Kirklees Safeguarding Children Board

Child D

Executive Summary

Version 1 July 2019

Reason for the Serious Case Review

This Serious Case Review (SCR) concerns Child D. Child D was seriously assaulted by Adult A his Mother's partner of approximately 5 months on 13th February 2018 when he was aged 22 months. Child D was at home alone Adult A at the time of the assault. Child D underwent a Child Protection Medical on 13th February 2018 and injuries were noted; red marks and bruises to the thigh, back, shoulder, elbow, buttock, eye, ear, cheek, chin, temple and head with a split inside mouth on the upper gum line. Adult A was arrested on the day of the assault and served a 21 month custodial sentence. Child D lived with his mother and his 4 siblings in Kirklees. All of the children were subjects of child protection plan at the time of the assault.

The Local Safeguarding Children Board (LSCB) agreed on the 11th April 2018 to commission a Serious Case Review (SCR) concerning the assault of Child D. The scope of this SCR was to cover the timeframe from 26th June 2015 to 13th February 2018 (the date of the assault of Child D). It was agreed by the KSCB Serious Case Review Workstream that any significant events prior to this date would also be included within the scope of the SCR.

Agency involvement

The following agencies have provided information:

- Kirklees Children's Services
- Calderdale and Huddersfield Foundation Trust
- West Yorkshire Police
- The Siblings primary schools and Sibling 1's secondary school
- Locala Primary Care Health Services including midwifery, school nursing, G.P. practices
- CHART (substance misuse service)

Agencies that identified significant background histories on family members pre-dating the scope of the review provided an account of that significant history.

Reviews of all records and materials that were considered included;

- Electronic records
- Paper records and files
- Patient or family held records.

Two Learning Events for practitioners and managers who had worked with the family (or who could contribute to learning) were held in October 2018. The outcomes from the Learning Events were twofold:

- Practitioners and managers were able to share their experiences of working with the family and contribute to the information provided by agency chronologies i.e. understanding not just 'what happened' but 'why it happened'.
- Practitioners and managers were able to contribute to discussions about what improvements in policy and practice might be required.

Terms of reference and Key lines of enquiry

The KSCB Serious Case Review Workstream agreed the scope of the SCR. The workstream also considered key lines of enquiry which were then included in two broad headings which were: *Sustaining Services and Support and Assessing Risk*

The Independent Reviewer then drew up lines of enquiry which participants of the Learning Events considered and which frame the analysis within this report:

1. Were single and multi-agency assessments and interventions child focussed, accurate and acted upon? Did agencies recognise and assess risk in respect of Child D?
2. How were Mother's needs recognised, assessed and responded to?
3. Was the parenting capacity of Child D's Mother assessed effectively?
4. What, in this case, reassured practitioners that Child D and his siblings were safe and well?
5. How did practitioners know that what they were doing was reducing risk?
6. How were the risks associated with males, including Child D's father, identified and assessed and responded to?
7. Explore whether Mother and/ or Mother's partners were able to collude or deceive agencies, why this was able to happen and whether there are lessons that can be learnt.
8. Was professional practice and supervision informed by research and evidence based practice?
9. Were single and multi-agency communications and information sharing appropriate, accurate and acted upon? How well was information shared, understood and responded to between agencies?
10. Consider whether there are any common themes from previous serious case reviews or critical incident reviews and the effectiveness of agency's actions in relation to these.
11. Identify learning that will help partners and the LSCBs to strengthen understanding of and response to Child D and to all vulnerable children and young people.

Learning from this Serious Case Review

- The KSCB may wish to consider seeking assurance from relevant partners that the voice of the child and the daily lived experience of the child is the primary focus of all agency interventions, risk assessments and child protection processes. The age of the child should be taken into account when considering the learning from this and other SCRs and reflect the specific vulnerabilities of babies and very young children.
- The KSCB may wish to consider seeking assurance that the views and concerns of family members are listened and responded to and that there is evidence that these views and concerns have contributed to assessments and planning.
- The KSCB and partners may wish to consider the use of validated parenting assessments for parents with vulnerabilities including their own adverse childhood experiences which can indicate that parenting may be compromised.
- The KSCB and partners may wish to consider the 'Assessing Parental Capacity to change when children are on the edge of care' resource and how it might be used to inform practice with families in Kirklees.

- The KSCB may wish to consider seeking assurance that routine ongoing analysis takes place to include; whether or not risk is decreasing/ increasing/ static particularly paying attention to patterns of behaviour/ capacity and willingness to change.
- The KSCB may wish to consider seeking assurance that non –compliance with plans will be explicitly addressed at child protection meetings and that contingency plans are explicitly described and agreed and timescales set for intended outcomes/ interventions.
- The KSCB may wish to consider seeking assurance from partners that their current single and multi-agency risk assessment approaches encourage and facilitate 'big picture' analysis of risk which would include:
    - Routinely gathering information from other agencies and other family members
    - Full parental history including parents' childhood experiences of abuse, loss or trauma which may impact upon their own parenting.
    - Routine use of genograms
    - Current family context specifically focusing on fathers / male partners.
    - Consideration of who is part of a child's life and whether or not they are a protective person.
    - Evidence and research including lessons from other serious case reviews
    - Routinely sharing the outcome of assessments or seeking information about the outcome of assessments particularly when there are multiple vulnerabilities and risks.
- For many parents/ carers, child protection agencies are perceived as a threat, which means they may be reluctant to work with professionals, hide or cover up information, or appear to be complying. The KSCB may wish to consider whether or not current practice and supervision reflects that there is a perceived 'disincentive' for parents / families to be honest or, in some instances to ask for help.
- Where there would otherwise be delays between Core Groups or other Inter or multi-agency meetings the KSCB may wish to consider seeking assurance that alternative arrangements will be made. For example a substitute chairperson will be identified and the arrangements communicated with all agencies.[1]
- Whilst there is a rationale for why information in respect of the two incidents of alleged threats to children by Adult A was not shared, the KSCB and partners may wish to consider how 'cross checks' are carried out in future incidents of a similar nature.
- The KSCB may wish to seek assurance that the effective use of supervision and management oversight of complex cases is standard practice.
- For agencies where safeguarding supervision may not be routine; for example in primary schools, the learning from this review may be useful to help schools consider how they support staff in their response to mounting safeguarding concerns.
- Consideration of what happens when TAF arrangements are closed for example; that there should be a written closure summary detailing the reasons for closure and if any concerns remain. In cases where the TAF has ended due to a lack of compliance from parent/s or

[1] *Possible solutions to delays in core group meetings were suggested by the practitioners and managers who participated in the Learning Events including setting the dates for core group meetings in advance at the initial CP meeting, enabling practitioners who cannot attend in person to join the meeting by 'Skype' or similar mechanisms, agreeing a deputy Chair at the initial meeting.*

withdrawal of their consent and concerns remain that there is a clear written process for what happens next e.g. escalation to CSC.

- The KSCB and partners may wish to consider the use of criminal proceedings in cases of neglect where other interventions have not worked and where children and young people are suffering the ongoing harm caused by neglect.
- CSC and other relevant partners may wish to consider allocating co-workers to complex 'multiple children / household' cases such as this.
- The KSCB may wish to consider that separate child protection meetings are held for each individual child in cases where there are multiple children with different parentage and/or separate living arrangements.

Good practice identified in this review

Whilst Child D remained largely invisible to agencies (he was pre-school age and Mother did not engage with the Health Visiting service) until he became a subject of child protection arrangements his siblings attended local primary schools with Sibling 1 joining secondary school in 2016.

Sibling 1's secondary school were managing his distress and resultant behavioural issues on a daily basis and this enabled Sibling 1 to remain in school. He also trusted staff sufficiently to share what had happened when Mother had possibly been raped. This led to the school making an immediate referral to CSC as they were concerned about neglect. They had also made a previous referral to CSC following Sibling 1 stating that Mother had thrown a mobile phone at him causing bruising to his chest.

Sibling 2, 3 and 4 changed primary schools in November 2016. Their new primary school was proactive in being alert to and recording concerns about the children and they responded to the children with empathy. However they could have considered an earlier referral to CSC as there were rapidly mounting concerns including Sibling 4 reporting hunger and a possible non accidental injury, Sibling 2 appearing tired and unkempt and staff observations of Mother drinking alcohol outside the family home and Sibling 4's distress.

On the two occasions within the timescales of this review that Mother presented to book for antenatal care she disclosed CSC involvement with her family to the midwives. On both occasions the midwives immediately contacted CSC in response to this to share and gather information.