIS reference number which related to the allegations of sexual abuse on Child A.

114. The hospital HTT carried out a home visit that day and undertook a mental state examination. The only risk identified was: *'from ex-partner who can physically attack her, has been harassing her with texts, threatening to her to her and even hacking into her email etc'*. It does not appear that the earlier reference to potential psychotic illness was considered.

115. The final home visit by HTT was in mid-May, Pierre was present and Danielle reported she was receiving support from WCS. She was due to be discharged and expressed anger about being referred to MH services in the first place, saying that her physical health complaints were not being taken seriously. She attributed her panic attacks to physical pain. She was observed to become upset when the HTT nurse was writing notes and asserted that it was her right to see what was being written about her. She denied suicidal ideation. The IMR author has commented that the discharge summary makes no mention of the notions about Danielle's ex-partner.

116. A Social Worker (SW) visited Danielle over the next few weeks and reported observations to the supervising CAIT DS. A week later, the DS met with Danielle to discuss the investigation. Danielle repeated the allegations she made to Westminster police in 2012 and confirmed she believed Luke was tracking her through her Blackberry phone because some of her text messages disappeared before she could read them and she understood the flashing red light in the corner of her phone was a sign Luke was hacking into her emails. She added she had sought medical attention on a number of occasions for Child A's bowel problems. She inferred this was connected to the disclosure made the previous week by Child A that Luke had: "*Come up behind him and put saliva in his bum and then his finger*". Danielle did not know when this happened. When asked if any of the medical investigations provided evidence of abuse, Danielle said they had not.

117. While there was a healthy scepticism of the veracity of Danielle's account, the investigation plan was for Child A to be spoken to and then conduct an Achieving Best Evidence (ABE) interview if he made any disclosure of abuse. Danielle agreed to this approach but was: "*not 100% sure*" that she wanted him to go to court.

118. A few days later, the TAC meeting was held at School 1 and Child A was reported to be making good progress, both socially and educationally.

119. In late May there was another strategy discussion between the CAIT and WCS and it was agreed a joint visit with a social worker to see Child A should be completed. The IO for the investigation ascertained that Child A had been visited at school by the allocated social worker the previous week. He did not make any allegation of sexual abuse against Luke, but did disclose that he had "smacked him on the bum" when he was naughty.

120. Later that day, the IO and another officer visited Child A, spoke to him on his own, and asked him what he had discussed with the social worker and what made him sad. He replied that Luke made him sad and when they probed his response further, Child A said that, one day when he was in a toilet cubicle with Luke on a trip to the beach, Luke touched him on the buttock when he was having a wee. Child A gave widely varying accounts of how long this went on for, from 40 days to 20 days. They appropriately probed further, but he did not provide any account which suggested that penetration had taken place. Danielle was informed that the officers would consult with their supervisors and WCS before deciding what would happen next.

121. A further strategy discussion the next day considered the information the two agencies had gathered. As no evidence of an assault by penetration had been offered by Child A, it was agreed the CAIT would discontinue their investigation and WCS would continue as a single agency S47 investigation. One omission in this plan was to seek consent for access to Child A's medical records prior to withdrawing from the investigation.

122. Danielle contacted police on a number of occasions over the following weeks to express her displeasure at the case disposal decision. She was advised how to make a complaint against police and given contact information for the Independent Police Complaints Commission (IPCC). It was noted by several officers that she would not listen to the explanations given for the closure of the police investigation. The IMR author has commented that if they were concerned for her mental health then consideration could have been given to a MERLIN ACN (Adult Coming to Notice) for sharing with Mental Health Services.

123. In early June, Pierre arrived at School 1 with Child A who was observed to be "very jittery". Child A had scratches on his arm that Pierre explained was caused by accidental scraping against a wall. The usual social worker was away and the replacement expressed concern to the school about the way Danielle had presented over the phone. She sounded distressed and mentioned questioning Child A over what he had said to the police and wanting to attend a central Family Court the next day to find a Judge to speak to.

124. In mid-June, the IO for the investigation had a lengthy conversation with Danielle in which the rationale for closing the police investigation was explained. Danielle reported that Child A was having nightmares because he was concerned Luke was going to come and kill him. The IO advised her to seek assistance from her doctor to deal with the anxiety issues but reiterated that the absence of abuse disclosures meant the investigation would not be reopened. She confirmed her unhappiness with the decision and felt as a result that: "*A paedophile would walk free*".

125. Five days later, Danielle called police to allege that Luke had hacked into her mobile phone, her cousin's mobile phone and her Facebook account. Multiple attempts to arrange an appointment were unsuccessful. A CRIS report was created to record the allegation and transferred to the CSU for further investigation.

126. A few days after that, Pierre collected Child A early from School 1 and told the teaching assistant that he and Danielle were taking him to France until the end of June. He was told

to complete a leave request for consideration but he did not comply. He later claimed that he did not know the requirement. In a telephone call, he said that Child A was in hospital in France and this was related to the court case. Social workers raised concerns and Pierre responded by accusing the teaching assistant of lying.

127. Also at the end of June police sent a routine letter to Danielle requesting she make contact within seven days regarding the phone hacking allegation made in mid-June or the investigation would be concluded. On the same day, WCS closed 'Referral 1' as the Child and Family (C&F) Assessment was completed with the conclusion that Child A was not in contact with the alleged perpetrator and not at current risk of harm. Early help support was in place.

128. In early July, another call to police reported that Luke was hacking her mobile phone and Facebook again. Danielle added that she had a court order against him which prohibited him from approaching or contacting her. She was: "*at her wits end*" because of his behaviour and was going back to court the next day. Research linked the similar incident reported several weeks before. The intelligence also highlighted the previous referral to the CAIT in relation to Child A.

129. The next day Danielle shared three notifications in March and April 2014 that her Facebook account had been logged into by different iOS IP5 addresses. She also produced an interim non-molestation order (NMO) she had obtained in 5 June and which was due to expire the next day. [A full order was then granted which extended to July 2015]

130. Danielle showed the officer a number of messages sent by Luke via Skype during the period the interim order was in force. On examination, it was apparent that the messages were requests to see his son Child B, including apologies for the relationship breakdown. Danielle had not responded to the messages. The IIO noted that Luke appeared to believe she was in a new relationship and intimated he felt jealousy, however, none of the messages were threatening in nature.

131. A DASH RIC was completed with Danielle and, although she gave positive answers to a number of the questions, the risk was graded STANDARD on the basis that Luke did not know where she was living and the contact was not threatening in nature. She was advised to change her passwords to Facebook and email accounts and to block Luke from Skype. The case was reviewed by the CSU and a comprehensive investigation plan was set. The case was allocated to a CSU investigator and efforts made to locate and arrest Luke on suspicion of harassment. Danielle reported another call from Luke the next day which added further evidence of the harassment.

132. A week after this allegation, Luke was posted on the PNC as 'wanted' for questioning regarding harassment. Following advice from his solicitor, he presented himself to West End Central police station later that evening. He was arrested and taken into custody. Prior to interview the next day, Danielle provided supporting evidence that the NMO had been sent to Luke and his solicitor. He was further arrested for its breach and then provided an account in the presence of his solicitor.

133. Luke said he had been in a relationship with Danielle when she became pregnant. At an early stage in the pregnancy, he lost a lot of money in a business venture and when Danielle found out she 'disappeared' without telling him where she was going. She told him she had lost the baby but he was not convinced and found out from Danielle's brother that she was still pregnant. In a Skype call with her in March 2013 he heard a baby cry in the background and Danielle admitted it was his son, Child B. In the months following, Luke claims to have given Danielle £45,000 towards property and between £5,000 and £10,000 per month to support her and the children. He given her another lump sum of £20,000 about eight months prior to his arrest (December 2013).

134. Luke ceased giving money to Danielle about three months prior to his arrest and this was when the allegations that he had sexually assaulted Child A had started. [Note: First allegation made in late April 2014]. He did not deny sending any of the subsequent emails but pointed out that Danielle had often contacted him and also had repeated to his friends and associates her (on his account unfounded) allegation that he had sexually assaulted Child A.

135. He engaged a solicitor to negotiate child access. The solicitor wrote to Danielle offering to support Child B but would expect regular access to Luke's son in return. That day he received the email with the NMO attached. He denied that he had harassed her, rather, she has contacted him and his father and he could produce evidence of that. He denied 'hacking' into any of her accounts.

136. Luke was released on bail pending enquiries to the end of the month. When Danielle was updated, she expressed upset that he had not been charged and kept in custody. She raised the concluded sexual assault investigation and was advised that the officers could only comment on the harassment investigation. She ended the call and then Pierre also called to challenge the decisions and it was explained that the investigation would only be reopened if new evidence came to light.

137. The harassment investigation was reviewed by a supervisor and there was evidence of contact on both sides, which mainly concerned child access. It was noted that Danielle had deleted some of her responses to the messages sent by Luke. It was felt that there was insufficient evidence to place before the CPS and the investigation was closed with no further action.

138. In mid-July, a TAC meeting was held at School 1. Danielle wanted to talk about the earlier incident with the Head Teacher in late March. A health visitor advised Danielle to speak to the school nurse regarding Child A.

139. At the end of July, a member of the public called police to Danielle, barefoot, with Child B in her arms, walking in front of cars near their home. She was clearly upset and agitated, saying she wanted to kill herself. The member of the public helped Danielle until her 'cousin', Pierre, arrived and took charge of Child B. The officers calmed Danielle down and ascertained she was distressed that an allegation of sexual abuse she made concerning

her other son, Child A, had not been taken seriously by police and Children's Services. She decided on impulse to "*storm down*" to Children's Services to demand justice[12].

140. Consideration was given to powers under the Mental Health Act, but Danielle had calmed, appeared more rational and understanding of the folly of her actions. Pierre complained that the helpful member of the public had used excessive force to restrain Danielle but the officers judged that this had been proportionate in the circumstances. She was left at the home in the care of Pierre and Danielle's sister. A MERLIN PAC was completed in in respect of both children and passed to WCS. Despite having concerns for Danielle's mental health state, the officers did not complete a MERLIN ACN for the attention of Wandsworth Adult Services (WAS) and the Mental Health team. The IMR author has not made a recommendation because the MPS has since introduced their Vulnerability Assessment Framework (VAF) in September 2015 that provides comprehensive guidance.

141. Early in August, Danielle reported her 'partner', Pierre, missing. She had last seen him the day before at about 15:30 hours when she went to collect her son from football practice. On her return at 19:00 hours he was not at home. The rear doors to the property were left open into the garden, which she thought was unusual. Danielle had been unable to contact him overnight and was concerned for his wellbeing. A MERLIN MISPER report was completed and assessed as MEDIUM. Danielle called police six times that day and complained she had been promised hourly updates. The Duty Inspector reviewed the report which was passed to the Missing Persons Unit.

142. Three days later, Danielle reported she had just found a text from Pierre on the day he went missing. It read that he was going away for a short time and for her to take care of herself and the kids. She believed she hadn't seen the text due to a problem with her phone. She apologised and said she had been under a lot of pressure, again citing the child sexual abuse allegation. She felt this had put pressure on their relationship and he had returned to Paris for respite.

143. Due to concerns [WCS 'Referral 2'] about Danielle's mental health arising from the incident at the end of July, an Initial Child Protection Conference (ICPC) was convened in early August and a Child Protection Plan (CPP) implemented under the category of 'Emotional Abuse'. The CPP was reviewed in late October with no concerns identified around the children's safety. At the next CPC in early November the CPP was stepped down to a Child in Need Plan (CNP) which was in place until closed in March 2015 as there were no safety concerns for the children and Danielle did not want further intervention.

144. In mid-August at about midday, the local Mosque called the LAS due to concerns generated by Danielle walking in with her two children saying that she needed someone to read the Quran to her, that she feels ill and that, whenever she eats or drinks water, she vomits. The caller said she sounded angry. On arrival of the paramedics, Danielle had left the scene and was located about 200 yards away near to her home address.

145. On examination, her clinical observations were all within normal parameters, however, she felt weak and complained of abdominal pain at the level 6/10. She was depressed due

[12] In mid-September Danielle raised this with her GP and claimed she was only avoiding roadworks. It was noted that she seemed rational and there was no obvious mental health disorder

to her second husband having abused the children and felt unable to cope with the children. She was conveyed to St Georges Hospital, Tooting. A safeguarding referral was made. She was assessed in hospital and the Doctor concluded she was tired and fed up with not being believed about the alleged sexual abuse of Child A. There were signs of depression but treatment not required and she was discharged.

146. In mid-November, Child A called an ambulance to Danielle drifting in and out of consciousness. He thought his mother could not breathe. On examination, she had flu-like symptoms. She declined hospital and said she would see her own doctor.

2015

147. Child A was enrolled at Primary School 2, Wandsworth[13] in February, midway through Year 2. Early in February, a meeting was held with School 1 and safeguarding notes were shared, in particular a chronology of significant event between August 2013 and August 2014. It was noted the Children A and B had been subject of Child Protection Plans.

148. In mid-March, Danielle called 999 in a distressed state and could be heard arguing with a male in the background. Database research indicated a potential location for the caller and that she had come to notice for past mental health concerns. On arrival, officers found her in the street crying and screaming that a newsagent had accused her of stealing. The officers managed to calm her and escorted her home. She then started shouting again, saying: "*Police never help me*" and she wanted to register a complaint. The duty inspector spoke to Danielle and she appeared reassured by the inspector's undertaking to speak to the officers. The IMR author has commented that, although mental health concerns were noted, the opportunity was missed to complete a MERLIN ACN on Danielle and a PAC version with respect to the children. This was about a week before the closure of the WCS CNP with respect to them and it is debatable whether this would have changed the decision to close, given that the incident did not involve the children directly.

149. In mid-June, Danielle contacted the CAIT and asked that the investigation into the alleged CSA of Child A, be reopened as she had new information. When asked what new evidence had come to light she said that Child A was having nightmares that Luke was going to kill him. The officer's research established the information was already known to police and did not amount to new evidence. The officer explained the situation and suggested that she seek further help from her General Practitioner (GP), Child and Adolescent Mental Health Services (CAMHS) or WCS. A MERLIN PAC was completed and shared with WCS that day [WCS 'Referral 3'].

150. Late in the evening about a week later, Danielle informed police that Child A had contacted the National Society for the Prevention of Cruelty to Children (NSPCC) and told them he had been sexually abused by Luke. She stated she wanted an appointment the following day to report the matter to police.

151. Police attended and spoke with Child A who reported being sexually assaulted by his mother's ex-partner three years before (2013). Danielle explained that Child A had been made aware of the NSPCC in a school lesson and had called them after that. The IIO

[13] A 2-minute walk from home

noted that Child A appeared to be seeking approval from his mother as he recounted the allegation. Danielle added that she had not heard from the suspect for three years.

152. The IIO generated a CRIS record (later closed and linked when the original record from 2014 was reopened) with a MERLIN PAC for WCS to provide the details of the original allegation. This was reviewed by a CAIT supervisor who set an investigation plan of: a multi-agency strategy meeting, securing available medical evidence, contacting NSPCC for a record of the call and interviewing the suspect. The strategy meeting was held in late July and WCS reported that the NSPCC had no record of a call from Child A. Enquiries with the GP had not revealed any medical concerns. Inconsistencies in the accounts by Danielle and Child A were noted. School 2 were not involved in this meeting.

153. At about 05:30 that morning, Child A had called the LAS to attend his mother who was unconscious, lying on her front. She had a history of panic attacks. On arrival the crew found that Danielle was awake, complaining of a migraine. Clinical observations were in normal parameters and she declined hospital, saying she would see her own doctor and that a friend was on way to look after her.

154. Five days later at 00:25, a Child A again called the LAS to attend his mother who was having a panic attack and was not awake. The call was terminated and a call back by the contact centre was answered by Danielle. She complained that doctors were not helping her and she was upset with her partner.

155. On arrival of the ambulance staff, Danielle said she had a panic attack after her son told her about previous incidents of abuse to him by her previous partner. These had been earlier reported to the police and she and her son were communicating with Children's Services and the NSPCC. She added that the case was closed due to lack of evidence. This day, Child A had opened up in more detail about the incident and this had upset her. It was noted that all abuse was historic and there was no evidence to suggest anything had happened recently. Clinical observations were within normal parameters and Danielle declined hospital attendance. She had contacted a friend to stay with her.

156. In late July, the NSPCC informed police that Danielle had alleged to them that Child A was the victim of CSA. The NSPCC had linked it to an almost identical referral to the NSPCC in early July. The MERLIN PAC in relation to this call was not created and shared with WCS until mid-August. It has not been possible to ascertain the reason for this delay.

157. Meanwhile, in early August the CAIT investigator attended a meeting between WCS, Danielle and a French interpreter. The DS explained that the initial investigation had been closed due to a lack of disclosure by Child A. The NSPCC had no record of a call from Child A. Danielle countered that he called Childline rather than the NSPCC. She did not mention the call she had made to the NSPCC. The evidential weaknesses exposed by the investigation were explained and there would be no benefit in conducting an ABE interview with Child A. Danielle expressed dissatisfaction with the decision and then produced documents pertaining to Child A's medical history, none of which provided corroboration of sexual abuse. The DS noted that Child A was a: "*lively, bright young boy*" and added that enquiries with his school had not raised any concerns. The only investigative action outstanding at that point was to interview Luke under caution.

158. In mid-September, Luke contacted police by email to report that someone had posted a message on Facebook accusing him of sexual assault of a 4-year old boy. He believed Danielle was responsible and he alleged an offence of 'malicious communication'. The CSU secured a warrant to search for Danielle's home, which was carried out in mid-October, and they took possession of her social media devices. Danielle was alone with Child B at the time and it was agreed she could come in for interview at a later date (arranged for early November).

159. In the planning for the search warrant, the investigating officer consulted the family's social worker which was good practice. Thus, it was executed in the morning during school hours so that Child A was not likely to be present. They knew that Child B, aged 2, would be present. The SW advised that Danielle had a personality disorder for which she received 'low level' counselling. A MERLIN report was not completed due to the fact that children's services had already been made aware. An intelligence record was filed on the police CRIMINT system.

160. The WCS Section 47 investigation into 'Referral 3' had by this time neared its conclusion that there was no evidence of significant harm or concerns for the children and the case was closed in mid-October.

161. In late October, Luke contacted the IO for the reopened investigation into CSA as he was aware of police enquiries to speak to him. He was now living in the US and had sent his complaint email from there. He was aware of the CSA allegation as he was interviewed when Danielle reported him for harassment. He said his work involved him being in the media and Danielle seemed to start issues again with him whenever he appeared in the media. He provided contact details and said he would be willing to be interviewed again upon his planned return to the UK in December.

162. Danielle did not attend for interview and it was put back by agreement with her solicitor to late November. Danielle attended on that day with a solicitor and admitted making the Facebook post, having set up a fake account in a false [male] name, with these words:

> *"Ladies and gentlemen let me tell you a big secret that I keep away from everyone, today I decide to speak out [emoticon face with a surgical mask covering mouth]. [Luke], he is a paedophile he sexually abused a 4 hears old boy and told the boy if he tell anyone no one will believe him and he will kidnap him and he will kill him, it's really sad [4 sad face emoticons]. The child had blood in his bum and pooped himself when the evil [Luke] was around. Today, the child keeps having nightmares and keep talking about it. The evil [Luke] thought the child will forget, but he will never forget and want justice to be done".*

163. She explained that her motivation was that people needed to know what sort of person Luke is. It was decided that a simple caution would be a suitable method of disposal and Danielle accepted the caution (meaning an admission of guilt) in December.

164. Three days later, Luke presented himself for interview for the alleged CSA of Child A. He provided a history of his relationship with Danielle and admitted that, during the relationship, he disciplined Child A when he was naughty by smacking him on the bottom.

He said he had acted as a parent to Child A and had bathed him and help clean him up when he had been to the toilet. He denied digital or any other penetration of his anus.

165. The CAIT supervisor reviewed the interview and noted the additional enquiries with NSPCC that had established Childline was in fact part of their call answering operation and extra checking had not found trace of a call from Child A. While remaining concerned for Child A's welfare the DS felt the case did not pass the evidential threshold test for referral to the CPS and directed the investigation should be closed. The IO was directed to refer the matter to WCS for additional support for Child A.

166. The IO spoke with the social worker who said the case was closed to WCS. CAMHS support had previously been offered but Danielle said she did not trust the NHS because they had not disclosed all of the information they held on Child A. She said she would get private counselling for him. The social worker's opinion was that this case did not reach the threshold for a child protection conference to be held in relation to the emotional impact on Children A and B. The CRIS record was closed as 'undetected' in January 2016.

2016

167. In January, Fleur travelled from her home in France to take up employment as the family nanny/au-pair to Children A and B.

168. In late February, WCS opened 'Referral 4' following an email from Luke alleging that Danielle was associating with "murderers and drug addicts" and that she was coercing Child A to make false allegations against him. There is no separate police record of Referral 4 but this may be because the MPS had made a referral to WCS in mid-March following a visit to Danielle. A C&F Assessment was completed in early April and the case closed because there were no safety or welfare concerns for the children. In this context, a social worker noted for the first time in April the presence of a nanny when Child A showed his bedroom which *"also had a bed for the female [French] au-pair who sleeps in the room with them"*. Fleur's presence was also observed on home visits in May and July 2017 and there were no indicators, observations or concerns about her treatment from the mother and "stepfather".

169. In mid-March, Child A made a disclosure to the educational psychologist at School 2 that his mum was having panic attacks and he had to call 999. He said that mum can shout at him when he gets angry; that his mum hit him *"with something long"* and he has been locked in his room. He added that he wished his "dad" (believed to be a reference to Pierre) would move back to London. A referral was made to the MASH and a social worker responded that the family had been visited the week before in response to an email from Pierre in which he had expressed concerns. It was not passed to the police for investigation. The school record notes that Danielle was not happy about the referral to children's services.

170. Three days later, Danielle contacted police to report that Luke was harassing her despite the NMO in force. She alleged he had called Children's Services and told them she has been beating her children and she believed that Luke was trying to manipulate Children's Services to harass her. An appointment was made for the mid-March and she repeated

her allegation. She did not suggest that Luke had contacted her directly but she was unhappy that Luke had told WCS that she may be hitting her children and wanted to raise this as a concern.

171. The IIO explained that WCS have a duty to follow up such allegations and were not acting at his direction and that, should children's services establish this was a malicious allegation, it would be recorded as such. Danielle did not accept the explanation and she that she would go to a judge. She added that she was recording the conversation as she believed police needed to act.

172. The IIO completed a MERLIN PAC report with regard to the children and noted they appeared well dressed, well fed and were being cared for by a 'nanny'[14]. This was sent to WCS without police checks as it was identified as an 'open case' with WCS. It is likely that the nanny present was Fleur but the IIO did not record her details in the "Other Roles" section of the report which was a missed opportunity. The IMR author has made a recommendation in respect of this for the personal learning for the officers.

173. In September, Child B started part time at Nursery School 2.

2017

174. In early February, Child A disclosed to the School 2 Deputy Headteacher that he had seen Luke looking through the fence at school while holding a torch under his chin. He took staff to show them the area and pointed to a small gap of approximately 10cm between two residential garden sheds. The opposite end was blocked off and the space was too narrow to fit between. It was felt that it was highly unlikely that Luke could have been there. Danielle and Pierre attended the school for a meeting to discuss the incident and the staff concern that Child A seemed unhappy. They also raised concerns about his observed behaviour toward Fleur: being openly rude to her, arguing back and on one occasion attempting to grab a toy from her hand that he wanted to bring to school.

175. The parents[15] were supportive and agreed that he could be referred for counselling, providing they could meet the counsellor. In mid-April, a consultation was held with the educational psychologist, which Danielle did not attend, and a seven-point plan of action agreed. One action was for Danielle to re-apply for the restraining order against Luke and communicate this to Child A which might make him feel safer at home.

176. The next police contact with the family was on a Sunday in May, when they were called to a Homebase store in Wandsworth. Staff had become concerned over the presence of an 8-year old boy (Child A) who had been wandering the store for at least an hour without an adult. Police arrived promptly and spoke to Child A. He claimed he did not know who he was, including his name, where he lived, how he got to Homebase or who his family were. He said that he believed that he was adopted and might live in France. When probed further, he said he had been abused, tortured, beaten and locked inside a car by a man called Luke.

[14] The first recorded sighting of Fleur by police
[15] This designation used in the IMR

177. The LAS attended and, following clinical observations and examination, assessed that he had no apparent illness or injury. They noted his claim to have bumped his head the previous day when "running away from a man with blonde hair"[16] and to have "concussion" which caused his memory loss. When asked how he knew about concussion he said he had seen this on television. The crew noted that Child A was calm, alert and orientated, able to make appropriate and rational observations of the people in the room, for example, who they were and what jobs they were doing. He was non-committal to answering questions, mainly responding with: "I don't know".

178. Then Danielle and Pierre attended Homebase looking for Child A and identified him to the officers. They said he had run away from Church; they had been looking for him and had entered Homebase because they saw police cars parked outside. Danielle said that Child A had been a victim of sexual abuse by her ex-partner when he was 4 years of age. She added this had been reported to, and investigated by, police.

179. When Child A was told that his mum and step-dad were at Homebase, he became upset and asked if they were angry with him. He then disclosed his name and address and explained that he ran away because he didn't like going to Church. He said he was upset because he was made to do homework every day and wasn't allowed to play 'Minecraft' on the Xbox and upload videos to YouTube. He confirmed that he had never been assaulted, touched or hurt by Danielle or Pierre, only ever Luke. He said he wanted to return home with his parents.

180. Police attended Danielle's home to ensure it was a suitable environment, and it was so assessed. The IIO commented on the MERLIN PAC for the incident that Child A appeared to: "*come from a loving supporting family*". There was no note about Fleur or a nanny being present. It is not clear if any enquiries were made to clarify which Church Child A fled from and if there were any witnesses. He had been alone in the store for more than an hour before staff called police yet Danielle had not reported him missing. Neither the MERLIN PAC nor MERLIN FOUND reports record if this line of enquiry was pursued with Danielle or Pierre. It appears that consideration was not given to whether child neglect had been revealed. The IMR author has made a recommendation in respect of this for the personal learning for the officers and to address any training needs.

181. Nonetheless, the MERLIN generated 'Referral 5' within WCS that was discussed at a MASH meeting the next day and a further C&F Assessment was commissioned. It was revealed that Danielle had informed the school about the incident at the church, saying that Child A had run away from Fleur and that had he been missing for 24 hours she would have reported it to the police. The C&F Assessment was completed in July with a recommendation for a CIN Plan that was transferred to the CIN team in August.

182. In late May, Child A refused to go into class saying that he had a: "hospital problem". He added that, due to what Luke had done to him, he now cannot hold his bowel movements and has to run to the toilet quickly. He insisted on going home to shower. It took the school 3 hours to raise a response from Danielle. Fleur was sent to collect him. At no time was there any odour or other evidence of the toileting accident. Child A returned to school 10-15 minutes later and carried on his day normally.

[16] Luke has blonde hair

183. In early June, there was another toileting accident with Child A when he "bumped his tummy" on way to school. Again, he wanted to return home to shower. Fleur attended with a change of clothes and Danielle indicated she would take Child A to the GP investigate bowel issues. In a follow-up telephone call from the school expressing concern that Child A seemed unhappy, anxious and having the toileting accidents, Danielle disclosed the Homebase incident in May which the school had not been told about. She said that, while in the care of Fleur, Child A had seen Luke in the street and run away to Homebase and nobody could find him. Homebase called police and children's services were alerted. Danielle added that she had been questioned for three hours. She did not give permission for children's services to see Child A at school about this; it was done at the home instead.

184. About a week after that, the GP who had seen Child A with Danielle about the toileting incidents contacted the school. The doctor felt that mum was blaming the abuse situation and this was not the issue. Child A had been referred to the hospital last year for constipation but they did not attend the appointment. Danielle had seemed vague in her answers and the doctor could not find any previous GP notes. The GP would contact SGH for advice as there was a 'gut feel' of concern that the presentation is a manifestation of psychological stress and suggested a Team Around a Child (TAC) meeting with all professionals to share information. This was held with Danielle and Pierre the next day and they agreed to a wider meeting with professionals.

185. In mid-July, police were sent a referral by WCS followed a disclosure child A had made to a social worker at School 2 that Luke had: "*put his finger up his* [Child A's] *butt*". The original CRIS report created in 2014 was reopened to record details of a Strategy Discussion between the CAIT and WCS. It was felt that Child A was now ready to disclose details of the incident and it was agreed that police would explore the possibility of conducting an ABE interview with him.

186. Two days later, a TAC meeting at the school with Danielle, Pierre and the social worker shared 14 actions, including that the police would conduct a single agency assessment. The SW would be recommending a CIN Plan. Danielle would renew the NMO and support for a legal aid application would be provided.

187. Within a further two days, officers visited the home and noted that Child A appeared troubled. Danielle provided material relating to medical treatment he received at USA Medical Centre in 2013 when aged 4, just prior to the end of Danielle's relationship with Luke when she was pregnant with Child B. Child A was found to have a perianal abscess and a bacterial infection called folliculitis. Later in 2013, he was under a Consultant at St Mary's hospital. Danielle added that Child A had issues with his bowels and toileting ever since that were getting worse and she had seen her GP for referral to a specialist. She said Child A had nightmares, was emotional and showed signs of frustration. The officers did not note whether Fleur was present at this visit.

188. In late July, an ABE interview was undertaken with Child A. He recounted that Luke had put his finger in his bum *"a hundred times"* and said the abuse mostly happened when he and Luke were alone or when they were in public toilets at the swimming pool or the park. He said that Luke threatened him and said he would kill him. Child A explained that he only

told someone a year and a half later because he felt it was safe to do so. Preparations began for the submission of a case file to the CPS for consideration.

189. In mid-August, Danielle called police and reported that, in May 2017, her 'baby-sitter' had taken her children to meet a male. She added that the male told them he was their dad; their parents were not their real parents and that he would kill them with a gun. Danielle did not know where this incident had happened but provided the sitter's name, Fleur. An incident log was opened and, given the passage of three months since this happened, she was offered an appointment, but chose instead to attend Lavender Hill Station in person to make the full report. She was accompanied by Fleur.

190. This police station is open for a few hours a day for public access. The officer on station duties spoke to them at length and, when Danielle was insistent, put her through to the duty sergeant by telephone. These officers have been interviewed by the IMR author. A number of inconsistencies in Danielle's account were noted. She said that Fleur was at home in charge of the children whilst Danielle went out. When she came back, Child A made remarks similar to those recorded in the incident but, in this version of the story, Danielle made no mention of a gun. She could not explain why she had waited for three months to report the incident and, moreover, had been content to continue with Fleur in her employ since then.

191. She responded that she could not understand her child's remarks on that day and wanted police to 'interrogate' her babysitter to make sure nothing had happened. The incident log notes that the officer explained that: *"interrogation to the extent that she wanted, was not a tactic used by the met*"[17]. It was left that Danielle would reconsider whether Fleur was right for her family. The officer closed the incident log as no offences were disclosed and the event did not amount to a domestic incident. Fleur took little part in the conversation but appeared untroubled and there were no signs of injury.

192. The IMR author has commented that it is obvious that the officer did not believe the account from Danielle. Consideration could have been given to conducting a welfare check on the children. No details for the child were recorded on the log and no intelligence checks conducted that would have revealed the children had been subject of a CPP. A MERLIN PAC was not completed and the Vulnerability Assessment Framework (VAF) was not applied. Consideration also could have been given to a 'non-crime incident' CRIS record which would then have come to the attention of the CAIT.

193. So far as Fleur is concerned, this was the second mention of her name within an MPS system and this officer did not record any details gleaned about her in the log. A police visit to the home may also have discovered the conditions she was living in and potential evidence of her being subject to modern slavery[18]. The IMR author has made a recommendation in respect of this for the personal learning for the officers and to address any training needs.

[17] It is known from phone recordings at the trial that Danielle had started 'interrogating' Fleur two days before that visit, but this was not known to the officers

[18] Section 1 of the Modern Slavery Act 2015 provides an offence of slavery, servitude and forced or compulsory labour

194. Shortly after this, Danielle contacted the IO for the reopened investigation into the CSA allegation against Luke. She had some additional documents to share. The IO attempted to contact Danielle in mid-August to take a statement and collect the documents. However, she did not respond to messages so the IO finished the case file for submission to the CPS. In early September, the case was reviewed by a CAIT supervisor and a comprehensive rationale was recorded for the closure of the investigation with no further action being taken.

195. Meanwhile, the WCS C&F Assessment following 'Referral 5' had recommended transfer to the CIN team. The allocated social worker made every attempt to contact and visit the children and family. During the IMR interview, she reported also contacting the previous social worker to identify the best strategies for visiting and working with the family. When the family were not at home for a planned visit at the end of August, this was escalated to the team manager.

196. The friend of Danielle's, EF, later informed police that she had fallen out with Danielle about five weeks prior to the murder because of her increasingly erratic behaviour. She said that Danielle had "*kicked Fleur out*" in early August so Fleur stayed with her and her family for a couple of days. Danielle then appeared at EF's house and shouted at Fleur who eventually left with her. EF stated that Fleur looked "*lost*". The next day, Danielle called EF and said she was sending Fleur home to France. EF saw Fleur again by chance in early September whilst out shopping. She asked her if she was OK and she replied she was but appeared very reserved and quiet. She said she would be going home soon. EF told Fleur to call if she needed anything but she did not hear from her after that.

197. Also early in September, Child B started full time in reception at School 2. Child A started Year 5 and his behaviour was concerning: he was reluctant to do his work and was withdrawn (covered his eyes and head). He cited various reasons: friendship trouble with another child in the class; wanting a tuna sandwich at lunch time (but his mum had told the school that he was vegan); toothache; disappointed as mum had promised she would collect him after school but had phoned at the last minute to book him into afterschool club. There were no references to problems at home. Fleur was not seen at the school; their last sighting of her was at the close of the summer term.

198. Child A's behaviour was raised with the social worker about five days later because he was by now having meltdowns at school and refusing to do much work. The inquiry was about the therapeutic support for Child A being organised through CAHMS. The response was that the family had not engaged and had ignored calls and knocks on the door. When contact was eventually made on the phone during the holidays, Danielle was aggressive and said to leave them alone as they were on holiday. As the result of the escalation to a team manager, the social worker sent a letter highlighting concerns and to set a TAC meeting for late September[19].

199. One of Fleur's jobs was to take the children to and from school but she had not been seen there since the autumn term began. The last use of Fleur's phone was in mid-September when Pierre called her. Police enquiries established she was last seen by a neighbour in

[19] Not held because the homicide had occurred

company with Child A outside the home on the afternoon of the Sunday before the homicide.

Discovery of Fleur's homicide

200. At approximately 14:30 hours in late September, a member of the public was walking along a road near the property when they noted smoke coming from the rear of the house on the corner. They believed it to be a garden fire and as it did not appear to be out of control, they did not feel the need to take any action.

201. At 18:04 hours the same member of the public again walked past the address, attempted to see if anyone was present by knocking at the side door but received no response. As they were concerned by the amount of smoke, they called 999 to get the London Fire Brigade (LFB) to attend. Upon arrival the LFB forced entry to the garden via the side gate and found a male (Pierre) in the garden standing close to a barbeque while the fire was ablaze nearby. The firefighters doused the fire because of the risk to the building and discovered the charred remains of a body which had the initial appearance of a young adult. The firefighters asked Pierre what the body was and he replied that he had been cooking a sheep. They immediately requested police assistance.

202. When the firefighters were speaking with Pierre, his mobile phone rang. He did not answer the call but when asked he said the call was from his partner. The phone rang again a short time later and he answered the call and spoke to Danielle. One of the firefighters took the phone from Pierre and asked Danielle if she was Pierre's wife and asked if she had the children with her. She said she had and asked if she should come home. The firefighter told her not to.

203. Police attended, viewed the scene and arrested Pierre on suspicion of murder. Shortly after Danielle returned to the location with Children A and B. They were directed to a neighbour's property where she was spoken to by police. She told the police officer she lived at the address with her partner, Pierre and her two children. She confirmed they had had a nanny, Fleur, but said she had left two days before without telling them. Danielle had not reported her to police as a missing person.

204. Danielle then told the officer she believed that Fleur was in contact with Danielle's ex-partner, a man named Luke. She stated police were investigating Luke because he had sexually abused her son. Danielle said Fleur left because she told her she was going to report her to the police. Danielle was evasive when asked if she had Fleur's phone number and claimed that Fleur used a phone belonging to her which was in the flat.

205. As police had concerns with the veracity of Danielle's account and believed that the body may have been Fleur, she was arrested on suspicion of murder. Children A and B were taken into Police Protection until they could be handed into the care of WCS.

206. It transpired that Danielle had arrived at the school at, for her, an unusually early time. To keep the children away from their home, and therefore the fire, she took them to a trampoline centre known as "Flip Out" which is in Wandsworth. A thorough police search of the flat and Fleur's belongings did not find her passport.

207. The subsequent homicide investigation revealed that Danielle and Pierre had psychologically and physically abused Fleur in the six weeks leading up to her death. Forensic examinations of Danielle's and Pierre's phones for that period revealed more than eight hours recording, some on video, of them interrogating Fleur who appeared emaciated and upset. She was pressured to confess to having colluded with Luke to abuse the children, whereas, it is beyond doubt that he had never met or spoken to Fleur. She was beaten, kicked and subjected to waterboarding prior to her death. When Danielle and Pierre realised Fleur had died, they placed her body in a suitcase to hide it before attempting to dispose of her remains by fire in the back garden.

208. A post-mortem examination was conducted but the Pathologist was unable to confirm the cause of death due to the damage caused to Fleur's body by fire. However, she was able to identify ante-mortem injuries: a fracture to the right cheek bone, fracture to the right jawbone, fracture to the hyoid bone in the neck (a common indicator of strangulation), fracture to breastbone and five rib fractures on the left side. Fleur also had bruising to her chest, back and arms.

Evidence of abuse to Fleur discovered by the homicide investigation

209. There are three material sources of evidence on what was really happening inside the flat, first, from notes or letters written by Fleur; second, from what Fleur told others, in particular her mother; and third, most bizarrely and disturbing of all, the conduct of the perpetrators. They exerted considerable and ever-increasing pressure on Fleur to make confessions in agreement with the allegations that Danielle had made against Luke since 2014.

210. Fleur's notes and letters were recovered from inside the flat. They establish that life was far from conventional in that they appear to be notes written by Fleur to or for the benefit of Danielle. In one note, Fleur denied that she had taken one of the boys to a strange place and denied that she had ever left him alone with anybody. She wrote: *I myself don't understand these stories why I am in it and I am confused and a bit offended*.

211. She noted that there was no reason to be insulted and that she should not have been called a "whore" and a "bitch" and a "slut". On one piece of paper Fleur wrote: *I want to leave*. On another piece of paper: *I wish to go home … I need a break … I miss my family, my friends – my family first and foremost … so please, I am asking this for the last time, I want to go home. My mother told me that if you don't let me go, she was going to send the French Embassy*. These notes plainly demonstrate that the perpetrators were able to control and manipulate Fleur and they give an insight into Fleur's desperate state of mind and her feeling of helplessness, the probable reason why she did not feel able to leave that oppressive and unhealthy environment.

212. In an earlier note: *I would like to speak about my returning to France. To be honest it is now a bit more than three months that I try to ask you to go back but I am stopped because I am scared and shy. We had said 1 year, it is now 1 year and 5 months that I am here. I have not even gone back a single time, neither for a weekend, nor a week during the holidays, nor the summer holidays, nor Christmas, or New Year. It has been a long time. My family, my friends, my relatives, I miss them a lot, my family most of all. They miss me*

a lot also and don't stop demanding my return and are fed up hearing the same reply; which is "soon"

213. In a revealing letter to her father, in June 2017, she wrote: *I have to say sorry for the long wait without news. I no longer have Internet access and do not have enough credit to phone France. I should have written this little letter some time ago, but I have been very worried about what is happening here. There are a lot of tensions and I'm being accused of things that I would NEVER dare to do. … she (my boss) believes that it is true when it's not. In short, suddenly I feel worried.* She went on: *But I'm coming back very soon, in July. And that's for sure. Because due to the tensions that they are here and the hassle, it's better for me to come back for everyone's good*

214. The second way of discovering what life was like for Fleur is to examine what she had to say about it to others. The principal recipient of such information was Fleur's mother who continued to live in France throughout these events. At the start, Fleur told her mother that she was happy and even that she was well paid, although as her mother has noted, Fleur had never worked before and may well not have known what being well paid meant.

215. During the last six months of her life, Fleur described a rather different experience. She said that she was bored, that the children had become difficult to manage and that she wanted to come home.

216. Danielle telephoned Fleur's mother on two occasions during the summer of 2017 and, in the first, complained that Fleur was lazy and would not do anything at home for her. She also said that Fleur was going out with dubious, older characters and described a man who was almost certainly the local shop owner, CD. She claimed that Fleur would come home late and drunk.

217. There were seven examples of Facebook and text messaging between Fleur and her mother that were used to illustrate to the Jury the trail and progression of abuse endured by Fleur:
<u>June 2016</u> - "Yes Mum, you are right, I have been fooled, not by people who are nothing to me but by words … I was a stupid idiot."
<u>August 2016</u> – "I am going to come home. But at this moment I haven't any answer yet. At this moment she goes out nearly every evening. I have very busy days and in the evening I go to bed quite late. They never stop telling me "you can go home soon" … She says she won't let me go until the pendant has returned to its place of origin … why does she accuse me for no reason?"
<u>November 2016</u> – Fleur describes feeling ill and asks her mother to transfer some money to her account so that she can travel home for Christmas. Regrettably, Fleur's mother did not have the money to send her
<u>December 2016</u> – Fleur reported that Danielle had accepted all her apologies and had agreed that she would pay the salary owed so she could be home for Christmas
<u>February 2017</u> – Fleur reported that Danielle needed her to look after the children because she was so busy, that she could be hired for modelling. Danielle could not find the time to interview a replacement nanny
<u>August 2017</u> – Fleur asked her mother for sufficient money to return home because Danielle could not or would not pay her. Her mother deposited 40 Euros in her bank

account the next day and wrote; "See you on Monday". Four days later, the recorded interrogations of Fleur began.

218. In the second telephone conversation that summer with Fleur's mother which was about this time, Danielle shared the allegation that Fleur had taken Child B to meet Luke and about the threat to shoot the family. She added that she had taken Fleur around the neighbourhood to identify the house where this incident occurred but Fleur could not do so. Danielle then said that she was going to keep Fleur until she had identified the house. Fleur's mother begged Danielle to let her daughter go, but she refused. Danielle made it clear that without the information she sought, Fleur would have to stay. Throughout this odd, rather alarming telephone conversation, Fleur could be heard crying. After that point, Fleur's mother sent a series of desperate text messages to find out what was going on, but heard nothing back.

219. In early September 2017, Fleur's mother wrote this:
Hello Fleur, how are you? What's happening, I'm not sleeping even with the help of tablets at the moment. I hope nothing has happened to you, and your boss will finally let you come back. I miss you my daughter. I love you come home soon even if you are ill or there is something else, kisses.

220. The third source of evidence is the recording of Fleur's interrogations in 19 sessions amounting to more than 8 hours that ran over the six weeks from early August until mid-September and can be dated and timed. The interrogations were sometimes calm but more often than not, aggressive. The purpose of the interrogations was plainly to record Fleur making a confession, but what they would then have done with the recordings is not clear.

221. The recordings reveal much more about the perpetrators than they do about Fleur. They were dominating and intimidating Fleur throughout and she was threatened with imprisonment, rape and violence if she did not cooperate. Danielle kept demanding "the truth". It was not the truth that she sought, but confirmation of her perverted suspicions and thoughts. Fleur struggled for answers, unsure of what her interrogators wanted to hear, sometimes attempting to please them and sometimes defying them, her will not completely overborne.

222. Pierre at times displayed a prurient interest, obsessed as to whether Fleur had had sex with Luke or with anyone else. And, believing that he had been sexually abused by Luke, Pierre referred to him as a "demon" that Fleur had brought into the house.

223. These 'interviews', as the perpetrators called them, were an exercise in control and fear. They became more and more oppressive and Fleur must have become tired and, towards the end, unsure as to where this was leading. Late on an evening two days before the homicide was discovered, the perpetrators decided to make a video recording of Fleur making her 'confession' and three videos were made until they were satisfied with the content, the final one lasting 18 seconds at 23:22. Fleur by now was completely compliant, her will and spirit finally crushed following her arduous examination at the hands of both perpetrators. In the recording, Fleur repeated merely that Luke had come to the house when Pierre was asleep.

224. What becomes apparent from the recordings themselves is that they formed only *part* of Fleur's ordeal: much of this prolonged process happened without being recorded. In addition to the three material sources from the flat, there was a human source, Child A, who was interviewed by specialist officers under appropriate conditions.

Evidence of the abuse witnessed by Child A

225. Some of the account from Child A was presented to the Jury, including Fleur being subjected to violence, some of it more appropriately described as torture. He described one incident when his mother had kicked, slapped and punched Fleur in his bedroom and that Fleur had collapsed onto the bed and then onto the floor.

226. Child A said that his mother required Fleur to write down all of the bad things she had done, and that Fleur was only allowed to go into the bedroom he, Child B and Fleur shared and sit at a desk and write notes. He added that for about two weeks, Fleur was not allowed to speak to anyone. As an example of the influence the perpetrators had over Child A, he characterised Fleur as "evil". The question put to the Jury was: "Is that what you would expect from a 9-year old or is that the effect of indoctrination?"

227. Child A went on to describe an incident which he had heard taking place in the bathroom. He said that he could hear the voices of both his mother and Pierre and could hear Fleur screaming and lots of splashing of water. He said that he kept on hearing Fleur go under the water and that his mother and Pierre would then say "breathe". Child A could see water flowing out of the bathroom. The following morning, Child A asked his mother why they were drowning Fleur and she said that they were not drowning her and added that: "Fleur didn't give me, like, a real answer".

228. Danielle also told him that Fleur tried to get out of the bath and that "they" were not letting her do so. She again added similar words: "We'll let you out when like tell us … where did you take [Child B]". They had eventually let Fleur out of the bath when it became clear that she was not going to admit to something that she and they knew to be untrue. When Child A was asked if Fleur had said anything during the bathroom incident, he replied: "Well she was not talking because maybe because she was afraid if she says one word wrong, she would get even worse pain".

229. Child A last saw Fleur the morning after the bathroom incident; after that she had apparently left. He said that his mother told him that Fleur had returned to France. After Fleur had left, his mother appeared much calmer and happier.

230. There is indisputable evidence from the last of the audio recordings that Fleur was alive at 23:53 that same evening. At some point after that, she was murdered and her body concealed, almost certainly in a suitcase, and kept somewhere in the flat until the fire and discovery of Fleur's body.

ANALYSIS

231. IMR authors were invited to undertake analysis from the perspective of their organisation and these are summarised below in the order in which they came into contact with the family.

Metropolitan Police perspective

232. Fleur did not have any recorded contact with the MPS from her entry into the UK in January 2016 to the time of her murder. It is possible she was present in Danielle's home when police visited in March 2016 but the only reference to her in MPS indices relates to the unsubstantiated allegation Danielle made to police in August 2017. It cannot be known what Fleur may have told police had she been spoken to on that date but this review has highlighted a missed opportunity to complete a MERLIN PAC with regard to Child B on that occasion.

233. The issues around Fleur's vulnerability and poor treatment by Danielle and Pierre came to light after her death. It is now known she was paid a minimal amount (if at all) and appeared to live in fear of Danielle. She was prevented from returning home to France, she was not encouraged to make friends in the community, had restricted access to food and was clearly a victim of modern slavery.

234. In many of the police contacts with Danielle her behaviour was described as erratic and, on several occasions, officers suspected she may have mental health issues. There were several opportunities to highlight these concerns to Adult Children's Services through the completion of a MERLIN ACN reports but these were not identified at the time. The Vulnerability Assessment Framework (VAF) was introduced in 2015 to address this issue.

235. The allegation of Child A's sexual abuse was correctly recorded and there was appropriate engagement with WSC. Whilst the matter has been reinvestigated on two further occasions, it has not been possible to determine the veracity of the account or how much Child A was influenced by Danielle to recount the allegation.

Children's Services perspective

236. Westminster Family Services contact with the family ceased in early 2013 and no comment was made by the IMR author. From the information gathered in Wandsworth children's case file records and interviews with relevant staff, the death of the Fleur presents as an escalation of the presenting behaviours of the mother combined with her obsession to implicate Luke in the sexual abuse of Child A. There is no evidence to suggest the children were exposed to violent or physically abusive behaviours from their mother or any other adult, rather, the concerns were regarding emotional abuse, specifically in respect of Child A.

237. Danielle presented with a range of mental health indicators (13 potential references in the case file) but was not formally assessed or diagnosed as having mental ill health by a health professional. On the contrary, health professionals concluded that Danielle's presenting mental health was a result of her reactions to the alleged sexual abuse of her

son and that this had not been managed by the relevant professionals (meaning social work and the police).

238. Case file records may also indicate that Danielle presented as being 'in control' of her 'mental health' episodes and that she may have created events as opportunities to raise the historical sexual abuse. For example:
- Presenting at SGH following a 'nervous breakdown' and making her first disclosure of alleged CSA of Child A by Luke. The follow up CMHT assessment concluded no mental health concerns but anxiety due to alleged abuse of her son
- Walking in front of car traffic whilst carrying Child B, disclosing the alleged sexual abuse of Child A, reporting she wants to kill herself. Police initially considered a Section (S136 MHA) but then Danielle quickly became 'calm, insightful and aware of how her actions could have been harmful'
- Reporting depression at the Mosque due to sexual abuse of Child A; the follow up hospital assessment concluded she was tired and fed up of not being believed about the alleged sexual abuse and showed no signs of depression

239. In the absence of a mental health diagnosis, further consideration could have been given to other causes for mother's behaviours. For example, referrals regarding her presenting erratic behaviours were followed by calmer and co-operative behaviours which could have been an indicator of medicine drug use or misuse (she was reported to have back pain and although the GP indicated she was not given prescription drugs, these could have been obtained elsewhere) or other drug misuse (the email referral from Luke in February 2016).

240. Danielle made repeated allegations of the historic CSA. The allegations referred to the same incident on a continuous basis and were made repeatedly to a range of professionals: police, Children's Social Care, the GP, GMHT, NSPCC, hospital staff and Mosque members.

241. Danielle also made reports of Child A's faecal soiling, an indicator of sexual abuse, especially anal penetration, but there was limited evidence of this until June 2017 when he was taken to the GP. The GP found no evidence of constipation or a medical underlying reason but rather that the soiling behaviour represented psychological acting out of distress. This was presumably attributed to the historical sexual abuse. Earlier in May and June, the school also recorded the self-reported faecal soiling by Child A but they had no evidence he had soiled himself and there was no smell. They were concerned and had offered wipes and clean clothes, but Child A was adamant he needed to go home to shower and see his mother. Given the obsession Danielle had about the alleged historical CSA, there are some similarities with the issues and indicators of Fabricated or Induced illness guidance and procedures[20].

242. Although Child A had been safe from any sexual abuse from Luke[21] since he was 4 years old, mother consistently and repeatedly reported the same historical allegation to a series of professionals over the period of social work intervention. Danielle had discussed the allegation of sex abuse in front of Child A in the presence of the social worker, indicating it

[20] Safeguarding Children in Whom Illness is Fabricated or Induced (DCSF 2008, s2.3 p13)
[21] Which has been strenuously denied and largely discredited

was also likely discussed with him when professionals were not present. The assessment of July 2017 reports Child A to be anxious about Luke "being able to get to him" and that "the police said they are closing the case, so he can come back". The information about police case closure would have been reported to Danielle rather than Child A. There is also no evidence that Luke had returned to the UK.

243. Whilst the children were not physically harmed or injured, Child A presents as emotionally traumatised by mother's repeated allegations that he was sexually abused by Luke. During the assessments in 2014, Child A said that Luke was a bad/naughty person and had touched him in his bum, drew a picture of his mother covered in blood and drew circles to contain the things he cannot say.

244. In 2017, at the Homebase incident Child A told police that he had been adopted and maybe lived in France. When asked further questions, he said he had been abused, tortured, beaten and locked inside a car by a man called Luke. He then disclosed that he suffered from memory loss due to a head injury but quickly recovered on the arrival of Danielle and Pierre. He later said that Luke had locked him the car for a day and that he had a dagger which nearly fell on him. In July, he was anxious that Luke could get to him by referencing the time in February when he told the school he had seen him looking through the fence.

245. Danielle did not seek to comfort or assure Child A of his safety, but rather increased his fear of Luke. Regardless of whether the sexual abuse happened or not, Child A has been consistently led to believe, or induced by his mother to report, he had been sexually abused by Luke. As noted in the S47 enquiry of August 2414: *[Danielle] spoke of the allegations in front of [Child A] and almost appears to be coaching him in this regard*.

246. Regardless of whether Danielle had a mental health diagnosis or not, Child A had lived with his mother for all his life and was drawn into her drama and chaos of the sexual abuse allegation. There is a 'darkness' in some of the direct work and contacts with Child A as indicated above. Danielle would not co-operate with CAMHS to support Child A's trauma. Child A also gave evidence during the trial of his mother and step-father.

247. The IMR author expressed the view that WCS should currently be concerned about Child A's emotional welfare and ensure he is receiving specialist therapeutic help and healing and that both children are being supported in the loss of their mother, stepfather, nanny and their family home and connections. [Note: This observation had been urgently addressed by WCS prior to the IMR being received and Child A is now placed in the care of his biological father]. Child B presents as being better protected from the emotional trauma. He was not the subject of the alleged sexual abuse and the repeat referrals, except for the incident where he was carried by his mother through traffic. He was seen on home visits and at his nursery. Child B appeared happy and was well presented. There have been no concerns for Child B during social work visits.

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Education perspective

248. School 1 were concerned for Danielle's mental health and have identified that Pierre aided her delusions. From their perspective, it was impossible to find out the truth of the family relationships from the various 'titles' that he and Danielle used to describe his role.

249. School 2 have identified that Danielle's mental health and complete delusional obsession with Luke contributed to Fleur's death. She was from a small community and was vulnerable and isolated. She possibly did not know who to talk to in order to get support. She did not have any friends or family in the country who she could get help and support from. There was also a language barrier – although this had improved from when she first started working for the Danielle family, she still had limited English fluency. Child A would initially translate for her and the nursery teacher would converse with her in French.

250. If the members of the community that knew about the abuse had the confidence and knowledge to report it or even share this with the school, this tragedy might have been avoided. The escalated abuse occurred during the summer holidays where services had no access to the children for six and a half weeks. Even if the children wanted to talk about it, they would not have had the opportunity. Provision could have been made for the TAC meeting to go ahead without the school during the summer holidays and regular visits could have been arranged – or possibly attendance at a summer club. Due to the change in social workers and the family not being contactable during the holidays, nobody was monitoring the children for an extended period.

Health perspective

251. Fleur was not a patient at the GP Practice and was only seen by the GP when consulting with them about Children A and B's health needs. GPs in Wandsworth are trained in level 3 Safeguarding with specific focus on sexual exploitation and this could possibly have been a point at which further information about Fleur's role within the family could have been ascertained, albeit that nannies are commonplace in Wandsworth and often attend GP appointments with children on behalf of their parents.

252. It was presumed by GPs that Pierre was the father of the children and presented as one of the main caregivers of the children. He also presented well and in a caring and appropriate manner when seen in the surgery. Danielle (registered at the surgery under her middle name) told doctors that he was her brother, then a friend and, eventually, her partner. In her complaints to the GP about unfair treatment by police or children's services, Danielle disclosed that Pierre acted as an advocate who helped her to "navigate around the system". Perhaps this meant he knew how to "play the system". One GP asked Danielle for more information about Pierre (whom she said she had known since aged 18) and was told that Pierre: "Can't recall how to spell his surname", which does seem a strange thing to say and could be seen as elusive.

253. Danielle herself was a complex patient with complex needs from the start of her registration at the practice. The chronology highlights many of the difficulties faced by her GPs in piecing together her medical and social history. This was despite copious evidence of professional curiosity and efforts to understand and triangulate her story. A recurring

pattern is clear of Danielle presenting with multiple problems, demanding multiple referrals and then repeatedly not attending these referral appointments. She presented to her GP with a history of alleged Domestic Abuse from her ex-partner, a complex story of serious injury and a fall which she would not describe (possible domestic abuse) and suffering with chronic pain. As a victim of Domestic Abuse and the mother of two children under 5 she was identified as vulnerable from registration.

254. The lead GP for Safeguarding acted as her named GP and, consequently, saw more of Danielle than other doctors at the practice. The named GP was asked to make multiple assessments of Danielle's mental state as there were concerns raised by social care, the police and education. The doctor felt that, while Danielle was showing understandable distress and anxiety about her son's disclosure of sexual abuse, she was not displaying signs of mental illness, noting: 'In my opinion she has no psychopathology or mental ill health but is acting appropriately distressed due to recent events'.

255. By 2017, the named GP was also starting to question the story because evidence was lacking, for example, about the fall from a building and a road traffic collision, and there was no documentation around the alleged domestic abuse against her. Danielle displayed classic 'disguised compliance' by requesting multiple referrals then repeatedly failing to attend her out-patient appointments, logging multiple DNAs (Did Not Attend). When challenged she always provided a plausible excuse and asked for a repeat referral. The same behaviours were observed in relation to her children.

256. Disguised compliance has been repeatedly seen and documented as behaviour often displayed by abusive parents. It should lead to referrals to social care in relation to potential medical neglect of children. Danielle seems to have managed to explain her non-attendance when appropriately challenged and her explanations accepted. There is a question around whether GPs should perhaps have had a lower threshold for rereferral to social care when multiple DNAs occurred.

257. As both children were placed onto a child protection plan in August 2014, the GP staff knew that the family were of concern and notes were flagged and coded appropriately. The entry in Danielle's notes during this time highlight her ongoing concerns about the allegations of sexual abuse against Child A not being followed up by the police. She talks frankly in her consultations with the named GP about her concerns that the alleged perpetrator of the physical abuse against her and Child A and the sexual abuse against Child A is still in contact with him. She shares her fears for Child A's mental health and is keen for him to have a CAMHS review. It is only later that she decides she doesn't want him to have this support even when it becomes available following a long wait. The IMR author has commented that, even in her son's appointment she dominates and the consultation is very 'her' focused with the voice of the child being lost.

258. When the named GP saw Child A in June 2017 for the feacal soiling incidents, the IMR author has noted that Child A was asked only one direct question and he was not spoken to alone. There was little professional curiosity as to what might be going on emotionally to cause this. With hindsight, it is possible that these symptoms were triggered by witnessing, or being aware of, what was going on at home with regard to the abuse and torture of Fleur. Danielle did acknowledge that Child A's soiling could be emotionally linked but

related it to the alleged sexual abuse he suffered. This presentation again poses the opportunity for professional curiosity and challenge back to a very difficult patient with complex needs herself. Danielle added that Child A was "screaming in his sleep" and that would have been a perfect opportunity to ask Child A about his nightmares and to explore further his emotional state and wellbeing.

259. Child A was felt to be safe with his mother and the protective factors of Pierre. Given that Child A had been on a child protection plan previously there is an argument that the threshold for rereferral to social care should have been lower. However, the problem was referred to the complex case paediatric team and educational psychology was being arranged. The named GP sought expert help in managing the situation, discussing the case with both the head of safeguarding at Child A's school and the designated doctor for child safeguarding for Wandsworth. The TAC team were consulted and a plan for referrals to CAMHS, Psych Ed and Complex Needs Paediatrics were made.

260. Child A had not received any psychological therapy surrounding the allegations of sexual abuse to date at the point he presented with encoparesis (the faecal soiling). This was because Danielle had not wanted to engage with CAMHS, declined referral and DNA'd educational psychology input on more than one occasion. This is another example of disguised compliance as she would request psychological therapy and referral and then not attend or decline it further. Despite the named GP explaining the referral process and the need to manage both the emotional complexity and the physical manifestations of it, Danielle arranged to see a private gastroenterologist seeking a physical explanation for Child A's soiling. This could perhaps be viewed as avoidant behaviour.

261. Child B was seen far less at the GP surgery than his elder brother. Consultations are uneventful and appropriate. As the younger sibling there was less opportunity for seeing him alone and hearing his narrative but, in view of the protection plan, it would have been good practice to try and ask him about his life at home opportunistically. His DNA (was not brought) appointments were followed up appropriately. His health concerns presented by his mother were appropriately managed and referred. He was discussed at the regular health visitor liaison meeting held at the practice.

262. SWL&SGH Mental Health Trust have completed analysis of the case as to why they did what they did. There is no evidence to indicate this was a predictable act based on the information available to Wandsworth HTT in May 2014. However, had further information been gathered as described below, it cannot be ruled out that this would have led to consideration of the risk of harm to the children and the victim.

263. WHTT did not focus on parenting; that is, did not appear to 'Think Family'. There appears to be threads of possible elements of a developing/emerging psychosis in the assessments and that a level of paranoia has developed in relation to the ex-partner in response to the belief regarding the actual or alleged abuse of their son, and this was the central focus of the team.

264. There was a lack of a multidisciplinary approach to the ongoing assessment process. No support was requested from the WHTT medical team to support the formulation of the assessment prior to her discharge from services, or from social work while under the care

of WHTT. There appears to have been a lack of curiosity about the mental state of the children, the stability of the home, and the ability of Danielle to continue to parent effectively during what appeared to be a psychotic crisis.

265. No follow up of the referral to children's services was made, and no named worker was identified until Danielle was discharged from services. The notes indicate that they had been in touch but not the outcome of the contact with Child and Family services.

266. The London Ambulance Service found that staff followed National Clinical Guidelines to aid their decision making. The Trust is satisfied with the 999 call management and the care and treatment provided by the ambulance staff were in accordance with expected practice. The Trust has in place children's safeguarding policy and practice guidance and a safeguarding referral was made in April 2014 due to concerns that there was not a responsible adult to look after the two children.

267. Similar findings were made regarding the Mosque incident. At the Homebase incident, LAS staff noted that Child A's mother and stepfather had arrived on scene though they had not called police themselves to alert them of Child A's disappearance. Child A's mother appeared not to be overly concerned or frantic about him.

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CONCLUSIONS, LESSONS LEARNED, AND GOOD PRACTICE IDENTIFIED

268. Hindsight always highlights what might have been done differently and this potential bias or 'counsel of perfection' must be guarded against, along with 'outcome bias'. Opening the window as widely as possible on what happened has been the intention of this joint review so as to understand what learning may be identified to improve the system for safeguarding.

269. When pregnant with child B in 2012 and following the birth in 2013, the relationship between Danielle and Luke began to fragment. Police were called twice without specific allegations of abuse, then in October Danielle alleged two instances of a choking assault by Luke for which an arrest warrant was issued, although later withdrawn because neither Danielle nor Luke were in the UK. In 2014, Danielle referred police to 'abusive' emails from Luke, including one that contained religion-based abuse. This did not result in police action, however, in the context of a dispute with the school, an IDVA completed a DASH RIC regarding the alleged abuse by Luke and Danielle that was referred to the MARAC. A number of safeguarding actions were taken and the case was closed.

270. Over the following few months, there is a substantial body of evidence from the review that Danielle developed an obsession with Luke after the end of their relationship. From April 2014 she embarked on a campaign to discredit and humiliate him through an accusation that he had committed a sexual assault by digital penetration on her son, Child A when aged 4, some three years earlier in 2011. It is possible, if not probable, that this was at the time Luke ceased financial support to her and Child B.

271. This discredited, and probably bogus, allegation was frequently and repeatedly shared with agencies; then with the wider public through an on-line post naming Luke in December 2015 for which, with the benefit of legal advice, Danielle accepted a criminal caution for malicious communications. Undeterred, her imagination and inventiveness was boundless even to the last few weeks as Fleur was accused of taking the children (three months earlier) to meet Luke who had a gun and threatened to shoot them.

272. Danielle needed the unwitting cooperation of Child A to provide credence to the original allegation, and there is significant inference that she indoctrinated him with her fabricated story and schooled him over time, on the other frightening manifestations of Luke as his nemesis, thereby cruelly inflicting severe emotional abuse upon him. This had become the pattern of abuse to Child A, long before Fleur appeared on the scene in February 2016, employed under a private family arrangement, as nanny/au-pair to Children A and B.

273. Fleur's vulnerability, and our understanding of the extreme suffering she endured once under the control of her employers, came to light only after her death. It is now known that she soon became trapped in a domestic nightmare. Fleur was prevented from returning home to France, she was cut off financially, with restricted access to food, and the two friends she developed in the community were seen off by Danielle.

274. There is also evidence of 'Gaslighting'[22], a form of manipulation that seeks to sow the seeds of doubt in a targeted individual, in this case Fleur, hoping to make them question their own memory, perception and sanity. Using persistent denial, misdirection, contradiction and lying, it attempts to destabilise the target and undermine belief. The false accusation that Fleur had stolen a valuable pendant is but one example.

275. It was Fleur's first job and the first time away from her family in a strange country, while having to cope with learning a second language. Her passport was not recovered, so was probably impounded. She was assaulted by Danielle when a friend of hers was at the house and again, at least once, in the presence of Child A. The control and coercion on her life by Danielle even extended by proxy to her mother. She did not raise the alarm with anyone else other than close family. It is not known whether she knew to whom to make any concerns to, although Fleur did make reference to her mother contacting the French Embassy in one of her notes recovered from the crime scene. With these factors alone, Fleur is accurately described as: a victim of modern slavery through domestic servitude[23]. This review exposes a situation that nannies/au pairs are a particularly at risk group given the lack of regulation and specific safeguarding advice for them.

276. Through Fleur's victim status of coerced and controlled servitude, she became the lightning rod for the ongoing, fixated obsession about Luke . This is obvious from Danielle's contact with police in mid-August 2017 to allege that Fleur had taken Child B to meet Luke who said he would use a gun to kill the family. This was the beginning of six weeks of systematic, inhuman torture upon her, apparently in order to extract confessions to perceived new transgressions in relation to Luke that she could know nothing about, because they could not possibly have happened. It remains unclear what the utility might have been for these 'confessions'.

277. It is possible that Danielle had somehow convinced herself they were true. If that were not the case, she took a great risk by marching Fleur down to Lavender Hill police station for her to be 'interrogated'. The recorded torture sessions had started only two days before and she would have to be supremely confident that Fleur would not speak out in the presence of a police officer. She took a further risk of discovery later that month when she called the investigating officer into the re-opened CSA investigation to collect some additional documents at the home. She may have reconsidered, because she did not respond to requests for a witness statement and disclosure of purported medical evidence.

278. Not only did Danielle exercise control over Fleur, she was adept at manipulation of authorities to achieve her goals. Deception around her physical limitations, secured a doctor's letter and change of school. The medical notes relating to the alleged fall never did arrive. The dramas, such as the ambulance calls by Child A, the Homebase incident, the walking barefoot walking in traffic with Child B in her arms, can now be seen to be completely staged by her. Furthermore, as identified by her GP, Danielle was adept at 'disguised compliance'. She viewed professional curiosity as something to be challenged; in doing so she was aggressive and often threatened to complain to the higher level.

[22] Origin the 1938 play and 1940's film 'Gas Light'
[23] Home Office Research Paper 93 – Typology of Modern Slavery

279. Pierre was alongside Danielle for virtually the whole of this journey and played his part in supporting Danielle by challenging agency decisions she did not like and joining with the fabricated crises, such as the Homebase incident in May 2017. Yet, at times, he was observed to be a calming influence, especially around Child A. Towards the end he was an active collaborator in the torture sessions and displayed a prurient interest in the salacious aspects of the 'confessions'. It is a strong possibility that he was driven by paraphilia[24]. The prosecution suggested he had been "indoctrinated" by Danielle into believing the "complete fiction" of an alliance between Fleur and Luke.

280. Their respective defence to the murder charge was to deny personal responsibility and infer the other was culpable, each claiming to be asleep at the time; yet each admitted perverting the course of justice by cremating Fleur's body in the garden. The key eye-witness account from Child A that both were involved in the bath torture was sufficiently compelling for the Jury to find each guilty of murder. The final recorded video confession coerced from Fleur that she had indeed let Luke and two associates into the home in order to compromise Pierre sexually, marked the finale to the labyrinth of lies, elaborately constructed and sustained over more than four years, that had started with the false allegation of CSA by Luke on Child A.

281. The psychology and motivation for the murder of an innocent may be inexplicable. Danielle had caused mental health concerns from as early as 2008 when she and Child A were assessed over six weeks in a residential unit. There was no evidence of psychosis and the Consultant Psychiatrist could find no evidence to support a diagnosis of Borderline Personality Disorder or Personality Disorder. This was before she had the relationship with Luke.

282. The next opportunity for mental health assessment occurred in April 2014 and was presented in the context of Child A's recent allegation of CSA three years earlier that caused Danielle to have an acute stress reaction three days after his disclosure and be admitted to hospital. The initial psychiatric assessment noted that Danielle may have 'delusional paranoia'. The concluding assessment before discharge from hospital confirmed the acute stress reaction and noted the belief that Luke was using black magic was either due to that stress reaction or may be part of a psychotic illness. Multiple follow-up visits by the HTT in the next two weeks did not identify any new conclusions and their support was ended by Danielle who expressed annoyance that her acute stress reaction had been treated as a mental health issue.

283. In July 2014, the episode where Danielle was found wandering in traffic with Child B in her arms was considered by police for their powers under the Mental Health Act, but not exercised as Danielle had calmed. WCS implemented a CPP as a result under the category of 'Emotional Abuse' which was later stepped down to CNP and then closed as there were no safety concerns. In October 2014, the GP has noted that Danielle showed no signs of psychiatric disorder. There is no further assistance available from IMRs regarding the state of Danielle's mind.

[24] Abnormal sexual desires, typically involving extreme or dangerous activities

284. There is substantive research[25] available that relationship-based homicides are rarely spontaneous and the '[He] just snapped' explanation which suggests an immediate proximal provocation is not supported. Instead, there is an 'emotional journey to homicide' that develops over time. Schlesinger describes 'catathymic homicides' as occurring when:

> *There is a change in thinking whereby the offender comes to believe that [he] can resolve [his] inner conflict by committing an act of extreme violence against someone to whom [he] feels emotionally bonded*

285. It is not suggested that Danielle had formed an emotional bond with Fleur in the conventional sense, rather, Fleur became the surrogate for Danielle's engulfing emotional connection with Luke, the father of Child B. Danielle's behaviour toward him following the breakdown in their relationship is analogous to one definition of stalking[26]: *any fixated[27] and obsessive[28] attention designed to make the victim fearful or distressed.*

286. This recent study into stalking, *'The Homicide Triad'*[29], examines the coincidence of three groups of characteristics, namely, the offender's emotional or psychological state, the presence of acknowledged high-risk markers and the triggers which create escalation. The organisation within the study of key characteristics relevant to homicide, has prompted speculation that Danielle:

> Psychologically had issues with challenge and rejection;
> Had increasingly exhibited the high-risk marker of versatility: vexatious litigation, criminal allegations and child contact battles;
> Which, following the triggers of rejection and humiliation, had escalated the resolve to complete her own 'emotional journey to homicide' by killing Fleur

287. The Court were told in mitigations by Danielle's barrister that, in May 2017, she had been diagnosed with depression and borderline personality disorder and that her actions were "entirely driven by her delusional and personality disorders". This left her with "irrational and completely overwhelming fear" that Fleur had been recruited by Luke. The Judge was not convinced and remarked, "I do not think for one moment you thought you were acting lawfully".

288. The Panel sought assistance from a learning perspective to understand the psychology or personality type of the perpetrators. The mental health adviser to the Panel provided this response:

> *I have discussed this request with the Consultant Clinical Psychologist and Head of Psychology and Psychotherapies. It was agreed that it was not possible to formulate a view of the psychological profile of Danielle or Pierre from the limited information in the draft report. The report does not contain any of the psychological measures or tests or other parameters required to be able to make a reliable formulation. Without that level of detail, it would not be possible to complete a*

[25] Schlesinger 2002, Adams 2007, Monckton-Smith 2012
[26] Monckton-Smith, Szymanska and Halle 2017
[27] The state of being unable to stop thinking about something or someone, or an unnaturally strong interest in something or someone – Cambridge Dictionary
[28] A persistent disturbing preoccupation with an, often unreasonable, idea or feeling; an idea or thought that continually preoccupies or intrudes on a person's mind – Webster Dictionary
[29] Monkton Smith, Szymanska, Haile (2017)

meaningful assessment as it could only be speculative and, thereby, potentially misleading.

289. On the wider perspective of Fleur's employment as a French national in the UK, she was entitled to work anywhere in the EU without disclosure to the Home Office[30]. Had she become known to local agencies, the Local Authority have statutory duties and powers to:

- Notify the Home Office that they have encountered a possible victim of slavery as specified in the Modern Slavery Act 2015
- Refer Fleur to the National Referral Mechanism[31], providing she consented
- Provide support to Fleur by use of their powers under the Housing Act, Localism Act and Care Act, the EU Directive, the ECHIR (The European Convention on Human Rights) and ECAT (The Council of Europe Convention on Action Against Trafficking in Human Beings 2005 CETS 197)
- Ensure that Local Authority staff are trained in recognising how to spot the signs of slavery and trafficking and what support should be provided to victims
- Raise public awareness of Modern Slavery by placing information posters around the borough (in libraries, schools, parks, shops, etc) and provide details of who to contact if a member of the public suspects that someone is a victim of Modern Slavery.

290. In considering what support should be available for young people coming to the UK as au pairs and nannies who may be vulnerable to exploitation and modern slavery, the following has been identified as good practice:

- The offer of information sessions after they arrive in the UK
- Make it universal practice for all migrant workers attending the visa application centre to be seen physically apart from their employer and to receive verbal and written information in a language they can understand informing them of their rights in the UK, including where to get assistance from should they suffer abuse. These terms should be expressly referenced in the contract between UK Visas and Immigration and commercial partners providing services at Visa Application Centres
- Outline their rights such as, to retain their own passport and to be given the minimum wage for UK workers plus information about access to support in a language they can understand
- Provide a presumption of an employment relationship of at least three months' duration in the case of an employment dispute between an employer and an undocumented worker, with the burden of proof being on the employer.

Good practice identified

291. IMR authors have identified and listed good practice:

<u>Metropolitan Police Service</u>

- In December 2012, securing a first instance warrant for the arrest of Luke to ensure the window for prosecution did not close after six months

<u>Wandsworth Children's Social Care</u>

[30] This will change from 1 January 2021 but the arrangements have yet to be advised on the Gov.uk website

[31] A process in place in the UK since 2009 for identification and support of victims of slavery and human trafficking

- Good evidence of multi-agency working and frequent/regular contacts with police, health and education and good, insightful analysis by social workers following visits to the children and family
- Good examples of direct work with Child A including the use of signs of safety '3 houses' tools and of the children being seen alone during home visits. A very good child directed safety plan was agreed with Child A following his missing episode. Assessments were of a good quality; thorough with good, balanced analysis of the presenting needs and risk factors for the children
- There was good social work management of Danielle's challenges, outbursts and resistance to social work visits and interventions. There was a very good example of suitable challenge to Mother by the social worker during the home visit in July 2017

<u>School 2</u>

- When Child A joined, a TAC meeting was held with the previous school in order to transfer any relevant information. Relationships were built with parents in order to provide support and to share concerns(as previous they did not have much involvement with the school). Numerous TAC meetings were held between school, parents and other professionals involved at the time to provide emotional support for Child A
- The school identified symptoms indicating a cause of concern in Child A. Behaviour changes were flagged up to the Designated Safeguarding Lead and records of actions were noted. Staff were aware of the child's needs and were vigilant to report any small concerns. Detailed, accurate and secure CP notes were kept, including phone calls, emails, meetings, disclosures, etc.
- The school made the relevant referrals and involved the educational psychologist; social workers, doctors, police, CAHMS and parents which led to a 'child in need' plan. The school attended and contributed fully to all TAC meetings. Clear actions were identified and carried out as a result of the TAC meetings (eg: referral to CAHMS for specific therapeutic support to be held at school; support from Intensive Intervention Team; Police to do a single agency assessment; etc)
- The children knew who a trusted adult was at school in order to share their worries. The learning mentor and various other adults were known and available for the children to speak to. Minor incidents in school (eg: friendship issues) were dealt with promptly and appropriately

<u>Local GP Practice</u>

- The IMR author has highlighted good practice by the Practice staff and the named GP to the family who was the lead GP for child safeguarding and trained to level 3, in particular:
- Attending child safeguarding case conferences and TAC meetings
- Information was shared with the multi-agency team promptly, appropriately and effectively. Reports were received and acted upon appropriately
- The named GP met with her liaison health visitor regularly (6 weekly) and discussed her concerns about the family regularly. This demonstrates excellent information sharing and multiagency working, including directly liaising with education colleagues when she had concerns and wanted to triangulate the history and make appropriate referrals. She spoke to the allocated social worker for the family directly with her concerns and followed the appropriate escalation policy when she had concerns and needed further expert advice from the Designate Doctor for Safeguarding
- The GP challenged Danielle about the DNA's of both her own and children's appointments and was professionally curious about who attended appointments with them

- Vulnerability factors were recognised in Danielle and flagged and coded, as were the protection plan notes regarding the children

South West London and St Georges Hospital

- Danielle's physical health needs were noted and there was a well-documented MASH referral in April 2014

RECOMMENDATIONS

292. IMR authors identified recommendations that should be implemented internally. If an agency is not listed below, then no recommendations were made. The eleven recommendations are consolidated in **appendix 3** with progress recorded and also summarised below. Recommendations from IMRs for wider consideration are listed in the next section and, along with strategic learning points identified by the Panel to form the action plan.

293. The MPS IMR author identified three interactions with Danielle, in March 2016, May and August 2017 where senior officers of the local South West command unit should arrange to debrief the officers involved to identify individual and wider safeguarding training needs across the command.

294. The Wandsworth CSC IMR author has identified five internal matters to be implemented within the agency, also set out in full in appendix 3, and summarised here:
1. Practice standards to be updated to include nannies and au-pairs
2. Develop specific procedures to respond to parents who make continuous claims of child abuse
3. In complex parental behaviour cases, consider a separate chronology to record the child's voice
4. Review the threshold of case escalation
5. Staff to be reminded of the fabricated illness procedures

295. Recommendations from the review of the local GP Practice, include:
1. Continue with Level 3 training on the 'voice of the child'
2. Train clinicians to recognise 'disguised compliance'

296. The one internal recommendation for SWLSTG is to embed 'Think Family' further across all services.

For wider and multiagency consideration

297. From the WCSC IMR the following recommendations are for Panel consideration:
1. The WSCP should consider clarifying the role/status of nannies/au-pairs in the safeguarding children agenda
2. Multi-agency domestic abuse procedures should consider the role of nannies/au-pairs in terms of their place in a domestic family home environment
3. As nannies and au-pairs remain an unregulated, private family arrangement, consideration should be given to wider discussions across LSCB's regarding their regulation and protection on a national and international level. Currently, no-one is

looking after their interests or welfare and they remain very vulnerable to abuse and exploitation

298. The local GP Practice IMR has identified:
    1. Organise multiagency training to focus on the voice of the child in Domestic Abuse families
    2. Continue to improve multiagency working by continuing to establish close liaison eg; 8 weekly health visitor meetings with GP practices , social care liaison, Joint training
    3. Identify in training the need to be aware of professional manipulation by complex patients who have multiple vulnerability factors for abusing their children

299. School 2 identified:
    1. Children's services to raise the profile of domestic abuse and make it clear that it doesn't have to be between partners – it is anyone in the house. Information on posters about what to do if you are concerned about an adult or if you are a victim of domestic abuse yourself should be visible in the community. Information should be given on where to get help and support. Information on how and where to report any concerns such as a help line that you have about friends or family should be readily available
    2. New regulations should be brought in to ensure that au-pairs and employers have DBS checks and are monitored to ensure their safety as well as the safety of the children in their care. New regulations should be brought in to ensure that all au-pairs need to be registered
    3. Robust systems for sharing information should be in place between agencies and boroughs

300. As well as identifying that this was a clear example of modern slavery by domestic servitude, the Panel also reviewed current Home Office guidance[32] on employing someone to work in the home. Had Danielle been employed as a nanny, she would have had access to employment rights. Given the conditions of her visit with Danielle's family that was obviously not the case, therefore, as understood by her family, she was brought in as an au-pair. Au-pairs usually live with the family they work for and are unlikely to be classed as a worker or an employee. However, to be classed as au-pair (and not employee), 'most' of 12 points listed in the guidance must apply. It could be argued that only one of the twelve points is applicable to Danielle: the fact that she was an EU citizen. It is not suggested that the guidance is wrong but learning from this exceptional case indicates that more information could be included to safeguard young people in the au-pair situation.

Strategic Learning Points

301. This joint review of an extraordinary and unpredictable homicide, committed within a very complex family setting, following quite extensive engagement with safeguarding agencies, has identified strategic learning points to draw together the learning from agency IMRs.

[32] https://www.gov.uk/au-pairs-employment-law/au-pairs

302. Learning Point 1

Guidance is required to ensure that the employment of nannies/au-pairs is safe for them as employees, the children in their care and their employers and to minimise the risk of modern slavery by domestic servitude

303. Learning Point 2

Improve public awareness that domestic abuse does not just involve family, it can be anyone in the household, and how to report concerns and access advice

304. Learning Point 3

Expand and reinforce Level 3 Child Safeguarding awareness training on the voice of the child

305. Learning Point 4

Reinforce the need for healthy scepticism, an open mind and, where necessary, an investigative mindset when dealing with complex families who have multiple vulnerability factors

306. The following recommendations have been identified by the Panel to address these learning points and an action plan is set out in appendix 4. The first is a national recommendation, followed by recommendations to be implemented in the London Boroughs of Wandsworth and Richmond:

1. Department for Education to review the current guidance regarding employment of nannies/ au-pairs that protects them, children who may be in their care and their employers to reduce the risk of Modern Domestic Slavery through Domestic Servitude
2. Community Safety Partnership is to use the learning of this review to raise awareness of the risks of Modern Day Slavery through Domestic Servitude
3. To implement a robust awareness raising campaign and plan within the borough's proposed new VAWG Strategy is to be overseen by a specific sub-group involving statutory stakeholders, schools and NGO's
4. To ensure that the 'voice of the child' and the learning from this review is used to reinforce Level 3 Child Safeguarding Awareness Training for front line Professionals across the Partnership
5. To ensure that learning in respect of 'Professional Curiosity' from local and national SCR's and DHR's is cascaded to front line professionals and those bodies

AUTHOR

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2 October 2020

Domestic Homicide Review Panel – LB Wandsworth CSP
'Fleur' found murdered in September 2017 in Wandsworth

Glossary

CAIT	Child Abuse Investigation Team
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
cjsm	Criminal Justice Secure eMail
CNP	Child in Need Plan
CPP	Child Protection Plan
CSA	Child Sexual Abuse
CSC	Children's Social Care
CSU	Community Safety Unit
DA	Domestic Abuse
DASH RIC	Domestic Abuse Stalking and Harassment Risk Identification Checklist
DHR	Domestic Homicide Review
ERO	Evidential Review Officer
FLO	Family Liaison Officer
GP	General Medical Practitioner
GPMS	Government Protective Marking Scheme
gsi	Government Secure Internet
HTT	Home Treatment Team
IDVA	Independent Domestic Abuse Advocate
IIO	Initial Investigating Officer
IMR	Individual Management Review
LBW	London Borough of Wandsworth
MARAC	Multi Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
MERLIN	Police safeguarding report shared with agencies
MPS	Metropolitan Police Service
NHS	National Health Service
PAC	Pre Assessment Checklist (attached to MERLIN report)
pnn	Police National Network
SGH	St Georges Hospital
SWLSTG	South West London and St Georges Hospital NHS Trust
TAC	Team Around the Child
ToR	Terms of Reference
WCCSC	Westminster City Children's Social Care
WCSC	Wandsworth Children's Social Care
WHTT	Wandsworth Home Treatment Team
VAWG	Violence Against Women and Girls

Names used

Danielle	Mother of Children A and B
Pierre	Partner of Danielle
Child A	Danielle's eldest child
Child B	Danielle's youngest child
Fleur	Family au-pair from January 2016
AB	Father of Child A
CD	Local shopkeeper
EF	Friend of Danielle

Domestic Homicide Review Panel – LB Wandsworth CSP
'Fleur' found murdered in September 2017 in Wandsworth

Distribution List

Name	Agency	Position/ Title
Paul Martin	London Borough of Wandsworth	Chief Executive
Cllr Jonathan Cook	LB Wandsworth	Deputy Leader of the Council and Cabinet Member for Community Safety; lead on domestic abuse
Liz Bruce	LB Wandsworth	Director of Adult Social Services
John Johnson	LB Wandsworth	Director of Children's Services for Wandsworth
David Peplow	LB Wandsworth	Safeguarding Children Partnership
Richard Neville	LB Wandsworth	Safeguarding Adults Board
Peter Green	Wandsworth CCG	CCG Designated Doctor Safeguarding Children
Claire Taylor	Wandsworth CCG	CCG Designated GP Safeguarding Children
Liz Royle	Wandsworth CCG	CCG Designated Nurse Safeguarding Children/Head of Safeguarding
Marino Latour	Wandsworth CCG	Designated Safeguarding Adults Lead
Brian Reilly	LB Wandsworth	Director of Housing & Regeneration
Angela Middleton	NHS England	Patient Safety Projects Manager (London Region)
Sally Benatar	Metropolitan Police	South West BOCU Commander
Janice Cowley	Metropolitan Police	Detective Sergeant Specialist Crime Review Group
Bill Griffiths	Independent Chair	Independent Chair/Author of the Domestic Homicide Review
Tony Hester	Director Sancus Solutions Ltd	Independent Administrator and Panel Secretary
Quality Assurance Panel	Home Office	-
Cressida Dick	Metropolitan Police Service	Commissioner
Sophie Linden	Mayor's Office for Crime and Policing	Deputy Mayor
Baljit Ubhey	Crown Prosecution Service	London Chief Crown Prosecutor

Domestic Homicide Review Panel – LB Wandsworth CSP
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Appendix 1

Context

In January 2016, a few days after her 20th birthday, Fleur left France to work as a nanny for Danielle's two children, aged 9 and 5, at a house in LB of Wandsworth. Also living there was Danielle's partner, Pierre. They are both French Nationals with Algerian heritage.

Within a few months, Fleur had become the subject of abuse and exploitation, led by Danielle with Pierre a willing collaborator. The trail of abuse degenerated to the point of starvation and torture, culminating in her death shortly before its discovery in September 2017.

The Fire and Rescue Service were contacted by a neighbour concerned about a fire that had been started close to the rear of the house. The firefighters who attended were troubled by a number of factors and eventually they discovered 's remains under the ash of the fire. Danielle and Mr were arrested and charged with murder and perverting the course of justice.

In May 2018 at the Central Criminal Court, each was convicted of the charges and they sentenced in June to Life Improsonment.

<u>People involved</u>
1. The murder victim: **Fleur** aged 21 at the time of the fatal incident
2. The first perpetrator: **Danielle** then aged 35
3. Her eldest son: **Child A** then aged 9, father: AB
4. Her youngest son: **Child B** then aged 5, putative father: Luke
5. The second perpetrator: **Pierre** then aged 40

<u>Addresses</u>
1. Home for all the above: **Address 2** in Wandsworth, London SW18
2. Prior address for Danielle and Child A): **Address 1** in London W2 (City of Westminster)

Purpose of review

1. Conduct effective analysis and draw sound conclusions from the information related to the case, according to best practice.

2. Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and support victims of domestic violence, including its impact on children in the home.

3. Identify clearly what lessons are both within and between those agencies. Identifying timescales within which they will be acted upon and what is expected to change as a result.

4. Apply these lessons to service responses including changes to policies and procedures as appropriate; and

5. Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.

6. Highlight any fast track lessons that can be learned ahead of the report publication to ensure better service provision or prevent loss of life

Domestic Homicide Review Panel – LB Wandsworth CSP
'Fleur' found murdered in September 2017 in Wandsworth

Terms of Reference for Review

1. To identify the best method for obtaining and analysing relevant information, and over what period prior to the homicide [Note: Agreed by the Panel on 12 June to commence on 1 January 2008 and end in September 2018] to understand the most important issues to address in this review and ensure the learning from this specific homicide and surrounding circumstances is understood and systemic changes implemented. Whilst checking records, any other significant events or individuals that may help the review by providing information will be identified

2. To identify the agencies and professionals that should constitute this Panel and those that should submit chronologies and Individual Management Reviews (IMR) [Note: Agreed that, in addition to agencies represented on the Panel, an IMR would be sought from 1) the named GP for Safeguarding, 2) mental health practitioners in Westminster and 3) Children's Services in Westminster] and agree a timescale for completion [Note: Agreed to be returned by 31 August 2018]

3. To understand and comply with the requirements of the criminal investigation, any misconduct investigation and the Inquest processes and identify any disclosure issues and how they shall be addressed, including arising from the publication of a report from this Panel [Note: Established that the Criminal process is complete, there are no known misconduct issues and the Coroner is likely to close the Inquest following the trial verdict]

4. To identify any relevant equality and diversity considerations arising from this case [Note: Fleur is female and Catholic. Danielle and Pierre are Sunni Muslim with Algerian heritage] and, if so, what specialist advice or assistance may be required [Note: Agreed that expert advice for the Panel would be sought on 1) domestic abuse from Victim Support, 2) modern slavery and 3) French culture]

5. To identify whether the victims or perpetrator were subject to a Multi-Agency Risk Assessment Conference (MARAC) and whether perpetrator was subject to Multi-Agency Public Protection Arrangements (MAPPA) or a Domestic Violence Perpetrator Programme (DVPP) and, if so, identify the terms of a Memorandum of Understanding with respect to disclosure of the minutes of meetings [Note: There are no records of such referrals in Wandsworth and Westminster]

6. To determine whether this case meets the criteria for a Serious Case Review, as defined in Working Together to Safeguard the Child 2015, if so, how it could be best managed within this review [Note: Wandsworth Children's Safeguarding Board have not commissioned a SCR and have agreed this will be a joint 'lessons learned' review with the DHR]

7. To determine whether this case meets the criteria for an Adult Case Review, within the provisions of s44 Care Act 2014, if so, how it could be best managed within this review and whether either victim or perpetrator(s) were 'an adult with care and support needs' [Note: Danielle is known to have been treated for mental health issues in Westminster and the criteria will be kept under review upon provision of further and better particulars]

8. To establish whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim or the children she was looking after, prior to the homicide (any disclosure; not time limited). In relation to the family members, whether they were aware if any abuse and of any barriers experienced in reporting abuse, or best practice that facilitated reporting it. [Notes: The Chair met with Fleur's mother and step-father during the trial with the assistance of a French translator. The DHR process and their role in it was explained and a copy of the Home Office leaflet in French was provided. Fleur's mother has consented for copies of both her witness and impact statements to be provided to the Chair. A further meeting will be held at the sentence hearing in June

when Fleur's parents will be provided with a copy of the ToR in French and be invited to contribute with any issues they wish to be explored by the DHR. Two witnesses at the trial who knew Fleur will be asked to meet with the Chair. The Chair will, in due course, write to the Governor of the prison establishments for Danielle and Pierre seeking an interview for their perspective on learning for agencies from what happened]

9. To identify how the review should take account of previous lessons learned in the LB Wandsworth and from relevant agencies and professionals working in other Local Authority areas [Note: Links to prior published reports with be provided to the Chair. There is no other DHR work in progress]

10. To identify how people in the LB of Wandsworth gain access to advice on sexual and domestic abuse whether themselves subject of abuse or known to be happening to a friend, relative or work colleague

11. To keep these terms of reference under review to take advantage of any, as yet unidentified, sources of information or relevant individuals or organisations

Panel considerations

1. Could improvement in any of the following have led to a different outcome for Fleur , considering:
   a) Communication and information sharing between services with regard to the safeguarding of adults and children
   b) Communication within services
   c) Communication and publicity to the general public and non-specialist services about the nature and prevalence of domestic abuse, and available local specialist services

2. Whether the work undertaken by services in this case are consistent with each organisation's:
   a) Professional standards
   b) Domestic abuse policy, procedures and protocols

3. The response of the relevant agencies to any referrals from 1 January 2008 relating to 1) Fleur , 2) Child A and Child B, 3) Danielle and 4) Pierre. It will seek to understand what decisions were taken and what actions were or were not carried out, or not, and establish the reasons. In particular, the following areas will be explored:
   a) Identification of the key opportunities for assessment, decision making and effective intervention in this case from the point of any first contact onwards with victim, the perpetrator(s) or Danielle's children
   b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.
   c) Whether appropriate services were offered/provided, and/or relevant enquiries made in the light of any assessments made.
   d) The quality of any risk assessments undertaken by each agency in respect of victim, the perpetrator(s) or Danielle's children

4. Whether organisational thresholds for levels of intervention were set appropriately and/or applied correctly, in this case.

5. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

6. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

7. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse processes and/or services.

8. Identify how the resulting information and report should be managed prior to publication with family and friends and after the publication in the media.

Operating Principles

a. The aim of this review is to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse (as defined by the Government in 2015 – see below)
b. The aim is not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system
c. A forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned
d. The review findings will be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences
e. The review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process. Similarly, the wellbeing of Child A and Child B will be paramount in the Lessons Learned Review component of this work
f. It will take account of the protected characteristics listed in the Equality Act 2010
g. All material will be handled within Government Security Classifications at 'Official - Sensitive' level

Definition of Domestic Abuse
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

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Appendix 2

Independence statements

Chair of Panel

Bill Griffiths CBE BEM QPM was appointed by the London Borough of Wandsworth CSP as Independent Chair of the DVHR Panel and is the author of the report. He is a former Metropolitan police officer with 38 years operational service and an additional five years as police staff in the role of Director of Leadership Development, retiring in March 2010. He served mainly as a detective in both specialist and generalist investigation roles at New Scotland Yard and in the Boroughs of Westminster, Greenwich, Southwark, Lambeth and Newham.

As a Deputy Assistant Commissioner, he implemented the Crime and Disorder Act for the MPS, leading to the Borough based policing model, and developed the critical incident response and homicide investigation changes arising from the Stephen Lawrence Inquiry. For the last five years of police service, as Director of Serious Crime Operations, he was responsible for the work of some 3000 operational detectives on all serious and specialist crime investigations and operations in London (except for terrorism) including homicide, armed robbery, kidnap, fraud and child abuse.

Bill has since set up his own company to provide consultancy, coaching and speaking services specialising in critical incident management, leadership development and strategic advice/review within the public sector.

During and since his MPS service he has had no personal or operational involvement within the London Borough of Wandsworth, nor direct management of any MPS employee serving there.

Secretary to Panel

Tony Hester has over 30 year's Metropolitan police experience in both Uniform and CID roles that involved Borough policing and Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigation.

Upon retirement in 2007, Tony entered the commercial sector as Director of Training for a large recruitment company. He now owns and manages an Investigations and Training company.

His involvement in this DVHR has been one of administration and support to the Independent Chair, his remit being to record the minutes of meetings and circulate documents securely as well as to act as the review liaison point for the Chair.

Other than through this and two other reviews, Tony has no personal or business relationship or direct management of anyone else involved.

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Appendix 3

Consolidated Internal Recommendations From Agency IMRs

Rec No	Agency/Source	Action taken or to be taken within agency	Outcome of action, what has been achieved and date of completion
1	Metropolitan Police Service	That SW BCU SLT debrief officers involved in the completion and administration of the MERLIN report on 16 March 2016 (when Danielle was present in the home) to remind them of the importance of capturing the details of all persons living in the home with vulnerable persons	The learning from this report will be discussed for wider dissemination at the MPS Safeguarding Recommendations Panel in July Debrief completed on 17 May 2019
2		That SW BCU SLT review the MERLIN for the Homebase incident of 7 May 2017 and debrief individuals concerned to assess and address any requirement for safeguarding training	Debrief completed on 17 May 2019
3		That SW BCU SLT review the response to the visit by Danielle and Fleur to Lavender Hill Police Station in August 2017 and debrief individuals concerned to assess and address any requirement for safeguarding training	Debrief completed on 17 May 2019
4	Wandsworth Children's Social Care	WCSP Practice Standards to be updated: Nannies and au-pairs need to be considered as relevant caregivers to children and as adults in the home, and therefore be part of	Online Practice Standards updated

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		assessments, strategy discussion checks, S47 investigations and follow up CIN or CP planning. This should include the recognition that there is no legal basis/duty and any refusal to co-operate either by the adults with PR or the nanny/au-pair should be treated with professional curiosity and potential attempts to hide or obscure relevant information or safety considerations	The learning has been included in regular staff briefings Complete
5		WCSP to consider developing specific procedures in the management and response to parents who make continuous claims of child abuse	This will be managed in accordance with LCPP. The need for curiosity and challenge to repeated allegations of abuse has been included in briefings
6		In cases involving complex parental behaviours over a long period of interventions, WCSC should consider a separate chronology of the journey of the child (direct work with child, child presentation and discussions during home visits, conversations and observations of other professionals with the child) so there is a separate record of the child's voice, journey and lived experiences	The variability of separate chronology has been discussed. Current chronologies include the issues raised
7		WCSC to review the current threshold of case escalation to senior managers to include senior management oversight of repeat referrals of children	WCSP has a multi-agency escalation process which is available to all agencies and was updated in June 2018 There is now closer oversight and tracking of re-referrals into CSC. Audits of re-referrals are also undertaken

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8		As part of the dissemination of learning from this IMR/DHR, WCSC staff should be reminded of the Fabricated Illness procedures and indicators of drug misuse (legal and illegal)	Included in staff briefings above Training on FFI and parental substance abuse is part of single (CSC) and multi-agency (WCSP) training programmes
9	Local GP Practice	To continue to deliver Level 3 Child Safeguarding training to all GPs and clinical general practice staff highlighting the need to hear the voice of the child	Ongoing
10		Train GPs to recognise disguised compliance in parents and to empower them to challenge and take action when they identify it	Ongoing
11	South West London and St Georges Hospital NHS Trust	Embed Think Family further across all services within SWLSTG – linking to triangle of care for inpatient teams All clinical staff whose work may involve direct contact with children or adults who are parents/carers of children must also attend the trust or LSCB Level 2 course within two years of attending Level 1. Staff should attend a refresher course every three years. Borough Safeguarding Leads and all staff working in CAMHS should attend the trust or LSCB Level 3 training course 3 yearly.	The new Safeguarding Children Training Competence Framework (2019) introduces a mandatory requirement for all clinical staff to complete children safeguarding training at level 3. This will greatly increase the level of staff awareness and embed the understanding of the Think Family agenda across all Trust services. The Executive have commissioned a comprehensive Action Plan to fully implement the new Safeguarding Children Training Competence Framework (2019), it is anticipated

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			it will be completed within 12 month timescale. Ongoing

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Appendix 4

ACTION PLAN

Learning Point 1: Guidance is required to ensure that the employment of nannies/au-pairs is safe for them as employees, the children in their care and their employers and to minimise the risk of modern slavery by domestic servitude						
Recommendation	**Scope of recommendation**	**Action to take**	**Lead Agency**	**Key Milestones Achieved in enacting recommendations**	**Target Date**	**Date of completion and outcome**
1 Department for Education to review the current guidance regarding employment of nannies/ au-pairs that protects them, children who may be in their care and their employers to reduce the risk of Modern Domestic Slavery through Domestic Servitude	National guidance by Home Office	**1.1** To use the learning from this case study to review the legislation and regulatory environment for the employment of au-pairs. **1.2** Consider the Childcare Act 2006 and whether Ofsted has a role to play in respect of au-pairs. **1.3** Review unregulated 'domestic work' such as nannies/au-pairs as part	Department for Education	Submission of Overview report Quality Assurance Panel review	October 2019 March 2020	Ongoing with Home Office if accepted

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		of new Slavery Research Centre **1.4** Consider 'Light Touch' regulation for au-pairs **1.5** Consider extending to schools & nurseries, Au pairs/childminders who collect/drop children off to include staff awareness				
2 Community Safety Partnership is to use the learning of this review to raise awareness of the risks of Modern Day Slavery through Domestic Servitude	London Boroughs of Richmond and Wandsworth	**2.1** Embed the learning from this review within the production of the local R and W VAWG Needs Assessment **2.2** Formation of MDS Slavery Steering Group **2.3** Ensure that MDS is embedded into the Community Safety Communications Plan	Community Safety Partnership	Production of Needs Assessment MDS Steering Group Formed Production of Communications Plan	October 2019 January 2020 January 2020	Ongoing with CSP until June 2020

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		2.4 Ensure that the 'Specialist Desk' of the Wandsworth MASH has a dedicated MDS SPOC **2.5** Create a MDS checklist of indicators **2.6** Training event for all First Responders across Richmond and Wandsworth **2.7** Develop a mandatory e-learning package for all Council employees **2.8** Devise and implement MDS pathway		Identification and Training for specialist lead Creation and circulation of list Event Held Package developed Pathway implemented	January 2020 March 2020 June 2020 March 2020 March 2020	
Learning Point 2: Improve public awareness that domestic abuse does not just involve family, it can be anyone in the household, and how to report concerns and access advice						
3 To implement a robust awareness raising campaign and plan within the borough's proposed new VAWG Strategy is to	London Boroughs of Richmond and Wandsworth	**3.1** Complete Richmond and Wandsworth needs assessment	Community Safety Partnerships	Completed Needs Assessment	October 2019	Ongoing with CSP until March 2020

be overseen by a specific sub-group involving statutory stakeholders, schools and NGO's		**3.2** Implement Strategic Executive and delivery structures for VAWG across boroughs. (Parameter: An Awareness and Training Sub-Group workstream)		First Steering Executive	October 2019	
		3.3 Draft and agree 2020/23 VAWG Strategy		VAWG Strategy	December 2019	
		3.4 Ensure a comprehensive public awareness plan is implemented.		Annual Awareness Plan Drafted	December 2019	
		3.5 As a minimum, Wandsworth is to host a Community Engagement / Problem Solving Event on Domestic Abuse		Community Problem Solving Event	December 2019	
		3.6 Develop a mandatory e-learning package for all Council employees		E-learning package designed and delivered	March 2020	
Learning Point 3: Expand and reinforce Level 3 Child Safeguarding awareness training on the voice of the child						

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4 To ensure that the 'voice of the child' and the learning from this review is used to reinforce Level 3 Child Safeguarding Awareness Training for front line Professionals across the Partnership	London Boroughs of Richmond and Wandsworth	**4.1**: Learning from DHR to be shared across partnership by integrating learning into Safeguarding training via Wandsworth Safeguarding Children Partnership (WSCP) training sub group	WSCP	At next training and development sub group the action plan for delivery to be agreed	January 2020	Ongoing with CSP until March 2020
		4.2: Multi-agency and single agency learning events to be promoted including: (a) an annual spotlight events to be co-ordinated across Richmond and Wandsworth in respect of SCR and DHR learning,(b) quarterly dissemination 'bite size' training events	WSCP and CSP	Annual Plan First Spotlight Event	January 2020 March 2020	
Learning Point 4: Reinforce the need for healthy scepticism, an open mind and, where necessary, an investigative mindset when dealing with complex families who have multiple vulnerability factors						

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5 To ensure that learning in respect of 'Professional Curiosity' from local and national SCR's and DHR's is cascaded to front line professionals and those bodies	London Boroughs of Richmond and Wandsworth	**5.1** Learning from DHR to be shared across partnership by integrating learning into Safeguarding training via WSCP training sub group	WSCP	At next training and development sub group the action plan for delivery to be agreed	January 2020	Ongoing with CSP until March 2020
		5.2 Multi-agency and single agency learning events to be promoted including: (a) an annual spotlight events to be co-ordinated across Richmond and Wandsworth in respect of SCR and DHR learning,(b) quarterly dissemination 'bit size' training events on having an 'investigative mindset'	WSCP and CSP	First Spotlight Event	March 2020	