Kirklees Safeguarding Children Partnership

CHILD D SERIOUS CASE REVIEW 2019

CHILD D
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Contents

Key People in Child D's Life

Mother	Child D's Mother
Adult A	Mother's partner and the perpetrator of the assault against Child D
Sibling 1	
Sibling 2	
Sibling 3	
Sibling 4	
Father	Father of Child D
Father of Sibling 1 and 2	
Father of Sibling 3 and 4	
MGM	Maternal Grandmother to Child D
PGM Sibling 1 and 2	Paternal Grandmother to Siblings 1 and 2

Glossary of Acronyms

SN	School Nurse
GP	General Practitioner
HV	Health Visitor
PO	Police Officer
SW	Social Worker
TAF	Team around the Family arrangements
CSC	Children's Social Care
CPP	Child Protection Plan

Introduction

1. This Serious Case Review (SCR) concerns Child D.
2. 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.
3. Child D was at home alone Adult A at the time of the assault.
4. 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.
5. Adult A was arrested on the day of the assault and served a 21 month custodial sentence.
6. 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.
7. Further detail and family history is described below.

The SCR: Process and Methodology

8. 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.
9. The KSCB Serious Case Review Workstream made a recommendation that the LSCBs should conduct a proportionate, appropriate and participative SCR with the emphasis upon professional involvement, to address how agencies had worked together in this case, identify any learning, aggregate lessons from individual organisations and ensure that an improvement action plan was put in place if appropriate.
10. The goal is to move beyond the specifics of the particular case to identify the underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them will contribute to improving practice more widely.
11. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding

children. For example, a 2011 study of recommendations arising from SCRs 2009 -2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from SCRs can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.

12. The KSCB Serious Case Review Workstream established the identity of services in contact with the family during the time frame agreed for the review.

13. Reviews of all records and materials that were considered included;

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

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

15. 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)

16. 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.

Key Lines of Enquiry

17. 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*

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

A. 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?

B. How were Mother's needs recognised, assessed and responded to?

C. Was the parenting capacity of Child D's Mother assessed effectively?

D. What, in this case, reassured practitioners that Child D and his siblings were safe and well?

E. How did practitioners know that what they were doing was reducing risk?

F. How were the risks associated with males, including Child D's father, identified and assessed and responded to?

G. 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.

H. Was professional practice and supervision informed by research and evidence based practice?

I. 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?

J. 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.

K. 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.

Independence

19. The lead reviewer Ms Hyde is independent of any service or agency in Kirklees. Ms Hyde was CEO of Kirklees Women Centre for 14 years (between 1994 and 2009) and developed internationally acclaimed, high quality services and support for at risk women and families. Ms Hyde was a member of Baroness Corston's review team which was commissioned by the Government following the deaths of several women in custody.

20. Ms Hyde is currently working with local health, social care and criminal justice commissioners and families to re-model how support services are commissioned and provided.

21. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair and Reviewer of several SCRs and Domestic Homicide Reviews and has designed and led several Learning Reviews on behalf of local safeguarding children and adults boards.

Confidentiality

22. Working Together to Safeguard Children (2015) clearly sets out a requirement for the publication in full of the overview report from SCRs:

23. "All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR

reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."

Family involvement

24. Child D's family (mother, father, paternal and maternal grandmothers) were advised that a Serious Case Review was taking place and were invited to contribute and to meet with the Lead Reviewer. Father met with the Lead Reviewer and the Business Manager for the KSCB in January 2019 and his views and concerns are reflected within the report.

Staff involvement

25. Working Together to Safeguard Children 2015 lists seven "principles for learning and improvement" that should be applied to all reviews. One of these is that "professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith"

26. The staff who were involved with Child D's family participated in a Learning Event in October 2018. The Learning Event was attended by practitioners and a separate Learning Event was held for managers. In addition to the Lead Reviewer who facilitated the event was attended by the Kirklees LSCB Learning and Development Officer and Serious Case Review Co-ordinator, the Designated Nurse for Safeguarding Children (Kirklees) and the Kirklees LSCB Business Support Manager.

Race, Religion, Language and Culture

27. Child D's family are White British. The cultural identity of other people involved in Child D's life is not known therefore this did not inform assessments by services or the SCR process. Similarly it is not known if religion was a feature of the family's life. The family's first language is English.

Summary of Family history

28. What is known about Child D's family history and the history of some of the other adults involved in his life is detailed below.

29. During the child protection process in respect of Child D and his siblings Mother's mother (MGM) disclosed that she had experienced a significant trauma and that she uses alcohol but that she does not regard herself as an alcoholic. It is not clear what age Mother was

when the traumatic event occurred or the impact that this and MGM's alcohol use had on her.

30. Mother became pregnant with her first child when she was 18 years of age.

31. Mother and the children had been known to services in Kirklees since at least 2013 because of concerns about neglect and because of Sibling 1's distress and resultant behaviours.

32. Mother had five children. She became pregnant with her sixth child in January 2018 and Adult A was named as the father. This child was born outside the timescale of this SCR.

33. There are 4 different fathers of the children (with Adult A being the fifth).

34. The relationships between Mother and the fathers of the children was affected by domestic violence and each of the fathers has a history of offending.

35. Child D's father has convictions for violent and other offences. He is described as a 'heavy drinker and drinks every day'. He also reported drug use.

36. Mother was the possible victim of a rape in July 2017 whilst she was drinking alcohol with 4 males in the family home. It was this incident which led to Child D and his siblings being made subjects of child protection arrangements because of neglect.

37. The relationship between Mother and Adult A began in September 2017.

38. Adult A has convictions for a serious assault and other offences. He was on a supervised methadone programme at the time of the assault of Child D.

Overview of events and agency involvement

39. Although the timeframe for this SCR was 26.6.18 to 13.2.18 agency records held historical information which is relevant to the case and this has also been considered.

40. This section of the report does not chronicle every single agency contact with Child D and his family but describes key contacts and other information held by agencies.

Child D and Mother

41. Mother who is now in her early 30's had her first child (Sibling 1) when she was 18 years of age.

42. There were 2 reported incidents of domestic abuse in 2011/2012

43. In 2011 when Sibling 1 was aged 6 he went missing from home and was found playing at a friend's house. He had told the parents of his friend that he did not want to go home as Mother hit him.
44. Team around the Family (TAF) arrangements were in place for the family in 2013. Home conditions and neglect including missed health appointments were of concern.
45. There were also concerns about Sibling 1's behaviour and weight. Sibling 1 was referred to CAMHS and was self-harming and aggressive. Mother stated that early trauma was affecting him although the detail of this trauma is not documented.
46. In June 2015 MGM called the police reporting that Mother was drunk in charge of the children. CSC visited the family home and found she was not drunk and no further action was taken.
47. In August 2015, when she was pregnant with Child D, Mother admitted to using cocaine at an ante natal appointment and to CSC involvement with her children. The Midwife contacted CSC who confirmed that this was an open case due to neglect.
48. Throughout this period there were ongoing missed ophthalmic appointments for Sibling 4.
49. Throughout September 2015 there were also missed CAMHS and physiotherapy appointments for Sibling 1
50. In February 2016 police were called to a domestic abuse incident. Mother was pregnant with Child D at this point. Child D's father was the perpetrator. All the children were present.
51. In April 2016 Mother missed ante natal related appointments.
52. Also in April 2016 Sibling 4 was not taken to ophthalmic appointments.
53. On 19th April 2016 Child D was born
54. During 2016 Sibling 2's behaviour was noted to be problematic at school. His behaviour included drawing sexual images.
55. Mother did not engage with the Health Visiting Service in respect of Child D following his birth.
56. In June 2016 there was a further missed health appointment for Sibling 4.
57. In July 16 Child D was not taken for an appointment with the GP practice nurse
58. On 25th July 2016 a referral to early help was made by the Police following Sibling 1 going missing for 4 hours. He was aged 11 at this point.
59. On 1st September 2016 Child D was not taken to an appointment with the GP practice nurse.
60. On 29th September 2016 Child D was not taken to a further appointment with the practice nurse
61. In November 2016 the children changed schools due to a house move

62. Also in November 2016 Mother changed GP and took Child D who was 'wheezy' to an appointment.
63. Mother did not take Child D for his follow up GP appointment 10Th November 2016.
64. On 10th and 11th November 2016 Sibling 1's behaviour was noted by his school pastoral care staff to be controlling, manipulative, attention seeking, impulsive and dangerous.
65. On 17th November Sibling 1 ran away from home after an argument with Mother. He was aged 11 at this point.
66. On 28th November Sibling 1 was involved in violent incident at school and used sexualised language. He was also killing insects and throwing them at classmates. School put plans in place to build his self esteem
67. 1st December 2016 Child D was not taken to a GP appointment.
68. 12th December 2016 Child D was not taken to appointment with the GP practice nurse
69. 4th January 2017 Sibling 4 was not taken to an ophthalmology appointment.
70. On 10th January 2017 the HV attended the family home for a 'year 1' visit to Child D and did not gain access. There had been only 1 successful visit by the HV service since his birth.
71. 8th March 2017 Sibling 1 exhibited more 'extreme' behaviour at school.
72. On 13th March 2017 the School Nurse wrote to Mother about Sibling 4's missed ophthalmology appointments and asked her to make contact.
73. May 2017 a further incident of problem behaviour from Sibling 1 occurred at school
74. 23rd May 2017 the School Nurse tried to ring Mother regarding Sibling 4's missed appointments. School also text Mother to let her know.
75. On 26th May 2017 a referral to CSC was made by school after Sibling 1 said that Mother had thrown a mobile phone at him causing a mark to his chest.
76. On 5th June 2016 Sibling 4's school recorded that she was very hungry at school
77. On 16th June 2017 Sibling 2, 3 and 4's new school were informed by their previous school that a TAF was in place but no information about whether or not the case was still open.
78. Also on 16th June 2017 a bruise to Sibling 4's face was noted by school. Sibling 4 said that Mother had pulled her off a wall and she had banged her face.
79. On 20th June 2017 Sibling 3 told school that he was allowed to play an 18 rated PC game at home.
80. Also on 20th June Sibling 4 asked twice for food at school saying that she was 'so hungry'
81. On 3rd July 2017 Sibling 2 was noted by school to be very tired and unkempt. School provided a clean uniform for him so that he could go on a school trip.
82. By 3rd July 2017 school attendance was noted to be an issue for Siblings 2, 3, and 4.

83. It was also noted that Sibling 4 was struggling socially at school and that she was seen by a member of staff outside school hours out in the garden with Mother who was drinking alcohol and that Sibling 4 was upset.
84. On 4th July 2017 an incident took place at the family home. Mother was drinking alcohol with 4 males and may have been drugged and raped. All the children were present in the home.
85. On 5th July 2017 Sibling 1 was recorded as having a 'bad day' at school and on 6th July was able to tell school what had happened on the evening of 4th July.
86. On 6th July Sibling 1's school made a referral to CSC concerned about the impact of Mother's drinking on the children who were present when the incident took place.
87. On 6th July a strategy meeting took place and S47 enquiries which led to a decision to hold an Initial Child Protection Conference.
88. During this period of time the children each moved into the care of family members.
89. On 10th July Mother re-registered Sibling 3 and Sibling 4 at their previous primary school.
90. On 4th August 17 all children were made subjects of a Child Protection Plan because of neglect. It was agreed at the initial child protection conference that safety goals were:

- Mother would access support in respect of the rape,
- that parents will address their alcohol consumption
- That the children would be surrounded by safe and trusted adults and not exposed to inappropriate adult behaviour or conversations
- The children will receive the help and support they need to adjust to their new circumstances.

91. It was also agreed that if Mother allowed unknown adults into the home the children could be placed at risk of physical, sexual or emotional abuse and that they could witness inappropriate behaviour including sexual assault.
92. On 7th August 2017 a HV visited Child D at Father's home.
93. On 16th August 2017 a Core Group meeting was held and noted that Sibling 2 had said he may not want to go back and live with Mother. It was unclear if Child D was back with Mother as no contact had been made with Father.
94. By 29th August 2017 Sibling 1 returned to live with Mother as his father and step-mother had separated.
95. In September 2017 Child D returned to live with Mother who had, by then, started a relationship with Adult A.
96. Police checks carried out detailed Adult A's past offending history and Mother was told by the SW that he should not be in the family home.

97. Throughout there were ongoing issues for Sibling 1 with anger and distress at school.
98. On 15th September 2017 the core group was cancelled as the social worker was ill. The next one was planned for 12th October 2017 which was a 9 week gap.
99. On 28th September 2017 Adult A told his substance misuse key worker that he had started a relationship with Mother and told the worker that CSC were not happy about his involvement with the family.
100. On 3rd October 2017 the family were discussed at a GP link meeting' as a family of concern
101. At the 12th October 2017 core group the relationship between Mother and Adult A was discussed and it was noted that he shouldn't be at the property.
102. Sibling 4 was noted to have started bed wetting. She was aged 5 at this point.
103. At the 18th October CP review meeting Sibling 1's school explicitly shared that he was becoming more stressed.
104. Child D's father and the sibling's fathers/ carers attended the review meeting and shared concerns about Adult A being at the house.
105. It was further recorded that Mother (who was not at the meeting) was not to have any males visiting the house.
106. It was also noted that health appointments for the children had also been missed.
107. On 20th October 2017 Adult A's key worker attempted to make contact with CSC.
108. On 24th October 2017 School Nursing started to arrange health assessments for the children as they were on a Child Protection Plan.
109. On 1st November 2017 Adult A's substance misuse key worker spoke to a Social Worker who was calling on behalf of the allocated Social Worker. The substance misuse key worker explained that s/he had not known Adult A for very long and that he had a long standing relationship with the 'prescriber'.
110. During his health assessment on 2nd November 2017 Sibling 1 told the School Nurse that Adult A lives with them.
111. Also on 2nd November CPOMS* advised that Sibling 2 was moving schools as he was returning to live with Mother. Grandma shared concerns with school that Mother was allowing contact with Adult A. *CPOMS is a software application for monitoring child protection, safeguarding and a whole range of pastoral and welfare issues within a school setting. Working alongside a school's existing safeguarding processes, CPOMS helps to manage and record issues such as child protection, behavioural issues, bullying, special educational needs, domestic issues and more

112. At the 17th November 2017 Core group information was shared that Adult A was in the family home by school and Grandma.

113. It was noted that Sibling 4 was still missing ophthalmology appointments.

114. A new SW was allocated to the family on 19th December 2017 and the core group planned for 21st December was cancelled as the new SW could not attend.

115. On 5th January 2018 Father attended the substance misuse service to access help with his use of alcohol.

116. On 6th January 2018 the police attended mother's address following a phone call about an alleged assault. There was no evidence that an assault had taken place and Mother told police that this was likely to have been a malicious call from Child D's father as she was not allowing him contact with Child D because of his drinking.

117. On 9th January 2018 the new SW carried out a home visit and noted that Adult A was present and concerns were noted about how loudly he spoke to Child D

118. On 17th January 2018 Mother booked for ante natal care and disclosed CSC involvement with her family. She denied any domestic abuse with her partner (Adult A) who was present at the appointment. The Midwife contacted CSC and requested a pre-birth assessment. Mother had told midwife that all her children lived with her when in fact Sibling 3 and Sibling 4 had not returned to her care at this point. Mother also told the midwife that she had previously used cocaine but had not taken any since 2017.

119. On 26th January 2018 Sibling 3 and Sibling 4's paternal grandmother expressed concern that no core group meeting had been held since November.

120. A Core group was planned for 7th March 2018 almost 4 months since the previous meeting. By this point in time Mother was pregnant and all the children had returned to her care.

121. On 13th February 2018 Child D was seriously assaulted by Adult A when he was alone with him in the family home (Mother had taken the other children to school).

Analysis

122. The analysis is set out in response to the key lines of enquiry which formed the terms of reference for the SCR. The analysis is informed by:

- chronological information provided by agencies,
- the minutes of the child protection meetings

- the views and contributions of the practitioners and managers who attended the Learning Events
- Research and evidence
- Analysis of other serious case reviews

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? How is Child D's voice heard?

123. The single and multi-agency assessments in this case did recognise some of the risks to Child D (and his siblings) which were associated with Mother's alcohol use and her relationships and vulnerabilities with males.

124. Mother's admitted use of cocaine was not discussed at the multi-agency child protection meetings and there is no information contained in the agency chronologies to show that this information was shared by the midwife with CSC and by CSC at the multi-agency CP meetings. It was not therefore recognised, assessed and responded to as a risk to Child D.

125. There was recognition of the impact of the wider family members' use of alcohol on the children when the children were placed with them following the possible rape of Mother.

126. Following the Initial Child Protection Conference in August 2017 which detailed the offending history of the children's birth fathers, each of whom had a history of domestic abuse, drug and alcohol related offending and in Father of Child D's case, ongoing domestic abuse in his current relationship there was no consideration of the impact of domestic abuse on the children.

127. It is abundantly clear from research that living with domestic abuse is always harmful to children, and it is rightly seen as a form of child maltreatment in its own right (Humphreys and Bradbury-Jones, 2015) however this was not discussed at the child protection meetings and did not inform risk assessments.

128. In September 2017 it became clear that Mother had started a relationship with Adult A and that he had a history of violent offending and drug / alcohol use. The child protection meetings noted that he should not have contact with the children until a full risk

assessment had been carried out. Mother did allow contact however and this was discussed at further child protection meetings and reviews. Other than repeating that Adult A should not be in the family home there were no alternative plans put in place and he continued to have contact with the children and was known to be present in the family home on a regular if not permanent basis.

129. It is not clear from agency records whether or not there was a formal risk assessment of Adult A or indeed whether there was any direct contact with him apart from at the home visit carried out by the SW in January 2018 who noted concerns about how loudly Adult A spoke to Child D.

130. The impact of Adult A's presence specifically on Child D's wellbeing and safety does not appear to have been discussed further at any single or multi-agency forum and there was no information to suggest that direct work was undertaken with Child D in respect of this.

131. During a core group meeting the fathers of Child D's siblings reported that the children returned from contact with Mother 'tired and hungry'. Child D was a very young child and unable to articulate what and when he had eaten and this meant that he was especially at risk of going hungry.

132. Father reported to the Lead Reviewer that he had attempted to share his concerns about home conditions at Mother's with the social worker. He had taken photographs of the upstairs of the family home. Father also reported that he had written a list of his concerns and attempted to give the list to the social worker who did not read or take the list from him.

133. Family members including Maternal Grandmother, Maternal Sister and the fathers of the siblings were each reporting the same concerns about neglect, home conditions and the relationship of Mother with Adult A. These concerns were valid and some of them pre-dated the child protection arrangements. It is not clear from agency records or from conversations with the practitioners and managers how the family's concerns influenced decision making or assessments and management of risk.

134. The single and multi-agency assessments do not appear to have been sufficiently focused on Child D's daily life experience which included exposure to domestic abuse, ongoing neglect and regular contact with a man with convictions for violent and other offences and his voice was not heard.

Key Considerations for the KSCB

- **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.**

How were Mother's needs recognised, assessed and responded to?

135. Mother's needs were not assessed or understood. For example there was no discussion with her about her use of alcohol and cocaine, about her own childhood experiences (her mother- MGM- reported that she had experienced a significant trauma and that she uses alcohol to cope), the domestic abuse which affected her relationships with each of the children's fathers and the ongoing neglect of the children's needs and whether or not this was rooted in her own unmet needs.

136. Research suggests that women who neglect their children are:

- more likely to be poor
- less able to plan
- less able to control impulses
- less confident about future
- less equipped with sense of self-efficacy
- have psychological and psychosomatic symptoms
- have had poor educational attainment
- have a high sense of alienation

- struggle to manage money
- lack emotional maturity
- physically and emotionally exhausted
- experience depression
- lack of knowledge of children's developmental needs
- struggle to meet dependency needs of children
- experience feelings of apathy and futility.

(Kadushi 1988, Polansky 1981, Crittenden 1996, Gaudin 1993, Giovannoni 1979, Horwath 2007, Mayhall and Norgard 1983, Taylor and Daniel 2005, Stevenson 2007)

137. Mother was only 18 when she became pregnant with Sibling 1. She had a further 4 children and was a lone parent to the 5 children by the age of 29. Her relationships with the fathers of the children were affected by domestic abuse.

138. Her daily life may well have been difficult and she certainly struggled to maintain home conditions at times. The neglect of the children had been a concern to agencies since at least 2013 (at that point Mother was 26 years old with 4 children –one of whom had significant behavioural difficulties) but there does not appear to have been any direct work carried out with Mother in respect of her own needs.

139. Mother presented for ante natal care in January 2018. Adult A was present and named as the father. This pregnancy with a man she had known for only a few months was her 6th. It is not clear from agency records that any exploration of Mother's repeated pregnancies took place with Mother but this latest pregnancy would undoubtedly have compounded her difficulties; including financial and practical, and potentially increased risks for Child D and his siblings.

140. In summary Mother did not appear to recognise her own vulnerability or that her relationships with abusive men put herself and the children at risk. Neither did she appear to have any insight into the impact of long standing neglect on the children.

Was the parenting capacity of Child D's Mother assessed effectively?

141. Mother's parenting capacity was not assessed despite the family being known to agencies for at least 10 years because of neglect of the children, Sibling 1's distress and concern around alcohol use and home conditions.

142. Research suggests that early traumatic or adverse childhood experiences can have an impact on our ability to form attachments into adulthood –including our relationships with our own children. Mother's attachment to her children (and theirs to her) was also not considered or assessed but there were indicators that her attachment fluctuated and this led to the children's needs not being met.

143. These indicators that the children's needs were not being met consistently or adequately included the children being unkempt, tired, hungry, and exposed to adult behaviours that may have been frightening and that they were unable to control.

144. Mother's parenting capacity may have been compromised by her own childhood experiences and by the domestic abuse she experienced from a very young age in her relationships with the children's fathers however this does not appear to have been explored with her before or after the children became subjects of child protection arrangements.

145. In addition two of Child D's siblings reported that Mother had caused them physical injuries and Sibling 1 in particular exhibited signs of extreme distress from a young age and this manifested as behaviours which caused agencies concern. These behaviours included self-harming, going missing from home and other extreme emotional distress.

146. Where parents have unresolved or disorganised attachments, their resultant behaviours can impact on the nature of the relationship with their own children. Hesse and Main (2000) suggest that parents with unresolved or disorganised attachments may exhibit inconsistent behaviours or ones which frighten or alarm children who look to them for safety and care. The authors describe children in these circumstances as being confronted with a 'biologically channelled paradox: the simultaneous needs to approach, and take flight, from the parents' and suggest that this leads to disruptions in the child's behaviour'.

147. There is no information contained in agency records to suggest that Mother's insight or her capacity to change was explored with her or used to inform further assessments of risk to the children.

148. Factors that are known to be associated with risk to babies and very young children include domestic abuse and environmental stressors such as housing. Significant protective factors are the presence of a supportive non-partner, wider family and informal support and *parent's insight understanding and capacity to change*. Severe risk of harm is most likely where there is an absence of protective factors as in this case. (Ward, H., Brown, R., and Westlake, D. 2012) There is no indication that an assessment of the presence / absence of these protective factors took place.

149. 'Assessing Parental Capacity to Change when Children are on the Edge of Care' is an overview of current research evidence, bringing together some of the key research messages concerning factors which promote or inhibit parental capacity to change in families where there are significant child protection concerns. It is intended to serve as a reference resource for social workers in their work to support families where children's safety and developmental functioning are at risk. Its purpose is also to assist social workers and children's guardians in delivering more focused and robust assessments of parenting capability and parental capacity to change, and assist judges and other legal professionals in evaluating the quality of assessment work in court proceedings. The report brings together research findings from a wide range of disciplines, which are not otherwise readily available in one location for social workers, family justice professionals and other practitioners with safeguarding responsibilities.

Key Considerations for the KSCB

- **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.**

How did practitioners know that what they were doing was reducing risk?

150. The child protection plans outlined what needed to happen in order to reduce risk. This included:

- Mother to access counselling in respect of the rape

- Parents/ carers not to consume any alcohol whilst caring for the children.

151. In addition the plans described the risks posed to the children if Mother allowed males, about whom she had limited knowledge, into the family home.

152. Mother declined support or counselling in respect of the rape and by September 2017 was in a relationship with Adult A.

153. The risks posed by Adult A, whose offending history was known, were not formally assessed. Any such risk assessment should have included direct contact with him on a regular basis.

154. Crucially other risks emerged following Child D being made a subject of child protection proceedings. These included a further domestic abuse and alcohol related incident involving Father and the pregnancy of Mother with Adult A being the father. However because there were no inter or multi-agency meetings between November 2017 and February 2018 when the assault of Child D took place information about these incidents was not shared or acted upon.

155. Further indicators of risks were the two alleged incidents of threats made against children by Adult A whilst he was living in the family home which will be discussed in the next section of this report. (The children threatened were not living in the family home and were not family members)

156. In summary, risk to Child D *increased* during the period of time he was made a subject of child protection arrangements but this did not lead to a single or multi-agency reassessment of overall risk or influence decision making and planning.

Key Considerations for the KSCB

- **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.**

How were the risks associated with males, including Child D's father, identified and assessed and responded to?

157. Adult A has a long history of violent offending, drug and alcohol related offending, theft, fraud, criminal damage and traffic offences and was in treatment for a heroin addiction.

158. There were two incidents of him allegedly threatening children whilst he was living with Mother. The police responded to these incidents and on both occasions there was no further action to be taken. However the police officers who responded did not know that the children in the household were subjects of child protection arrangements or that Adult A should not have been present in the home. The information about these two incidents was not shared with other agencies and could not therefore influence assessments of risk or decisions about safeguarding Child D and his siblings.

159. Adult A told his substance misuse key worker about his relationship with Mother and that CSC were not 'happy' about the relationship. Following this the key worker contacted the SW but it is not clear how the substance misuse service, who held significant and important information about Adult A, contributed to ongoing assessments of risk through the child protection arrangements.

160. It was also clarified by the substance misuse service manager who participated in the Learning Event that a specific risk assessment of how methadone was stored within the family's home should have been carried out once it was known that Adult A was living with or having contact with children however Adult A refused consent for a home visit to take place. This refusal was, in itself, an indicator of risk.

161. Adult A was witnessed by the SW 'speaking loudly' to Child D during a home visit in January 2018 and this caused her concern. It is not clear from the CSC records provided to this review how this observation was used to reassess risk, seek advice or reconsider plans in respect of Child D. At that point the next core group meeting was not due to take place until March 2018 and effectively Child D was left in an unsafe and frightening situation.

162. Child D regularly spent time at Father's house before and after he became a subject of child protection arrangements.

163. As previously described Father also has a long history of violent offences including domestic abuse and a sexual assault. Other offences were drug and alcohol related.

164. The latest reported domestic abuse incident between Father and his partner was in *December 2017* and took place when Child D was in his care. Father had returned home heavily drunk and his partner had attempted to end the relationship which then led to the domestic abuse incident. The police recorded that the victim (Father's partner) had stated that "Arguments becoming more intense and more frequent, not escalated into violence other than what happened in May 2017".

165. Child D was subject to child protection arrangements at that point but there is no information to suggest that this incident prompted an urgent review of the risks to Child D posed by him being in the care of Father.

166. The risks posed to Child D by Father were not explicitly assessed and it is not possible to establish from agency records whether or not a formal assessment of his parenting capacity did take place following this being an agreed action at the Initial Child Protection Conference.

167. In summary, research and analysis of other serious case reviews highlights that the person causing harm to children varies according to the type of harm suffered; if it were a physical assault which proved fatal or seriously injured the child, the perpetrator was most likely to be the father or father figure/mother's new partner.

168. Further analysis established that the presence of a criminal record in itself should also be seen as a risk factor for serious or fatal maltreatment, particularly when combined with other parent/carer risks such as domestic abuse, substance misuse or mental health problems (Father reported that he suffered from Post-Traumatic Stress Disorder following being a victim of an assault). *New learning from serious case reviews: a two year report for 2011-2014. London: Department for Education, DFE-RR226.*

169. The use of alcohol by the adults who cared for the children was also recognised as an issue at the initial child protection conference and was discussed at subsequent meetings however it is clear from the December 2017 domestic abuse incident between Father and his partner that Father was still drinking heavily.

Key Considerations for the KSCB

- **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.**

Explore whether Mother was able to deflect or deceive agencies, why this was able to happen and whether there are lessons that can be learnt.

170. Mother had a history of agency involvement with her family. Concerns about her neglect of the children resulted in Team around the Family (TAF) arrangements being put into place in 2013 when missed health appointments and poor home conditions were of concern. (The minutes of the TAF meetings were not included in the information made available to this review)

171. The neglect of the children's health needs continued until 2017 when the children were made subjects of child protection arrangements. It is clear from agency records that Mother was able to reassure practitioners that she was intending to take the children to health appointments but it is also clear that she did not always do so. There were occasions when Mother was untruthful about why she could not take the children to appointments.

172. The neglect of the children's health needs and reports of Mother drinking alcohol whilst caring for the children were ongoing at the point at which the children became subject to child protection arrangements. This 'turning point' came as a direct consequence of the possible rape of Mother whilst she was drinking alcohol in the company of 4 males.

173. Prior to this Mother did not engage with the Health Visiting service following the birth of Child D and he also was not always taken to health related appointments, in other words, the pattern of neglect continued characterised by Mother's lack of engagement with services. This may well have continued if the alleged rape had not occurred.

174. Once the children became subject of child protection arrangements Mother was aware that a requirement of the plan was that she did not allow unknown males into the family home. Within 2 months Mother was in a relationship with Adult A. Mother did not attempt to hide her relationship with Adult A from agencies but she did state that she was not allowing him to have contact with the children. Agencies knew that this was not the case and that Adult A was frequently in the family home if not actually living there.

175. The most significant issue of Mother's continuing pattern of attachments with abusive males who were introduced into her children's lives, despite Mother being made aware of the potential harm this could cause them, was also a form of disguised compliance. In other words; Mother reassured practitioners that she understood and would not introduce unknown males into Child D's and his sibling's lives but continued to do so.

176. It is not clear from agency records how Mother was challenged about this or how this influenced assessments of risk and need.

Key Considerations for the KSCB

- **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.**

Were single and multi-agency actions including communications and information sharing appropriate, accurate and acted upon?

177. In this case there were significant delays between core group meetings. Ostensibly this was because there was a delay between one social worker leaving and another being allocated. Once a new social worker had been allocated there was a further delay in holding a core group meeting as she was unable to attend the meeting arranged for December 2017. A core group meeting was arranged for March 2018 which would have been 4 months since

the last core group meeting. Child D was assaulted by Adult A before this meeting took place.

178. The practitioners and managers who participated in the Learning Events spent some time discussing this delay.

179. The core group is the Interagency Forum for achieving the outcomes of a child protection plan. As a minimum core group meetings should be held every 6 weeks.

180. If there are difficulties implementing any aspect of the Child Protection Plan, the Core Group has an important role in identifying this and agreeing what action needs to be taken. In this case it was clear that a new and potentially significant risk to the children, Adult A, was having contact with Child D and his siblings. It was also clear that Mother was not accessing support or counselling in respect of the rape.

181. When agencies were made aware that the Core Group had been cancelled by the SW there was no discussion about holding the Core Group meeting without her and no agency or practitioner came forward to take responsibility for ensuring that a meeting took place.

182. Guidance exists for such circumstances and states that "The first or second core group meeting should be chaired by the line manager of the allocated social worker. Other meetings will usually be chaired by the social worker although this can be negotiated, if there is a specific reason for another worker taking on this role".

183. The chair has the additional responsibility of guarding against drift in the plan. Whilst it may be appropriate to revise the plan in the light of changes to the family circumstances or new information coming to light, it is important that the overall objectives of safeguarding children of the family remain the focus of the plan.

184. In this case new and significant risks to the children had been identified at the September and November Core Group meetings and new and significant risks emerged during December 2017 and January 2018 (see above) but a further meeting was not planned until March 2018.

185. There were instances where information sharing and communications were not effective or did not take place and these include:

- Father accessed support from the substance misuse service in respect of his alcohol use in January 2018 and this information was not shared with CSC.

- The two incidents of threats to children to which the police were called were not shared because the police were not aware that the children in the household were subjects of child protection arrangements.
- It is unclear from the agency chronologies when (or if) the TAF arrangements were formally closed and there is no record of any meetings taking place beyond May 2016. By this point Sibling 1 and Sibling 2's behaviour was still causing concern for their schools and other agencies. It was June 2017 before Child D's siblings primary school was provided with information from their previous school to advise that TAF arrangements had been in place.

Key Consideration for the KSCB

- **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.***
- **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.**

**** 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.***

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.

186. Themes which the KSCB may wish to consider which have emerged from previous serious case reviews have been referred to elsewhere in this report. To summarise these include:

187. Unknown males / new partners

188. The age of the child or children –very young children are especially vulnerable

189. An incident led response for example to the possible rape of Mother and to individual domestic abuse incidents

190. Longstanding neglect

191. Domestic abuse, substance misuse and mental health (Father and Adult A in particular)

192. Failure to hold child protection core groups in a timely manner.

193. Cumulative and ongoing nature of risk not recognised or responded to (see summary)

194. The author of this report specifically reviewed the 2014 Kirklees SCR relating to a 13 month old child who suffered serious head injuries. In that case as in this, there were long standing concerns about neglect, domestic abuse and multiple male partners. There are similarities between the findings and learning of both SCRs.

Was management oversight and supervision effective in this case?

195. There were no supervision records available to the Independent Reviewer during the SCR process nor was any information provided in the agencies chronologies to describe that supervision or management oversight had taken place.

196. Formal supervision provides an opportunity for critical analysis and reflective discussion about a case and is especially crucial in cases where there have been long term concerns about neglect or other forms of abuse.

197. In this case the family were receiving support and interventions under TAF arrangements between 2013 and 2016. It appears from agency chronologies that there was no formal decision to end the TAF arrangements however the last meeting was held in June 2016. At this point in time Mother was pregnant with Child D, Sibling 2's behaviour was of concern, Sibling 1, who was self -harming and distressed was transitioning to secondary school, the children were not being taken to health appointments including Sibling 1's CAMHS appointments and there was one report of Sibling 1 being hit on his head by his father whilst at contact (this did not lead to a referral to CSC).

198. Additionally there were reported incidents of domestic abuse including an incident in March 2016 when Mother was pregnant with Child D.

199. There is no information contained in agency chronologies to suggest that the TAF plans were reviewed or that advice or management oversight was sought or provided in respect of the ongoing concerns and changed circumstances of the family (Mother's pregnancy).

200. A referral to CSC was made by the police in July 2016 following Sibling 1 going missing from home but there is no information contained in the CSC chronology which describes what happened as a result of this referral specifically that it led to a review of plans for the family.

201. There was no further multi-agency involvement with the family until Child D and his siblings became subjects of child protection arrangements in July 2017.

202. In summary this case underlines the importance of good quality supervision, particularly where there is long term neglect and parental avoidance. Supervision has a role in challenging drift, monitoring professional standards and providing constructive advice

Key Considerations for the KSCB

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

Determine whether National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies were followed.

203. National, Regional and Local policies, procedures, thresholds and practice expectations of the agencies were not always followed during the timescales considered by this SCR. Key examples include the delays between Core Group meetings which occurred and which are described in more detail above.

204. A further example is the referral Sibling 1's school made to CSC in May 2017 following Sibling 1 disclosing that Mother had thrown a mobile phone at him causing bruising to his chest. There is no information available in agency records to explain what happened in response to this referral specifically in respect of a strategy meeting or discussion "*If the referral relates to a situation in which a crime has or may have been committed, including sexual or physical assault or physical injury caused by neglect, the worker receiving the referral must discuss the referral with the Police at the earliest opportunity. The Police, in consultation with Children's Social Care Services and any other agencies involved with the child, must consider whether there should be a criminal investigation and/or a Children's Social Care Services led intervention". (West Yorkshire Consortium Safeguarding Guidance)*

205. Strategy discussions provide opportunities for information and opinions to be clarified and in this case the other information which was known about the family e.g. history of neglect and domestic abuse.

206. Health practitioners did not always follow policy in respect of children not being taken to health appointments for example Sibling 4's missed ophthalmic appointments were not always communicated to other agencies.

Good Practice

207. 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.

208. 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.

209. 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.

210. 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.

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.

211. Key learning is identified within each chapter covering the key lines of enquiry within the report. However other learning has been identified and is summarised below.

212. In this case Child D and his siblings became the subjects of child protection arrangements following the possible rape of their mother whilst she was drinking alcohol with 4 males. This incident was preceded by many years of neglect and exposure to domestic abuse.

213. The long standing neglect of the children was discussed in detail by the practitioners and managers who participated in the Learning Events.

214. In particular the capacity or willingness of Mother to change her behaviours was discussed and there was agreement that there had been little understanding of what factors contributed to Mother's neglect of the children and her relationships with abusive males

and that despite supports being put in place the neglect and the relationships with males were ongoing.

215. The practitioners and managers also considered the research and evidence from other Serious Case Reviews which demonstrates the harm caused to children by neglect and discussed the possible use of criminal proceedings in cases of neglect where other interventions have failed. There was acknowledgment that this was not routinely considered in neglect cases despite what is known about the harm caused to children.

216. The practitioners and managers concluded that closer working between the police and CSC in some cases of neglect; could be effective particularly in entrenched cases. .

217. The crime of neglect came from the Poor Law Amendment Act 1868, which made it illegal to fail to provide a child with food, clothes, medical help or somewhere to live. It was redefined in the Prevention of Cruelty to, and Protection of, Children Act 1889 to only cover intentional physical neglect. The wording from this is largely used in the law we have now, The Children and Young Persons Act 1933.

218. Since then our understanding of the harm caused by neglect has grown. We now know that children who are emotionally and/ or physically neglected are more likely to develop mental health problems, have poor social and relationship skills, and end up in the criminal justice system. We also know that neglect can be 'transmitted' from one generation to the next. This is reflected in detail in the ***Kirklees Safeguarding Children Board 2018 Neglect Strategy***.

219. Section 1(1) Children and Young Persons Act 1933 was amended on 3 May 2015, by Part 5 Section 66 of the Serious Crime Act 2015 to update and modernise some of the language. The amended version provides that the offence is made out if:

"a person who has attained the age of sixteen years; who has responsibility for any child or young person under that age; wilfully assaults, ill-treats (whether physically or otherwise), neglects, abandons or exposes him, or causes or procures him to be assaulted, ill-treated (whether physically or otherwise), neglected, abandoned, or exposed; in a manner likely to cause him unnecessary suffering or injury to health (whether the suffering or injury is of a physical or a psychological nature)".

220. The offence covers a variety of conduct that can compendiously or separately amount to child cruelty. The four generally accepted categories are assault and ill-treatment, failure to protect, neglect and abandonment.

221. Section 1(2) provides that a person is deemed to have neglected a child or young person in a manner likely to cause injury to his health where a parent or person legally liable to maintain a child fails to provide adequate food, clothing, medical aid or lodging for the child or having been unable to provide the above failed to take steps to procure it to be provided.

222. It is of note that family members reported at core group meetings that the children returned from contact with Mother tired and hungry which was an indication that their needs were still not being met despite child protection arrangements being in place.

223. The family dynamics in this case were extremely complicated. Once the children became subjects of child protection arrangements they were cared for by 3 separate sets of family members which included fathers, grandmothers, partners and in Father's case a partner who had her own children living with them.

224. Each of the adults who took on or had existing caring roles for Child D and his siblings had significant risks and needs which included domestic abuse, alcohol and other substance misuse, possible mental health issues and histories of offending.

225. It would have been extremely difficult for one social worker to manage this complexity and carry out the required risk assessments, assessments of parenting capacity and statutory visits to the 5 children in between the child protection meetings.

226. Co-working with a family as complex and time consuming as this would help to ensure that children are safeguarded, that plans do not drift and ensure that a single worker is not overwhelmed by the scale of the tasks.

227. This complexity also made managing the dynamics between the different sets of Fathers/ carers challenging at the core group meetings. Practitioners described that the fathers of Child D and his siblings competed to be heard and that the meetings were 'chaotic'.

Key Considerations for the KSCB

- **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.**

Summary

228. Child D (and his sibling's) lived with several risk factors which were present in combination over periods of time. The 2011 to 2014 National Triennial Analysis of SCR's qualifies this cumulative pattern of risk "*We previously noted this particularly in relation to **domestic abuse**, parental mental ill-health, **and alcohol or substance misuse**, but it also includes other risks such as adverse experiences in the parents' own childhoods, **a history of violent crime**, a **pattern of multiple consecutive partners**, acrimonious separation, and **social isolation**. When presented with **any** of these risk factors, practitioners should explore whether there may be other cumulative risks of harm to the child, as well as any protective factors*".

229. The 'trigger' incident for Child D being made subject to child protection arrangements was something that happened to his Mother however it is clear from agency chronologies that his daily lived experience before that incident was not safe and secure.

230. It is also clear that no single practitioner or agency was aware of or focused on the reality of daily life for Child D who was living with domestic abuse, ongoing neglect and exposure to risks posed by unknown adults prior to the alleged rape of his mother.

231. Following the alleged rape and him becoming the subject of child protection arrangements risk to Child D increased as Adult A was living in the family home and there was a further domestic abuse incident between Father (who was drunk) and his partner which took place when Child D was present in December 2017.

232. The serious assault of Child D was perpetrated by a man who was known to agencies to have a history of serious violent and other offences. The child protection arrangements whilst acknowledging some of the risks associated with Adult A were not effective in preventing him from having contact with Child D. The inability or unwillingness of Mother to comply with the plans was, in itself, a further indication of risk and neglect.

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