Kirklees Safeguarding Children Partnership

# A Serious Case Review in Kirklees:

# (Child D)

This briefing has been produced to provide practitioners and managers with the key learning. A Serious Case Review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be

**Reason for the review**

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 and injuries such as red marks, bruises and grazes on almost every part of his body along with a split inside his 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.

**Background:**

In June 2015 Maternal Grandmother 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.

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.

Throughout 2016 a range of concerns were noted for Child D and his siblings including:

- Many missed health appointments for sibling 1, 4 and child D
- A domestic abuse incident whilst Mother was pregnant with Child D (by Child D's father)
- Missed ante natal related appointments up to 19th April 2016 when Child D was born
- Serious behaviour problems with Sibling 1 and 2 – exhibiting very worrying behaviours e.g. violence and sexualised language
- Sibling 1 ran away from home after an argument with Mother. He was aged 11 at this point.
- 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.
- In June 2016 Sibling 4's school recorded on 3 occasions that she had stated that she was very hungry at school
- Poor school attendance was noted to be an issue for Siblings 2, 3, and 4.

In July 2017 Mother was drinking alcohol with 4 males and may have been drugged and raped. All the children were present in the home. School became aware of this incident and made a referral to CSC concerned about the impact of Mother's drinking on the children who were present when the incident took place. During this period of time the children each moved into the care of family members. In August 2017 all children were made subjects of a Child Protection Plan because of neglect.

By December 2017 Sibling 1, 2 and Child D had returned to live with Mother who had, by then, started a relationship with Adult A this does not appear to have been an assessed, agreed or a planned move.

The SW made aware of Adult A's past offending history and was told that he should not be in the family home. Concerns were raised by Child D's father and the sibling's fathers/ carers about Adult A living in the home.

Core groups were cancelled due to the unavailability of the social worker this meant there was one gap of 9 weeks and one of nearly 4 months.

On 9th January 2018 the new SW carried out a home visit and noted that Adult A was present and spoke very loudly he spoke to Child D

## Overview and Analysis

**Strengths and Protective Factors**

- 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.
- Schools were consistent in raising concerns, especially about Sibling 1
- Midwives consistently raised concerns and followed pre-birth procedures

**Risk/Harm/Danger**

- Adult A was believed to be a risk to the children and mother was instructed not to allow him to have contact
- Mother prioritised her relationships and alcohol use above the safety and welfare of her children
- Timescales for core groups were not met
- Pattern of missed health appointments for all children
- Pattern of domestically abusive relationships which children were exposed to
- A range of concerns raised for children by shcools

**Grey Areas**

- Whether a formal risk assessment of Adult A was completed
- Whether it might be possible for 2 incidents of Adult A threatening children outside of the family unit could be shared as part of child protection assessments

**Complicating Factors**

- The number of children and involved fathers and grandparents mean that the case was difficult to manage, core groups and conferences were described as ‘chaotic’
- Instability in Children’s social care workforce leading to delays in allocation and gaps in oversight

**Voice of the Child**

- Child D was young and only just verbal, there was little evidence of consideration to his daily lived experience which could have been legitimately surmised from the given experiences of the older siblings
- The single and multi-agency assessments do not appear to have been sufficiently focused on Child D and his sibling’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

**Analysis**

- 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.
- Risk was not robustly reviewed due to the length of time between core groups

## Learning for Professionals and Multi-Agency Working

- The voice of the child and the daily lived experience of the child should be 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 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 use of validated parenting assessments for parents with vulnerabilities including their own adverse childhood experiences which can indicate that parenting may be compromised should be considered
- Non –compliance with plans should be explicitly addressed at child protection meetings and contingency plans are explicitly described, agreed and timescales set for intended outcomes/ interventions.
- Single and multi-agency risk assessment approaches encourage and facilitate 'big picture' analysis of risk
- 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 may be delays between Core Groups or other multi-agency alternative arrangements will be made. For example a substitute chairperson will be identified and the arrangements communicated with all agencies
- Supervision and management oversight of complex cases is standard practice.
- When TAF arrangements are closed 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.
- KSCP 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.

**For more information about National Reviews and learning visit:**
https://www.gov.uk/government/groups/serious-case-review-panel

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/

## Relevant Tools & Multi-Agency Responses for this case include:

Escalation / de-escalation procedures
West Yorkshire Multi-agency Child Protection Consortium Procedures on Child Protection Conferences and Core groups
Neglect Strategy and toolkit
Voice of the Child Strategy
CSC Practice standards

**For more information about Local Reviews and this case visit:**
https://www.kirkleessafeguardingchildren.co.uk/safeguarding-2/safeguarding-processes-and-systems/safeguarding-practice-reviews/