Serious Case Review

Family M

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Contents

1 INTRODUCTION....1
2 FINDINGS AND RECOMMENDATIONS....3
3 SUMMARY OF RECOMMENDATIONS....14
4 APPENDIX ONE: QUESTIONS FOR THE REVIEW....15
5 APPENDIX TWO: AGENCY INVOLVED IN THE REVIEW....17

1 INTRODUCTION

1.1 This is a report of the findings and recommendations of a serious case review commissioned by the Surrey Safeguarding Child Board in 2018. The review was commissioned as result of the serious harm experienced by children who were abused whilst living with a relative under a Special Guardianship Order.

Although this review was commissioned by Surrey Safeguarding Children Board, children within the family had lived in two other Local Authority areas referred to in this report as LA1 and LA2. Safeguarding Children Boards from both these areas have contributed to this review.

2 FINDINGS AND RECOMMENDATIONS

2.1 The overarching finding of this review is that the six children who are subjects of this report were failed by a system that did not consistently hear their voice, fully explore and understand the meaning of their behaviour and effectively work with the complexity of their lives and circumstances. As a result, four of the children were removed from one situation where they were likely to suffer significant harm to another where they experienced severe abuse.

2.2 Although the review has found individual examples of where practice could have been improved, the picture is of a system which too readily assumed that placement with family is best, without undertaking the critical thinking and full analysis of information that is needed to make safe decisions in these circumstances. Reports for court and other assessments did not take a whole family approach and fully analyse the situation of all the children in the family in order to understand the family's capacity to care for another child.

2.3 In respect of the Special Guardianship Orders and practice thereafter, it seems that thinking was unduly influenced by the assumption that previous court proceedings had granted Residence Orders and the suitability of The Perpetrator and his wife had been thoroughly assessed. Once the children were placed with The Perpetrator and his wife, any behavioural problems were too readily attributed to early trauma, confusing the analysis of the signs and indicators that were also evidence of current harm. This was further magnified by The Perpetrator's ability to groom the whole system and for development of a consistent narrative that he and his wife were "courageous and brave in taking on the children," "were brilliant" with the children, "child focused" and "lovely people".[1] Reducing the likelihood of errors of thinking as a result of grooming behaviour requires time for reflection and critical thinking and there is little evidence that this was present and supporting the decision making process.

[1] All these quotes are to be found within the records

2.4 The response to referrals received by Surrey Children's Social Care expressing concern about the children were treated in the same way as referrals about birth children, with a focus on early intervention and working in partnership with parents in order to provide the right support at the right time. For most situations this is good practice. However, this case demonstrates the need to think differently in situations where children are placed outside the birth family and there is an argument for an approach to allegations of abuse that is more akin to the expected response when a child has made an allegation about a person in a position of trust.

2.5 Although this review was commissioned by Surrey Safeguarding Children Partnership, there are lessons for all three Partnerships involved. The findings and recommendations should be reviewed by Safeguarding Partnerships LA1 and LA2 for relevance to their area and appropriate action taken.

Finding One
A proactive approach is needed to seeking and sharing information which focuses on the wellbeing of the child and keeping them safe from harm.

2.6 The need to share information across the multi-agency network has been a finding of numerous serious case reviews and this one is no different. Specific issues relating to Special Guardianship Order assessments are discussed further in Finding Three but there are a number of other relevant issues in this case:

- Early information about The Perpetrator's alcohol use and mental health issues was not properly shared across the health community and was not known to the Surrey GP.
- Community Health records for the children did not move to Surrey in a timely way and when they did arrive there was a further delay in contact being made with the family.
- When the family moved to Surrey, the organisation that had most contact with the family was the primary school who were reliant on information shared by The Perpetrator and his wife.
- Children's Social Care information was not proactively shared by LA1 when the family moved, and equally was not requested by Surrey when they became known to the department.
- When concerns about the children emerged in Surrey there was an approach which was too heavily weighted towards obtaining parental permission before sharing information in a situation where there were safeguarding concerns about a child.

2.7 Current social work practitioners told this review that one inhibiting factor was likely to be an understanding that information could not be sought without parental permission. Permission was not asked for, possibly due to constraints on social workers who were operating in an organisational context under pressure with a high turnover of staff. This case highlights the importance of asking for such permissions and gathering information in any situation where there are indications of a complex history.

2.8 Discussions with practitioners for this review considered how far the events of 2011 would have been dealt with in the same way today. The consensus opinion was that the response would not be dissimilar and schools and social workers cited the current approach within the family resilience model which aims to work in partnership with parents[2] seeking their consent and agreement before undertaking any work. For most children their best interests will be served by this approach with the right help being provided at the right time and with a focus on enabling children to remain within their family. Practitioners were all clear that the advice to any school making a similar referral (if a child had said that a parental figure had kicked them) would result in the same response today. This is of concern as best practice would have been to start from a position of understanding the whole family circumstances, considering the safety and wellbeing of children in the family and making sure that the child's voice was heard.

2.9 This approach to referrals is so embedded into practice that it is likely that as in 2011, schools today would not escalate concerns about any response from Children's Social Care which promoted speaking to a parent before speaking directly to the child who made an allegation of abuse.

2.10 A draft paper for Surrey Safeguarding Children Board in 2019[3] grappled with the dilemma regarding parental consent faced by professionals wishing to make a referral to Children's Services. The paper is clear that consent will only not be sought where there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm. This ultimately depends on the professional judgement of the referrer and the receiving social worker and hinges on how "reasonable cause to suspect" is interpreted. Government guidance on information sharing[4] promotes a positive approach to sharing information, seeking consent as appropriate but always considering the safety and wellbeing of the child.

The GDPR and Data Protection Act 2018 place duties on organisations and individuals to process personal information fairly and lawfully; they are not a barrier to sharing information, where the failure to do so would cause the safety or well-being of a child to be compromised. Similarly, human rights concerns, such as respecting the right to a private and family life would not prevent sharing where there are real safeguarding concerns. (p7)

2.11 From discussions with practitioners in Surrey, it seems that there could be more clarity as to how the voice of the child might be heard in order to decide whether suspicion is reasonable. Government guidance is clear that a distinction needs to be

[2] https://www.surreyscp.org.uk/wp-content/uploads/2018/12/Effective-family-resilience-SSCB-Final-March-2019-1.pdf

[3] Report to Surrey Safeguarding Children Board – guidance for requesting support from Children's Services. February 2019

[4] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/721581/Information_sharing_advice_practitioners_safeguarding_services.pdf

made between disclosures of abuse (as in this case) and concerns that emerge over time.

Children may disclose abuse in which case the decision to share information is clear, as actions must be taken to respond to the disclosure. In other cases, for example, neglect, the indicators may be more subtle and appear over time. In these cases, decisions about what information to share, and when, will be more difficult to judge. (P7).

2.12 As well as there being a clear disclosure of abuse, another key feature in this case is that the child was not living with their birth family and had recently moved to the area. The response to the disclosure and later more general concerns did not make the distinction between a family where there were emerging concerns that might need early help and a family where the child was living with adults other than their birth parents. This is an important distinction and should have led to an approach that recognised the potential for increased risks in this situation from those who wish to gain a position of power over vulnerable children.

2.13 The MARAC meeting was a good opportunity to share information and plan across the network. MARAC meetings are only held where the there is a high risk of harm in relation to the victim. Where children are involved in a situation where there is a high risk of harm it is arguable that this should always prompt child protection inquiries. In this case the response around the time of the MARAC did include a child and family assessment but overall the approach seems muddled with a lack of a coordinated approach between police and children's social care. This could have been improved by adherence to formal procedures with a clear focus on the lived experience of the children past and present and any risks associated with their family circumstances.

Recommendation One
Surrey Safeguarding Children Partnership should work together to establish a culture which promotes a positive approach to information sharing in cases of suspected maltreatment This approach should expect that information will be shared unless there is a good reason not to do so

Recommendation Two
Surrey Safeguarding Children Partnership should review guidance on the Family Resilience Model in order to ensure that there is a focus on the voice and lived experience of children in all assessments and interventions. All organisations should make sure that any internal guidance is consistent with this approach.

Recommendation Three
Surrey Safeguarding Children Partnership should remind practitioners that there are additional factors to consider when investigating any allegations of abuse made by children who are living outside their birth family. These factors include consideration of the child's history, the history of their current care givers and the motivation underlying their application to look after the child.

Finding Two
Practitioners need to be equipped with the knowledge and skills to undertake assessments which hear the voice of the child, understand the meaning of a child's behaviour, assess risk, family resilience and maintain the respectful uncertainty required to keep children safe.

2.14 Issues specific to assessments for court are discussed more fully in Finding Three, although there are general issues raised by this case in relation to all assessments whatever their role within the system.

2.15 Assessments in this case were based too often on self-reported information and did not incorporate a full understanding of the family history and circumstances. There is no evidence that standard practice tools such as genograms were used in any agency and as discussed above, records suggest that Surrey social workers pre 2015 did not understand the history of the family and did not seek information.

2.16 The transfer in of community health records to health visitors/school nurses was delayed. They were not sent immediately by community health in LA1 although a transfer in letter was received by Surrey. This did not prompt a request from Surrey for the records until two months later and the first contact with the family by the health visitor took place a month later. Practice today would be to immediately request the records and carry out a Family Health Needs Assessment. Practitioners felt that the format of the Family Health Needs Assessment does not lend itself to a full understanding of family history via a genogram and this could be improved. This is particularly important when understanding very complex family networks.

2.17 There is an issue about transfer of school files both from LA1, and between schools in Surrey. Although there is a statutory duty for schools to transfer information, the Surrey primary school did not receive or ask for information from previous schools and were reliant on information from the parents. They were unaware of the exact legal status of the children and feel that the admission form could be amended to make this clearer and that staff training should include a better understanding of the implication of Residence Orders and Special Guardianship Orders.

2.18 Schools felt that transfer of information is now easier where schools both use the same electronic information system, but this is not always the case and asked whether Surrey could promote a consistent approach across the Local Authority.

2.19 Having a full understanding of information via record transfer is important for all practitioners if they are to be able to move beyond self-report and triangulate information. It is particularly important in a case such as this where it is now clear that The Perpetrator was successful in grooming and controlling those around him and all practitioners were distracted by his apparently positive presentation.

2.20 This is a good example of the "garden path syndrome" whereby practitioners only heard and used information that confirmed their point of view. A more in-depth assessment of capacity to change, and the motivation driving the application to care for the children was needed particularly since the level of complexity within the family

circumstances was not hidden, even if all the detail was not known. This assessment of The Perpetrator would have been enhanced by better information sharing within the health community regarding his overdose, depression and alcohol use.

2.21 As a result of these assumptions about The Perpetrator, when problems emerged in the family, the children's behaviour and (less frequently) verbal information was always interpreted as resulting from past trauma in their birth family rather than possibly due to their current circumstances. There is an evident need to support practitioners in avoiding assumptions that current behaviour is a result of past trauma and the need to always keep in mind the dual possibility of past trauma and current circumstances.

2.22 No one model of practice can overcome this assumption-led approach and practitioners need to be able to draw on good information and a range of perspectives in order to make sense of complex family situations. Evidence suggests[5] that the best decision making is when fast intuitive responses are combined with the opportunity to slow down and consider the all available information. This involves taking time to reflect on emotional responses, critically analyse information and the opportunity to be challenged in a safe environment. Reflection, critical thinking and challenge will be helped by effective supervision and there is little evidence that this was in place in any agency.

2.23 The records with Surrey Children's Social Care indicate frequent changes of management and where one individual manager might have begun to ask the right questions this was not followed up. Frequent management churn would also have hampered the development of supervisory relationships where all the factors that could have influencing practice could have been explored.

2.24 Within community health, there is a well-established system of safeguarding supervision for children within that category. Children in Family M were not recognised as needing additional help despite their complex history and legal status. It is important going forward that supervision opportunities for community health practitioners include reflection on practice with children who may not currently be labelled as in need of "safeguarding" but whose circumstances may indicate that more in depth consideration of their needs is required.

2.25 Within schools, staff would also have benefited from the opportunity to stop and think about the way in which they understood the circumstances of the children. Today Ofsted guidance for inspectors' stresses that safeguarding arrangements should make sure that staff *receive regular supervision and support if they are working directly and regularly with children and learners whose safety and welfare are at risk*[6] and this may be an area for development within Surrey.

2.26 Ensuring effective supervision is a particular challenge where assessments are carried out by an independent contractor and in this case, there is no evidence of

[5] Kahneman, D (2011) *Thinking Fast ad Slow* London: Penguin.
[6] Ofsted (2019) *Inspecting safeguarding in early years, education and skills settings* Page 10

challenge when the Special Guardianship assessment provided by the independent social worker in LA1 did not address the issues raised in the viability assessment.

Recommendation Four
Staff development activities across the Safeguarding Children Partnerships involved in this review should include a focus on the way in perpetrators may be skilled at grooming networks and become alert to the possibility that seemingly "lovely people" can seriously harm children in their care.

Recommendation Five
All agencies should evaluate how effective their supervision systems are in providing an opportunity for practitioners to stop, think and analyse in complex family situations. Supervision should promote the use of standard practice tools including genograms in order to enhance the critical thinking required.

Recommendation Six
Schools should develop supervision systems for staff involved in safeguarding children in order to provide the emotional support challenge and space for critical thinking needed for effective practice.

Recommendation Seven
Surrey Safeguarding Children Partnership should seek assurance from schools that they have in place systems that support good record keeping and efficient transfer of records and that where records are not received for a new pupil this is followed up.

Recommendation Eight
Surrey Safeguarding Children Partnership should bring the findings of this review to the Safeguarding Children Partnership in LA1 regarding the need to quality assure the work of independent social workers who provide Special Guardianship Order assessments.

Finding Three
Friends and family assessments should always include consideration of the impact of placement on all children in the household and information should be shared about their current situation and any specific needs. This approach requires a good understanding of the meaning of Residence Orders and Special Guardianship orders across the whole professional community.

2.27 The issues driving all assessments in this case explored above apply equally to assessments prepared for court proceedings. Specifically, the need to move beyond self-report and triangulate information and when information is requested from another local authority area, ensuring that information given is as a result of a full file review by a suitably qualified individual.

2.28 Another common factor but particularly in relation to family and friends assessments were decisions driven by a focus on the positive benefits of placing children within

the family. One practitioner described being influenced at the time by their interpretation of judgements in the Court of Appeal[7] which stressed the need to only place children for adoption when "nothing else will do". This interpretation, which was not challenged by managers within the Local Authority concerned, did not take account of the fact that an underlying message from these judgements was also the importance of thorough evidence informed assessments. In addition, a later judgement[8] Sir James Munby, referred to the 'widespread uncertainty, misunderstanding and confusion' which has arisen since the decisions in Re B and Re B-S. He confirmed that:

Re B-S was not intended to, and has not, changed the law. It has not set any higher hurdle for placement orders. Sometimes adoption is in the best interests of the child and, where that is the case, the courts should not shy away from making a placement order. Children should not be kept with their birth families if it compromises their welfare.

2.29 The assessments that took place in the case were before the most recent regulations[9] in respect of Special Guardianship assessments. These regulations included a strengthening of the assessment of prospective special guardians to ensure that they can fully meet the needs of the child through until adulthood. In addition there was a new requirement to report to the court on the relationship between the child and the prospective special guardian(s), how they will help the child overcome the impact of any previous abuse or neglect, and how they will manage any risk to the child from the relationship between the special guardian and the child's birth parents.

2.30 Had these regulations been in place at the time the assessments in this this case were completed, it is likely that the assessments would have been strengthened in relation to how the need of the individual children would be met. However, this may not have addressed the information gathering that would have been required to address one specific issue in Family M. This was the cumulative effect on the family of additional children arriving in the household and how far this was considered at the point of placement. There is no consideration or analysis in any of the assessments seen for this review as to whether their care of other children was being compromised and this should become standard practice within Special Guardianship assessments.

2.31 It is not necessarily standard practice in family and friends' assessments to talk to all the children in the household and in this case, it could have given the children a voice and provided a vehicle to understand more fully the stresses within the environment. Even if The Perpetrator not been abusing the children, there are sufficient signs that by the time that Child 6 was placed this could have had a negative impact on the other children.

[7] Re. B and Re. B-S 2013
[8] Re. R 2014
[9] Special Guardianship (Amendment) Regulations (2016)

2.32 The GP in Surrey had very little contact with The Perpetrator or his wife and there was nothing on their medical records to cause alarm when they were contacted by the social worker carrying out the Special Guardianship Order assessment in respect of Child 6. This highlights the need for good information sharing across the health community as this GP did not have any records alerting them to The Perpetrator's previous referrals to specialist services due to alcohol, overdose and self-discharge from hospital in 2006. As is standard practice the request was in respect of the adults and the records of other children in the family would not be checked.

2.33 The GP was also not aware of the meaning of a Special Guardianship Order and assumed that The Perpetrator and his wife would be thoroughly checked by the local authority in the same way that foster carers would be and have the same level of social work involvement. This lack of awareness of the children's legal status and meaning of Residence Orders[10] and Special Guardianship Orders was also evident in schools.

Recommendation Nine
Guidance on Special Guardianship Order assessments and any associated templates in all three Local Authorities should be reviewed in order to ensure that the impact of the order on children already living in the household is fully assessed.

Recommendation Ten
The Surrey Safeguarding Children Partnership should ask for assurance from all agencies that all staff understand and record the correct legal status for all children within their records. The partnership should produce a simple jargon-free guide to help this process.

Finding Four

The possibility of child sexual abuse within a family setting was not sufficiently explored and practitioners need to develop confidence, knowledge and skills to recognise possible indicators and take appropriate action, including listening to the child.

2.34 There was one early opportunity to respond to the possibility that a child was being abused and it is positive that a GP recognised the significance of both the symptoms and gut reaction to The Perpetrator's behaviour. However, due to lack of medical evidence this episode went no further.

2.35 This is indicative of some of the current problems in responding to suspicions that a child may be abused within their home with as, without specific evidence in the form of an allegation or medical confirmation, little further is done.

[10] Now known as Child Arrangement Orders

2.36 A report by the Children's Commissioner (2015)[11] describes many of the features of this case and highlights the challenges in identifying abuse in younger children who may not recognise that they are being abused and that perpetrators may normalise their behaviour. It comments:
Children may not seek help for abuse, as they are worried about the consequences of service intervention for themselves and other family members, and they may have been threatened by the perpetrator……. Disclosure-led approaches are demonstrably failing the majority of victims of child sexual abuse in the family environment. Where there are concerns and suspicions, levels of knowledge and confidence among professionals in all sectors on how to progress concerns may vary. Some professionals are hesitant to seek information or clarification from a child for fear that such actions will be construed as 'leading the victim' and encouraging a false or inaccurate account, jeopardising the potential outcome of the criminal justice process.

2.37 The Children's Commissioner report does not explore the issue of medical examination although it does note that *proactive enquiry is therefore necessary to substantiate concerns and activate processes for the investigation of abuse and protection of the child.* Discussions for this review have highlighted the tendency to view medical examinations as intrusive and only required at a point in an investigation where they may provide forensic evidence for civil or criminal proceedings. This does not recognise their potential for providing a safe place where children can be listened to and have the opportunity to describe any worries and fears. Further work needs to be undertaken locally and nationally to explore the way in which medical examinations can be used as a positive aspect of inquiries where child sexual abuse is a concern. Within Surrey an additional issue is the need to increase the involvement of staff from the Sexual Assault Referral Centres in strategy discussions where child sexual abuse is a concern.

2.38 The possibility of sexual abuse was too easily dismissed and should have formed part of the ongoing thinking and assessment work particularly when trying to understand the later behaviours of the children in the family which are likely to have been a result of their experience of abuse within the home. This requires the possibility of sexual abuse to be clearly named and held in mind alongside other issues that emerge within the family and for practitioners to feel confident to challenge each other, explore difference of opinion in a positive way and escalate concerns where they feel that the approach being taken is increasing risk of harm to a child. The importance of effective supervision has been discussed in Finding 2 above and will be vital if practitioners are to be supported in managing the uncertainty and complexity involved.

2.39 The lack of response to the allegation of physical abuse described above is likely to have given the message to the children that their views would not be taken seriously and inhibited any future disclosures of sexual abuse by The Perpetrator. An

[11]The Children's Commissioner (November 2015) *Protecting children from harm: A critical assessment of child sexual abuse in the family network in England and priorities for action*

approach to all work with children and families that incorporates hearing their voice is an important foundation for practice in working with all forms of abuse.

Recommendation Eleven
Surrey Safeguarding Children Partnership should work with partner agencies to develop a strategy focused on recognising and working with child sexual abuse within the family. This strategy should:

- Move beyond a disclosure led approach
- Develop knowledge skills and confidence across the workforce in identifying and working with situations where child sexual abuse is suspected
- Include clarity regarding the role of medical examinations
- Specify within multi agency procedures that a practitioner from the Sexual Abuse Referral Centre should be invited to attend strategy discussions where child sexual abuse is a concern.

Recommendation Twelve
Safeguarding Partnerships should consider any barriers preventing the positive use of professional challenge where there are differing viewpoints and evaluate the way in which escalation processes are used within their area.

3 SUMMARY OF RECOMMENDATIONS

Recommendation One
Surrey Safeguarding Children Partnership should work together to establish a culture which promotes a positive approach to information sharing in cases of suspected maltreatment This approach should expect that information will be shared unless there is a good reason not to do so.

Recommendation Two
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Recommendation Four
Staff development activities across the partnership should include a focus on the way in perpetrators may be skilled at grooming networks and become alert to the possibility that seemingly "lovely people" can do horrible things to children in their care.

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Recommendation Twelve

Safeguarding Children Partnerships should consider any barriers preventing the positive use of professional challenge where there are differing viewpoints and evaluate the way in which escalation processes are used within their area.

4 APPENDIX ONE: QUESTIONS FOR THE REVIEW

1. What information informed the SGO's granted in LA1 and LA2 in 2007 and 2010?

2. What was the quality of information sharing by LA2 and LA1 social care, education and health agencies when the family moved to Surrey in 2010? Was there any indication of support that might be needed for this family?

3. What happened in Surrey and what was the quality of practice by agencies from 2011-2015? Could more have been done to understand the experience of the children in the home and identify the abuse that was taking place?

4. What was the quality of information sharing and analysis underpinning the SGO in LA1 in respect of Child 6 in 2013? By this time there had been referrals to Surrey CSC relating to The Perpetrator - were these known to agencies in LA1 and taken into account?

5 APPENDIX TWO: AGENCY INVOVLED IN THE REVIEW

Surrey
Cafcass
Children & Family Health
Children's Services
Acute Hospital 1
Acute Hospital 2
Surrey & Borders Partnership (SABP)
Surrey Education
Surrey GPs
Surrey Police

LA1
LA1 Children's Trust
LA1 Children's Trust Legal team
LA1 Community Health (partial)
LA1 Education
LA1 Mental Health Trust
LA1 CCG
LA1 University Hospital
LA1 Orthopaedic Hospital
LA1 Women & Children Hospital
Ambulance Service
Police Service

LA2
Police Service
LA2 Children's Services
LA2,CCG