RBSCP

ROCHDALE BOROUGH
SAFEGUARDING CHILDREN PARTNERSHIP

Rochdale Borough Safeguarding Children Partnership
Child Safeguarding Learning Review

Child I1

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Section 1: Details of referral submitted for a Serious Incident & Rapid Review.

Below is the information submitted for a Rapid Review and the events that followed notification to the National Review Panel.

A Serious Incident rapid review was requested by the Specialist Nurse Safeguarding Children, on 12/09/22 due to the following concerns.

- Child I1 has been supported from birth by the HMR Health Visiting team under Universal Partnership Plus (UPP) services due to him being on a child protection plan (CP) for 2 and a half years. Child I1 and his care giver have been supported around improving his development, accessing health appointments and contacting health professionals when Child I1 was not brought. HMR health visitors have liaised with doctors to establish if Child I1 has a clotting disease when he attended urgent care with a swollen penis and excoriation to his bottom with a large bruise to his inner thigh. A child protection medical did not take place as it was deemed the clotting disease was an explanation for the bruise. It was established with later testing he does not have the disorder.

- Support has been given to Mother regarding her mental health, Adverse Childhood Experience's (ACE's), including being a cared for child, familial sexual abuse, Intimate partner abuse, financial and psychological abuse from her family and possible sexual exploitation from P1. Paternity for Child I1 has not been established and prior to Child I1 being born P1 was named as father which was subsequently changed to F1. Since the Child protection Plan ceased, support has continued as above to ensure Mother was supported to ensure Child I1's Health and developmental needs are met and encouraging Mother to seek support for her mental health and support for any issues which may compromise his wellbeing and keep him safe.

- Child I1 was removed from Mother's care and is currently a cared for child as P1 was arrested for child abduction and is awaiting sentencing. There were concerns reported for sexual abuse of a child. Mother, P1 and Child I1 went on holiday together and a parent reported this to Children's Social Care as P1 was not to have contact at the time.

- Child I1 was seen in August 2022 at the local Sexual Assault Referral Centre (SARC) due to having contact with P1 and redness to his bottom. At present the findings by SARC are neutral and the sexually transmitted infection results are pending.

Immediate actions taken:

- *Child I1 is now currently living with foster carers and has supervised contact with Mother*
- *Child I1 has been seen by the Sexual Assault Referral Centre*
- *Child I1 does not have any contact with P1 who is on bail for charges relating to another child.*

Following the request a serious incident notification meeting took place with representatives of the three statutory partners on 16th September 2022.

Rapid Review Discussions

The rapid review concluded;

- In view of the known traumatic history and vulnerability of Mother, was there too much optimism in terms of her ability to parent consistently well and protect I1 from all risks.

- Limited professional curiosity prior to summer 2022 regarding risk of child sexual abuse to Child I1.

- Responses to numerous and unexplained injuries was not effective/ may need to be revisited.

- Risks were not shared or communicated between agencies

- Procedures regarding sexual abuse medicals of children are not being utilised

- Ineffective communication between agencies.

- All agencies present at the meeting unanimously agreed that the criteria was met in that abuse (child sexual harm) was suspected/ significant neglect had occurred and that Child I1 will have experienced serious harm from these experiences.

- The rapid review process has allowed a thorough examination of the known facts. All attendees felt that further review of the circumstances both for Child I1 and MOTHER was necessary. Additional scrutiny was required to identify improvements to safeguard and promote the welfare of Child I1, to examine missed opportunities in this case and to enable local agencies to work together more effectively in safeguarding Child I1 and other children. Areas will be explored in the LSCPR which have not previously been a key focus for other reviews in Rochdale including responses to unexplained bruising and work with parents with learning difficulties.

- The notification was submitted to the National Panel on 5th October 2022. The National Panel responded giving the following advice; *'We discussed your rapid review on 8 November 2022. Based on the analysis and evidence provided, we thought more detail and analysis of the key practice issues was required, together with a summary of actions that have already been taken. We also thought that it will be important to clarify the specific themes and learning you expect to draw out in a Local Child Safeguarding Practice Review (LCSPR). This may need to include, for example, some specific key lines of enquiry to consider whether the practice issues highlighted are of a wider systemic nature'*

- The matter was considered again by the Safeguarding Business Manager in consultation with the Safeguarding Partnership Chair. A decision was made to carry out a Learning Review.

- An independent author was commissioned to undertake the work in April 2023. The Key Lines of Enquiry were defined to explore further the information already considered and based on the National Panel's comments.

Agreed Key Lines of enquiry

1. Provide information as to whether your agency complied with all aspects of agency policy and procedures, and in line with multi-agency guidance as set out in Working Together 2018 and local GMP Trix procedures.

2. P1 is referred to from the outset of Mother's pregnancy as a potential risk to Mother and her unborn child. The Sunrise Team stated P1 was considered 'High Risk'. Mother described him as father (later retracted), and as a friend and supporter. Were those risks effectively identified and assessed?

3. Domestic abuse was responded to in relation to F1 whom Mother states is Child I1'S father. Actions were taken through police and court processes to protect Mother and Child I1. Was domestic abuse considered as part of any risk of assessment of P1, specifically coercive control?

4. Mother was regularly referred to as 'vulnerable' and at risk of exploitation from her family and associates. Mother was also described as defensive and resistant, and later her behaviours and responses were described as 'disguised compliance'. How were these concerns responded to in terms of the potential risks from P1 and Mother's ability to protect Child I1?

5. Child I1 was presented a significant number of times to hospital with health issues and injuries. Provide information on responses to unexplained injuries including the suspected CSA and whether agreed pathways including at the SARC were followed.

6. At the point of 'step down' to CIN (child in need), the final CP conference acknowledged Child I1 was no longer at risk from neglect, however it was stated concerns remained regarding P1, as he was being investigated regarding sexual grooming of young boys, and at that point was reported to be living with Mother and her child. Provide information which sets out how those risks were assessed and risk managed in relation to Child I1.

7. Assess the communication and information sharing between and within agencies regarding involvement with Child I1 and Mother, including appropriate challenge and identification of risks.

8. Provide information on learning and actions within the agency since the Rapid Review took place regarding Child I1.

A further meeting of the panel took place on 8th June 2023. Not all the original members were able to attend. However representatives of the same senior level were in attendance. Previous agency reports were considered. Individual agencies responded verbally to the key lines of enquiries and the majority provided a written response following the meeting. A final meeting of the Panel took place on 31st October 2023 to finalise and agree the information referred to in the learning review report.

Summary of relevant information known to the agencies involved about the parents/carers, and the home circumstances of the children.

- Child I1 is a white British child, aged 4 at the time of the serious incident notification, he had just started school. Child I1 was born when Mother was 18. Child I1's father's identity is not yet confirmed. It was reported Child I1 is a happy, sensitive little boy who enjoys school. It is also stated he easily settles with new adults. He is said to be healthy although suffers from asthma which is noted to be managed. Child I1 is currently in a foster placement.

- Mother of Child I1, had been in the care of the local authority since the age of 16yrs following disclosure of sexual assault and rape against her Mother's partner. Mother was made subject to Police Protection Powers and placed into foster care in November 2015 as her own Mother did not believe the allegations. Mother remained in foster care and later moved to supported housing in April 2017. Mother had mental health issues and suffered with depression, anxiety, and was known to self-harm. Her family were considered to be unsupportive and exploitative by professionals. At that time concerns were raised through a referral via the leaving care service that Mother was in a relationship with an older male P1 aged in his mid-thirties, with concerns regarding a possible inappropriate relationship with him and as P1 was believed to be in a 'Position of Trust' in his professional employment. Mother was aged 17yrs.

- It was noted in May 2017 a Local Authority Designated Officer (LADO) investigation took place in a neighbouring Local Authority where P1's place of employment was. After a number of meetings it was later found that P1's connection with Mother did not relate to his 'position of trust' role, and therefore there was no role for the LADO. This appears to have led to professionals to make assumptions that the matter was dealt with and did not question further his motivation for his involvement with Mother.

- The local specialist team (a multi-agency child sexual exploitation team) reported to the allocated social worker that the adult male P1 was known to them and advised about the LADO investigation, and that P1 also had a 'child abduction warning notice' served on him (used by police in cases of child sexual exploitation) regarding a 16 year old female, who lived in the same supported housing as Mother. The specialist CSE team were clear in their assessment that P1 was considered high risk in terms of CSE. Mother reported she was pregnant in September 2017. Mother disclosed to the midwife she had two previous pregnancies which were terminated and that P1 was the father of her baby, which she later retracted. Mother later gave the name of another male (F1), as the father of her child. F1 was known to police for violence and aggression. A 'non molestation' order was put in place in Feb 2018 due to his abusive and threatening behaviour towards Mother.

- Initially Child I1 was made the subject of a child in need plan in Feb 2018 following completion of a pre-birth assessment.

- Child I1 was born on 16th March 2018.

- Key concerns emerged regarding Child I1 and his Mother's parenting capacity, her mental health needs and questions regarding the involvement of P1 in their lives. A few weeks later a strategy meeting concerns were discussed regarding Mother's family's involvement

including Mother taking Child I1 to stay at various family homes. However overall it was considered that she was managing quite well. P1 was considered not to be a risk as it was said he was not involved with or seeing Mother. The conclusion was that the child in need plan should continue.

- A further strategy meeting took place in May 2018. On this occasion Mother's mental health was of concern, with an incident of self-harm, leaving Child I1 with other people Mother hardly knew, out drinking, rough handling of Child I1, seeing F1 whom she had a non-molestation order in place, and three hospital visits to A&E regarding Child I1. The matter was progressed to a Section 47 investigation. P1 was present at a professionals visit in May. Mother and Child I1 were noted to have stayed overnight with P1.

- A risk assessment regarding P1 was completed by the allocated social worker, in June 2018 just prior to the initial child protection conference. This concluded that '*overall the relationship between P1 and Mother was questionable. Mother was described as vulnerable with a lack of support networks. Mother reported that P1 lends her money. It had been suggested that Mother has sex with P1 in return for money. P1 is noted as significantly older than Mother and available information suggests he had exploited Mother. Mother's emotional well-being was of concern and leading her to be more vulnerable to exploitation and grooming.*' The risk assessment concluded that P1 was known to the Specialist CSE Team and had received a child abduction warning notice relating to a 16yr old. It was recommended that P1 was not to stay overnight with Child I1 & Mother, and that Mother was to be supported to better understand exploitation. The risk assessment was completed appropriately to provide information and professional judgement.

- **The initial conference took place in June 2018.** A solicitor was in attendance at Mother's request. Alongside this P1 was also present as a supporter to her. F1 was not present, although initially invited; due to the harassment order and the fact that his name is not on Child I1 birth certificate, he was not allowed. The conference notes refer to F1 as the 'putative father'. Professionals expressed their views that P1 had minimised Mother's parenting and risks that Child I1 was exposed to. There is no reference in the conference notes to the risk assessment and recommendations completed by the lead social worker. P1 was able to remain at the confidential section of the ICPC, where police information was shared regarding him. This appears highly inappropriate given the concerns raised by professionals and the completed risk assessment. The ICPC summary minutes reflects upon whether professionals were dealing with an abusive scenario or one of a young immature Mother, making mistakes that might be expected of many young parents. Discussion regarding her adverse childhood experiences and the impact upon her mental health and ability to parent were not prevalent. Child I1 was made subject to a Child Protection plan under the category of neglect.

- **A review child protection conference took place September 2018**. At this point Mother and Child I1 remained in supported housing. Mother shared with professionals in August that she was pregnant and that F1 was the father. This appeared to be accepted as fact. It is noted she made the difficult decision to have a termination. The intensive daily support that was made available to Mother and Child I1 was something that professionals were concerned about in terms of her ability to live independently. Whilst some progress was noted in her parenting, there were significant concerns that Mother would maintain her relationship with

F1 and therefore a written agreement was put in place to ensure Child I1s safety and wellbeing. The indication from the conference meeting was that Child I1 is healthy and developing' that Mother clearly loves her son, however she struggles to put his needs before her own. Mother was about to move to live independently and concerns were raised about her ability to manage this whilst caring for Child I1. The conference unanimously agreed for Child I1 to remain subject to a child protection plan under the category of neglect. Mother's solicitor and P1 were present at the meeting. No reference is made to any risk P1 may present.

- **In January 2019 the Family Group conference took place**. P1 was invited to the meeting as Mother stated he provides her with emotional and financial support. It was noted during the FGC that the social worker and other core group members stated they were aware of P1 taking Child I1 swimming, to children's centres, on walks and shopping on a weekly basis. It was also stated P1 had keys to Mother's property. This was information of concern due to the risks of control and exploitation. It appears P1 had a lot of power over Mother at this time, and the risks were not recognised by professionals. Following this the allocated health visitor had sought supervision raising concerns regarding the friendship P1 had with Mother. Specifically relating to the previous investigation regarding P1 and his interest in vulnerable young adults.

- **The second review conference took place in February 2019**. It was noted that overall Mother had moved into independent living and was managing the care of Child I1 well. This was supported by a recent Graded Care Profile (a tool in use at the time, to measure levels of neglect). Concerns were discussed regarding Mother's relationship with F1. Mother denies there was any ongoing relationship with him. Professionals were sceptical as Mother was known not to be truthful. It was considered that the category of neglect no longer applied. However due to the concerns regarding F1, including violence and deteriorating mental health issues, the conference unanimously agreed Child I1 should remain the subject of a child protection plan, under the category of emotional abuse. The conference chair was clear that the expectation was for the next conference to end the plan either due to positive progress or to escalate concerns through legal process. An action was for a child and family assessment to be completed by the social worker regarding Child I1's Mother and P1, who was closely involved with the family and seen as a support. The focus of the conference was potential risk presented by F1. P1 was not noted to be a risk. And in contradiction to previous risk assessments and concerns, was referred to as a support to Mother and Child I1. P1 was in attendance at this conference.

- **A third review child protection conference took place in August 2019.** A fourth lead social worker was appointed. The child and Family assessment had not been completed by the previous social worker, which was to include an assessment of any risks. This third period noted a deterioration in the care of Child I1 due to poor supervision of Child I1 where he had suffered bruising through falls, including two of him falling down stairs. Concerns were raised regarding Child I1 increased mobility and a lack of supervision of Child I1. The health visitor expressed concerns regarding repeated patterns of behaviour including missing health appointments and non-attendance at family centres. It is noted this seems to correlate with times when Mother was distracted through her fractious and sometimes confrontational relationship with extended family. F1, the stated father of Child I1 had also been in contact with Mother. He was said to be in a mental health institute at the time.

Professionals were concerned Mother was still involved with F1.

- The health reports set out a number of incidents in February, April, June, July and August 2019, where Child I1 attended the local accident & emergency department due to bruising and injuries to the head caused by falls down the stairs. These are noted as appropriately reviewed by the paediatric team and deemed as accidental. However these incidents raised concerns regarding safety, supervision and neglect within the home. In February Mother attended A&E with Child I1 where she had reported that she had returned home with Child I1 and when turning to open the door his pram had fallen backwards resulting in Child I1 hitting the back of his head. No further treatment was indicated by A&E, based on the documentation received by social care. In April further concern was noted regarding an A&E visit to another neighbouring hospital. Child I1 was brought to hospital by ambulance due to severe nappy rash still in a very full wet nappy. On examination was found to have a swollen penis with erythema and excoriated broken skin to the perineum. A bruise was also noted to the inner aspect of his right thigh. Mother admitted she had been to the GP 3 weeks previously about the nappy rash and had been prescribed cream but had not used it. There is no information provided as to Child I1's emotional state or whether he was in pain.

- The health visitor liaised with the duty social worker and was informed Child I1 had a CP medical for suspected non accidental injury and was deemed accidental. The health visitor questioned if sexual abuse had been considered due to another hospital attendance in March 2019 where Mother reported blood in Child I1's stool. At that time a diagnosis of cow's milk protein allergy was made. The duty social worker advised she would escalate to the line manager. The HV also liaised with the consultant paediatrician. It was deemed the bruise was related to Von Willebrand disease, VWD (a blood clotting disorder). It is noted in the key lines of enquiry health response, that the pathway for suspected child sexual abuse was not followed and no referral made to the police. A referral had been made to the haematology team for further investigation. None of the above lead to liaison with the police for consideration of a strategy meeting and potential section 47 process.

- L1 had a further attendance to A&E in **June 2019** via ambulance with Mother, who reported she fell down the stairs after feeling faint and was carrying l1 at the time. No injuries were noted. L1 was observed on the ward for 4 hours then discharged home. Again in July Child I1 was taken to A&E by ambulance with bruising to his head which Mother said was the result of a fall on the living room floor at home. Child I1 was checked over and discharged home. Concerns were raise by the professionals at A&E in relation to neglect and these concerns were referred to CSC in August. It is noted a strategy meeting was held at hospital over the weekend, due to another fall downstairs with Child I1 brought in by ambulance. Medical examination stated an accidental fall. Child I1was discharged. There is no record of any strategy discussion on the CSC case file. A discharge planning meeting was held instead.

- The social worker made a request for an assessment of Mother through Adult Services to consider whether she had a learning needs and advised this would have to be pursued through the GP. Concerns were also voiced at the child protection conference regarding P1's involvement and Mother becoming too dependent. P1 was known to still be involved. It is noted in case records Mother owed P1 £500. Issues of P1 having control were noted including P1 holding Mothers passport. Conference agreed P1, who was not present, was not to attend any conferences or core groups going forward. Mother was to receive

appropriate support regarding controlling relationships. The conference unanimously agreed Child I1 should remain subject to a CP plan under the category of Neglect, moving away from the category of emotional abuse.

- **In September 2019** the GP referred l1 to the observation and assessment unit at the hospital. Mother had brought Child I1 to the GP. This related to concerns of bruising to the inner area of the left buttock, left Hip and left shin. This did not elicit a child protection medical and was deemed accidental due to VWB. The HV notes in October 2019, Child I1 was seen with nappy rash and a bruise to his cheek. This was also noted during a child protection visit on the 1st November by the social worker. Mother stated this was due to Child I1 falling against the TV. No specific action was taken. Mother continued to state Child I1 had VWD.

- **In November 2019 the fourth review child protection conference took place.** It was acknowledged that a child protection plan had been in place for 17 months and that involved professionals continued to be concerned for Child I1 welfare. Attendance to health appointments remain problematic. Alongside Child I1 receiving further minor injuries considered to be the result of poor parental supervision. Mother was noted to regularly avoid engagement and questioned its value. It was noted that on many occasions Mother had either *'inadvertently misled professionals, and at worst blatantly lied regarding a number of issues*'. The case was about to be present the legal Gateway Panel, due to the ongoing concerns. The conference were unanimous that the threshold criteria had been met under the category of neglect.

Section 2: Facts from the review period of January 2020 to the point of Child I1 being placed into foster care under an interim care order.

- Further testing in January 2020 concluded that Child I1 blood tests were within the normal range and did not suggest Von Willebrand Disease (VWD). At this point an urgent review should have taken place in the context of reviewing all previous incidents of bruising, including whether any immediate action should be taken, and should have been considered as part of the PLO process.

- **On 20th January 2020** a joint unannounced visit took place by the social worker and health visitor, directly after the core group meeting as Mother had sent a message stating she was unwell and could not attend. The HV recorded that P1 was supervising Child I1 downstairs whilst Mother was upstairs decorating. The HV noted Mother's reason for none attendance were false. It is noted P1 and Mother had made complaints about the social worker. P1 stated he disagreed with the PLO process and that social workers deliberately target families. P1 was also described as disrespectful and rude to professionals. P1 was known to regularly stay overnight and was stated by Mother to be able to settle Child I1 better and manage his behaviour. This was a key point of risk to Child I1.

- The social work record noted Mother's aggressive and defensive behaviour, along with P1's critical and confrontational behaviour towards both professionals. This was said to be in front of Child I1 although Child I1's demeanour was not noted. P1 goaded the social worker to ask him what was on her mind. The social worker questioned what his motivation was to continue to have contact with Mother and Child I1, and asked whether he was the father of Child I1. P1 denied this but did not state why he remained involved with Mother.

- **On 21st February 2020** Mother made a call to the supporting families' key worker (SFKW) concerned that Child I1 had been taking his nappy off at night and soiling in the bed. Advice was given. This issue does not appear to have been discussed in any formal setting either from a medical perspective or from the perspective of a possible indicator of sexual abuse.

- **On the 2nd March 2020** P1 arrived at Mother's home whilst the SFKW was completing a visit. It was reported he had not visited for some time and had been on holiday in Iraq. The SFKW noted in her write up that Iraq was an unusual place to go on holiday. Child I1's demeanour was not noted.

- **On the 18th March 2020** the allocated social worker received information from the police about P1. He had been arrested on suspicion of sexual assault on a number of boys aged between 12 and 15 years. Bail conditions were in place and specifically included '*Not to have any unsupervised contact with any child under the age of 18 without their parents being present and only after being risk assessed and approved by children services.*' This was an opportunity to set out clearly that no contact with P1 should take place due to the risks posed by P1 and with Mother's continued denial of that risk.

- **20th March 2020 Covid Lockdown commenced**.

- **On the 20th March 2020** a written agreement was put in place which stated P1 was not to have any unsupervised contact with Child I1 at any time. It also confirms legal advice would be sought should this happen. It is noted Mother signed the agreement and that P1 was present during the home visit. However it is also noted that Mother informed the social

worker that P1 would be self-isolating with them. At this point there is a clear lack of recognition of the risks that P1 presented. There is no detail as to how this would be managed or observations of I1 made, given the Covid lockdown commenced on the same day. The fact that P1 was present at the time Mother signed the agreement is of significant concern, and should have led to action being taken to protect Child I1.

- **On the 26th March 2020 the 5th Review conference was held under emergency measures due to the Covid lockdown**. (via online meeting) The conference concluded that Child I1 remained at risk of significant harm through neglect due to Mother not meeting his needs consistently in terms of health and developmental needs. A graded care profile had been updated which indicated little progress had been made. A significant amount of professional support was in place including, a personal advisor and family support worker supporting Mother, along with a health visitor, social worker a weekly crèche placement and a children's centre worker to Child I1. At times progress was noted to be made, however this was inconsistent.

- An example of this was given when Child I1 had breathing difficulties due to asthma and Mother called an ambulance. She had also used her own inhaler on Child I1. Mother then left the hospital before I1 was seen and assessed, which caused concern for his welfare. Mother remained resistant and presented an unwillingness to be honest with professionals. It was reported Mother would often lie about situations, events and her decision making. Child I1's lived experience was therefore not fully understood. Mother's resistance was thought to be worsened with unhelpful advice given by friends of Mother's, P1 and a female friend, who lived in a neighbouring local authority. Reference is made to a police investigation regarding P1 and the written agreement, although no detail is recorded. It is noted that Mother's continued resistant responses led professionals to be concerned regarding her ability and willingness to make safe decisions regarding Child I1. Mother stated that she and Child I1 do need support but that he does not need protection from her parenting or from her friends. Consequently, Mother was frustrated there was to be a continuation of the Child Protection Plan. No specific actions were taken to respond to Mother's resistance and denial of risk to her son.

- **In July 2020** Mother reported that F1, the stated father of Child I1 had attempted to make contact with her. The police were informed and attempted to take the matter further, however Mother said she would not pursue this with police. Mother changed her telephone number and told the social worker that her phone contract was in P1's name, and that she had to contact her friend to ask to arrange to change the telephone number. This is a point of concern and considered in the context of Mother stating she owed P1 £500 and he had her passport. This was not picked up as a matter of significant concern.

- **On 6th August 2020** it was reported Mother and Child I1 were seen out together with P1 in the local area. This was put to Mother who denied this saying it was her step-father, and later saying she may have bumped into P1. It is noted Mother struggles to be truthful. The social worker met with Mother's step-father to confirm this. His recollection of walking with Mother and Child I1 was reported to be vague. It is recorded that he looked nothing like P1.

- **On 17th August 2020** a decision was made to step-down the case from PLO, via the legal Gateway panel. There is no information as to how this decision was reached, or whether the

concerns regarding P1 were part of the PLO plan.

- Shortly after this a call was made to children's social care stating that shouting and swearing could be heard coming from the home of Mother. The caller was concerned that the child (I1) was being hit. The caller was a neighbour who wanted to remain anonymous. During a joint visit Mother denied this had happened. She was said to have become angry and upset. The professionals involved noted their concerns that Mother was struggling with bedtimes with Child I1 and would not admit to this despite stating this previously. The focus is very much on Mother and not Child I1 and his welfare.

- The Child & family assessment was updated on **21st August 2020** setting out a clear history of Mother and of the concerns regarding her ability and willingness to parent Child I1 safely and well. Expectations for Mother to attend all appointments and adhere to the PLO agreement were set out and it was clear the Covid lock down had limited any appointments and meetings. It was reported there had been a significant reduction in instances of bruising and injuries due to a lack of parental supervision. Mother stated she had worked very hard since February to have l1 stepped down from PLO and a Child Protection plan and felt she has done enough for this to happen. However Mother reported that although shocked to learn of the accusations made against P1, she did not believe what had been alleged and ' *knows* ' he would never do anything to hurt her or Child I1. This highlights Mother's naivety and lack of capacity to recognise risk. The assessment states there is a lot of evidence of disguised compliance from Mother with her not being honest and open with professionals. Mother is stated to have accepted the concerns stating this was because when she was growing up she would get beaten for telling the truth. The assessment refers to the allegations of sexual abuse by P1 of a number of boys over a long period of time and the potential risk posed to Child I1 however also note P1 vehemently denied the allegations.

- Mother reported she had not had contact with P1, however it was reported they were seen together only two weeks previously. Mother denied this. Child I1 was reported to be behind in communication and language. He is also described a 'happy and giggly child'. The assessment states progress has been made through the GCP assessment, however a 'stand out' area was 'safety' 'that Mother does not always appear to recognise the risks or dangers that Child I1 could be exposed to'. The conclusions was to step down from the PLO process and recommended 'to ensure the Local Authority is not being oppressive', that step down to child in need should take place at the next child protection conference. The risk posed by P1 appears to be minimised and Mother's denial of contact accepted. The focus is very much on Mother and not on the need to ensure Child I1 safety with regard to P1; nor his relationship with Mother in terms of it seeming to be controlling.

- **In early September 2020** the Graded Care Profile was updated and that there were clear improvements. During a conversation with Mother she was again noted as 'not accepting P1 could be a risk to Child I1. There was no evidence of reflection and consideration of risks to Child I1 by Mother or the professionals involved.

- **The 6th review conference was held the 23rd September 2020.** This concluded that Child I1 had been subject to a child protection plan for a lengthy period, under the category of neglect. That the matter had been escalated to the Public law Outline. This had now been stepped down as the criteria was no longer met. The GCP had shown improvements in

Mother's practical parenting skills and clearly showed Child I1 was no longer suffering neglect. He was described as a happy and '*well attached little boy who receives much love and warmth from his Mother*'. Reference was made to P1 and concerns remained about contact between Mother and P1. The conference notes refer to Mother's unwillingness or inability to be honest with professionals, stating Mother would often lie regarding situations and events.

- P1 is described as a friend and supporter to Mother, although acknowledging the continuing police investigation regarding matters relating sexual abuse allegations over a long period of time regarding young boys. The bail conditions are referred to. The incident of P1 being seen with Mother and Child I1 was referred to, which had been denied by Mother. It is noted professionals remain sceptical of Mother's honesty regarding this. However it is also stated professionals could not prove one way or the other what the truth was. The case was stepped down to child in need having made it very clear to Mother that she was responsible for safeguarding Child I1 although issues of concern remained regarding P1. Based on the information discussed and shared about P1's involvement and Mother's frequent dishonesty, serious risk remained for Child I1, however no further action was taken by professionals.

- **On the 29th September 2020.** Concerns were raised that P1 had been having contact with Mother. There had been an anonymous referral that P1 was staying at Mother's home. A home visit was carried out. Mother denied P1 was there or had been there. The social worker believed P1 had been in the house. Efforts to confirm or refute this were said to remain difficult.

- **Child in need meeting held on 12th October 2020.** Mother stated she was not having contact with P1. It is noted that Mother is isolated with little contact or support from her family. Mother was observed to be of low mood. 1-1 work on the Freedom programme was continuing with the family support worker. Nursery were supporting Child I1 in his development with regard to stimulation and socialisation. The Health visitor was to reassess Child I1 in terms of his developmental milestones in the coming months. No specific concerns were raised regarding Child I1.

- **On 13th November 2020** Mother was not at home for her session with the family support worker (SKFW), stating she had forgotten. She went on to say she was having problems with l1 and his behaviour. She had put a reward system in place in order to manage this. Mother also reported she had fallen out with her sister, who had said she would report her to social services. When questioned on this Mother said she did not know what her sister would report. Mother also reported she had stopped receiving money from P1. The support worker challenged this and said she did not believe her. The support worker comments in her case note about P1 continuing to pay money so that he can have a hold over Mother. It is not clear if this was discussed with the social worker.

- **On the afternoon of 13th November 2020** Mother reported to the family support worker a bite mark on Child I1's lower leg. She stated it happened at the nursery. This information was emailed to the social worker. At this point no concerns had been raised. The SKFW discussed the case with her supervisor. In the supervision note she referred to risk around P1 due to another boy coming forward to the police regarding concerns of inappropriate

sexual touching, that it is reported P1 is staying at Mother's and that P1 is paying a regular amount of money into Mother's account each month. The note concludes that Child I1 may be at continuing risk from P1 as 'Mother is not safeguarding him'. The same day an unannounced visit took place. Mother confirmed she believed the injury occurred at nursery. P1 was not seen at the property. The social worker contacted the Nursery. Staff reported they looked at CCTV of the day and observed there were no incidents of Child I1 hurting himself, that he had been wearing wellington boots all day and the bruise was placed lower than the top of the boot. Mother also contacted her GP.

- **On the 16th November 2020** Child I1 was seen at Nursery by the social worker. Mother had taken a photograph of the bruise. Child I1 was described as 'unusually very quiet' and would not engage with the social worker. The social worker is noted to have said '*although the bruising was concerning took the view that Child I1 seemed unconcerned about it*'. The social worker did not feel a '*Child Protection medical was required as had already established that injury was unexplained and nothing to suggest injury was non-accidental*', but would discuss with her manager. It is noted the manager agreed with the social worker's view. The social worker informed Mother that the injury is being recorded as 'unexplained' but that the matter was not being taken any further. Mother reported she had booked an appointment with the GP to look at the injury. The Social Worker questioned the reason Mother had done this and she said *'because I am so worried about it'.* The Social worker advised that no medical intervention appeared to be required that Mother should think about if the appointment was necessary. It is unclear why the social worker advised this.

- On the same day the Nurse practitioner contacted the social worker informing that Mother had been in touch and sent a photograph to her of the injury. The nurse practitioner stated she was concerned it did look like a bite mark and felt a child protection medical should place. The social worker did not agree and stated that the purpose of the CP medical is 'not to cover backs, but is requested when there are concerns that a non-accidental injury has been caused'. The Social Worker advised she had established the injury was unexplained, but there was no evidence to indicate it was non-accidental and therefore did not feel a Child Protection medical was appropriate. She did however consult with her manager again who confirmed not to pursue a medical examination. Neither the social worker nor the manager had the skills and training to decide if an injury was non accidental or not in these circumstances.

- The social worker explained what a Child Protection medical was to Mother, who stated Child I1 had a sore bottom at the moment but she was using cream. Child I1 was noted to be wearing a nappy. The social worker checked the injury again with nursery staff and Mother present. It was agreed it appeared to be a bruise and that the skin had not been punctured and 'there was nothing to prove it was a bite mark'. Mother was insisting it did not happen whilst I1 was in her care. The social worker questioned Mother about having sight of Child I1 the whole time. She advised Mother should ensure she appropriately supervises Child I1. No further action was taken. Despite the fact the social worker stated the bruising was unexplained there was an assumption that it was due to poor supervision. It is of significant concern that the bruising which was described 'like a bite mark' by Mother and the nurse practitioner, was not properly assessed through child protection procedures. Had this happened Child I1 would have had a full medical examination including checking his 'sore bottom'. Consideration was not given to the bruise potentially been caused by P1. There was

ongoing concern P1 was staying with Mother giving him access to Child I1. This was a missed opportunity to undertake appropriate child protection processes in order to protect Child I1.

- **A child in need meeting was held on 1st February 2021.** It was stated that no further concerns were raised with regard to Mother's care of Child I1. There was a unanimous decision to close the case. Previous concerns were not considered or reflected upon according to the case records.

- **In February 2021** a referral was received regarding F1 the stated father of Child I1. F1 was reported to have arrived at Mother's door telling Mother he had a contact order in place to see Child I1. A previous non molestation order had been in place. F1 had not been involved with Mother for approximately 2 years. Mother reported this to the police but chose not to make a formal complaint. The Police position was that this was a high risk situation. The case was discussed at their High Risk Domestic Abuse meeting.

- It was acknowledged F1 is not named on the birth certificate and does not have parental responsibility. F1 was noted as a high risk domestic violence offender and Mother as a high risk domestic violence victim and was not willing to engage with a non-molestation order. Concerns remained that Mother was very vulnerable, unwilling to engage with services and may not be prioritising the needs of Child I1. The outcome was for the case to be referred to children's services.

- Social care liaised with Mother who was adamant she did not want Children Social Care involvement. However it was noted by the social worker that Mother had acted appropriately. A joint visit by police and CSC was made to further advise Mother about ensuring contact did not take place with P1. Mother was reported to be very angry about this and told the social worker and police officer to leave. No further action was taken. At this point Child I1 had been completely lost sight of, in terms of professional concerns and involvement.

- **On 25th May 2021** a referral was received from a neighbouring authority raising concerns about Mother being in a relationship with P1, and that a child from the neighbouring authority had made an allegation stating P1 had on a number of occasions tried to kiss him and on one occasion had pulled his pants down. The child, who was the son of a friend of Mother's, had said he wanted P1 to stop and that his mum had told P1 to stop more than once. At this point the case had been closed regarding Child I1 in February 2021.
- A strategy meeting was convened and the long standing concerns of risk relating to grooming and sexual abuse were shared regarding P1 and his involvement with Mother and specifically Child I1. No current concerns were raised regarding Child I1. The meeting concluded no further action was required as at this stage there is no known information suggesting that Child I1 has any unsupervised contact with P1. A joint visit took place between social care and the police. Mother said she knew that her friend had referred her to CSC. Mother explained away the concerns raised by saying she had been at her friend's house who was having a BBQ and had not known P1 was going to be there. Mother said she and Child I1 remained at the BBQ as she had paid for a lot of the food etc. Mother stated that the friend's son had lied about P1.

- Mother reported that the last contact she had with P1 was in June 2020. Mother admitted to contacting P1 when Child I1 was closed to CSC earlier this year. She said they were 'good friends' and she wanted to celebrate with him. Mother said she and Child I1 went to a seaside town in the south of England the previous week, and also to Wales. Mother assured that only she and I1 were present, but when asked for the details of where they stayed Mother said she couldn't remember. Mother became defensive and was shouting. Mother then screamed at the Social Worker and Police to get out of her house. There is little information regarding Child I1 at this point, including his response to his Mother's outburst. Given the seriousness of the allegation concerning P1 and what was known regarding Mother and her dishonesty, that Mother stated the other child was a liar, a child & family assessment should have taken place as a minimum response. P1 was known to be a 'high risk' and that there were ongoing police investigations. No further action was taken.

- **In December 2021 Mother's** leaving care personal Advisor, made a referral that Mother had left I1 in the care of his maternal grandmother overnight. Concerns were in relation to maternal grandmother's substance misuse and domestic abuse. The matter was progressed and a child & family assessment was completed. This concluded that Mother would continue to supervise any contact with maternal grandmother. **The case was then closed on 15th March 2022**.

- **On the 16th June 2022** a referral was received from Child I1 Nursery. Another parent at the nursery raised concerns regarding P1, whom she had read about in the local paper. The parent had seen P1 with Mother and Child I1 on a recent flight she had been on. They had been on a holiday. A Strategy meeting was held and the decision made for a section 47 investigation to commence. Legal advice was to be sought. Concerns were in relation to Mother and Child I1's vulnerability in terms of being groomed by P1. The matter was to be discussed with the Head of Service.

- **An unannounced home visit took place on 23rd June 2022**. Mother initially denied she had any contact with P1, stating it was over a year ago. However when presented with the evidence Mother agreed she had been on holiday with P1 as it was booked a long time ago. Mother stated they did not share a room and did not see each other. Following the unannounced visit a strategy meeting was held on 24th June. Discussions with senior managers and solicitors took place.

- **On the 27th June 2022** direct work took place with Child I1 at Nursery. Child I1 spoke about 'Daddy P1' living at home, going to stay at P1's, describing where he lived and going on holiday with P1 and his Mother. On the 30th June 2020 a follow up strategy meeting was held where professionals shared their considerable concerns. The Section 47 investigation was to continue.

- **On the 8th July 2022** an Interim Care order was granted in relation to Child I1 on the basis of being at ongoing risk of sexual abuse and grooming by P1 and the risk not being managed whilst I1 remained in the care of his Mother. L1 was placed into foster care on the same day.

- **On the 26th July 2022** concerns were raised within the court that Mother had been in touch with P1 and had shared the social workers report. A request was made for Mother's phone to be analysed.

- **On the 4th August 2022** the first Child Looked after review took place.

- **On the 5th August 2022** a SARC medical took place. This concluded Child I1 had perianal erythema which is a nonspecific finding relating to possible irritation from contact with faeces or inflammation from infection. A swab was taken. There is no evidence of any sexually transmitted disease noted.

Section 3: The key lines of enquiry

Understand if partners had complied with their policy and procedures and in line with multi-agency guidance as set out in Working Together 2018

- Each agency was asked to respond to each key line of enquiry. All agencies other than Children Social Care responded regarding policy and procedure adherence. However CSC were clear in responses to other questions that there were gaps and in adherence. Overall there is reasonable evidence of partnership work within the child in need and core group meetings. Open discussions took place regarding Mother and her care of I1 and concerns

regarding P1 and his involvement with Mother and Child I1. Child I1 was known to professionals from birth through to 4yrs, and appeared to be central to the plans regarding his safety and welfare, however his daily lived experience is not reflected in the available information. One key issue is the presence of P1 at the initial and following two review conferences and included some of the core group meetings. This is highly likely to have impacted upon the professional's ability to be curious, to challenge and to critically evaluate information.

- Community Health partners (health visitors and midwifery) note that procedures and guidance were followed. However as the case became more complex and challenging it is reported there were failures in escalating concerns through appropriate processes, for example escalation of concerns where professional views differed, which could have led to different outcomes for Child I1. These are referred to in the body of the report.

- Police information indicates all aspects of policy and procedure were adhered to. It is noted that on the occasions of hospital admissions regarding bruising, including those without explanation, the significant severe nappy rash and the incident of what appeared to be bruising potentially caused by a bite mark, these were not reported to police as potential child protection matters.

- Early Help services along with health services relating to mental health and Hospitals also reported adherence to policy and procedures.

- Having reviewed all available information it is clear there are four key episodes where procedures were not adhered to. The first related to Child I1 attendance to hospital with severe nappy rash and unexplained bruising in April 2019. The communication between health partners at the hospital, Children's social care and the health visiting service was disjointed. This appears to be due to the diagnosis of Von Willebrand Disease, which led to an assumption the bruising was accidental, and there were no multi agency discussions to consider this. There is no description of Child I1's presentation at the hospital although it could be assumed he was very distressed and in pain. The Health Visitor involved at that point raised her concern about the possibility of sexual abuse both with the duty social worker and through the paediatrician's office. Neither resulted in any serious consideration of possible sexual abuse.

- Continuing on from the previous incident the second period of concern occurred with Child I1 attending hospital on three separate occasions with bruising to his head reported to have been caused by falls down the stairs in June, July and August 2019. The reported fall down stairs in August (which took place over a weekend) resulted in the Consultant Paediatrician requesting a strategy meeting and a Sec 47 medical was stated to have been completed. However, through what appeared to be poor communication there was no strategy meeting and instead a discharge planning meeting took place on the Monday. The concerns were focused on Mother's ability to supervise I1 and avoid injuries. The consultant was clearly concerned for the welfare of I1 although ultimately concluded I1 could be discharged. It remains unclear if this was the reason for not holding a strategy meeting. Police records

show no information that a strategy meeting was held or that there was a request for their attendance. Following this in September 2019 I1 was referred directly to hospital due to bruising to his inner buttock, upper and lower leg. The outcome was VWD was presumed to be the reason for the bruising.

- A third episode of concern related to what Mother reported to be a bite mark to Child I1's calf in November 2020. Mother stated 'it must have happened at nursery'. CCTV at the nursery showed I1 was wearing wellington boots all day and that he did not remove them and the bruise was below the top of the boot. Mother wanted I1 to be seen by the GP although the social worker tried to dissuade her from this. The GP Practice Nurse stated the injury required a CP medical. A photograph was taken by Mother who shared this with the Practice Nurse. The photograph which is on CSC's case file does appear to show what looks like a bite mark. The social worker spoke with Child I1 who gave no response when asked about the bruise. The social worker and her manager concluded there was no need for a child protection medical as there was no evidence of a non-accidental injury. There was no discussion with police and given the history of I1 with unexplained bruising this could have been a sign of abuse. It is unclear why the practice nurse's concerns were dismissed, why the social worker tried to dissuade Mother not to attend the GP surgery, or why the decision was made about not to pursue a child protection process.

- The fourth incident was where a child from another local authority had disclosed potential sexual assault by P1 and was known to Mother in May 2021. At this point the case regarding Child I1 had been closed in February 2021. The notes of the strategy meeting are limited and there is no attendance of a representative from the neighbouring Local Authority. It is stated that there was no known information regarding P1 having contact with Child I1. The notes do not refer to the information provided by the neighbouring Local Authority regarding Mother, which stated P1 was in a relationship with Mother. The completion of a section 47 investigation regarding Child I1 was declined due to insufficient information. It was stated there was no evidence that P1 had been having contact with Mother and Child I1. The decision was agreed by all agencies attending. However from the information provided by the local authority EHASH and Quality Assurance in the Rapid Review process, it is indicated over the previous year there had been three incidents in April, August and September 2020, where concerns were raised that P1 was having contact and that when investigated Mother denied it. On each occasion professional were doubtful of Mother's honesty. Alongside this the information relating to the other child, indicated Mother was undermining the evidence of P1's grooming behaviour. This was a missed opportunity to collaborate with the neighbouring Local Authority in an effort to establish the level of contact P1 was having with Mother and Child I1 and therefore the level of risk posed. The referral regarding the child from another local authority with allegations against P1 was made over three months after case closure, and yet the written agreement that Mother signed in March 2020 was said to be still in place. There is a need to question how this was going to protect Child I1. Child I1 therefore remained at risk of sexual abuse from P1.

- The case regarding Child I1 had been closed in Feb 2021 on the basis that P1 was no longer on police bail with conditions, although P1 remained under investigation. It was stated in the case record this did not mean the police were any less confident in a conviction, rather that CPS required further information. It was stated that extending the bail conditions was not possible as these were time limited. Information on the case file state P1 and Mother told

the family in the neighbouring LA that the case against P1 had been dropped, which was clearly not the case.

- The rapid review panel reported spending some considerable time discussing the situation relating to I1 and considered that based on the shared information, the work undertaken was adult focused. That Mother had such needs herself that this took up much of the discussion. However the panel were equally aware that due to Mother's considerable childhood trauma and the impact of this upon her, that this was a key contributor to Child I1's neglect and exposure to possible sexual abuse. There are clear instances where appropriate child protection actions and processes were not followed and it was considered that Child I1's welfare and safety was not sufficiently focused on. Overall the panel concluded that information sharing and communication was ineffective.

Understand how P1, who was considered to be 'high risk' was assessed and managed in this complex situation, including the issue of coercive control.

- The specialist child exploitation team considered from the outset that P1 was a highly risky adult to children and young people. This related to concerns that he had formed a relationship with Mother inappropriately and that he used his position as a professional to strengthen his importance and status with Mother. He had also been issued with a child abduction warning notice (CAWN) regarding an incident at the supported lodgings relating to another young person known to Mother, who was also considered to be vulnerable. P1 is stated to have used a false name to gain access to the accommodation. For this reason he was banned from the building. The incident referred to above, was reported to police. The details from the supported accommodation have not been accessible in this process due to a change in the provider.

- A risk assessment was completed in June 2018 by the allocated social worker on the basis of this prior to the commencement of the initial child protection case conference. This clearly indicated P1 was considered to be a risk to both Mother and potentially Child I1. The child protection conference minutes do not indicate this was discussed or what the recommendation was. Reference to the LADO investigation in a neighbouring local authority stated that concerns related to P1's 'friendship' with Mother and that 'no further action was felt to be required following this'. No specific detail was noted. P1 was able to be present at the ICPC without challenge and was able to take part and even be included as a member of the core group. Factually the LADO investigation commenced due to concerns about P1 in his professional role forming a relationship with Mother who was considered very vulnerable.

- It later transpired that P1 had met Mother through different means, which led the LADO to discontinue the investigation as P1 had not formed a relationship with Mother through his work setting i.e. in a position of trust. This information was shared with the specialist sexual exploitation team, and graded P1 as high risk. It is clear from this and the risk assessment that regardless of the context of making connection with Mother, he still utilised his professional status as leverage to gain trust and exploit Mother and manipulate professionals into believing he was trustworthy and a supporter. It is noted in the initial

child protection conference minutes that 'professionals expressed views that P1 minimised concerns regarding Mother's parenting and the risks presented to Child I1. This did not appear to have an impact upon the decision to support P1's continued involvement. The key questions is how P1 came to be seen as a supporter to Mother and how his attendance at the first conference was not challenged.

To also understand how he was able to be in attendance at the initial child protection conference and the following two review conferences without question or challenge.

- P1 was known to the police to be a high risk regarding sexual exploitation based on the above concerns. P1 attended the first child protection conference and then the first and second review conferences. It is also know he attended core group meetings. Mother brought a solicitor to the first and second conferences. It is however unclear how P1 was able to attend the conferences. There is no evidence to indicate there was any challenge to P1's attendance either from the chair or any of the professional's in attendance. The risks posed by P1 were know and had been stated regarding sexual exploitation, with a risk assessment having been completed, which concluded that P1 should not stay overnight with Mother and Child I1; that Mother was vulnerable to exploitation and grooming; with a lack of support networks; and that potentially Mother had sex with P1 in return for money. The risk assessment is not referred to during the initial conference, nor again in any of the following review conferences. However it is noted P1 was a support to Mother. The LADO involvement was referred to, stating that this was in relation to P1's friendship with Mother and other vulnerable young people. It was also stated no further action was felt to be required. The fact is that the LADO from the neighbouring LA held the matter for a number of months due to the level of concern.

- The LADO matter was only closed when it was concluded that the issues being investigated were not related to P1's role in a 'position of trust'. Also at this time the initial CP conference held a 'confidential slot' during the meeting, where police shared confidential and sensitive information. P1 was allowed to remain whilst Mother had to leave the meeting. The police information states that P1 was present for information shared regarding himself and Mother. It is of significant concern that P1 was able to remain and then to comment upon his own information i.e. reference was made to P1 being at Mother's supported housing accommodation with another young person and that P1 had signed in under a false name. P1 stated it was done as a 'test of the system'. It is known through the LADO that P1 received a written warning from his employers for this. The conference notes do not refer to the CAWN (child abduction warning notice) issued to P1 following this incident.

- There is no written account of the Chair's view regarding P1's attendance, nor the Chair's views with regard to potential risks to Mother and Child I1. P1 was also named as a member of the Core Group. Professionals were noted to have expressed concern that P1 minimised concerns. It is clear Mother had no support networks and that P1 is likely to have been seen by Mother as someone she could rely upon. Understanding why professionals did not challenged P1's attendance and involvement is important. The social worker had completed a risk assessment which it appears was not referred to. At this point P1 was provided with the opportunity to be able to influence not only Mother but also the professionals involved in the protection of Child

I1. [1] It is clear that P1 was a predatory male, who placed himself in a position of power in his professional role, who targeted young and vulnerable females and males with the aim of sexually abusing them and to coerce them into believing he was trustworthy.

- P1 regularly provided money to Mother, giving him access to her and Child I1. The biggest external barrier in terms of access to a child was to convince the professionals around the family that he was safe and supportive. He used all means to achieve this i.e. using his status as a professional to attend the initial child protection conference; the presence of a solicitor may have supported his attendance in that he was considered a supporter by Mother and there was no challenge from the solicitor; P1 already had Mother convinced he was the only person who cared for her and helped her; the indications are that professionals felt uncomfortable with his involvement but did not challenge him or his presence.

- Domestic Abuse was responded to in relation to F1, stated to be the father of Child I1. Actions were taken through police and court processes due to the risk he posed and to protect Mother and Child I1. Was domestic abuse considered as part of any risk assessment of P1, specifically coercive control?

- Mother had provided professionals with details of F1 as the named father of Child I1. No professional was able to put this assertion to F1. Although there is some evidence that he had a relationship early on with Mother. Responses to F1 making contact with Mother were met robustly by professionals due to the known risks he posed regarding violence. However very little is known of F1 according to the information available. The previous question identified that P1 was a predatory male, considered to be high risk. Despite this and contrary to the response to F1, P1 was able to overcome barriers to form a 'supportive' relationship with Mother. In other words P1 was able to overcome a significant external barrier (child protection conference) that was in fact in place to protect Child I1. In terms of Child I1 he was a very young and vulnerable child who could be targeted for sexual abuse, as his Mother was unable to protect him. Mother had such trust in P1 due to his influence over her that she only listened to his perspective.

- This is a very clear sign of coercive control, and this had not been considered through any assessments that were completed through the child protection process. P1 was able to achieve this again when he was arrested by police for sexual abuse of young boys. P1 was not only able to convince Mother he was innocent but persuaded Mother to lie in order to cover for him. He was present when the social worker presented the written agreement for Mother to sign and was living with her through the Covid period without challenge. He used his skills to show he was a great carer for Child I1 in fact stated to be better at settling Child I1 at night than Mother. [2] [3]

[1] David Finkelhor, Sociologist (1984) who carried out research on child sexual abuse, defined four preconditions that need to be in place in order for abuse to take place. He asserted *that 'it required an 1 1 offender who has a predisposition to sexually abuse a child; that they had the ability to overcome any internal inhibitions against acting on the predisposition; the ability to overcome any external barriers such as lack of access to the child; and the ability to overcome any resistance or reluctance by the child'.*

[2] According to the NSPCC and Ann Craft Trust (Skills Platform Blog) *"grooming is a form of abuse that involves manipulating someone until they're isolated, dependent, and more vulnerable to exploitation".*

[3] Women's Aid describe Coercive Control as; 'This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.

Mother was isolated from her family and did not have a support network. She also suffered sexual abuse and neglect and has been described through this process as having 'adverse childhood experiences' leading to trauma, which in turn had a significant impact on her mental health and ability to protect herself and later her son. It is absolutely clear P1 had successfully isolated Mother, making her dependent on him and making her more vulnerable to exploitation. With the potential ultimate outcome being access to Child I1.

- It was also important to understand how well Mother's vulnerabilities were understood in relation to P1 and critically how it was understood Child I1 was being protected. Disguised compliance was noted as an issue and it is important to consider how this was assessed and responded to.

- Mother was stated to have had lengthy involvement with mental health services. Whilst her mental health is referred to, discussions as to how best support and enable her to make the changes needed to safely care for her son Child I1 the type of support and treatment she needed following a neglectful and abusive childhood including sexual abuse and rape, was not clearly set out in order to understand how best to try and engage Mother, and to understand the impact of the type of trauma she had suffered. Mother had spoken to the SKFW (family support worker) about her childhood and the abuse she suffered. This is something that should have been explicitly understood and considered. Adverse Childhood Experiences can and do impact upon levels of vulnerability to exploitation, parenting capacity in terms of mental wellbeing and attachment. [4] Manchester University NHS Trust. Professional's understanding of ACE's is an important factor in assessing parents and supporting them in all aspects of support and specifically in this case where a child is at risk of or is suffering significant harm. The Initial child protection conference minutes note that the '*conference considered whether professionals are actually dealing with an abusive scenario or one where a young immature Mother is making mistakes that would be expected of most parents her age'.*

- However it is also noted Mother had a longstanding history of mental health issues and at that point presented with a concerning low mood and severe anxiety. The ICPC set out some of the behaviours of Mother in regards to Child I1 and how she responded to his needs, noting Mother was observed to disengage from Child I1, affecting the way she handles him when she was upset or angry, stated to occur 2-3 times per week; and that Mother was seemingly unaware of this. Comparing Mother's own challenges in terms of her traumatic childhood and adolescence to an average young parent making mistakes appears incongruous.

- The rapid review considered whether Mother had learning difficulties. A referral to Adult Services was made in August 2019 by the allocated Social Worker. The social worker was advised that a referral would need to be made via the GP. At this time Child I1 had another fall down the stairs at home, which resulted in concerns being raised by the consultant paediatrician and Child I1 remained in hospital. Ultimately Child I1 returned to his Mother's care. The matter of referral for a learning needs assessment does not appear to have been pursued again during the period up to Child I1 removal from Mother's care in 2022. Mother was described at times as difficult

[4] Adverse Childhood Experiences (aces) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity." (Young Minds, 2018).

and challenging. Becoming highly emotionally volatile when challenged and also frequently lying to professionals. This is likely to have had an adverse impact on making positive progress and building relationships. Some of these behaviours if not all will have stemmed from her childhood experiences in terms of being able to trust anyone. [5] P1 was able to access Mother's trust through providing money and through coercive control, by making Mother believe he was the only person who could help and support her. It is likely Mother felt P1 was the only person she could or should trust.

- Mother attempted to access support for her mental health at times, including taking antidepressants and engaging with 'Thinking Ahead' a support service. However she was also reported to have self-harmed, stopped taking antidepressants and fluctuated in engaging with mental health support. The impact of Mother's Adverse Childhood Experiences were not fully considered or understood in terms of her ability to see and understand risk and protect her son. The absence of direct observation of Mother's behaviour and the impact of her regular outbursts and loss of control on her son Child I1 are not known. There was too much focus on Mother attending courses, which in themselves do provide valuable opportunities for self-development and understanding, however Mother often disengaged due to anxiety. Simply telling Mother what the risks are or were in relation to P1 would not have any impact on building insight, resilience and confidence in herself. These were the personal strengths Mother lacked.

- Child I1 was presented a significant number of times to hospital with health issues and injuries. Provide information on responses to unexplained injuries including the suspected sexual abuse of Child I1 and whether this was appropriate and in line with child protection requirements.

- Child I1 had a significant number of hospital visits including minor ailments and injuries. Mother instigated the hospital attendances herself. Often calling ambulances inappropriately, which may have been related to her anxiety. It is reported through the child protection reports and child in need minutes that she loved her son and would not intentionally harm him. However it is clearly noted her ability to respond consistently to Child I1 needs was limited, often putting her own needs before his. Professionals were aware of the hospital attendances regarding bruising. Initially the falls were put down to a lack of parental supervision, although in April 2019 following a further admission to A&E with bruising, Mother reported Von Willebrand Disease (VWD) ran in her family. The blood test at the time suggested to the attending paediatrician that Child I1 had VWD and this was the accepted answer. With an absence of reflective and professional curiosity in terms of how the bruising occurred this led to a general assumption by professionals' that VWD was the cause of any bruising.

- The Child I1 health visiting service noted that a family group conference took place in January 2019. P1 was in attendance. He openly stated he had regular contact with Child I1 and Mother, and had a key to Mother's home, therefore was able to access Child I1 and Mother at any time. P1 appeared to have significant control over Mother and Child I1. Mother was heavily reliant on P1, receiving regular financial support from him. He also put himself forward to care for Child I1

[5] 'Victims and survivors of child sexual abuse cope and respond to abuse in different ways, and their response can change over time. For some, the psychological harm can be at least as severe – and at times more enduring – than the physical injuries sustained during the sexual abuse.' (Effect on emotional well-being and mental health) ICCSA Truth Project 2022

were he to be removed from Mother's care. At the time of the hospital attendance and admission in April 2019 the duty health visitor raised the question with the duty social worker of whether sexual abuse has been considered, given Child I1's previous hospital attendance to hospital in March 2019 with blood in his stool. The Health Visitor also liaised with the paediatrician's office to ensure the previous hospital attendance had been taken into consideration. No details of the medical report have been found. It is therefore not known if the question of possible sexual abuse had been considered by the paediatrician. The Health Visitor's concerns regarding this were not pursued and the matter was not formally escalated.

- A further admission to hospital took place following a direct referral from the GP in **September 2019**. Child I1 was seen to have bruising to the inner area of the left buttock, hip and shin. This was again deemed accidental due to VWD. Given the number of previous hospital visits and admissions relating to bruising and neglect placing Child I1 at further risk of significant harm, consideration should have been given to convene a strategy meeting involving health partners and police representation to consider any potential criminal processes in relation to sexual abuse and to consider criminal actions regarding the ongoing neglect. A strategy meeting would also have allowed professionals to consider the need to reconvene the child protection conference, to consider amending the child protection plan. Further blood testing in January 2020 following this point concluded Child I1 did not suffer from VWD. Given the finding of this blood test all previous bruising incidents should have been reviewed and possible further actions considered, including through the PLO process.

- **The final child protection conference in September 2020** concluded Child I1 was no longer at risk of significant harm and the matter was stepped down to child in need with Child I1 becoming the subject of a child in need plan. Further bruising was reported by Mother in November 2020 relating to what was reported as a bite mark to Child I1's leg. There was no explanation. Current local authority Trix guidance is clear for non-mobile children that *'A bruise/injury must always be assessed in the context of medical and social history, developmental stage and explanation given. Assessments will be led by Children's Social Care and a lead medical professional (local acute or community Paediatrician) to determine whether bruising is consistent with the explanation provided or is indicative of non-accidental injury. It was also important to consider historically the number of instances with unexplained bruising.'* It is also clear in the NICE guidance 89 [6] *'It is the responsibility of Children's Social Care Services in conjunction with the local acute or community paediatric department to decide whether the circumstances of the case and the explanation for the injury are consistent with an innocent cause or not. Children should NOT be referred to GPs for a decision as to whether any 'bruising' is accidental or otherwise'.* It is clear from the guidance that a specialist paediatrician is the appropriate professional to refer to in such circumstances, and a neither a GP, nor a social worker can carry out such assessments. Whilst Child I1 was aged 2yrs he had a history of child protection concerns for neglect and bruising; and the guidance suggests 'careful consideration' is given to taking appropriate safeguarding actions.

- The Rapid Review concluded that In view of the known traumatic history and vulnerability of Mother, was there too much optimism in terms of her ability to parent consistently well and protect Child I1 from all risks, and that responses to numerous and unexplained injuries was not effective.

[6] https://www.nice.org.uk/guidance/ng204/chapter/Recommendations

- At the point of 'step down' to child in Need. Further concerns regarding P1 and allegations of sexual grooming and assault of young boys emerged at the final child protection conference, and at this point he was reported to be living with Mother and Child I1. It is important to understand how those risks were to be managed outside of the child protection process.

- At this point the Public Law Outline process had commenced December 2019 due to continuing concerns for Child I1s safety and welfare. The Covid Lockdown commenced in March 2020 following the arrest of P1 in March in relation to sexual grooming and sexual assault on four males aged between 12 -15 years. Bail conditions were put in place, which stated that P1 was '*not to have any unsupervised contact with any child under the age of 18 years without their parent being present and only after being risk assessed and approved by children's services'*. This was a very clear condition and gave CSC the opportunity to disagree with P1 having any contact with Child I1 given Mother's history of not being honest and truthful. A written agreement was drafted in line with the above conditions. P1 was believed to be living with Mother and was present during the home visit. Mother signed the agreement but at the same time told the Social Worker P1 would be self-isolating with them and that Child I1 would never be left alone with P1. There is no information as to how Mother would ensure this. And key to this is that Mother appeared happy to have P1 living with her despite these very serious allegations.

- Mother's own vulnerabilities to exploitation and P1's control over her was enabling him to remain in the family home. There is no information showing discussion about the risks between the social worker and her line manager in terms of how this could be realistically managed, or what other actions could or should be taken. This was a missed opportunity to protect Child I1 and set clear and unequivocal boundaries. Mother later informed the social worker that P1 did not stay with her as she was concerned it might impact on the PLO ceasing and for Child I1 to no longer to be subject to a child protection plan. This was said with an aim of ending profession P1's involvement, rather than trying to protect her son. Mother was known to lie regarding her relationship with P1, and continued to state she did not believe P1 was involved in sexually assaulting boys or that he would ever harm Child I1.

- The Covid lockdown clearly would have had an impact on Child I1 daily lived experience. The case records from CSC showed Mother frequently broke the lockdown rules by having a female friend over, and by sharing car trips with her. However home visits continued, including unannounced. Concerns remained that P1 was living with Mother and Child I1. The lockdown did impact on the 5th review child protection conference. This evidenced the challenges in keeping children safe and supporting vulnerable families. Mother and Child I1 were unable to attend the family centre or the nursery and therefore contact, observation and assessment was limited. However it is clear the key professional's remained concerned, specifically about Mother's honesty about events and decision making and minimisation of concerns, leaving professionals unable to fully understand I1's lived experience on a daily basis. At this point the PLO process was in place. It is not entirely clear what the focus of the PLO was at that time, however the indications are it was very much related to the neglect concerns. Any positives in place were thought to be due to the considerable support and 'scaffolding' provided by services.

- During the final child protection conference in September 2020 it was noted the PLO process was still being followed. However this was not the case. The process had ceased. Stepping down from a protection plan to a child in need plan for Child I1 is likely to have had a detrimental

impact upon the welfare and safety of Child I1. It was stated in the minutes Mother had been armed with the information about P1 and told many times of the risk. And it would be down to her if anything happened to Child I1. Mother clearly still held the belief that P1 was not a risk. Details of sexual assault allegations were known to professionals and the conference chair. It is significant that despite the remaining concerns regarding P1 and regarding Mother's inability to recognise the risk P1 posed due to her adverse childhood experiences and her ongoing mental health needs, the responsibility to protect Child I1 from P1 was laid firmly with Mother. At this point the case had been open for over 2 years and considerable effort had been made to support Mother as a parent. Mother was not easy to work with and at this point professionals may have reached a point where Child I1 became 'invisible', coupled with external circumstances including the ongoing Covid concern and a number of 'lock downs'. [7] This is likely to be the same for other professionals who are heavily involved in complex child protection cases. It is clear Mother was unable to recognise the risk of sexual abuse to Child I1. Professionals also became unable to evaluate or address any of the risks P1 posed.

- In May 2021 a referral came from a neighbouring local authority where Mother's friend's son had disclosed that P1 kept trying to kiss him and pulled his pants down. The friend had also allowed her son (aged 9yrs) to stay overnight with him. This is a clear sign of grooming by P1. The neighbouring LA dealt with the matter through the child in need processes. However their concern was more related to the reported ongoing relationship between P1 and Mother and the risks posed to Child I1. The duty Social Worker stated that a strategy meeting should be held and that a representative from the neighbouring LA should attend. Whilst a strategy meeting was held in response to this it does not appear any representative was invited to attend. The meeting concluded there was no evidence that P1 was having contact with Child I1. However there were a number of instances in the prior 12 months where concerns had been raised that P1 was still having contact and therefore access to Child I1. In April 2020, August 2020 and September 2020 concerns showed evidence that P1 was still having access to Child I1 and that professionals believed this was likely to be the case. The case was closed in February 2021. The Rapid Review concluded there was limited professional curiosity prior to summer 2022 regarding the risk of child sexual abuse to Child I1.

- How well partners communicated and shared information, including appropriate challenge and identification of risks. There is evidence of some good communication between professionals involved whilst Child I1 was subject to a child in need plan and child protection plan. For example the Supporting Families key worker records indicated positive and regular communication between core group members with clear evidence where concerns have been shared. Incidents of concern were also reported and case records indicate regular contact between professionals.

- However there is also evidence that whilst information was shared the opportunities taken to facilitate open discussion, reflection and challenge were limited. The heath visitor who raised concerns about possible sexual abuse in April 2019 sought supervision on the matter but did not take the step of escalating her concerns. The consultant paediatrician had such concern regarding the bruising to Child I1's head in August 2019 it is noted in the CSC record, they

[7] Research regarding social workers shows they can be 'overcome by the emotional intensity of the work and complex interactions with angry, resistant parents and family friends'. H Ferguson. British Journal of Social Work. Issue 4. June 2017.

requested a strategy meeting, although there is no evidence the police were contacted. The medical assessments throughout are noted not to have elicited any suspicious injuries, rather it was considered they related to issues of poor supervision and a faulty stair gate. The diagnosis of VWD was an accepted as an explanation, although no further blood tests were ordered until months later. There was a lack of professional curiosity, an over reliance of Mother's reporting and responses during the section 47 medical examination, and there was no social worker present during this. As stated above from guidance in place in the local authority, bruising to the head is noted to be 'by far the commonest site of bruising in child abuse'. This should have been at the forefront of thinking by key professionals in relation to the safety and welfare of Child I1.

- The child protection conferences heard a great deal of information and provided a setting where professionals had the opportunity to fully reflect upon concerning incidents. It was noted that Child I1 had a fourth allocated social worker and that a child & family assessment had not been completed in a timely way, which was to include a risk assessment of Child I1 home situation and daily lived experiences. This appeared not to have been challenged by the conference chair. P1 remained as a significant concern for professionals in his undermining of social care and also his expectation to attend conferences. The written agreement put in place in March 2020 was assumed to still be relevant and active at a time when the case had been closed. Professionals focus appeared to be very much around Mother's parenting, her difficult and challenging behaviours and her own significant levels of need. The evidence suggests that professionals were not communicating effectively and that this led to professionals losing sight of Child I1 and the very significant harm he was suffering.

Understand what learning and actions had taken place since the rapid review.

CSC – have liaised closely with police to ensure they attend every strategy meeting with non-attendance to be escalated to ensure robust information sharing. A focus on ensuring effective communication and handover between service areas, to prevent concerns and information becoming lost. The importance of newly allocated social workers having time to read the case files, as in this case much information was available on the file including the risk assessment of P1. This is to be shared through managers meetings and team meetings across the service.

Safeguarding & Health visiting – A meeting took place between the safeguarding team and the health visiting service following the rapid review to consider the information shared and the findings. The escalation policy in place is now discussed within safeguarding supervision and training within the agency. Training is now being developed around Trauma informed Practice and adverse childhood experiences through the partnership.

Police – Following the rapid review, confirmation was sought from the EHASH police officers to establish if there was contact with the sexual assault referral centre (SARC). It was confirmed there is no record of this. It was considered that were this the case, the expectation was for a strategy meeting to be called to discuss the concerns and ensure a safety plan was in place.

PCFT Safeguarding Children & looked after Children – Training packages regarding level 3 safeguarding and the looked after Children training package has been refreshed to include: information regarding Sec 47 medicals and process; Consideration of a care-leavers ACE's in relation

to their own parenting capacity; information re changes to legislation and guidance regarding domestic abuse, particularly relating to coercive and controlling behaviour, as well as children being victims in their own right.

Early help Responses – Early help training in relation to domestic abuse & coercive control has been delivered. Staff link into the new domestic abuse pathway and have access to tools to identify risk and support action planning. Honest discussion about 'not victim blaming' has taken place. Supervision and case work sessions have moved to capture the voice of the child. Audits and observations of supervision are now taking place with outcomes discussed with managers regarding change and actions necessary.

Alongside the above there has been an **update and refresh of RBSCP Neglect strategy** and resources- a multi-agency launch took place in January 2023 followed by several briefings and other promotion of the amended neglect response within Rochdale borough. This replaced the Graded Care Profile used in the case of Child I1.

Section 4: Analysis and Summary of findings

- Mother became a cared for child (looked after child) as a teenager after she disclosed sexual abuse and rape within her family home. Her childhood was described as difficult, abusive and with fractious relationships within the family. Mother never returned home to live. She was also stated to have mental health needs. The information available and the case notes have not provided any significant information regarding Mother's mental health or the impact of the abuse she has suffered. It is reported Mother was open to CAMHS for a period as a child and also Clinic Psychology. The issue and focus on consideration of Adverse

Childhood Experiences has emerged through the Rapid Review process. Consideration was also given as to whether Mother had learning needs. The issues raised were Mother had poor decision making skills and difficultly risk assessing. The SW was advised that a referral would need to go through Mother's GP. This did not progress further.

- Concerns arose about Mother's level of vulnerability to exploitation and being in a relationship with an older male, P1. Concerns were raised in regards to P1 targeting vulnerable young people, with the specialist sexual exploitation team classing him as a high risk individual. It was believed P1 was the father of Mother's unborn child. However without clear evidence F1 was stated to be the father of Child I1 by Mother and is recorded as such in reports and in some case records. Child I1's birth certificate does not have a named father. The involvement and concern regarding F1 took up a great deal of key the professional's anxiety and to some degree actions. However ultimately he was not the person who was of most risk to both Mother and Child I1. F1 appeared to be a diversion and distraction from the fundamental risks posed by P1.

- Child I1 was born in March 2018. P1 attended the birth as Mother's birthing partner. Mother appeared to have considerable trust in P1. He was providing financial and practical support. Mother's ability to parent was of concern prior to Child I1 birth and a child in need plan had been put in place. Following Child I1 birth the concerns grew and an initial child protection conference was held resulting in Child I1 having a child protection plan, under the category of 'neglect'. The risk assessment completed prior to this regarding P1 concluded that 'overall the relationship between P1 and Mother was questionable, and available information suggests he had exploited Mother. Mother's emotional well-being was of concern and leading her to be more vulnerable to exploitation and grooming.' The risk assessment highlighted that P1 was known to the Specialist CSE Team and had received a child abduction warning notice relating to a 16yr old.

- The child protection process is in place to gather and share information regarding a child who is thought to be at risk of suffering significant harm. The conference chair's role is critical. There is a need to prepare well for the conference, including reading key documents on the child's case record and prepared reports, reflect on available information, ensuring the conference and associated activity is child-focused and the safeguarding of the child is paramount. That the running of the conference ensures the right people are present and also ensures the management of those who are in attendance where difficulties and concerns may arise, with the ability to prevent anyone attending who should not be there. As already noted P1 should not have been allowed to attend the child protection conferences due to the significant concerns regarding risk of sexual exploitation of Mother, due to incidents already referred to above, and the information provided through the completion of a risk assessment which indicated P1 should not have contact with Mother. As stated, P1 was able to overcome external barriers by using his status as a professional to place himself within the group of professional's that were there to support and protect Child I1. The key Professional's, including the child protection chair, were unable to see the significant risk posed by P1, which was in 'plain-sight' and had not forensically considered the risks in terms of Mother's vulnerability to exploitation and the potential of further significant harm to Child I1. This model of child protection conferences relied upon professionals reporting in a formal setting. P1 was seen as high risk in terms of being a predatory male with risk of sexual harm, and a high risk individual. Information that the

LADO investigation ceased, seemed to lead to a view there was no real 'evidence' to support this.

- The model of child protection conferences has now changed in this local authority. The framework is much more explicit and includes a clear focus on potential risk to a child. The new model focuses on; support & harm factors, what life is like for the child, strengths, harm concerns including unknown harms, required changes and contingency planning. The model allows for discussions rather than reporting and promotes families and children to contribute

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- In order to respond to the issues raised in the rapid review and the subsequent findings through the case discussion tool, it has been important to reflect upon the level of professional involvement over a significant period of time, in which concerns continued regarding the safety and wellbeing of Child I1. The focus had very much been upon Mother's parenting capacity, specifically neglect; although for a short period as the neglect issues had appeared to diminish this changed to 'emotional abuse' in relation to her contact with F1, which on occasion became the focus of concern. P1's involvement continued and he attended the first three child protection conferences. By the fourth conference his involvement was diminishing. It is recorded in the conference minutes that P1 should no longer attend meetings including core groups. This was based upon Mothers over reliance on his support as opposed to concerns about any risk he posed to Child I1 regarding sexual abuse.

- By the fifth child protection conference there had been a significant decline in Mother's care of Child I1 who attended hospital on five different occasions with bruising. Each of these visits could be considered as 'missed opportunities'. Incidents of bruising to Child I1 were for a period frequent, the details of which are set out above. However the incidents of injuries did not prompt coordinated actions in line with policy, procedure and above all good practice in relation to safeguarding Child I1. Child I1 was a very young and vulnerable child who was unable to say what had happened to him and how. Currently there is clear guidance in the local and surrounding authorities regarding bruising to immobile babies and children. Bruising to the head is noted to be 'by far the commonest site of bruising in child abuse'. At this point Child I1 appeared to be more at risk than ever. Throughout this period, apart from the requested strategy meeting (according to the CSC record) referred to above, there is little evidence of consideration of strategy discussions, bringing together all involved agencies to consider and reflect upon what was happening in Child I1 household.

- To consider what the risks were, consider why Mother reported all incidents through attendance to hospital whether Child I1 was left to his own devices making him highly vulnerable, whether Mother was capable of causing physical harm, whether P1 was involved or even perpetrating abuse and what appropriate actions could be taken to protect Child I1. P1 was very much involved in the previous three conferences that had taken place and had attended a number of core group meetings. His influence is likely to have brought about minimisation of any concerns and potentially brought about a reluctance for professionals to

openly raise any concerns.

- There is little evidence of reflective thinking and discussion regarding P1, the risks he posed, and whether he had caused any of the injuries. His continued involvement with Mother and Child I1 was a serious concern, which should have heightened concern when he was arrested for sexual assault. This was a key 'missed opportunity'. The core professionals the social worker and manager had an opportunity to scrutinise the allegations against P1 and set out an unequivocal written agreement, in that P1 should have no contact with Child I1 under any circumstances. The written agreement that was in place was ineffective. Simply to tell Mother not to allow P1 any contact with Child I1 was also ineffective and unreliable. Alongside this when the case was closed professionals considered that the written agreement would remain effective, without any understanding of how this was to be overseen. Child I1 was left in a situation where he had no voice. Assumptions were made that Mother would not allow unsupervised contact despite being known to lie and mislead due to her own vulnerabilities.

- Concerns regarding Mother's resistant responses and level of dishonesty were frequently referenced. The term disguised compliance was used in recordings. She would react to professionals by screaming and shouting at them if she was not in agreement with what had been said or decided. Whilst this is referenced in recordings it is not explicitly raised as a concern. This type of behaviour is a further way of attempting to deflect professionals from challenging her. It also has an impact on any key workers and needs to be an issue that is explicitly raised within supervision in order to discuss the issue of disguised compliance. [8] Having mental health services involved more proactively with the core group in order to inform, educate and support professionals in understanding and engaging with Mother in relation to her behaviour, would have had a better chance of having an impact; therefore ensuring Child I1 was protected not only in terms of improving Mother's ability to, not be neglectful, but also by enabling her to care for herself and therefore her son, and to ensure Mother better understood adults who pose a risk to her and therefor her child. Ultimately it was critical to understand and evaluate Mother's ability to protect her son from harm and whether this was achievable.

[8] Disguised Compliance is defined by the NSPCC as *"a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention."*

Section 5: Conclusion

- The background sets out the difficult and traumatising childhood of Mother, culminating in her becoming 'looked after'. The truth of who Child I1's father is remains unclear. The initial concerns which led to a child in need plan and later a child protection plan related to Mother's parenting capacity. However a key factor from the outset was the concern regarding the involvement of P1 with Mother and then later following his birth, her son Child I1. It was absolutely clear P1 was a predatory male seeking out vulnerable young people and children, and was considered high risk from the outset. Accessing information through the learning review process has shown the risks P1 presented; the professional's lack of focus on those risks, and thereafter an ongoing failure to see what was in plain sight.

- Mother had needs of her own as a victim of familial sexual abuse and rape, along with a neglectful and abusive childhood. She had little or no support networks as her family were noted as exploitative and abusive. The impact of this upon her ability to form healthy relationships with trustworthy people was profound. She fell victim to being groomed and exploited by P1, believing everything he said because Mother believed he cared for her. P1 made every effort to undermine the work and support professionals were providing. He was bold enough to attend the initial child protection conference, taking up the opportunity to be seen as a supporter for Mother and therefore Child I1; alongside taking the opportunity to defend himself and his actions. P1 was successful in his efforts and became a member of the core group, providing further opportunity to undermine and confuse professionals and obscure the truth.

- In the midst of this was Child I1. Despite, through this process, reading many records and reports it was difficult to gain a picture or sense of Child I1's daily lived experience or indeed his relationship with his Mother. He was described in places as a placid child; presenting as happy and content. He was described as giggly and loved to engage with professionals who visited. He was also noted to have a good attachment to his Mother. However alongside this there are many descriptions of him suspected of being left alone in his bedroom for long periods. Regularly seen in heavy wet nappies. Regular nappy rash. Dirt under his finger nails. Then the bruising through poor supervision, including bruising to his thighs, buttocks and legs. Whilst the incidents of bruising were noted there was no description on any of the occasions of how Child I1 presented, other than the incident where Mother reported a bite mark. Was he upset, distraught, quiet, withdrawn etc. Alongside this there is little information as to how Mother presented at the hospital attendances. Although on one occasion was noted to have a friend's 11 year old daughter with her, who appeared to be taking the caring role for I1. The Von Willebrand diagnosis from the outset allowed professionals to step back from any key worries they may have had and assume VWB was the root issue. Incidental comments made by Mother should also have elicited a better response. .

- Ultimately Child I1 himself was able to draw attention to P1, by speaking about P1 as 'daddy'. There is a question as to why it took so long for action to be taken regarding P1s involvement. Mother is reported to have presented at times, as difficult and challenging, showing 'disguised compliance', frequently noted as 'lying' and being 'dishonest'. She 'covered' for P1 but was also belligerent in her belief P1 was innocent and 'knew he would never hurt Child I1'. Mother's responses are potentially as a result of her own trauma and

adverse experiences throughout her childhood. Mother called the ambulance on all the occasions Child I1 was taken to hospital, apart from the direct referral to the assessment unit and this came from the GP. Did the key professionals ever considered this was a way of deflecting responsibility or blame, or avoiding the truth? This remains an unknown.

- There is also evidence of Mother's mental health needs including suffering with anxiety and depression with antidepressants being prescribed. Mother's own considerable needs as a care leaver were complex enough. Having P1 involved with all the risks he presented and a very young child made the matter highly complex. In situations like this social workers, key workers and other professionals need access to the highest quality support through reflective supervision. It is clear supervision took place separately with all professionals in their settings. In situations like this consideration should be given to accessing expert systemic supervision, allowing a space to fully reflect upon all aspects of the case, including each individuals views and responses to events and how they had formed those views and responses, alongside reflecting upon the impact of the work they undertake, how they process disturbing and distressing possibilities, including the abuse of a child, and other issues such as societal norms and expectations. Having a systemic approach to working with families helps shape the way social work practitioners interact with families, exploring relationship patterns and understanding how they impact on children.

- The key question for the partnership to consider is, how P1 achieved such success in being trusted to a degree where he became an influential part of the child protection process. And later after his arrest for sexual abuse on a number of young boys, being able to overcome what should have been stringent safety planning, including an unequivocal written agreement that no contact should take place. The key professionals involved will have no doubt reflected upon the events leading to I1's removal. To reflect upon those events together, would be a supportive and important opportunity; with focus on some key questions; was this based on the persona he presented? At times he was challenging to professionals, also critical and rude, it is important to understand why this was not challenged.

- The professionals involved should also had the opportunity to consider the dynamics and subtleties of the initial child protection conference: to consider whether the social status of the solicitor who was present with Mother, influenced an acceptance of P1's attendance and being presented as a supporter to Mother. In particular the social worker who had completed the risk assessment did not raise any question as to P1's presence. Was there an issue of professional hierarchy i.e. a lack of confidence to be able to question or challenge.

- Key professionals should also be encouraged to consider how this apparent acceptance of P1 led to his continued involvement for a considerable period of time. Did the key workers have significant doubts and concerns about P1 and if so what prevented them from raising their concerns through other processes? Ultimately at the final conference the protection of Child I1 was placed firmly with Mother. Given the serious concerns raised regarding Mother and her inability to tell the truth or to work with professionals and the continued involvement of P1, albeit hidden; and given his arrest for allegations of sexual assault on children, how did professionals come to believe this was the right decision? Was there over reliance on the 'written agreement'? Elements of workload pressure, complexity of cases and exhaustion from confrontational parents needs to be considered as children can become 'invisible' to

professionals.

- During this period we were also in unprecedented times due to the Covid 19 pandemic. The partnership will need to consider the significance of this on professionals attempting to go about their everyday work. Evaluation of the impact of Covid and subsequent 'lock downs' in terms of the challenges in child protection work is important. The challenges faced by professionals potentially impacted upon judgements in this case, which were not made in the normal context. Professional services were in crisis mode. Reviewing the local arrangements put in place at the time is something the partnership may consider, which should include what the local policy and procedures are now were similar events to occur.

- Overall this has been a difficult case to review. Notwithstanding the complexity and challenges within the case, the fundamental risk regarding P1 had not been recognised. Having access to the child's social care record helped to piece Child I1 story together. The findings reflect the fact that Child I1 became lost within the processes and his Mother's own considerable needs; combined with the involvement of a manipulative predatory male.

Section 6: Learning Considerations:

1. All agencies needs to consider how to ensure all professionals are supported to recognise that if they have concerns about a person who presents as someone of 'good standing' and/or holds 'professional status' to be explicit about this to their supervisors and managers, to scrutinise the information available, to enable them to see past the persona and to act upon their concerns and instincts and to escalate concerns confidently. This should be evidence through Quality Assurance processes to the Safeguarding Partnership.

2. Alongside this, all Agencies need to assure the Safeguarding Partnership that they are ensuring professionals' have a high level of awareness of the behaviours of predatory individuals, relating to child sexual abuse grooming and exploitation through current research and training. Currently there is a child sexual abuse thematic review commissioned by the partnership which may identify further learning and developmental objectives.

3. The Safeguarding Partnership via all Agencies, should review current training on trauma informed practice and adverse childhood experiences and evaluate the impact of this on everyday practice within the key agency settings via quality assurance processes.

4. The Safeguarding Partnership, via key agencies should consider how to increase understanding of and responses to 'Disguised Compliance' ensuring professionals have heightened awareness of the behaviours, to be provided with support and supervision to address and manage this, in order to ensure the focus remains specifically on the needs of the child.

5. The Safeguarding Partnership should evaluate key agencies' efforts to determine awareness of staff of 'coercive control' within their current training programme for domestic abuse, and the effectiveness of this on day to day practice through quality assurance processes.

6. The Safeguarding Partnership to consider how effective key agencies are in raising awareness of 'bruising on immobile babies' policy and guidance, and ensure those non-verbal children who are mobile receive the same level of attention – particularly those already subject to CP plans. The processes and procedures around child protection are in place. The actions and responses of the professionals need to reflect skilled knowledge and practice, which should be evidenced through quality assurance activity.

7. All key agencies need to assure the Safeguarding Partnership that they have considered how social workers, key workers and other professionals are able to access to the highest quality support through reflective supervision. It is clear supervision took place separately with all professionals in their settings. In complex cases like this consideration should be given to accessing expert systemic supervision, allowing professionals a space to fully reflect upon all aspects of complex cases.

8. The Safeguarding Partnership need to ensure learning is widely shared with professionals from all partners, specifically including the practitioners involved with l1 and Mother, to consider their views and actions from a systemic perspective in order to enhance their practice and learning, through supporting professional curiosity, objectivity and development.