DONCASTER SAFEGUARDING CHILDREN PARTNERSHIP

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CHILD SAFEGUARDING PRACTICE REVIEW CHILD G

OCTOBER 2021

Executive Summary

On 9th January 2020 Child G, died in hospital from head injuries sustained within his own home in a community within Doncaster local authority area. He was 2 years and 3 days old. At the time of his death, he was living with his mother Adult GF, her new partner Adult HM and his two siblings aged 9 and 4 years.

Following his death, a criminal investigation was launched by South Yorkshire Police and the Statutory Safeguarding Partners for Doncaster commenced a Rapid Review of the circumstances and partnership involvement with the family and key individuals.

The police investigation subsequently led to the conviction of Adult HM for the murder of Child G as well as assaulting, ill-treating, neglecting, or abandoning a child or young person to cause unnecessary suffering or injury. Adult GF was acquitted of his murder but convicted of causing or allowing the death of a child or vulnerable person.

Adult GF and her children were not at any point in contact with the statutory service of children's social care and not known to any other statutory safeguarding agency other than for routine health appointments.

The three children all had different fathers, the details of whom were not known to any statutory partner, at the onset of the review one had an impression of Adult GF as a single mother bringing up her children as a single parent.

In contrast to Adult GF, Adult HM was well known to all statutory safeguarding services with a lifetime of involvement as a child through the Child Protection system and then as a young offending adolescent and adult. He has a history of violence to all those he forms personal relationships with as well as exhibiting significant and serious violence to strangers of both sexes. He had convictions for a range of offences including violence with and without weapons. He had been made subject to various and somewhat repetitive orders by different courts aimed at community reparation as well as to address his violence and his behaviours within relationships.

This review has identified areas of specific learning in relation to the safeguarding of children as well the partnerships' ability to understand the strategic intelligence picture of domestic violence and the lived experience of those who regularly suffer violence and abuse in their family homes providing an opportunity for a more pro-active response to the issue.

The review worked to clear and specific terms of reference set and overseen by an Executive Oversight Group. The initial insight of the review team as well as the Rapid Review findings identified that domestic abuse and violence were a key theme in relation to the case and in particular Adult HM. As a result, the scope of the review was agreed to specifically consider the issue in trying to answer the terms of reference.

The review suggests that the partnership does routinely and successfully safeguard and promote the welfare of children but highlights learning in relation to how the multi-agency partnership is effective in their use of information and intelligence to identify need, harm and risk as early as possible and to focus on the offending and behaviours of prolific domestic abuse offenders who cause harm to their partners and the children who live with the abuse.

The review found no evidence that any specific risk assessment tool within any partner organisation has prevented the identification of need, harm or risk to families and children. The review has identified learning, which will provide opportunities for stronger multi agency understanding of multiple risk assessment outcomes from different partners to achieve stronger cross partnership working to support any organisation who is attempting to safeguard and promote the welfare of children.

The review has identified areas of particular learning which can be grouped within three core themes: Domestic Abuse and Violence, Assessments and Risk Assessments and Partnership working (Appendix 3 for consolidated list). We also identify additional recommendations for consideration by the partnership and individual partners (Appendix 4).

Adult HM was found by the review to be a long-standing prolific violent offender within multiple relationships. He abused the majority of the 14 known female partners he had over a ten-year period leading up to his murder of Child G.

Although Adult HM was actively managed and supervised by both the National Probation Service and South Yorkshire Community Rehabilitation Company, both of whom sought information from children's services and the police, the partnership as a whole did not at any time create a fulsome assessment of him or understand the true risks he posed to women and children. Children were present within the families where domestic abuse was perpetrated by him on his partners and on occasions, it is known he directly abused and assaulted children.

Doncaster Safer Stronger Partnership had reviewed and renewed their Domestic Abuse Strategy in 2017, delivering a strong document with clear intentions and an appropriate governance structure to embed practice learning and positive change.

The review identified that the overall governance and impetus of the strategy had been diluted over time and as a result the partnership was not best placed to identify its strategic intelligence picture in relation to the impact of domestic abuse and violent offenders in respect of children.

A section of the report offers a review of the application of The Domestic Violence Disclosure Scheme 2016 (Clare's Law) and how this can be improved by the partnership (para 17.45).

On many occasions the review identified children and young people within relationships living with the domestic abuse and violence of Adult HM and other serial perpetrators, on occasion being directly subjected to violence and abuse. However, on no occasion when a risk assessment was completed on Adult HM was the risk graded as higher than medium of him causing serious harm to a child or young person even when there was substantial information that he had hurt and abused children within family settings. The review has articulated there needs to be a recognition that children and young people suffer the consequences of domestic abuse in terms of their development and emotional wellbeing: they do not just witness it they ***'live it'***.

The review identified one specific incident on the 11th August 2019 when South Yorkshire Police attended an incident and an opportunity existed for them to potentially identify that Adult HM was living with Adult GF and her children. This awareness did not materialise (para 17.13).

The review has considered in detail the multi-agency working across Doncaster Safer Stronger Partnership and found both good practice as well as clear opportunities for greater collaboration and understanding. Information sharing between partners was being sought in particular by both Probation Services when they were attempting to risk assess Adult HM but the outcome on several occasions, within the review time parameters, between them and Doncaster Children's Services Trust did not aide the requesting service in its attempts to carry out its statutory functions and safeguard and promote the welfare of children.

The power of integrated multi- agency working should never be understated when professionals are attempting to identify need, harm and risk to children and young people. The review has identified occasions since 2014 where a more collaborative, structured and multi-agency approach would have potentially ensured a more robust understanding of Adult HM and the risks he posed. This report identifies the potential opportunities for example, for closer partnership working through for example the Multi Agency Public Protection Arrangements (MAPPA) guidance and processes for the

partnership to support the Probation Services in their work and also work more cohesively and collaboratively. (para 18.109)

The review was pleased to learn of the commencement of the new Multi-Agency Tasking and Co-ordination (MATAC) forum, which is intended to address the issues raised by the review concerning the partnership visibility and management of prolific offenders of domestic abuse and violence. This new forum will have a key place within the journey of the partnership to create positive change from the learning and recommendations we have identified.

All the learning from this review has been accepted by the senior leadership of Doncaster Safeguarding Partnership who have already shown enthusiasm and vigour in delivering positive improvement activity across the partnership and within individual services. These are highlighted within the report.

The partnership did not have a specific opportunity to safeguard and protect Child G and his siblings who may well have suffered the trauma of domestic abuse and witnessed or suffered direct abuse and violence. These young children were not visible to the services who were tasked to protect them. Professional practice and curiosity on differing occasions over the years, when both Adult HM and Adult GF were themselves available to services, may have enabled the children to be more visible prior to Child G's death.

The review wishes to thank all those who engaged in this review and believes the learning generated in partnership with the many safeguarding professionals who we worked with across Doncaster will provide opportunities for improvement in practice and processes. This in turn will support the work and desire of all to safeguard and promote the welfare of children and to protect those suffering the damage caused by domestic abuse and violent crime.

Anne Coyle

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**Early Help is a way of thinking and working together as services with families that have additional or more* complex *needs.*

1. Report

1.1 This Local Child Safeguarding Practice Review relates to the death of Child G born 6th January 2018 who died on the 9th January 2020 aged 2 years and 3 days.

1.2 The Local Child Safeguarding Practice Review was commissioned following a Rapid Review undertaken by the Doncaster Safeguarding Partnership. The decision to conduct a review under the Children Act 2004 (as amended by the Children and Social work Act 2017) is recorded as being taken on the 11th February 2020.

1.3 Due to the Covid 19 pandemic, the review was not able to commence until July 2020 and has had to be conducted within the backdrop of three national lockdowns and multiple constraints on the social interaction of professionals and professional working practices.

2. Criminal investigation and subsequent convictions

2.1 Following the death of Child G on 9th January 2020 South Yorkshire Police launched a criminal investigation into his death.

2.2 Adult GF and Adult HM were both charged with the murder of Child G and associated offences relating to the child's death.

2.3 Both stood trial in the Autumn of 2020 the outcome of which for each was:

2.4 Adult HM was convicted of:

- Murder (Victim one year old or over): Imprisonment Life Minimum of 22 years
- Assault/Ill-Treat/Neglect/Abandon a Child/Young Person to Cause Unnecessary Suffering/Injury: No Separate Penalty.

2.5 Adult GF was acquitted of murder. She was convicted of:

- Cause/Allow Death of Child/Vulnerable Person: Imprisonment 8 years.

3. Rapid Review

3.1 Following the death of Child G on the 9th January 2020 Doncaster Safeguarding Children Partnership instigated a Rapid Review of the case.

3.2 A meeting took place attended by the Statutory Safeguarding Partners as well as the South Yorkshire Community Rehabilitation Company and the National Probation Service on the 29th January 2020.

3.3 At the time of the meeting, a criminal investigation was underway into the murder of Child G.

3.4 The purpose of the review was recorded as:

- Identify any immediate learning
- Consider whether the threshold for a Local Child Safeguarding Practice Review had been met, and the rationale and scope of this

- Consider whether this may have met the threshold for a national review and to make a recommendation on this matter to the National Panel.

3.5 The rapid review recommended the following immediate actions:

- All partners need to have an understanding of other agencies risk assessment processes and their definitions of risks. In the short term, a practice briefing will be issued across the multi-agency partnership. Face to face training being delivered in the medium term
- Immediate practice changes are to be implemented to ensure close liaison and agency checks take place between the local NPS, CRC, Police and Children's Social Care in respect of persons posing a risk particularly in relation to domestic abuse cases
- South Yorkshire Community Rehabilitation Company have already agreed to partner in the current development of an all-age multi-agency access point for social care. The Probation Service has been invited to also participate in this work
- Clear practice guidance will be issued in relation to the use of "Risk to Children" markers not "Hazard" markers, in relation to known violent offenders.

3.6 The Rapid Review recommended the case met the criteria for a Local Child Safeguarding Practice Review. The signatories to the review document identified some relevant areas for focus of the local Child Safeguarding Practice Review, which were subsequently articulated and reflected within the agreed Terms of Reference.

4 Local Child Safeguarding Practice Reviews

4.1 Section 17 of the Children and Social work Act 2017 amended the Children Act 2004 and introduced Local Child Safeguarding Practice Reviews.

4.2 The purpose of a Local Child Safeguarding Practice Review under subsection (1)(b) of the Children and Social work Act 2017 is to *identify any improvements that should be made by persons in the area to safeguard and promote the welfare of children*.

4.3 Working Together 2018 provides guidance concerning the commissioning, oversight and conducting of Local child Safeguarding Practice Reviews. The guidance is clear the purpose of a review is to identify learning: *to promote and share information about improvements*…

4.4 It clearly identifies that practitioners should be involved, being able to *contribute their perspectives without fear of being blamed for actions they took in good faith* with families also being requested to participate.

4.5 Working Together 2018 identifies that safeguarding partners should agree the methodology with reviewers, taking into account systems methodology recommended in The Munro Review of Child Protection: Final Report: A Child Centred System (May 2011).

4.6 It is also clear that a review *should reflect the child's perspective and the family context.*

National panel

4.7 The Children and Social Work Act 2017 provided for the creation of the independent Child Safeguarding Practice Review Panel.

4.8 The panel is responsible for:

- Supervising reviews they commission
- Ensuring they are of a satisfactory quality
- Ensuring reports are completed in a suitable timeframe
- Identifying improvements that should be made by safeguarding partners.

4.9 The panel:

- Has its own statutory powers
- Is independent of government
- Can make its own decisions.

4.10 The statutory guidance on 'Working together to safeguard children' sets out how the panel operates and works with safeguarding partnerships.

4.11 The panel meets regularly to decide whether to commission national reviews of child safeguarding cases that are notified to it. The panel's decisions are based on the possibility of identifying improvements from cases which it views as complex or of national importance.

4.12 Local authorities should notify the national review panel:

- If a child dies or is seriously harmed and abuse or neglect is known or suspected:
  - In their area
  - Outside of England, but they are normally resident in their area
  - To report the death of children looked after by a local authority whether or not abuse or neglect is known or suspected.

5 Terms of Reference

5.1 The terms of reference agreed by the Executive Oversight Group for this review stated that the review would report on:

- What opportunities existed to intervene within the partnership that could have prevented the death of Child G?
- How effective is the Doncaster partnership in safeguarding and promoting the welfare of children, particularly through the use of information and intelligence to identify need, harm and risk?
- Consider the effectiveness of the various risk assessment tools and approaches in use across the safeguarding partnership, to establish the strength of the multi-agency approach to maintaining public safety, in relation to children and families.

5.2 **The objectives of the review being to:**

- Identify learning from this case that can be used to improve the safety of children who reside in Doncaster and nationally
- Identify learning points / recommendations that can be implemented and will be of practical benefit for improving the safety of children in Doncaster

- To offer assurance in regards to how effective the partnerships across Doncaster are now in providing for children's safety and wellbeing.

5.3 The review has been governed by a multi-agency executive leadership group, known as the Executive Oversight Group. Progress meetings have taken place at least monthly, where the opportunity to explore and capture learning has been a core part of this review.

6 Conduct and Methodology of the Review

6.1 The review followed the practice learning methodology of the Welsh Practice Review Framework and methodology, the principle being to ensure that staff are included throughout the review process, and as active live learning takes place, so too does the improvement and reparation of practice.

6.2 At the heart of the Welsh Child Practice Review Framework and methodology is the absolute involvement of agencies, staff and families in a collective endeavour to reflect and learn from what has happened in order to improve practice in the future. Through a range of live learning opportunities there is the potential to develop competency and more confident multi-agency practice in the long term.

6.3 The focus of this methodology is based upon accountability and not on culpability, with a clear and concise recognition of the impact of the tragic circumstances of non-accidental child deaths or serious harm on families and on staff, providing opportunities for serious incidents to be reviewed in a culture that is fair and just. The methodology aims to strengthen accountability of managers to take responsibility for the context and culture in which their staff are working and to see that they have the support and resources they need. (Welsh Government, 2016).

6.4 Central to the approach are Multi-Agency Professional Forums.

6.5 Forums are facilitated events for practitioners and managers from different agencies, as part of their continuous programme of active learning. Grasping the opportunity to improve local knowledge and practice, including the quality of work with families and strengthening the ability of services to keep children safe.

6.6 The learning framework, ensures that the identification of the practice and organisational learning is drawn from:

- Production and analysis of merged timelines and genograms
- Analysis of case records
- Practice reviews will always have a Learning Event for practitioners who have been working with the child and family, and their managers. This review ran one such event with all safeguarding professions present. The event was facilitated by the reviewers, to examine current case practice within an agreed limited timeline and using a systems approach
- Learning events for senior managers are also organised during practice reviews and are considered to be very useful. This review ran one such event with all safeguarding professions present.

6.7 The Learning Event is a centrepiece of the Practice Review Framework:

'there was consistent support for the Learning Event which was felt to be a quality product, supporting the emphasis of a learning culture for practitioners and managers across agencies'

(Welsh Government, 2015: Review of the implementation of the Child Practice Review Framework)

- Family perspectives are considered. Practice reviews engage directly with children and family members, if they wish and as appropriate. This review was able to take the views of close family members of Adult HM (prior to his conviction)
- Discussion at Review Panels (several meetings take place during a review).

6.8 The positive participation of staff directly involved with Child G has been an invaluable one, enabling those involved to walk through the professional lived experience of Child G's life and explore the strengths and challenges of practice across the multi-agency group.

7 Multi-Agency Learning Activity

7.1 To ensure a good forensic review approach the reviewers were granted full access to the Doncaster Children's Services Trust children's case file database, this enabled a full and thorough examination of the relevant children's case files, and all other related reports were made accessible.

7.2 All partners provided information to the review against set search parameters designed by the review and agreed by the Executive Oversight Group. The review used the Chronolator software to assist with presentation and searching of the vast amount of data.

7.3 The information provided to the review and entered into the Chronolator amounted to 3,028 individual entries all of which have been assessed and analysed by the review.

7.4 Discrete to this review has been a significant high volume of contact between the reviewers and the individual practitioners and managers across the whole safeguarding partnership.

7.5 As reviewers, we have had the privilege of facilitating a range of one-to-one interviews with practitioners and line managers in each individual agency as well as interviews with groups of multi-agency staff together. We have taken the opportunity to provide outcome focused reflective multi agency group work sessions focused upon the practice wisdom gathered as the learning unfolded and supported a range of learning conversations with middle managers and strategic leaders.

7.6 We have attended all of the challenge and support sessions of the Executive Oversight Group in which reviewers have presented findings and learning across the breath of the review. The reviewers' approach has been to forensically understand practice in the context of a multi layered- multi agency system and to triangulate the level of practice wisdom held within the leadership group that set the expectations of practitioners on the ground, so as to maximise learning and improve practice.

7.7 Inherent to this approach was the facilitation of a practice Learning Event on the 17th of September 2020, for all of the front-line practitioners who were directly involved with Child G and his family. We also included those professionals involved with Adult HM. The event was fully supported and endorsed by the Executive Oversight Group who fully understood the value of supporting staff to reflect on their lived experience of practice at the time of their involvement.

7.8 The Learning Event also included the reflection in respect of an ex-partner of Adult HM who was herself a perpetual victim of domestic abuse and violence by multiple partners including Adult HM. This case was chosen so as to maximise the opportunity to explore how effective practice was in safeguarding and promoting the welfare of children, identifying children living in domestic abuse afflicted families and identifying high risk perpetrators particularly through the use of information and intelligence to identify need, harm and risk.

7.9 Participants of the Learning Event included:

- School (Primary school of Children GR1 and GR2)
- Doncaster Council
- Doncaster Children's Services Trust
- Health (Rotherham Doncaster & South Humber NHS Foundation Trust)
- South Yorkshire Police
- South Yorkshire Community Rehabilitation Company
- National Probation Service.

7.10 The process of the Learning Event involved the reviewers presenting information and intelligence gathered from across the partnership, placing professionals back into the situation at the time that their work took place and guiding a reflective and open conversation about how agencies work with children, their families and other adults either simultaneously or individually.

7.11 The event provided the opportunity to test and learn from practice and to examine what helped or hindered meeting the needs of children across the partnership, either through agency norms, local practice, national standard or procedures.

7.12 Essentially, this provided for those who were the closest to the children and families the opportunity to reflect and make recommendations on practice from the ground upwards to senior leaders. These views and recommendations were considered and triangulated against the findings of other parts of the review methodology.

7.13 All participants at the Learning Event were invited to reflect on the day and consider providing written feedback concerning the practice issues and learning as they saw it in terms of their own personal practice, for their organisation and for the partnership. A selection of quotes from this feedback can be found in Appendix 5.

7.14 A strategic leadership Learning Event was also held where the key areas of learning across practice, process and multi-agency interaction were presented and considered. The group, which was represented by all the strategic partners involved in safeguarding children across Doncaster, recognised the issues as identified, the interdependencies between their organisations and articulated individual and partnership ambition to turn learning into sustainable change.

7.15 Focussing on answering the terms of reference through the methodology, which has been followed, has provided evidence-based answers to the set questions within this Local Safeguarding Practice Review but also identified strategic and operational learning, which it is hoped will support improvement of service delivery, individual and organisational practice standards and better outcomes for children and families. This learning is central to the 3 main objectives set by the safeguarding partnership.

8 Scope and Parameters for Research

8.1 After initial consideration by both the Rapid Review and then the Local Child Safeguarding Practice Review it was apparent Adult HM has a propensity to, and a significant history of, domestic violence within multiple relationships. Many if not all of these relationships (all

with women) had children within the family and living at the addresses when he moved in to co-habit.

8.2 It was evident in the very early stages of the review when determining scope that to understand the risks to Adult GF and her children, and the murder of Child G it would be necessary to fully understand the issues surrounding the key adults in the case in respect of domestic abuse, its impact on children and the escalating behaviours and violence of Adult HM in particular.

8.3 Adult HM became a significant adult in Child G's life within 5 weeks of meeting Adult GF in the summer of 2019. So as to maximise learning and in line with the above considerations, the Executive Oversight Group wished to understand the impact of the presence and visibility of Adult HM in other relationships.

8.4 The review therefore focused on its clear terms of reference but in order to do so effectively it had to consider the issue of domestic abuse and violence in respect of both Adult HM and Adult GF.

8.5 This review has been able to map 14 significant relationships over a 10-year period, of which:

- One was a marriage where Adult HM had three children
- Ten were with single mothers who had children at home
- Eight out of these ten relationships ended following domestic abuse
- It would appear Adult HM left each relationship at the point where domestic abuse was reported to services or the relationship was ended due to his behaviour
- The remaining two of the ten relationships were for short period of time (one lasting for one month and the other for two months)
- Children Social Care undertook Child in Need assessments in respect of four of the families where he was domiciled and had direct influence over the children (8 children in total)
- Records indicate Adult HM directly abused two children (not including Child G) within the relationships either as part of a domestic abuse incident or separately from it.

8.6 In order to satisfactorily answer the questions within the Terms of Reference the review was required to understand the full histories of both Adult HM and Adult GF, the impact and involvement of both on children and specifically in terms of Adult HM (and other domestic abuse offenders connected to Adult HM's partners) the impact and visibility (to the safeguarding partnership) of his persistent domestic abuse on women and children across his adult life as well as his escalating violence.

8.7 As a result, the review clearly identified defined parameters of research within which individual partner organisations within the partnership could identify all its contacts with identified individuals and all information held concerning them.

8.8 The parameters were considered in terms of the necessity, proportionality and relevance to the review and its intended outcomes in order to ensure compliance with the Data Protection Act 2018 and the General Data Protection Regulation. Parameters were formalised against individual services in line with the four tests and an overall proportionality statement provided by the review.

8.9 The review has identified key learning for the partnership and individual partners through the thorough examination of the available information deemed within scope, discussions with key professionals from across the partnership and the issues identified from the Learning Event. All learning is identified within the specific sections of this report and a consolidated list can be found at Appendix 3.

8.10 The review clearly identifies a continual thread of sustained domestic violence affecting the multiple partners of Adult HM and their children both by him but also by other male and female partners of the same women.

8.11 By piecing together the complex partnership picture surrounding Adult HM and his offending and behaviours since 2005 leading to his eventual introduction to the lives of Adult GF, Child GF2, Child GF1 and of course of Child G, the review has been able to answer the Terms of Reference and identify learning for the partnership.

9 Hindsight Bias

9.1 Comment was made during the review by the Executive Oversight Group concerning Hindsight Bias in relation to the conclusions of the review in respect of the answers to the Terms of Reference.

9.2 The review has considered several varying descriptions of the phenomena of which the following two are potentially useful in discussing any potential for it within the findings of this review.

9.3 Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities. Hindsight bias stems from:

(a) Cognitive inputs (people selectively recall information consistent with what they now know to be true and engage in sense making to impose meaning on their own knowledge)

(b) Metacognitive inputs (the ease with which a past outcome is understood may be misattributed to its assumed prior likelihood)

(c) Motivational inputs (people have a need to see the world as orderly and predictable and to avoid being blamed for problems)

Consequences of hindsight bias include myopic attention to a single causal understanding of the past (to the neglect of other reasonable explanations) as well as general overconfidence in the certainty of one's judgments.

https://journals.sagepub.com/doi/10.1177/1745691612454303 accessed 17.03.21

9.4 Hindsight bias, also known as the knew-it-all-along phenomenon or creeping determinism, is the common tendency for people to perceive past events as having been more predictable than they actually were.

People often believe that after an event has occurred, they would have predicted or perhaps even would have known with a high degree of certainty what the outcome of the event would have been before the event occurred.

Hindsight bias may cause distortions of memories of what was known or believed before an event occurred and is a significant source of overconfidence regarding an individual's ability to predict the outcomes of future events.

https://en.wikipedia.org/wiki/Hindsight_bias accessed 17.03.21

9.5 Much of the academic discussion regarding Hindsight Bias is somewhat out of focus in terms of the potential mindset of reviewers who by the very nature of the task are looking back to understand issues through experience based reflective consideration of all the available facts. In the case of a Local Child Safeguarding Practice Review, this being safeguarding practice, structures and processes in order to identify potential learning.

9.6 The review is and has been mindful of Hindsight Bias and in fact a range of other biases during its work. One of the reviewers has experience of working with academic support in a previous review concerning bias within practice and decision making. The conclusions drawn in this review are based on the significant safeguarding experience of two practitioners from very different professional backgrounds.

9.7 The review accepts the potential for focusing on what now may appear to be individual causal factors or opportunities to intervene on occasions in relation to the outcome under review. In this review the danger would of course be to identify single or multiple events over many years, given the understanding of the final outcome for Child G and the events which led up to his death, and suggest that it was these events which led to the resulting outcome.

9.8 The review has not sought to do this and understanding the risk for this potential has enabled the reviewers to guard against it and remain proportionate and focused on the task of identifying learning and answering the Terms of Reference set by the Safeguarding Partnership.

10 Child G

10.1 Child G was born in hospital at 8.22pm on 6th January 2018. He was in hospital for a single night, being discharged the following day. There were minor concerns regarding Child G's weight up until he was 6 months old, and the appropriate additional health visiting support was provided for a short period of time. There were no noted complications or specific needs in relation to Child G.

10.2 On the 26th April 2019, Child G had his one year health visiting assessment; this was undertaken by a nursery nurse who comments positively about Child G's development and the family circumstances.

10.3 Throughout Child G's short life the professional network surrounding the family noted no concerns regarding him whatsoever, and all is seen as fine within the family context.

10.4 Child G was born into a family of two older siblings aged 2 and 7 years and his single mother, with all children bearing different fathers. Child G's father was not identified by Adult GF to any of the professionals who interacted with her, however we understand from the children's Social Worker that in the aftermath of Child G's death both his siblings have talked about Child G's father as someone who visited the family home, gave Adult GF money to support the family and also on occasions brought presents for the children.

10.5 From the age of 9 months, Child G attended a range of groups at an outreach centre run by the Family Hub from September 2018 until June 2019. In essence, Child G's experience was one of a relatively normal family life. He accompanied his mother as she took his siblings to nursery and school on a daily basis, the family taking a short bus ride to school.

10.6 Child G was well known by the nursery and school staff at the local primary school attended by his siblings. The nursery and Early Years staff describe Child G as a bubbly little boy who

was a regular in their classroom, he would potter around as his older sibling (Child GF1) settled into the day. They talk of how Child G would either sit happily in his pushchair or wander around saying hello to staff and goodbye to his sibling.

10.7 However, a further look at Child G's life through the knowledge gained from the police investigation and social work staff working with Child GF1 and Child GF2 after Child G's death paints a very different picture of his lived experience, an experience that appears to have gone unnoticed to the professional community.

10.8 The police investigation into the murder of Child G has shown that Adult GF's family and friends had awareness that all was not fine at home, they shared photographs of various marks and bruising on Child G through their social media and also directly through text messaging, such communications indicating that Child G's life was not always safe.

10.9 To understand Child G's lived experience it is worth considering some of the knowledge gained since his death.

10.10 On the 28th May 2019, (half term) Child G and his family attended a children's party, where the organiser of the party took photographs some of which are of Child G. In the photographs it is clear that Child G has bruising above his left eye and on his cheek bone. The adult describes the facial injuries as a large 2-inch bruise to the left-hand side of his face and a large lump to the right-hand side of his forehead like a golf ball. She also recalls seeing bruising to his chest.

10.11 The adult asked Adult GF how the bruising had happened and was told that Child G had fallen down the stairs. It is noted by this adult that the children didn't engage much in the bouncy castle activities and that Child G is said to have remained in his pushchair for most of the day, being allowed out to get some cake.

10.12 In early July 2019, just before the summer school holiday break, an adult known to Adult GF joined her and the children as they all walked home after the school day. The adult noticed that Child G had what was described as a very noticeable bruise that was blue colour and appeared to be fading. The bruise was described as the size of the top of a 50 pence piece and started from his left eyebrow and down into his eyelid. The adult asked how Child G's bruising had happened to which Adult GF replied that he was play fighting with Child GF1 who at the time would have been aged 4 years.

10.13 From this incident in July 2019 to the end of August 2019, the police investigation has revealed a succession of injuries: another incident of bruising to Child G's forehead and by the end of August he was noted to have had bruising to his lumbar region and to his left elbow.

10.14 The review has identified an incident on the 11th August 2019 which suggests Adult HM was at that time living in the home of Adult GF and her children. Police were called to an incident where Adult HM assaulted a female neighbour and then returned to the home address of Adult GF and her children where a witness describes hearing a domestic incident taking place.

10.15 Evidence gathered by the police during the murder investigation strongly points to the fact that Adult HM had moved in to live with Adult GF and the children in early August 2019. It therefore appears likely that Child G was living with domestic abuse within days of Adult HM arriving into his family home.

10.16 It must be remembered however that police evidence identifies that members of the community around Adult GF noticed injuries (bruising) to Child G as early as May 2019 when Adult HM was not involved with Adult GF.

10.17 At the time Adult HM moved into Child G's home he was awaiting a court appearance for failing to comply with a court order imposed following a conviction for a racially aggravated attack on a stranger (female) in the street. He was being supervised by the South Yorkshire Community Rehabilitation Company during this period. Adult HM appeared at court on the 22nd August 2019 and a new order was made and again he became subject to supervision by the South Yorkshire Community Rehabilitation Company. He remained under supervision for the remainder of Child G's life without any agency being aware he was residing with Adult GF and her three children.

10.18 It is clear from police evidence that Adult HM was trusted by Adult GF throughout their relationship to have on occasions, sole care and control of Child G, Child GF1 and Child GF2 while she was out of the family home.

10.19 In October 2019, there is evidence of conversations between Adult GF and her mother and also with Adult HM about Child G having fallen down the stairs.

10.20 By the end of October 2019, there are photographs of Child G with severe bruising to both eyes, and a mark to the centre of his forehead. Adult GF sent the photograph to a friend and a conversation took place whereupon Adult GF said she was not at home when the injures happened. Adult GF tells her friend that Child G is bruised all over. Both adults talk of the need to take him to hospital, but Adult GF says she hasn't and is concerned Social Services might be called.

10.21 Of note in October 2019, another of Adult GF's friends called into the family home and noticed the bruising to Child G eyes. He was also being sick. This friend told Adult GF that she should take Child G to the doctors to which Adult GF replied, '*he'd be alright'*.

10.22 Child G is believed never to have been taken to hospital, a doctor or received any medical assessment for any of his injures.

10.23 For Child G this meant they went unnoticed and untreated by those who could have assisted him professionally, instead he was left to manage his own pain as a very young child.

10.24 We have learnt from Child GF2 who has disclosed to their Social Worker following the murder of Child G that on Guy Fawkes night 5th November 2019 Child G was left alone shut in the garden at his home as fireworks were set off whilst Adult HM and the rest of the family watched from the safety of the house. Child GF2 shared that they were scared and distressed by this describing how this was a deliberate act by Adult HM to leave Child G alone in the garden with the fireworks. Child G was 22 months old at this time.

10.25 On the 7thDecember 2019, adult members of the community shared a bus ride with Adult GF and her children including Child G. The adults sat together, and one noticed bruising to Child G's left cheek describing it as yellowing and looking like a thumbprint. When asked how the bruise had happened, Adult GF did not answer.

10.26 Two of the other adults recall seeing two marks to one of his cheeks and one on the other suggesting they looked as if someone had '*grabbed Child G's face'*.

10.27 They also asked Adult GF and she said she didn't know how he had done it.

10.28 On the 14th December 2019 there is another photograph in which Child G had bruising to his temple and at the end of the month there are further photos of Child G having bruises to his face and his neck.

10.29 On the 6th January 2020, Child G's birthday, we know that he was taken to soft play and had takeaway food for his lunch.

10.30 On the 7thJanuary 2020, Child G spent some time in the afternoon with his grandmother and returned home with Adult GF. The evidence suggests at some point between then and late morning the following day Child G suffered significant head and back injuries.

10.31 On the 8th January 2020 at 10.56 am, Adult GF and Adult HM alerted the ambulance service that Child G was lifeless and not breathing. He was taken to hospital and following a series of examinations Child G was found to have suffered a non-survivable brain injury.

10.32 Child G died at 15.04 hrs on the 9thJanuary, aged 2 years and 3 days old.

11 Adult GF

11.1 Adult GF was born on 29th September 1987 making her 31 years old at the time of Child G's death.

11.2 A mother of three and from a family of two siblings herself. It is understood that her parents separated when she was younger and she grew up with her mother, Adult ARF, an older sister and a younger brother.

11.3 One's initial view of Adult GF's life experience is that it presents as nothing out of the ordinary. She has been a single parent since her first child (Child GF2) turned 18 months and had two further children (her last being Child G) with fathers who did not co parent. Adult GF was close to her maternal family and sought help and support where needed.

11.4 Adult GF's first child (Child GF2) was born in July 2010. Adult GF's pregnancy with Child GF2 is noted to have gone well, there were no complications at birth and routine health visiting services were provided to Adult GF as a first-time mother. Child GF2's father (Adult AJM) is the one father out of the three siblings to be named on a birth certificate, and whom Child GF2 lived with in a family unit with Adult GF until around the age of 18 months.

11.5 Adult AJM and Adult GF moved away from Doncaster for a short while. The relationship ended and Adult GF returned to be closer to her family, this is where Adult GF began her experience as a single parent. Adult AJM kept in contact with Child GF2 during the school holidays, and Child GF2 spent time in the paternal grandparent's house. The contact stopped when Child GF2 was about 6 years old and was reinstated in the aftermath of the death of Child G.

11.6 From those who know Child GF2 (school staff and the current foster carer) it is clear that Child GF2 was a responsible older sibling who took their duties seriously. Child GF2 assumed the role as one of protector and carer. The school staff talk of how Child GF2 would seek out Child GF1 in the playground at school, redo their hair and make sure they were clean and tidy. On arrival at school Child GF2 is described as a child who would settle Child GF1 into class before heading off on their own for the day. The foster carer has observed Child

GF2 to be unusually neat and tidy, taking it upon themselves to clean and tidy the house without any prompting or encouragement to do so.

11.7 Child GF2 is reported to be close to their maternal grandmother and speaks of cousins whom they enjoyed a close relationship with. Child GF2 has taken the death of Child G extremely hard. Since his death they have spoken of incidents in which they tried to protect and support Child G. We know from the police investigation that Child GF2 tried to comfort Child G when he was distressed, on one occasion taking him into their bedroom and watching Peppa Pig to soothe him when he whimpered.

11.8 Since the death of Child G, Child GF2 has spoken to the fostering Social Worker about being scared and distressed on Guy Fawkes night in 2019 when Child G was left alone in the garden.

11.9 One has to ask the question as to how it was that a protective older sibling such as Child GF2 never felt able to reach out to any of the trusted adults in school or within the wider family?

11.10 Adult GF's second child (Child GF1) was born in hospital in June 2015 and remained in hospital overnight before being discharged home. There were no complications at birth and Child GF1 was considered a healthy baby, there were no concerns expressed for the family.

11.11 Child GF1's father was not at the birth; however, he did visit later on the day of the birth, and he had regular contact with them during the early stages of their life. He was not in a relationship with Adult GF and when Child GF1 was a few months old he entered into a relationship with another partner. Child GF1's father reports that Adult GF's attitude towards him changed as a result of his new relationship and resulted in him not seeing Child GF1 for about 8/9 months. Child GF1's paternal grandmother remained in contact and is noted to have been the mediator of contact enabling Child GF1 to frequently spend nights at her house and have time with their father.

11.12 At Child GF1's two year health check Adult GF raised the issue of Child GF1's speech development. This was considered but not viewed as requiring a referral. There were no other specific concerns. By February 2018, the health visitor discussed Child GF1's speech development, who was at this stage aged 2 years and 8 months, with Adult GF who had expressed concern that their speech hadn't developed or improved since the 2-year review. A referral was made to the Speech and Language Therapy Team (SALT). Child GF1 was taken by their mother to several audiology appointments in April 2018 and a Speech and Language Therapy Team appointment in May 2018 where they passed a hearing test. At this appointment Child GF1 was reported by Adult GF to be putting two or three words together. A follow up review was agreed at a point when Child GF1 would have been attending nursery for a period of time, which may have encouraged them to be more motivated to use language.

11.13 In September 2018, Child GF1 started in their nursery class at a local Primary School, which supported the child's social, emotional and educational development. Nursery staff describe Child GF1 as a quiet child but not silent, despite the speech challenges they describe them as a child who communicated in their own way. They were popular with the

other children and were often heard talking to their older sibling. Child GF1 was not a child who found leaving Adult GF difficult, in fact the opposite was said to be true. Child GF1 enjoyed the stimulation of nursery and was described as joyful in class.

11.14 That said the school where keen to ensure that Child GF1 had the speech and language support they needed and where they became aware that appointments had been missed they were more than supportive of Adult GF to have them re-established.

11.15 In October 2018, Child GF1 was due to attend a Speech and Language Team appointment but '*… was not brought*'. As a result, Doncaster and Bassetlaw Teaching hospitals NHS Trust (Doncaster Royal Infirmary) discharged them from the service in mid-November 2018 with no further attempt at contact. School intervened and re-referred Child GF1 and they attended a further appointment in early March and again on two dates in mid-April 2019. Adult GF did not respond to the next appointment letter and as a result, Child GF1 was again discharged from the service in late May 2019.

11.16 Between June and December 2019, Adult GF with the support of school did converse with the Speech and Language Team and new appointments were made but not kept. On each occasion, the referral was closed (discharged from service) although an appointment was accepted in December 2019 for mid-January 2020. This appointment was not kept as Adult GF by this time was on remand charged with offences concerning Child G's death.

11.17 The review has considered two relevant policies in place within Doncaster and Bassetlaw Hospitals NHS Foundation Trust in relation children not being brought to appointments. These cover 'Referral to Hospital' and the Safeguarding Policy. Neither document uses the phraseology of *'was not brought'* but an older term of '*did not attend'.* There is structured guidance for response by professionals when children do not attend appointments and/or when safeguarding is a concern but the review would recommend a review and update of both in respect of both documents to ensure they are fully in harmony with current national thinking and language (recommendation in Appendix 4).

11.18 It is our understanding that Adult GF had friends in the community and school staff describe her as a mother who was not demanding on their time, she brought her children to school, there were no attendance worries and the children were clean and well presented. Adult GF was polite and did not stand out from the other mothers around her. Adult GF was viewed as a relatively private person but someone who would engage when needed. Health professionals report observing a warm and reciprocal relationship between her and her children on each visit.

11.19 From September 2018 until June 2019, Child G attended a range of groups in line with his developmental age and stage, they were, First Friends, Stay and Play and the Growing Friends. All took place at the at the outreach centre run by the Family Hub.

11.20 Adult GF and her children were not at any point in contact with the statutory service of Children's Social Care and not known to any other statutory safeguarding agency.

11.21 One has an impression of a single mother doing her best for her children as she managed the day-to-day duties of family life, however the police investigation that followed Child G's

death has afforded greater insight into Adult GF's relationship with her children and with Child G in particular.

11.22 Evidence within the Police murder investigation identifies that Adult GF was particularly negative towards Child G, calling him cruel and derogatory names and potentially using physical abuse when stressed: settling her children to bed in the evening appears to have been a particularly difficult time of the day.

11.23 We know that Adult GF used social media to communicate with friends and family, often talking of being exhausted, and with low tolerance of the children who in conversation would describe their behaviours through foul and degrading language, with Child G being described in the most derogatory of terms. When stressed, Adult GF would ask family members to come and get the children and in particular Child G who she would describe as constantly whingeing. She would often message them about her annoyance with Child GF2's attitude and saying things such as "*I'm gonna batter them"*. In response, friends and family members would offer advice and tell her to ignore the children, or at times appear to simply listen and validate her annoyance.

11.24 We know that despite conversations and advice from her friends about taking Child G to the hospital or to the doctors, Adult GF is clear that she would not take him especially as she did not want social work involved.

11.25 Adult GF met Adult HM through social media early in July 2019, initially talking with friends about her caution about another relationship. Adult GF spoke with friends about being impressed that Adult HM had three children to his ex-wife and no other children since, her impression was of a man who looked after his family, worked where he could and lived with his mother and father. Adult GF talks to her friends about Adult HM as a man who is *'good with her kids, he cooks and helps around the house'*.

11.26 She met one of Adult HM's siblings within a few weeks of the relationship commencing and by the beginning of August 2019 (within 5 weeks) Adult HM had moved into the family home. The police investigation shows that despite this newfound happiness for Adult GF, she continues to be very negative about her children: Child G continues to be called derogatory names. Adult HM adopts the same attitude using the same derogatory terms as Adult GF.

12 Adult HM

12.1 It is now known that Adult HM started a relationship with Adult GF in the summer of 2019 and that he quickly moved into the family home probably in early August 2019. A member of his family commented that it was not unusual for him to move in with new girlfriends swiftly as he had been homeless on many occasions.

12.2 Adult HM's family representatives told us that they were pleased about the relationship between Adult GF and their brother, considering Adult HM to be a good influence on them as a family unit. They gave examples of how Adult HM took it upon himself to place some boundaries around the type of food the children eat and to be clear with Adult GF about the need to cut down on the amount of junk food consumed by them all. The family members spoke of getting to know Adult GF as a local girl who had children by different

fathers. They spoke of how they had come to know that Adult GF self-harmed at times and felt depressed. They believed that Adult HM had looked after her.

12.3 At this time unbeknown to other services the South Yorkshire Community Rehabilitation Company were supervising him as the result of a court order emanating from a racially aggravated assault on an unknown woman in the street. Adult HM was subject to a court process at the time (South Yorkshire Community Rehabilitation Company had breached him) he moved into the family home which would be finalised with a revised and new but similar order on the 22nd August 2019.

12.4 Adult HM himself has three children (aged between 10 and 17) from his marriage which ended in 2012, two of whom live with his paternal family.

12.5 Adult HM was born on 26th December 1983: he has a significant history of professional involvement since very early childhood, when he was made subject to Child Protection planning as a baby and then again in his adolescent years.

12.6 His early childhood experiences are fraught with troubled and troublesome experiences, leading to a significantly troubled adolescence and the beginnings of drugs and alcohol abuse.

12.7 Adult HM has 3 older siblings. His siblings have supported him throughout his life with a particularly close relationship with the eldest (Sibling AF) who had left home and was living independently by the time Adult HM reached his adolescent years. As a sibling group they appear to have been united in their support of each other as they endured a childhood in which domestic abuse, coercive control, and abuse was a feature. A childhood where professionals had substantial involvement throughout and where involvement with Child Protection and designated Early Help services had been substantial. Adult HM was also supported by school staff in his adolescent years as the multi-agency group agreed the step down from a Child Protection plan.

12.8 As an adolescent Adult HM was involved in youth violence and crime and by the time he was around 19 years old he was married to a local girl (Adult AF). His first child, (Child AF1) was born when Adult HM was aged 19, and the first domestic abuse in this marital relationship was reported to the police in 2005. At the time of this first domestic violence incident Adult HM was 21, his wife was aged 21 and pregnant with their second child (Child AF2) and Child AF1 was 2 years old.

12.9 His marriage ended in 2012 and it is our understanding that from this point onwards Adult HM has flitted from one relationship to another. It is our understanding that for the majority of these relationships reports of domestic abuse have been a feature, on occasions the abuse has not always been known about until after the relationship has ended.

12.10 A number of assessments have been undertaken in respect of the children and the management of Adult HM's violence has been considered by Multi-agency Risk Assessment Conference (MARAC) on at least three occasions. Multi-agency Risk Assessment Conference (MARAC) and social work assessments are subject to discussion later in this report.

12.11 Adult HM has a catalogue of serious violence in his adult life. He has two convictions that led to a custodial sentence. Adult HM has been under the management or supervision of the National Probation Service and South Yorkshire Community Rehabilitation Company since October 2013. He has a total of 5 convictions for offences against a person. Neither of his custodial sentences were for domestic abuse. His convictions are for a range of offences including drug supply, burglary, racially aggravated assault, and wounding.

13 Contact with Services:

13.1 Education

13.2 The daily routine of Child G's family meant that he accompanied his two siblings to and from the local Primary School, sitting in his pushchair as the family took the short bus ride to and from school.

13.3 School staff speak of knowing Child G's family well, Child G's oldest sibling having attended the same school throughout their education until becoming a child in care in the aftermath of Child G's death.

13.4 The Primary School, centred in the heart of the community, holds much intelligence and soft information about the children and families within its community. School staff know when a family becomes reconstituted through the various and complex nature of family relationships or adult partnerships that bring families together or indeed break them apart. The Primary School understood Adult GF to be a single parent who looked after her three children well, all be it with a bit of support from her extended family, or from playground adult friends who assisted in keeping an eye on Child G when she settled the other children into school. Adult GF did not present as a significantly isolated parent but as a mother who was quiet in presentation and of low maintenance to school staff.

13.5 It appears that at no time did school staff enquire with Adult GF as to the fathers' presence or their roles within the family and the upbringing of the children. The issue of fathers being missing and unidentified was explored at the Learning Event and all present accepted the need for a greater professional curiosity in this area and the need and professional right to do so.

13.6 As Child G became mobile, school staff have spoken eloquently about how he would get out of his pushchair and enjoy the business of the morning routine in preschool, watching Child GF1 settle in. At times he busied himself by playing with toys, pottering around the pre-school space as he engaged and chatted with staff. When we spoke directly to school staff (including pre-school), no one noted a change in Child G at any point or noticed injuries. We know from the police investigation that bruising to Child G's face and forehead was clearly visible on several occasions from May to December 2019.

13.7 There were never concerns around the children's attendance at school, Adult GF was the consistent adult who would bring the children to and from school. The school leadership team and safeguarding leads all reflected how it was that there appeared to be no specific changes in demeanour, behaviour or physical presentation of Child G as he suffered over the last few months of his life. Furthermore, school staff remain very concerned at what prevented Child GF2 from approaching them about their worries given that we now know from the police investigation that Child GF2 had reached out to the extended family members when Child G wouldn't stop crying.

13.8 *School community context*

13.9 In the Learning Event, we were able to consider the demographics of the families whose children attend the Primary School, in an attempt to think about the specific challenges or strengths in the community and where children could go if worried about something.

13.10 School leaders spoke of the fact that the catchment area included a high population of low wage working families and also of single parent families with young children. They spoke of the proud nature of an ex-mining community and the sense that people look after their own. Underneath this is apparently a current of mistrust in professionals who work within

the communities and school staff believed this to be a significant factor in not being aware of Child G's suffering or indeed that of his siblings.

13.11 The Primary School is signed up to Operation Encompass. In our view this is a very positive step for the community and an acknowledgement by school leaders about the proactive and protective position they know themselves to be in, where the needs of children impacted by domestic abuse is a real issue. The question is therefore about how the school then intervenes to provide support and protection for children as they walk the fine balance between intervention and interference in family life. This concept was tested at the Learning Event and as reviewers, we were left with a distinct impression that school leaders had high aspirations to intervene.

13.12 For many school staff they are themselves part of the community, living locally and for those who lead in the Primary School most of them have been there for many years.

13.13 Seeing the generations of families grow and having known the parents as children themselves they have therefore a deep understanding of the parents lived experience when younger, through adolescence and now as parents themselves. On listening to the professionals who work locally and to Adult HM's own sibling one is left with an impression that this is also a community that has many strengths.

13.14 The fact that Child G had visible injuries and that his demeanour is said to have been noticed by members of the public and other parents of school children, is an issue that school staff challenged themselves about.

13.15 There can be no mistaking that the role of an education and schools setting offers significant wisdom to the successful development of a stronger and safer community. They are, and will continue to be, a critical part in the welfare and protection of children as a key component partner agency in the safeguarding agenda, locally and nationally.

13.16 Leaders should consider the effectiveness of the partnership inclusion of education settings within the wider community safety agenda and the important role they have in protecting children. This review has asserted the idea of professional curiosity and the giving of permission to the school community to be professionally inquisitive in order to step in where children need the love, care and attention to detail in order to keep them safe. Such practice requires courage and a clear understanding of role. Education settings should consider what it is that makes children comfortable to express their worries and their experiences in family life particularly when family life has been disruptive.

14 Health

14.1 Health professionals involved with Child G and his family, had no concerns in respect of their health and wellbeing. Adult GF was considered to be a single parent who had a warm and reciprocal relationship with her children. As a small family unit they enjoyed the support of extended family who lived locally. Adult GF was noted to have kept a warm and tidy family home and there were no significant concerns in relation to care and protection.

14.2 On the 16th April 2019 Child G had his one-year health visitor assessment, this was completed by a nursery nurse who comments positively on Child G's wellbeing and his relationship with his mother, no concerns were raised.

14.3 Reviewers where curious about the fact that all three children were known to have different fathers, with the identity of Child G's father having not been shared by Adult GF. As such, reviewers were inquisitive about the strength of local practices within health services to identify fathers and to do all they could to assure themselves that such absent fathers were

safe. It is clear from health records and from discussions with health visiting staff, there was a general acceptance that the whereabouts or identify of the father is seen as an option for the mother to divulge or not.

14.4 Health records would suggest that the majority of recording about parental attachment is concerned primarily with the mother figure with little attention paid to the importance of the father figure. Where a mother refuses or decides not to name the father of the child this does not appear to be explored in any detail. Instead, there is an acceptance that this choice by a mother is satisfactory and has no significance on what the child's lived experience is to be.

14.5 There is a need for consistent professional curiosity to be applied to the paternity of children, left unexplored there can be a missed opportunity to understand where there is history of difficult, troubled or troublesome behaviours and where there may be unassessed safeguarding issues. Put simply there is the potential for risk to be left unseen as it is not explored initially at the earliest opportunity through the identification of key relationships.

14.6 For Child G, the professionals did not know the paternity of his father until his death, however whilst in foster care Child GF2 has spoken to their Social Worker about the fact that Child G's father would often visit their family home, he also supported Adult GF financially and on occasions he would bring presents for Child G's siblings.

15 Early Help

15.1 As part of the universal preventative offer across Doncaster, a range of Early Years groups are provided through the local Family Hubs and are designed to meet children's needs based on their age and stage of development. At times children naturally move from one group to another and families are able to come and go based upon their needs at the time.

15.2 Adult GF is exactly the sort of parent to which these services are aimed, as a single mother living on her own with her three children. Two of which were under 5 years old she was perfectly placed to benefit from the support offered within the Family Hub: particularly given the challenges and concerns about Child GF1's possible speech delay and to assist with Child G as he developed through his pre-school years.

15.3 Child G was introduced to these services in September 2018 and became a regular attendee from October 2018 to February 2019, taking part in the First Friend Group before he moved into the next stage group of Growing Friends group for one session.

15.4 The Growing Friends group is run as a partnership between council based Early Help, and health based early year's health service. The group is run with parents and for children who are from birth to five years old. It is designed to promote access support, advice, and guidance alongside engaging in age-appropriate activities with their child.

15.5 The aim of Growing Friends is for families to be alongside health services to promote interaction and attachment between parent/carer and their children, in addition to providing support around a range of topics, including child development.

15.6 The intention is to contribute to evidencing the impact on a child's:

- Personal, social and emotional development (PSED)
- Communication, Language and Literacy (CLL)
- Physical development (PD).

15.7 The objectives of Growing Friends is to:

- Support parents/carers to interact with their child around age-appropriate activities that they can do at home
- Enable parents/carers to understand and demonstrate positive interaction with their child
- Give parents opportunity to develop their children's PSED skills, including turn taking, sharing of resources and socialising
- Promote play and stimulation for children aged 0-5 years
- Provide every opportunity to enhance listening, understanding and speaking through play
- Promote health and self-care through session routine.

15.8 Stay and Play is another group run out from the Family Hub and is facilitated by council early year's development workers only.

15.9 The sessions are created in order to reach children and parents where there has traditionally been low engagement, therefore making the group for children aged between 0-5 years enables parents to have the opportunity to have more than one child with them at any one time. The sessions also focus on activities which promote school readiness in preparation for school nursery and engaging with families by providing a nurturing and structured environment which promotes school readiness and to contribute to evidencing the impact on a child's Personal, social and emotional development (PSED), Communication, Language and Literacy (CLL) and Physical development (PD).

15.10 Objectives of stay and play are to:

- Support parents/carers to interact with their child around age appropriate activities that they can do at home
- Enable parents/carers to understand and demonstrate positive interaction with their child and promote independence and choice
- Give parents opportunity to develop their children's Personal, social and emotional development (PSED) skills, including turn taking, sharing of resources and socialising
- Provide every opportunity to enhance speech and communication through play
- Promote health and self-care and independence through session routine
- Have a clear routine to get children ready for school, i.e. Hello song, self-registration, reviewing of learning, etc…

15.11 Child G started to attend the Stay and Play sessions, in June 2019. He attended for 2 sessions and then stopped. It is understood that the Family Hub made a phone call to Adult GF to establish if Child G would be returning but they had no reply, and no further contact was undertaken.

15.12 Given that Child G had benefited from the regular attendance at the Family Hub over a 9-month period the review was curious to understand how the Family Hub staff viewed their roles in having the opportunity to be more proactive and curious in their follow up with parents who stop attending with their children: we know that within weeks of Child G's non-attendance at the Family Hub Adult GF and Adult HM had started to form their relationship.

15.13 Reviewers questioned the benefits and pitfalls of relying on a phone call and not a home visit to attempt to re-engage with families who had not attended the hub and the potential for need, harm and risk to children to go unnoticed. The reviewers were mindful that had it been usual practice to undertake home visits Family Hub staff may, or may not, have had

the opportunity to notice Adult GF's new relationship and to have been curious about Adult HM's presence in the family home.

15.14 Of note:

- 28th May 2019, Child G is noticed to have had bruising above his left eye and on his cheek bone. The adult describes the facial injuries as a large 2-inch bruise to the left-hand side of his face and a large lump to the right-hand side of his forehead like a golf ball, bruising to his chest is also noted.
- 21st June 2019, Child G's last attendance at the Family Hub.

Learning

Education, Health and Early Help

Doncaster schools, health services and Early Help are ideally positioned to enhance family-based knowledge especially awareness concerning children's paternity through a relentless focus on children, the application of professional curiosity and the conscious use of practice wisdom. Such curiosity should be applied when seeking to identify other significant adults in a child's life as well understanding who else maybe in the family home.

Response to Learning

School

As an outcome of this review school leaders at the Primary School have put in place the following improvements:

Reception class staff now conduct home visits for all the families joining the school, and particularly for those children who have not risen as a result of the schools' own nursey cohort of children. The aim is to understand the child in the context of their family environment and to build a trusting rapport with parents and carers from the outset of school life.

Staff are now actively more professionally inquisitive when gathering information recording on their new starter forms where fathers have not been listed. Staff are more confident at asking the mother or carer the reason why the father hasn't been listed, importantly staff now make this clear on the child's school record. Leaders have embraced a more curious approach to support children whilst helping mothers and other family members to know why the child's paternity is an important factor in a child's life. By way of example:

- School noticed that a child's father was the only adult to pick up the child from school. Being curious school asked why this was. The father was able to explain the complex family dynamics, leading to a greater understanding and more targeted support for the child on a daily basis and a father much more involved in school life.

For all new children in school, communication with the health visitor is now a priority, this is to establish if there are any specific concerns for the child and their family at the point of admission.

For all new children parents are asked where other siblings attend school, taking a note of the schools and making contact where there may be a need to do so.

It is now usual practice for all reception class children to be guided to draw pictures of who lives in their house (this particular activity rapidly brought out something for one child which the school followed up on). In response to this learning school leaders are considering using this approach for other year groups within the curriculum as part of their child safeguarding practices.

Response to Learning
Health

The Health Visiting Service adheres to Doncaster Safeguarding Partnership policies and guidance and continues to include guidance around professional curiosity in Safeguarding Children training.

The service has updated practice during initial visits to include a consistent more in-depth level of professional curiosity to include exploration of paternity and parental responsibility at all Health appointments.

Visiting contacts. (Updated in March 2021). Fathers are encouraged to attend and participate in both groups and home face to face contacts with the Health Visiting Service where all aspects of parenting are discussed and specific research-based tools are used to encourage and promote engagement.

From May 2021 training around professional curiosity and paternity will be included in the Health Visiting Services yearly training updates for staff. This will be quality assured by a yearly dip sample audit and the findings will be fed back to the staff team and will inform the upcoming future training updates.

Response to Learning
Early Help

Senior leaders in Early Help services have identified training for all early year's staff on Trauma Informed Practice, to enhance their ability to recognise the signs and symptoms of trauma and how this may be noticeable within an early year setting.

Early Help policies, procedures and practice has been strengthened in response to the learning, they include:

- Practitioners in the Family Hubs now actively seek father's details, where the details are not forthcoming record clearly state why the father is not known
- Practitioners actively follow up with families where attendance at the Family Hub starts to drop off and a record is made of the outcome
- The 'Injury to child proforma' has been further developed and managers now provide oversite to identify themes or trends
- Training is being developed for Family Hub teams to develop staff's professional curiosity further within group work programs: supporting staff to focus on any changes to behaviour, appearance and attendance of both carers and children, the training will be implemented in spring 2021.
- The Family Hub Service Manager now attends the newly formed Domestic Abuse theme groups on vulnerable children alongside the Multi-Agency Tasking and Co-ordination (MATAC) meetings, to understand risk in the locality, and flag prolific perpetrators who may move from one relationship to another. Attendance also enables a better understanding of need in each locality area and an opportunity to tailor responsive services within the Family Hubs accordingly.
- Family Lead Practitioners are now co-located within Family Hubs and undertake visits to children and families at home.

16 South Yorkshire Police

16.1 Involvement in Domestic abuse

16.2 South Yorkshire Police have attended eight incidents of domestic abuse in respect of Adult HM over a number of years (July 2005, July 2006, Oct 2010, Dec 2012, Dec 2014, July 2015, Oct 2016, January 2018).

16.3 The force has arrested and prosecuted Adult HM for numerous, varied offences including:

- Violence on male and female victims (including a family member)
- Violence with and without a weapon
- Violence with racially aggravating factors and attacks on strangers who were not known to him

16.4 Until the 6th January 2020 they had no record of Adult GF within their multiple systems.

16.5 The majority of incidents concerning Adult HM were of domestic violence and abuse, all against female partners who had children within the family setting. Police records show the force was only aware of one incident where a child was subjected to violence (Child BF1) in January 2018 and this led to the arrest of Adult HM (no conviction). The police assessed him as high risk and referred the child to Doncaster Children's Services Trust.

16.6 As stated, the review identified that Adult HM had 14 relationships with women, including his one marriage, and police records suggest the incidents and violence commenced in 2005 when he was 21 years old. He also assaulted strangers and one of his own siblings.

16.7 This timeline and the available partnership evidence identify Adult HM as a prolific offender of domestic violence within Doncaster for 15 years without a single successful intervention to change his behaviour: all whilst his violence escalated and as he travelled from one woman and her children to another, eventually ending with Adult GF, Child GF2, Child GF1 and Child G in 2019. Separate pieces of the information picture which identified his offending and behaviours were known to individual organisations within the partnership but as stated elsewhere in this report the true holistic picture of his lifestyle and offending was not known to one or all of the safeguarding agencies.

16.8 On many occasions the levels of violence and abuse to both his partners and children can only be described as extreme. The effect in the form of emotional abuse this would have inevitably had on the respective children residing in a violent household cannot be understated. Adult HM was routinely arrested and on occasions convicted (never for domestic abuse) but on a noticeable number of occasions prosecutions were not successful due to witnesses withdrawing evidence or their intent to continue in support dwindling.

16.9 The review discussed this issue with South Yorkshire Police and its practice surrounding prosecution of domestic abuse including opportunities for victimless prosecutions.

16.10 Indications are the Police are very aware of the issue and attempting to improve this position in respect of all their dealings with domestic violence and similar offences in a range of ways. The force highlights good practice can be seen in pursuing victimless prosecutions for the most serious high-risk cases, but also accepts that there is still ongoing work required to see improvement, in particular for those assessed as medium or standard risk.

16.11 This focus of improvement is important and needs to be supported by a multi-agency approach concerning victim support and robust child and family assessment. As always in

safeguarding of the vulnerable no one partner can achieve full impact and improvement alone.

16.12 The review was pleased to learn that in April 2020 South Yorkshire Police had already introduced a dedicated Domestic Violence Prevention Order Unit. This team is now fully embedded within South Yorkshire Police's response to domestic abuse, in particular when taking a proactive approach on cases where difficulties arise in obtaining a prosecution. The force identifies a significant increase in obtaining successful Domestic Violence Prevention Order's across the force, as well as an improved response in dealing with breaches.

16.13 Incident of 11th August 2019

16.14 On the 11thAugust 2019 at 00:45 hrs South Yorkshire Police received a call from an adult female, reporting an incident and assault on her friend by a male neighbour in the communal garden area of her premises. The caller identified that the assault had ended but the offender had returned to an address next door where she stated a domestic incident could be heard taking place.

16.15 The incident was recorded as a domestic incident by call handlers on South Yorkshire Police's SMART Contact System and accordingly an emergency response was afforded to safeguard victims.

16.16 7 minutes later at 0052 the South Yorkshire Police SMART system records:

Shouting and banging and crashing was heard when the offender went home, the offender is Adult HM and he is having a domestic with his partner at the address the offender partner is Adult GF the caller told that Adult HM has recently been released from prison and has been at the address for 3-4 weeks – it is reported children are at this address as well.

16.17 Police attend and after unsuccessfully trying to raise the person reporting and victim of the assault, they attend at the address identified and see a male who is within the home of Adult GF, who gives a name of Adult BQM. They also see and speak to Adult GF who states there had been no domestic incident and that she did not require any police assistance.

16.18 The police did not enter the house but spoke to Adult GF through an open window. The children who had been identified as being in the property by the witness were not seen by the officers.

16.19 Whilst this was initially a report of an assault on a neighbour, further information was received to state that a domestic incident was taking place involving the perpetrator of the assault with his partner. Children were reported as also being present at the address. This was correctly graded as a domestic incident and an immediate response was allocated.

16.20 It appears that the Officers who attended this incident formed the view when speaking to Adult GF that no domestic incident had taken place. Had more professional curiosity been shown, then a different outcome may have been reached, this decision however resulted in a number of actions not being completed, that would ordinarily have been so if a domestic abuse incident had been recognised.

16.21 The lack of safeguarding activity and professional curiousness by the officers was out of harmony with the forces' most current policy guidance to officers in such circumstances. The policy issued in 2007 and last reviewed 28.01.20 states:

'that any officer attending a domestic incident should, 'establish who is or was at the scene, including children…….. carry out an immediate risk assessment to ensure the safety of the

victim, children, suspect and officers……..separate the parties, including children (at an appropriate time and in a sensitive way).'

'children should be spoken to separately, checked and their demeanour observed. Officers should be professionally curious and ask questions about the child's experience of living in that house, not just their recollection of the incident in question. It is important that officers attending domestic abuse incidents see and check all children present at the address and record…information regarding children present at the incident and children who are normally resident at the address.'

South Yorkshire Police

16.22 None of the other parties were seen on the evening but enquiries during the following week led to the police closing the original incident and assault allegation. On the 12th August 2019 officers spoke to another neighbour Adult BPF during their enquiries into the incident who positively identified the offender as Adult HM having been to school with him. She stated he had been living at the address with Adult GF and the children for about 5 weeks.

16.23 We are informed that the officers attending conducted Police National Computer (PNC) checks on the names of Adult BFM and Adult HM without dates of birth. It is apparent that the surname of Adult HM was recorded with the different spelling both within the control room and by the officers who spoke to Adult BPF. South Yorkshire Police state using this spelling produces multiple individuals on the Police National Computer (PNC) and without a date of birth or further information, it would have been problematic to identify Adult HM correctly.

16.24 If officers had identified this as a domestic abuse incident, more determined efforts may have been made to obtain the correct details of this male. Further Police National Computer (PNC) checks could then have been made and the identity of the male, believed to be Adult HM, confirmed.

16.25 In considering good safeguarding practice it is perhaps helpful to outline the following steps in this particular incident, given the fact that this is the first real tangible identification of Adult HM in Child G's family home in the middle of August 2019.

16.26 Significant factors in this incident:

- Clearly determined as a domestic incident and an emergency response was recorded to safeguard victims
- Adult HM was identified by name and as having been released from prison a few weeks earlier by the person reporting the incident to the police (surname recorded as different spelling)
- Adult HM has a Police National Computer (PNC) record (no warning markers at the time of the incident)
- Adult GF was named as the partner of the offender who had just assaulted a woman in the communal garden
- Witness identified shouting, banging and crashing and described a domestic within the premises where Adult HM had returned
- Children were reported as being in the address
- The children were not seen, and officers did not enter the house.

16.27 At the time of the incident Adult HM was subject to management by the South Yorkshire Community Rehabilitation Company (SYCRC). The standard of management of Adult HM during 2018 and 2019 is subject to consideration and comment elsewhere in this report. During the 5 weeks prior to the incident Adult HM was in breach of a court order and awaiting trial. He was stating he was not in a relationship and living with a family member. He was failing to attend the unpaid work appointments he was required to undertake but the South Yorkshire Community Rehabilitation Company were not taking action because he was already in breach.

16.28 In effect Adult HM was not being supervised in any realistic manner in this period due to him breaching his order and creating a two-month hiatus as he waited for a trial concerning the breach. His South Yorkshire Community Rehabilitation Company file notes clearly show they were waiting for the next court hearing and as such Adult HM was free to go about his life as he wished. This he did by starting a new relationship with Adult GF and moving into the family with her three young children un-noticed by professionals.

16.29 Adult HM was not wanted at the time of the incident and there were no markers on Police National Computer (PNC) concerning South Yorkshire Community Rehabilitation Company or any other partner seeking information on him.

16.30 South Yorkshire Police use the national Domestic Abuse, Stalking and Honour Based Violence (DASH) 2009 Risk Identification, Assessment and Management Model and form for notification of attendance at domestic abuse incidents to children's services. As the attending officers did not identify this as a domestic abuse incident, no DASH report was completed and therefore the incident was not notified to Doncaster Children's Services Trust.

16.31 Successful identification through a Police National Computer (PNC) check on Adult HM could have alerted the officers to the fact he was a violent offender and subject to a court order for a conviction concerning a racially aggravated assault on a woman he did not know in a public place. Knowledge of this information may have also influenced decision making around this being a domestic abuse incident and could have resulted in further safeguarding checks being made and a Domestic Abuse, Stalking and Honour Based Violence (DASH) risk assessment form being submitted.

16.32 South Yorkshire Police have confirmed from checking historic Police National Computer (PNC) records that Adult HM had no PNC markers for weapons and violence at the time of the incident. This is unfortunate as if they had been in place (and if he had been located through a PNC search) this would have been visible to the officers.

16.33 It is important to note the officers who attended on the night were aware from 00:52 hrs that the male offender for the assault was Adult HM (surname recorded differently) who had just been released from prison, this being only 7 minutes from the original call. They were also aware he had returned into the home address of Adult GF and her three children where it was reported he was having a '*domestic with his partner'*.

16.34 There appears to have been no follow up to the home of Adult GF after the information on the 12th August 2019 positively identifying him, and no record of the children being seen on the night, the following day or during the week when enquiries continued. The officers did not enter the house at the time of their attendance to check the safety of the children or Adult GF even though their response was graded as an emergency to safeguard victims.

16.35 If a Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH) had been submitted and Doncaster Children's Services Trust made aware of the incident, then the

Primary School who taught Adult GF's children may well have been informed as it is signed up to Operation Encompass.

16.36 Submission of a Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH) could also have triggered the consideration of a notification under the Domestic Violence Disclosure Scheme 2016: Clare's Law, in terms of a '*need to know*' notification to Adult GF concerning Adult HM's previous violent offending and behaviours.

16.37 It is also possible if the partnership had been effective in sharing information and identifying and managing its most prolific perpetrators of domestic abuse that South Yorkshire Community Rehabilitation Company would have been informed that Adult HM was living in an address they knew nothing about and that he was lying to them at that time concerning relationships.

16.38 The approach by the police in this incident and in particular the decisions made on the 11th and 12th of August 2019 appear to have resulted in Adult HM going unnoticed and the children not being checked or spoken with. He remained under the radar across the partnership despite the fact that the South Yorkshire Community Rehabilitation Company had a duty to supervise him at the time. Furthermore, the lack of sight of this incident meant that Adult HM was able to disguise the fact that he was living with Adult GF, Child G, Child GF2 and Child GF1 through the court hearing of the 22nd August 2020 in relation to the breach of the court order.

16.39 The evidence from the public on that morning strongly suggests he was continuing his violence within a new family home and exposing 3 children to abuse and violence. No other information is forthcoming to the safeguarding partnership that they are living together until the events of January 2020 and the murder of Child G.

16.40 In September and October 2019, the South Yorkshire Community Rehabilitation Company undertook new risk assessments and started new management plans with Adult HM. The lack of police involvement in the reported domestic incident in Adult GF's home address following the assault and the subsequent lack of information sharing by way of Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH) to Children's Services meant that effectively the South Yorkshire Community Rehabilitation Company undertook their assessments unsighted on the current risk.

16.41 Interestingly the Probation Officer from the South Yorkshire Community Rehabilitation Company requested police intelligence about domestic call outs on the 13thSeptember 2019 as part of her risk assessment, receiving a reply the following day that no new information was available in respect of Adult HM since the last check in April 2019.

16.42 This particular set of events was a potential opportunity for the partnership to have understood the risks that Adult HM posed to Adult GF and the three children.

16.43 This incident should have sparked the process of good Child Protection practice by following due process and procedure.

16.44 The response to this incident is professionally sobering when one considers the well-known pattern of Adult HM, the level of violence he presents and the fact that his presence within the family was noticed and reported by members of the public. The witnesses clearly, and unquestionably identified him at the onset of his relationship with Adult GF. Had the basics of practice been executed well, there is every likelihood, given previous behaviours of Adult HM that safeguarding action could have been taken which may have caused him to have left Adult GF and afforded some protection to the children in so doing.

Learning

When attending any report of domestic abuse or violence officers must make best efforts to identify all those involved both victims and perpetrators including those who may have left the scene and ensure all information and intelligence is shared in line with local safeguarding policies with their local Authority children's service.

Where domestic abuse or violence is reported, or suspected police officers and staff need to always be professionally curious to a point where they satisfy themselves (or not) that any potential victim is safe both at the time and when their contact with that person or their dependents finishes. This on all occasions must include all children and young people. Children and young people should be engaged with to a point where the officers can satisfy themselves of the identity of the child and that they are safe and well.

Officers should be professionally curious and be prepared to challenge any narrative provided by either a potential victim or perpetrator. They should be aware of the potential for unseen levels of coercive control which may be in place within relationships both between the adults and any children or young people who are within the family unit.

Police officers should be knowledgeable and confident in their use of powers of entry to premises in order to ensure the safety of victims, children and young people where domestic abuse and violence is or has occurred or is reasonably suspected to be or has been taking place.

Response to Learning

South Yorkshire Police have acknowledged the learning emanating from this incident and the review, in particular the incident of the 11th August 2019 and are currently investing in a range of remedial actions in order to enhance their provision of service in respect of domestic abuse and the safety of victims and children.

South Yorkshire Police in partnership with Safe Lives and the College of Policing has developed and is now in the process of delivering training to all relevant officers and staff within the organisation. The training aims are to enable all officers and staff to improve their knowledge, skills and response to domestic abuse cases, especially by recognising signs of domestic abuse as well as understanding why victims and perpetrators act in a particular way. For officers and staff to see and understand the devastating impact Domestic Abuse can have on victims, children and wider family members will show how important it is to treat every report of Domestic Abuse in the most effective way.

South Yorkshire Police are also intending to deliver a child centred training program across the Force. The training will include various elements of child protection and will highlight best practice when officers and staff are responding and dealing with incidents of domestic abuse where children are present or recorded as being in the household.

In 2019 South Yorkshire Police adopted the process of proactively initiating Right to Know notifications during the risk assessment of any domestic abuse incident assessed by the Force's central Domestic Abuse Risk Assessment (DARA) Team. Following partnership involvement and information research a decision is made by a Detective Inspector as to the provision of a 'Right to Know' notification to an individual.

16.45 Domestic Violence Disclosure Scheme 2016: Clare's Law

The Domestic Violence Disclosure Scheme 2016 (DVDS) or Clare's Law as it is widely known and is used across the four local authority areas covered by South Yorkshire Police as it is across all of England and Wales.

16.46 The scheme recognises two procedures for disclosing information. The first *'right to ask'* is triggered by a member of the public applying to the police for a disclosure. The second *'right to know'* is triggered by the police making a proactive decision to disclose information to protect a potential victim.

16.47 *'Right to ask'* and '*right to know'* are managed by the police service who working with their partners decide if a disclosure is necessary, lawful and proportionate to help protect the potential victim from abuse.

16.48 The Domestic Violence Disclosure Scheme has been implemented within existing legislation and common law.

16.49 Both procedures should be considered preventative.

16.50 The review has explored the use of the scheme in Doncaster and has found it is being used by some practitioners. In respect of the review, it is the '*Right to Know'* which is of particular interest in respect of this review's terms of reference.

16.51 The scheme is mentioned within a list of useful practice tools within the Domestic Abuse Strategy of the Borough (2016 – 2021) but has no commentary attached concerning its use.

16.52 At the time of writing the data for Doncaster Safeguarding Partnership held by South Yorkshire Police showed an increase in use in 2020 with Doncaster making more requests for determination by the police in the months from August to October 2020 than any of the other three local authority areas. This is not a normal trend with the City of Sheffield due to its size normally making the most. However, all the requests came following a domestic abuse incident and the majority through the Multi-agency Risk Assessment Conference (MARAC) process which indicates the incident had been assessed by the police as high risk.

16.53 It is positive to know it is being used but the review would suggest that for the scheme to be used more as a preventative tool as opposed to a reactive one the partnership needs to identify high risk and extremely violent offenders such as Adult HM who have changed relationships and are living with a new partner who is unaware of the others history of violence and behaviours prior to an incident taking place.

16.54 Discussions with lead decision makers within South Yorkshire Police indicate that they recognise the need for developing the use of the scheme in a more preventative way and there is a desire to work with safeguarding partners to attempt to achieve impact in this way.

16.55 Throughout the review discussions have taken place with the safeguarding partners concerning the need to be able to identify and monitor serial perpetrators of domestic abuse and violence in order to coordinate prevention and intervention activity and strategies.

Learning

Opportunities exist within the partnership for **The Domestic Violence Disclosure Scheme 2016 (Clare's Law)** to be used in a more preventative way focussing on the 'Right to Know' by 'partners' within relationships through the more detailed identification and analysis of repeat offenders thereby enhancing the current use of it through MARAC following an incident of violence or abuse.

16.56 It is worthy to note that Doncaster Safer Stronger Partnership have implemented a Multi-Agency Tasking and Co-ordination forum (MATAC) in respect of domestic abuse perpetrators.

16.57 The Multi-Agency Tasking and Co-ordination (MATAC) project has been funded by the Home Office and will introduce and embed a process within South Yorkshire Police and its partners to identify and manage serial perpetrators in relation to domestic abuse.

16.58 The intended overall outcome of the Multi-Agency Tasking and Co-ordination (MATAC) approach is to reduce reoffending of the most harmful and serial domestic abuse perpetrators and to safeguard victims and families. The police suggest the approach has been successful elsewhere in the country with an evaluation in the North East of England demonstrating a 61% reduction in the reoffending rates of identified domestic abuse perpetrators and a 65% reduction in domestic abuse related offending.

16.59 Data will be extracted from South Yorkshire Police systems in relation to crimes and incidents, particularly in relation to recency, frequency, gravity of offences committed, and the number of victims involved. From this the perpetrators most likely to cause harm will be identified and a process will be adopted for partner referrals to be made.

16.60 Initially, the top four perpetrators in each area will be considered and a subject profile for each perpetrator will be produced for discussion at a Multi-Agency Tasking and Co-ordination (MATAC) meeting.

16.61 The aim of the meeting is for Police and key partners to take an offender management approach with the perpetrator to reduce harm, offering engagement and intervention in the first instance to try and break the cycle of offending. If this fails, then the approach will become one of enforcement, disruption and prevention. Each perpetrator will have a harm reduction plan, which will be reviewed at a subsequent meeting.

17 National Probation Service & South Yorkshire Community Rehabilitation Company 2014 - 2020

17.1 Management and supervision of Adult HM

17.2 Adult HM was known to the majority of safeguarding partners in Doncaster (at different times and for different reasons) throughout his life, from early childhood through to the present day.

17.3 At the point he came into Child G's life there was a wealth of knowledge concerning him held within the individual statutory agencies who are tasked to safeguard children and adults within Doncaster.

17.4 It became clear to the review that to understand if opportunities had been missed to protect Child G, his siblings and his mother, then it was essential to understand the risk that he posed to the family and in particular the children at the time he arrived into their lives. All statutory agencies assess risk using a variety of profession specific risk assessment tools all of which rely on the quality and fullness of the available information and intelligence concerning the person who poses the risk.

17.5 There are well established legal processes underpinning the way in which information can be shared between organisations for the purposes of safeguarding and promoting the welfare of children. There is also national guidance published and support available from the Office of the Information Commissioner.

17.6 Information sharing across statutory and non-statutory partners is key in undertaking effective assessments and understanding the true risks a person may pose to others, both adults and children.

17.7 The fullest and most up to date knowledge is therefore essential to understand a current risk.

17.8 This raises two questions in terms of Adult HM and Adult GF in terms of the risk they posed to Child G during his short life:

17.9 Was there a comprehensive partnership picture of information and intelligence available on both Adult HM and Adult GF and if it was available was it obtained and used by those who were trying to understand the risks posed by either adult?

17.10 In terms of Adult GF, it is clear there was limited information within some agencies, predominantly health and services within the Early Help arena, and none of it when examined during the review gave cause for any concern relating to her posing a risk to her children and in fact her ability to parent.

17.11 The extremely worrying attitude and behaviours of Adult GF towards Child GF2, Child GF1 and Child G were identified through the police investigation following and into Child G's death. As identified earlier in this report Adult GF showed little affection, at times animosity and disregard towards Child G in the way she talked about him and on occasions failed to seek medical help for him knowing he had been injured. She also talked of physically abusing one or more of her children.

17.12 It is clear from the review that **no** information or intelligence was available to any partner, which would have suggested Adult GF posed a risk to her children prior to the police investigation.

17.13 Adult HM's case is markedly different. He had been known to services for the vast majority of his life both as the result of abuse to him as a child within the family unit and as the result of his offending. His propensity for violence both within his relationships with women and to strangers was well documented. The escalation of his violence is apparent through the available records as is the number of partners he resided with who became victim to his violence.

17.14 Not all the information necessary to build a full picture of him sat within one organisation which is not unusual.

17.15 The review identified multiple incidents of Domestic Violence against many women and 2 specific assaults against children. Not all these incidents were known to a single organisation thereby giving a full holistic understanding; for example, the police regarding assaults on children have only one recorded within their systems which they acted upon.

17.16 However, the review was able to build a fulsome picture of the life of Adult HM from the information held within the partnership and an experience-based assessment by the reviewers identified that by the time he moved in to live with Adult GF (his 14th known female partner), Child GF2, Child GF1 and Child G he posed a very high and real risk of causing significant harm to one or all of them.

17.17 It is not an understatement to suggest that given his history and ongoing failure by him to address his offending behaviours it was highly likely he would resort to violence against one or more of them within the family unit.

17.18 Given the questions posed by the Terms of Reference for this review it was therefore important to understand if the safeguarding partnership or an agency or agencies within it had identified the true picture of the risks posed by Adult HM when he became domiciled with Adult GF and her children. Also, to clarify the perceived level of risk he posed as well as what was being done to protect those adults (predominantly women) and children he came into contact with who were likely to suffer his violence.

17.19 In particular, the review wished to understand what the partnership and individual agency knowledge of Adult HM was when he commenced his relationship with Adult GF and what the opportunities were to potentially protect Child G and the others.

17.20 Coupled with this is the question of how the knowledge and the assessment of risk was being managed by an organisation, the practice surrounding this, and the impacts and outcomes being seen. All these dynamics had a bearing on the safety of Child G, his siblings and Adult GF.

17.21 It was therefore necessary for the review to consider the life story of Adult HM up to that time and explore how the partnership (or an individual organisation within it) was assessing and mitigating risk in respect of him based on the available information. This consideration goes to the heart of understanding a pivotal point: *what opportunities existed to intervene within the partnership that could have prevented the death of Child G* and to *identify learning from this case that can be used to improve the safety of children who reside in Doncaster and nationally.*

17.22 The specific agency directly involved with Adult HM at the time of him moving into the relationship with Adult GF and having direct access to her children was the South Yorkshire Community Rehabilitation Company.

17.23 Adult HM had been convicted of differing offences during his life, some of which received prison sentences and some community-based reparation. On occasions, orders were made for him to undergo courses to address his violent behaviours within relationships and his drug and alcohol abuse.

17.24 Adult HM was subject to offender management and supervision by both the South Yorkshire Community Rehabilitation Company and the National Probation Service from 2013 until he murdered Child G in January 2020.

17.25 The South Yorkshire Community Rehabilitation Company supervised him during two specific periods these being 22nd April 2014 to the 15th October 2015 and again from the 4th June 2018 through until his arrest in relation to the death of Child G in January 2019.

17.26 The National Probation Service managed him following conviction between the 15th October 2015 and the 15th October 2017. Adult HM was in prison until being released on licence early in January 2016.

17.27 Case notes and associated documentation were made available to the review for all periods Adult HM was subject to management or supervision and the learning themes identified in this report are all evidenced from within these original case notes and papers, from interviews with key individuals and from the Learning Event with practitioners.

17.28 The learning themes are identified as being pertinent to both organisations and the review recognises the impending merger of the two organisations back to the National Probation Service and hopes the recreation of a single service will aid the embedding of the learning and practice improvement. Discussions with senior leaders of both organisations indicate this will be the case and as identified within this report much work has already been undertaken to address the issues raised.

17.29 The evidence underpinning the learning themes has been provided to senior leaders within both organisations but is not directly quoted within this report to ensure brevity and a report that is usable in terms of construct and size. The learning themes have been recognised and accepted by leaders from both organisations.

17.30 Adult HM commenced his offending in his adolescence, offences consisted of violent and aggressive behaviours. His first known domestic abuse incident recorded by the police was on 13th July 2005 when he was aged 21 years.

17.31 It is clear that having been subjected to violence as a child in his own right he grew into an adult whose use of violence against adults and children, female and male, to known and unknown adults, with and without weapons escalated over the years. In his later crimes issues of racial offending started to emerge.

17.32 The chronology of Adult HM's life created by the review suggests he was rarely out of a relationship with a series of partners all of whom had children, totalling 13 women following his marriage breakdown in 2012. He always swiftly moved into any new partner's home address and where domestic abuse was an ongoing feature in many. Children within these relationships and his own marriage '*lived*' with his violence, which was perpetrated against his partners and on several occasions directly against a child or young person.

17.33 Risk assessments and Information sharing (Including interactions with Doncaster Children's Services Trust)

17.34 Throughout the different periods of time Adult HM was managed and supervised by the two services multiple Probation Officers owned him within their casework. As is required practice all the individual officers carried out risk assessments on him in order to be able to understand his story, the reasons for his continual offending and use of violence intending to identify the risks he posed and the mitigation of the risks which may be required.

17.35 The review identified that on the vast majority of occasions assessments were based on the presenting circumstances and a narrative proposed by Adult HM himself.

17.36 There are occasions where individual officers from both organisations did try to probe further to better understand him through analysis, challenge, and triangulation of available information and through attempting to seek information from partners. Two clear examples of good practice can be seen. One by the National Probation Service when he was raised to high risk in 2017, and through the work of the officers in South Yorkshire Community Rehabilitation Company in 2019.

17.37 However, on no occasion was any assessment able to create the whole life story picture of him (which the review was able to achieve from partnership information) and as a result his escalating behaviours and the risks he posed remained somewhat obscured or unrecognised for what they were to those who were tasked to manage the risks.

17.38 Officers on many occasions were presented with information by Adult HM which was false. Some attempts were made to triangulate and challenge such information but, on many occasions, it was accepted at face value and he was able to hide issues which were pertinent to any risk assessment concerning him. He routinely achieved this in relation to his relationships and where he was living. A more professionally curious and challenging approach would have found his narrative wanting and a clearer insight obtained of him as an individual and the risks he posed.

17.39 The review has found there to be a consistent theme within all the case notes of less than robust management of him in respect of his deliberate avoidance strategies, strategies we would suggest that he has learnt and survived on since early childhood.

17.40 Throughout the lifetime of Adult HM within the South Yorkshire Community Rehabilitation Company and the National Probation Service, risk assessments were carried out in line with their statutory requirements. The assessments when completed routinely graded Adult HM as Medium risk to all, including children. However, in January 2017 after having been recalled to prison for an extremely violent assault on a partner he was escalated to High risk (in relation to any adult partner). He remained as High risk through the remainder of his licence and management by the National Probation Service.

17.41 Adult HM was subsequently assessed as Medium risk when allocated to a new officer within South Yorkshire Community Rehabilitation Company on 4th June 2018 following conviction for an attack on a stranger in the street. The case notes do not reveal the rationale for this reduction after yet another violent incident and no visible change in behaviours.

17.42 Officers did make attempts to seek information from partners to increase their understanding of him.

17.43 Contact was made on occasions by different officers from the two organisations with the children's social work services via the front door of Doncaster Children Services Trust requesting information concerning children.

17.44 The question ***asked*** was always about whether he posed a risk to children. This question appears to have been ***received*** because of the way it was asked as a question and an information request about **his own** children.

17.45 Doncaster Children's Services Trust responded by giving feedback from the social work assessment undertaken in 2010 about Adult HM' s own children, missing the relevancy of information that South Yorkshire Community Rehabilitation Company and the National Probation Service held that he was living with other children therefore making him a risk to children other than his own.

17.46 The answer to the question was given that Adult HM *had been subject to assessment in April 2010 following a domestic abuse incident, his children were spoken to by the Social Worker at the time and the case was closed with no further action*.

17.47 The answer was always given by Doncaster Children's Services Trust that he was not a risk to **his** children.

17.48 On occasions Probation Officers did ask wider questions concerning Adult HM's risks in general to children. One response used from Doncaster Children's Services Trust was that the officer needed to submit a referral. There is no evidence across all the notes that a fulsome answer to this relevant question was ever forthcoming to either probation service or that it was followed up with referral. This ineffective practice of requiring a referral in such circumstances had gone unchallenged until pointed out by this review.

17.49 The review has identified the following in respect of the assessments which appear to be the basis for the replies when requests were made:

17.50 A contact was received in 2010 concerning a domestic incident and the contact states an assessment was carried out. The child's record system does not record a separate assessment. It is likely therefore that the 'assessment' mentioned was an initial assessment within the contact record which was then closed.

17.51 A further contact was opened in 2012 concerning another domestic incident between Adult HM and his wife. This contact record is closed as No Further Action (NFA) with no separate assessment being completed.

17.52 In January 2017 the Probation Officer from the National Probation Service recognises the High-risk Adult HM posed to any partner and attempted to ensure consideration was made for the safety of children by referring to Doncaster Children Services Trust when Adult HM was about to be re-released on licence. The officer identified his concerns regarding both female partners and children as well as information concerning the possibility of Adult HM being father to another child from another relationship. As the result of the safeguarding practice of this officer assessments were carried out on his children and those in the other family setting. Both were completed and closed NFA.

17.53 Police information was routinely sought concerning 'call outs' to domestic violence incidents. This information was supportive and important but did not significantly aide the fuller understanding of Adult HM.

17.54 No other information appears to have been routinely gathered when assessments were being completed adding further to the deficit of a holistic picture. There was no evidence that at any time Adult HM's life experiences as a child and adolescent had been sought and understood.

17.55 As has already been stated it is imperative when seeking to conduct a full assessment of the risks posed by an individual that all available information is gathered and analysed. Both the South Yorkshire Community Rehabilitation Company and the National Probation Service have a statutory duty (and legal right) to seek information for this purpose form their safeguarding partners and should exercise this duty with professional curiosity and purpose.

17.56 As the result of the review and the acceptance of learning, Doncaster Children's Services Trust and the National Probation Service have addressed this issue and there is now a structured information sharing protocol and process in place within Doncaster Children's Services Trust for all statutory information requests by the National Probation Service (and South Yorkshire Community Rehabilitation Company).

17.57 Given the information picture the review was able to identify, it is our view that Adult HM has been High risk as an adult for a considerable number of years, after the commencement, continuation and escalation of violence by him in his relationships, to any adult or child within a family unit where he had chosen to reside as well as the wider general public. His propensity for violence in relationships escalates and becomes a constant from his first known domestic incident in his marriage in 2005.

17.58 In order to see this level of risk though requires an analysis of his whole life story and behaviours. It was available to any professional who had access just as the review was able to do.

17.59 The Learning Event enabled practitioners to reflect on the issue of assessment in general and specifically in relation to Adult HM. Discussion and reflection on this issue enabled

honest feedback from practitioners in both organisations which resonate with and ratify the learning themes as identified.

17.60 The review believes any professional attempting to undertake an analysis of an individual in order to produce an accurate assessment of them as well as the risks they may pose should have had access to the whole intelligence and information picture surrounding the individual. This partnership information will by its very nature potentially enable the professional to see and respond to the lived experiences of adults and children who have been affected by the behaviours of someone such as Adult HM. These lived experiences will have a bearing on the understanding of the risk an individual poses.

17.61 This can only be achieved through effective and efficient information sharing by and to safeguarding partners. The South Yorkshire Community Rehabilitation Company and National Probation Service could not and should not be expected to manage risk only on what they can illicit, see or uncover themselves through contact with an offender. Such an approach is unlikely to provide an accurate assessment when working with the characteristics and behaviours of Adult HM and other such people who cause harm. They require support from their partners just as children's social work requires it to effectively protect children.

17.62 It was clear from the review of the case notes across both organisations that on many occasions risk assessments were not carried out in a timely fashion and the dynamic reviewing of assessments was not triggered by a change in the information picture. These issues of compliance were also routinely not identified by any management oversight or through supervision. Timeliness and constant dynamic review of risk assessment must be central to the management and mitigation of risk.

17.63 Having explored the issue of assessment and the analysis of information and intelligence upon which to base risk an assessment it is clear that when Adult HM entered the lives of Adult GF and her children those tasked with managing his risk and the partnership as a whole were not wholly sighted on the holistic picture concerning him and the true perspective of the risks he posed to any partner or their children. As identified earlier the review has built this picture of Adult HM and there is no doubt he posed a High risk of causing significant harm to Adult GF and her children.

Learning

Risk assessments are dynamic and require regular review and monitoring. Their effectiveness is increased when professionals consider all available information including relevant life history, their offending, behaviours and when triangulated with previous records alongside partnership information.

Assessment should attempt to recognise the voices of those around the individual both adults and children and include the widest possible partnership knowledge.

Professionals need to be curious and courageous in their management of offenders, seeking to utilise all the available information described to produce the most holistic assessment of need, harm and risk as possible.

Compliance and timeliness concerning the completion of risk assessment tools is essential in professional practice and requires constant management oversight and quality assurance. Risk assessment needs to be dynamic and timely in line with changing circumstances.

Information sharing is important to good assessment practice. Professionals need to consider information concerning an individual in a wider sense looking to establish the broadest understanding of the behaviours, risks and context upon which to assess risk and make decisions concerning supervision, management and case direction.

A more curious approach to information sharing, (when both requesting and providing) and analysis ensuring focus is not directed to the immediate concerns around an individual nor only on the immediate and obvious family context.

Processes and practice across the Doncaster Safeguarding Partnership should facilitate effective and efficient information sharing across the whole partnership in multiple directions in harmony with legislation and best practice guidance.

Response to Learning

South Yorkshire Community Rehabilitation Company has embarked on a structured mandatory training program intending to improve professional standards in relation to domestic abuse and child safeguarding, the assessment of risk in relationships and how to deal with disguised compliance. The program identifies the need for greater professional curiosity, stressing the need for courageous practice, and highlights an approach of always asking an additional three questions to ensure each piece of information is probed and knowledge is enhanced, triangulated or challenged.

Four modules are included within the program:

Module 1 - Safeguarding – Where Do I Begin?

Module 2 - Using the Life Map

Module 3 - The Child, The Perpetrator and The Victim

Module 4 - The Learning Journey - The links of Safeguarding and Domestic Abuse

The program emphasises the standards and need for good child focus and safeguarding and provides information concerning information sharing and the need for it within good risk assessment.

Guidance to staff for Offender Assessment System (OASys) reviews has been published in August and September 2020.

The National Probation Service have provided workshops for all managers in respect of child safeguarding. All managers attended and held workshops for their staff during 2020.

17.64 **Management and Professional Supervision**

17.65 Supervising or managing Adult HM either by the South Yorkshire Community Rehabilitation Company or the National Probation Service cannot have been easy or straightforward for the officers tasked to have him within their caseloads.

17.66 The case notes of Adult HM clearly evidence the fact that he adopted an attitude over the years of intentional non-compliance and non-engagement with all of the different orders, licences and management plans to which he was subject. He clearly had no intention of complying and appears to have lied and prevaricated at will to ensure he was always at arm's length from any type of meaningful management of him.

17.67 He constantly lied about relationships, where he was living and why he had again failed to attend a meeting or work placement. On occasions family and unknown others covered for him as well. The lies concerning his relationships and where he was living had a direct bearing on the risk assessments carried out to identify the level of risk, he posed at a given time to those around him.

17.68 Whilst reviewing the case notes which spanned the period of 5 plus years (2014 – 2020) it was apparent that management oversight and supervision of the staff efforts to manage him was not as robust and regular as one might have expected.

17.69 There was little evidence and articulation of management oversight in general and at key times for example: completion of the two standard probation service risk assessments Offender Assessment System (OASys) and Spousal Assault Risk Assessment (SARA) including the setting and escalation of risk, failure to complete risk assessments in a timely fashion or when circumstances should have triggered a review of the risks, oversight of progress and impact of action plans and supervision orders, relaxation of licence conditions (curfew) and when there were changes of officer.

17.70 There was evidence of action plan discussions and agreements on occasions when they were initially agreed but no structured oversight providing challenge concerning performance or just as importantly support to the member of staff in their efforts to supervise or manage Adult HM.

17.71 Notes of professional supervision were not shared with the review but there was no visible and constant footprint of such activity within the case notes. The review identified instances where management oversight should have prompted interventions with staff which in turn potentially would have impacted on the risk management of Adult HM and the mitigation of the risks he posed to adults and children around him.

17.72 It must also be stressed that supervision is also likely and designed to identify individual issues staff may have with working a specific case and may prompt a supportive intervention for the member of staff. An example of this sits within the case files and has been addressed by the relevant organisation.

17.73 There was no evidence of routine quality assurance through auditing which would have identified both compliance and practice issues during all the periods Adult HM was supervised or managed and triggered management intervention and supervision.

Learning

Management and professional supervision should be frequent, impactful, and well recorded. It should support the professional and provide unbiased, experienced, and clear insight into the supervision or management of the individual.

Staff and managers should be aware that any key event or concerning issue within a case should trigger the insight of management oversight and supervision.

Management needs to be understanding of individual casework through oversight, supervision, and audit to the point where they will intervene to ensure compliance, dynamic practice improvement and interventionist support to protect staff.

Management oversight, supervision and case audit should be considered as core practice requirements.

Response to Learning

South Yorkshire Community Rehabilitation Company have issued guidance for management oversight and supervision in April 2020. The guidance specifically covers issues identified within the review in particular Risk Assessments, support to officers and staff and ensuring a fresh look is routinely considered through management oversight and supervision.

Auditing is also identified as being routinely required.

The National Probation Service have ensured all Senior Probation Officers have attended a virtual briefing in 2021 regarding the new Touch Point Model in respect of the recording of management oversight.

The National Probation Service aims to continue its rollout across the re-unified probation service of the Skills for Effective Engagement Development and Supervision (SEEDS2) which will address issues concerning management oversight and supervision.

17.74 **Children and Young People**

17.75 Throughout the period when Adult HM was supervised or managed by the South Yorkshire Community Rehabilitation Company and the National Probation Service, he was subject to numerous risk assessment procedures using two specific risk assessment tools: the Offender Assessment System (OASys) and the Spousal Assault Risk Assessment (SARA).

17.76 The OASys is specifically for assessing the risks and needs of an offender. It is designed to:

- Assess how likely an offender is to re-offend
- Identify and classify offending-related needs
- Assess risk of serious harm, risks to the individual and other risks
- Inform the development of a plan to manage the risk of harm presented by the offender
- Link the assessment to the supervision or sentence plan
- Indicate the need for further specialist assessments.

17.77 'The Spousal Assault Risk Assessment (SARA) is a set of guidelines based on the structured professional judgement approach to risk assessment and it is designed to ensure that appropriate risk assessment is conducted for domestic violence. It consists of 20 items that have been identified from the literature as being of relevance to the likelihood of future domestic violence offending.'

Risk Management Authority 2019

17.78 The SARA is viewed by the Probation Services as a tool to prevent not predict violence.

17.79 Neither tool is specifically aimed at risk assessing the issues of need, harm and risk to children and young people (as potential victims of domestic abuse).

17.80 The review found on each occasion a risk assessment was undertaken on Adult HM, officers considered the risks posed by him to a range of potential victims including children. On the majority of occasions risk levels were identified to partners he was in a relationship with, children within the relationship, other members of the public and members of statutory organisational staff working with him.

17.81 On nearly every occasion, a risk assessment was carried out Adult HM was graded as a Medium risk to children. He was on one occasion graded as High risk to adult partners by the National Probation Service (2017 reduced in 2018 to Medium) but his risk to children remained as Medium.

17.82 On all the occasions he was graded the children exposed to him were graded as Medium: several occasions where he had been arrested for violent assaults against his partners in the presence of children and also when he used violence (some severe) directly against children and young people in the family setting. The review identified that Adult HM directly assaulted 2 children through his relationships with various women, so it was clear he was unable to control his violence, which was extreme on occasions even when children were present or were the victims.

17.83 Review of the case notes for the periods identified showed that on several occasions it was impossible to identify how many children (and who they were) Adult HM was having access to, although this information usually emanated from his own narrative.

17.84 On occasions when it was identified he had changed partners and was domiciled with a new female partner and her children checks were not made with Children's Services or other partners to consider the risks he may pose to those children at that time.

17.85 In addition, there were occasions when he provided a new address with another female and no consideration was given to checking if children and young people were present or what the risk may be to them.

17.86 As is identified elsewhere in this report officers from both organisations did on several occasions contact Doncaster Children's Services Trust with a view to attempting to identify information concerning Adult HM and his access to children. Unfortunately, the questions asked, and the answers given aided little to the overall understanding of risk to the children who were exposed to him at that time.

17.87 Children do **not** only witness domestic abuse they **live it** and suffer the consequences of it in terms of their development and emotional wellbeing. As identified on at least two occasions children suffered direct violence and abuse from Adult HM, this abuse was not recognised within any of the assessments undertaken either by the South Yorkshire Community Rehabilitation Company or the National Probation Service meaning that risk assessments were somewhat weaker than they could have been concerning risks to children

and young people. This lack of triangulation also affected Doncaster Children's Services Trust when considering individual cases referred to them.

17.88 The understanding of Adult HM and his life story generated by the review clearly identified the high and escalating levels of risk he posed to female partners and their children.

17.89 The damaging impact of Adult HM on a child's life, was there to see if the appropriate level of analysis had been carried out by any professional tasked to complete an assessment as were the indicators that it would continue and escalate. This review believes that children have the potential of being hidden in the plain sight of the professionals whose duty it is to step in and protect them if their lived experience within abusive adult relationships is not viewed as directly causing them harm.

Learning

Children need to be identified, considered and their lived experience understood when assessing the risks posed by an individual who violently offends within personal relationships.

Professionals need to recognise all children in their risk assessments and make clear what interventions need to be in place to reduce the harm posed by offenders.

When considering the risks to children it should be recognised, they experience serious and significant harm both visible and not, through the impact of Domestic Abuse therefore the risks to them need to be acknowledged as potential victims. There needs to be a recognition that children and young people suffer the consequences of it in terms of their development and emotional wellbeing, they do not just witness it they 'live it'.

Response to Learning

South Yorkshire Community Rehabilitation Company have delivered virtual training for staff focussing on child safeguarding and the impact of and harm caused by domestic abuse.

The organisation has also issued a practice guidance quality assurance bulletin entitled 'Working with Children'. Within the useful commentary is a reinforcement of the stipulation that a home visit must be completed within 4 weeks where a child protection concern is identified in relation to a service user.

17.90 **Risk Assessment Tools**

17.91 As identified above the South Yorkshire Community Rehabilitation Company and the National Probation Service use two risk assessment models these being Offender Assessment System (OASys) and the Spousal Assault Risk Assessment (SARA) in relation to individuals such as Adult HM.

17.92 In October 2017 the National Probation Service carried out Offender Assessment System (OASys) and Spousal Assault (SARA) risk assessments on Adult HM. In April and September 2019 two separate officers within the South Yorkshire Community Rehabilitation Company also carried out separate assessments using the two tools.

17.93 On each occasion the results conflicted, with the Spousal Assault Risk Assessment (SARA) identifying a higher level of risk to partners and children than Offender Assessment System (OASys).

17.94 In October 2017 the Spousal Assault Risk Assessment (SARA) identified Adult HM as High risk to partners but the Offender Assessment System (OASys) termination maintained him as Medium.

17.95 The assessment in April 2019 was a much fuller assessment in terms of seeking information from South Yorkshire Police and Doncaster Children's Services Trust (DCST) and recognised violence to women as well as a risk to children from domestic abuse. Control and disruptive behaviour issues were recognised as risk factors from a racially motivated offence and its aftermath. The case notes state the Offender Assessment System (OASys) Violence Predictor score (OVP) identified a high risk of violence.

17.96 This assessment clearly saw risk to women and children but retained risk as Medium to both.

17.97 The Spousal Assault Risk Assessment (SARA) identified the risk of domestic abuse as High as distinct to the Offender Assessment System (OASys) which suggested it to be Medium.

17.98 The case notes state: *It would be remiss to assess him as anything less than high to partners and others.*

17.99 This is interesting given the Spousal Assault Risk Assessment (SARA) is specifically aimed at identifying the likelihood of future domestic violence offending where children may well be present and is designed to ensure that appropriate risk assessment is conducted for the domestic violence.

17.100 The Offender Assessment System (OASys) is predominantly offender focused and designed to assess how likely an offender is to re-offend but will indicate the need for further specialist assessments.

17.101 Whilst these clear tensions were recognised, they were not subject to any professional or managerial discussion (as far as the notes identify) nor acted upon with the higher level of risk being discounted.

17.102 The Serious Further Offence review carried out by the South Yorkshire Community Rehabilitation Company following the murder of Child G articulates similar findings and has made recommendations for improvement in this area.

17.103 The issue of tensions between outcomes from different risk assessment tools cannot be limited to just the evidenced issue within the ones used by the South Yorkshire Community Rehabilitation Company and the National Probation Service. Other risk assessment tools are used by safeguarding partners across the partnership.

17.104 Recognising that each risk assessment tool is designed for a purpose and based on a different evidence base it is appropriate to acknowledge that each has its place but also consider as partners what the overall picture is if one considers the results of all when safety planning for adults and children in relation to violence and abuse.

17.105 There are opportunities within the partnership to embed this type of discussion within standing agendas of particular meetings.

17.106 The new Multi-Agency Tasking and Co-ordination (MATAC) and the established Multi-agency Risk Assessment Conference (MARAC) meetings seem appropriate arenas where a partnership consideration of risk assessment outcomes can add significant value to understanding true risk posed by offenders of domestic abuse and support safety planning for adult victims and children. (Recommendation in Appendix 4)

Learning

Tensions which arise from the results of differing risk assessments should cause professional concern and discussion.

Professionals and managers should use these tools to trigger management oversight discussion to further explore these tensions and amend risk management plans accordingly.

Safeguarding partners should look for new opportunities to enable multi agency discussions regarding the range of different risk assessment tools in use across the partnership to better understand what each is identifying as well as the tensions and differences between them.

Consideration by the partnership of the outcomes of multiple risk assessment tools as an integral part of the response to domestic abuse provides the opportunity to add significant value to understanding true risk posed by offenders of domestic abuse and support safety planning for adult victims and children.

Response to Learning

South Yorkshire Community Rehabilitation Company has published guidance for practitioners in January 2021: Contradictions between Spousal Assault Risk Assessment (SARA) and Offender Assessment System (OASsy) Risk Assessments. The guidance provides good advice and practice support in relation to the learning and issues raised within the review.

South Yorkshire Community Rehabilitation Company have issued practice guidance to staff re OASys Violence Predictor scores in June 2020.

17.107 **Multi Agency Public Protection Arrangements**

17.108 On 15th October 2015 Adult HM was convicted at Sheffield Crown Court of burglary and assault and sentenced to 27 months imprisonment. His case file within South Yorkshire Community Rehabilitation Company identifies on the 23rd October 2015 a recognition that the offence was an *index* offence requiring a Multi-agency Public Protection Arrangements (MAPPA) flag which had not happened. The MAPPA flag, which the review was advised would lead to immediate allocation to the National Probation Service, was not in place but the notes identify that it would be applied for on the date.

17.109 An Index offence is one which enables the offender to be managed within a higher level of Multi-agency Public Protection Arrangements (MAPPA) classification due to the offence being one as defined.

17.110 This was a conviction which would have been seen as an 'Index' offence and allowed him to be registered as Multi-agency Public Protection Arrangements (MAPPA) Category 2 offender. A decision was then available to the National Probation Service to manage him at level 2 which could have created a partnership approach to his management.

17.111 This use of Multi-agency Public Protection Arrangements (MAPPA) did not occur, and it is not possible to find the professional rational that evidences thinking either for or against the opportunity.

17.112 Entries a year later in September 2016 after his release from prison in August 2016 identify Adult HM was being managed at Multi-agency Public Protection Arrangements (MAPPA) Category 2 Level 1 (by the National Probation Service as a single agency). The review suggests there was ample information and intelligence to identify Adult HM as an extremely violent man at this point and a significant and High risk to adults and children alike. The National Probation Service had graded him as a Medium risk at this point and they saw his risk to children as Medium. The cases notes **do** state that referral to level 2 would be kept under review.

17.113 In October 2016, Adult HM was recalled to prison after a serious incident of violence against a partner and one of his own siblings, which was eventually withdrawn, as witnesses would not pursue the case. He was increased to High risk of serious harm to partners by the National Probation Service a grading which remained throughout his licence period. The risk level to children remained as Medium.

17.114 It is also interesting to note that National Probation Service violence predictor tools do not take account of withdrawn prosecutions only convictions. In Adult HM's offending life, several very serious incidents of violence against women and children did not make it to successful prosecution and conviction. A recommendation has been made concerning a review of this issue (Appendix 4).

17.115 The review would highlight the further conviction on 4th June 2018 of racially aggravated violence against a female stranger in the street as another clear opportunity to see the continuing and escalating violence of Adult HM and assess the holistic risks posed by Adult HM and take the opportunity to manage him differently within the Multi-agency Public Protection Arrangements (MAPPA) categories and levels.

17.116 A Pre-Sentence Report was prepared by the National Probation Service and graded Adult HM as Medium risk of serious harm to the public. There is no mention in the case notes regarding risk to any partners or to children. The report is a record of an oral report made to the court on the day. The rationale for allocation to the South Yorkshire Community Rehabilitation Company was based on a very minimal knowledge of the behaviours of Adult HM or his life story.

17.117 The level of historic detail required to understand Adult HMs behaviours appear not to have been available in the very short space of time the Probation Officer would have had at court to complete the report. The availability of a recent fully complete assessment recorded within his previous case notes could have aided the officer. The notes record that no previous Offender Assessment System (OASys) assessment was seen whilst completing the report.

17.118 The allocation was not challenged by South Yorkshire Community Rehabilitation Company nor is there record of any escalation by the organisation.

17.119 A risk assessment carried out on 5th October 2018 by South Yorkshire Community Rehabilitation Company does not fully recognise the serious risks Adult HM posed and a required update to the Offender Assessment System (OASys) was **not** carried out by the Probation Officer. The risk assessment re-affirmed the level of risk as Medium and identified the risk to be in relation to children, partners, and the public.

17.120 The Serious Offence Review carried out in parallel with this learning review has led South Yorkshire Community Rehabilitation Company in particular to consider in these cases where there are Multi-agency Risk Assessment Conference (MARAC) flags connected to offenders whether a more structured management oversight should be in place concerning risk assessments.

17.121 Had Adult HM been managed at Multi-agency Public Protection Arrangements (MAPPA) category 2 level 2 in 2015 (or at any time prior to the murder of Child G) the review suggests this would have enabled full partnership involvement and the ability to use Multi-agency Public Protection Arrangements (MAPPA) processes effectively.

17.122 It is our view this would have been a vehicle to collectively mitigate, manage and identify the serious and escalating risks Adult HM posed between 2015 and 2020. This partnership approach would have ensured collective risk assessment, effective information sharing and a conversation, which would have ensured children, were seen and the specific risks to them would have become visible.

17.123 It would have enabled the partnership to have the clarity of vision concerning him that the review has had but in real time. It would have enabled the partnership to work together to manage him and the risks he posed in the community and his relationships. It would have enabled Doncaster Safeguarding Partnership to do what Multi-agency Public Protection Arrangements (MAPPA) was intended for:

17.124 'The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders.

They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.'

Multi-agency Public Protection Arrangements (MAPPA) Guidance 2012 (Updated 2019)

17.125 It is possible the use of the Multi-agency Public Protection Arrangements (MAPPA) structures and strong effective partnership working in support of South Yorkshire Community Rehabilitation Company would have identified that Adult HM had moved in to live with Adult GF and the three children in August 2019 at the time when they stopped attending Family Hub and Child GF1 was not being taken to speech and language appointments.

17.126 Conversations during the review identified one reason why maybe the opportunity to manage Adult HM as a MAPPA nominal at level 2 was not taken. It was suggested that MAPPA 2 was viewed locally as somewhat less effective at that time and that it was more pragmatic and potentially more impactful to manage Adult HM through the Integrated Offender Management Unit where at least one partner, the police could contribute and support by way of home checks. The decision to manage through the Integrated Offender

Management Unit was made and South Yorkshire Police supported with home checks in relation to the curfew requirement of his licence.

17.127 There are records of two 'Compass Review' meetings (now known as Local Offender Management Meetings) in February 2016 but no other record of multi-agency meetings of any description or name, or involvement of other partners such as children's services.

17.128 A more multi agency approach to support the National Probation Service would have ensured the information deficit which existed, may have been dealt with and those tasked with managing the risk posed by Adult HM could have seen him with more clarity for who he really was.

17.129 MAPPA also allows the designation of an individual at Category 3 if they are deemed capable of causing serious harm to the public and a partnership approach is required to manage the individual. Adult HM could have been designated in this category given his violent history with women and children especially given his escalating violence and involvement in stranger attacks together with racial aggravating factors.

17.130 While there are strict time limits set for Category 2 offenders managed at level 2 (guidance stipulates a review must take place), the statutory guidance allows the partnership to continue to register an individual at Category 3 requiring partnership management.

17.131 The review believes managing Adult HM with a strong partnership approach such as within the MAPPA structure could have provided enhanced opportunities to ensure Adult GF and her children, other female partners of Adult HM and their children were more visible to those responsible for safeguarding them and promoting the welfare of children.

17.132 The National Probation Service identifies that the South Yorkshire MAPPA Unit is operating in a more positive way in terms of referrals than it was and identifies that referral rates to MAPPA 2 and caseloads managed within the arrangements are significantly higher in 2021 than at the time of Adult HM's conviction for the index offence in 2015.

17.133 The review acknowledges and respects that a decision may of course have been made in 2015 or following not to manage Adult HM within the MAPPA structures but would have hoped to see the consideration of the partnership opportunity and the rationale for not escalating his status within the case notes.

Learning

The multi-agency partnership should recognise the strength in working together in an integrated manner to manage offenders who pose a significant risk of harm to others, they must understand that the NPS cannot do this alone. The NPS and its partners need to recognise the benefits in the wider use of the categories and levels of the Multi-agency Public Protection Arrangements (MAPPA) guidance.

Decisions as to where an individual should be managed within Multi-agency Public Protection Arrangements (MAPPA) should be based on a full history of offending and behaviours and kept constantly under review through professional practice, management oversight and supervision. Key contextual and behavioural changes should prompt re-evaluation.

Response to Learning

The review was advised there is now a Multi-agency Public Protection Arrangements (MAPPA) screening multi agency filter meeting in place within where cases such as Adult HM can be considered. Practice guidance has been published in respect of this multi-agency initiative and staff briefings have been delivered.

17.134 **Recording of Case Notes**

17.135 The review of case notes across both organisations identified the issue of the standards of case note recording. There were many examples of a lack of detail of important pieces of information or the articulation of the rationale for key decisions. For example, names of individuals relating to a piece of information which would have affected a risk assessment, the reasons for changes in officers at critical times and the reasons for the instigation of a breach.

17.136 The issue of case note recording was seen as a relevant learning issue within the day-to-day management notes by officers and the articulation of management oversight.

Learning

Case notes should be not only descriptive of events but provided considered analysis of information to provide an accurate understanding of a case. They should include reasons for key decisions and enquiries made to triangulate and challenge information.

Professionals must review these case notes over time to establish patterns of risky behaviour and review risk assessment and management plans as required. This is particularly pertinent during episodes of case transfer between professionals when experiential knowledge of an individual may be lost.

Response to Learning

South Yorkshire Community Rehabilitation Company have delivered virtual training for their staff in 2020 in respect of case recording standards and issued practice directions.

Both organisations wished to draw attention to a practice direction Quality Recording published in 2018 which has been reinforced in recent training: Impact and achievement of orders and licence conditions

The National Probation Service have re-issued Quality Recording practice guidance to all staff and Managers have discussed content and expectations in all team meetings in 2021.

17.137 **Addressing Behaviours and Compliance with Orders**

17.138 During the 3 periods he was supervised or managed by the South Yorkshire Community Rehabilitation Company or the National Probation Service there is little evidence to identify much was achieved concerning the need for Adult HM to focus on violence within relationships.

17.139 Adult HM was ordered to attend a Respectful Relationships course on three occasions (a 20 day course, repeated within several orders) and his attendance featured in multiple risk management plans. Adult HM did not complete any of the set numbers of hours, only ever attending 2 sessions on the same date (14.11.19) before failing to attend again on the 28.11.19.

17.140 Adult HM was set plans by various officers in both services all along the same lines: some better than others. None were achieved to any great extent and little if any impact was made concerning the key areas of concern relating to his violence and relationships.

17.141 Adult HM was subject to multiple orders by different courts following convictions and a period of licence following conviction for the index offence in 2015.

17.142 He was ordered to carry out unpaid work on several occasions and ordered by the court to undertake Respectful Relationships courses on more than one occasion.

17.143 Analysis of the records by the review identified no less than 101 occasions where he failed to attend either a meeting with his manager, a rehabilitation type of course or scheduled unpaid work which was required as the result of a court order. He was breached on numerous occasions, which resulted in a return to prison or another slightly different community-based order to which he adopted the same successful behaviour.

17.144 As identified earlier in the report Adult HM managed to manipulate the system to an extent at which he failed to comply in any great way with any requirement made upon him following his offending.

17.145 It is sobering to see how successful he was in avoiding consequences and in not addressing his behaviours at all.

17.146 During the period 2016 and 2017 Adult HM failed to comply with his licence conditions relating to curfews, disclosing new relationships, engaging in behavioural courses and in relation to contact with a previous victim.

17.147 He also failed to achieve the majority of the management plans set for him in this period including failing to abstain from drug and alcohol and to develop more self-control of heightened emotions- to reduce risk to others.

17.148 During the lifetime of Child G in 2018 he failed to complete any of the 20 Rehabilitation Activity Requirement (RAR) or 150 Unpaid Work (UPW) days he was ordered to complete by the court as well as failing to comply with appointments to address drug or alcohol misuse**.**

17.149 In 2019 he failed to comply with both requirements of a community order: to attend 20 RAR days (on both occasions it was ordered by the court in the same year) and complete 80 hours UPW.

17.150 It is apparent from the review of the case notes that increased management oversight concerning achievement may have been beneficial.

Learning

Professionals and those who manage them should ensure there is routine oversight and assessment of achievement against Community Orders and Licence conditions, to ensure impact is captured and revisions put in place to further manage risk and promote desistance from offending behaviour.

Response to Learning

The National Probation Service have ensured all staff and managers attend a workshop regarding expectations and good practice. All VH/HRoSH* Assessments and some complex MRoSH ** assessments are quality assured and signed off by a Managers.

*(Very High/ High risk of Serious Harm) **(Medium Risk of Serious Harm)

The National Probation Service Quality development team undertake dip sampling on a regular basis and provide constructive feedback to individuals.

The National Probation Service advise a set of National Standards are due for release and implementation in 2021.

18 Doncaster Children's Services Trust (DCST)

18.1 Doncaster Children's Services Trust became the social work provider for Doncaster Local Authority area on 30th September 2014. Prior to Child G's death Doncaster Children's Services Trust was not involved in his or his family's life.

18.2 This review has identified that domestic abuse was a feature of Adult HM's marital relationship. Police records identify the first Domestic Abuse incident they recorded for Adult HM was in 2005.

18.3 Social Work services in Doncaster have been involved with Adult HM, having undertaken assessments in relation to his own children in 2010, 2012, and again in 2017. The 2010 and 2012 assessments were following domestic abuse incidents within his marriage. The first (2010) was a basic assessment within a contact record and closed down as No Further Action (NFA) with no rationale as to why. The second (2012) was a child and family assessment but again closed NFA. Both were carried out by social work services which at the time were within Doncaster council.

18.4 The 2017 assessment was carried out as the result of the referral by the National Probation Service when Adult HM was about to be released on licence following recall for a serious and violent assault. The assessment was closed as NFA. This assessment was carried out by Doncaster Children's Services Trust who as the first Children's trust in the country and provider of social work services for Doncaster Council had full and unfettered access to all of Children's Services information in order to make informed decision in order to execute their statutory duties.

18.5 The quality and subsequent usefulness of the assessments of 2010 and 2012 are problematic as there was no exploration or consideration of any historical factors about the family's life and centred only on the domestic disputes. The Social Work Child and Family Assessment in 2017 did not go further back than the 2010 piece of work and therefore did not explore historical factors either.

18.6 There was no consideration of the *life story* of Adult HM, which would have provided rich information concerning him and his behaviours.

18.7 This review has considered the available historic information on children's service case records that identifies Adult HM was a victim of abuse as a child, growing up in a household where domestic abuse and coercive control were significant issues that impacted on him as a young child and as an adolescent. In his teenage years his troubled and troublesome behaviours resulted in him being involved with the police for youth crime.

18.8 The assessments in 2010 and 2012 appear to have been relied upon whenever another agency, such as the National Probation Service and South Yorkshire Community Rehabilitation Company, made enquiries about Adult HM and whether the children's social work service believed him to be a risk to children or not.

18.9 Both Probation Services approached Doncaster Children's Services Trust attempting to gather information concerning his potential risk to children in their attempts to carry out risk assessments. The interchange and responses which hampered the depth of information sharing and obscures a true understanding of the risk to children have been articulated elsewhere in this report, but it is clear that the reliance on the original assessment of Adult HM from the incidents in 2010 and 2012 shaped thinking and responses of Doncaster Children's Services Trust concerning his risk to all or any children over subsequent years.

18.10 There appears to have been no professional curiosity to identify if Adult HM had been involved in violence with other children and families when answering the question posed by the requesting service.

18.11 The lack of professional curiosity by those initiating and receiving the information requests as well as policy and practice concerning information requests within Doncaster Children's Services Trust at the times of requests did nothing to aid the free flow of information which the Probation Services should have expected when attempting to assess the risks posed by Adult HM.

18.12 Since the social work assessment in 2010 Adult HM has had upwards of 13 additional intimate relationships with women over this period, all of whom live around the Doncaster local area and close to where he grew up.

18.13 This review has discovered that the majority of these relationships have involved domestic abuse where Adult HM was the perpetrator. When the domestic abuse was revealed and reported to the police, Adult HM always appears to move on from the relationship with no conviction against his name.

18.14 South Yorkshire Police have arrested Adult HM on multiple occasions for domestic abuse incidents but for a variety of reasons none of the prosecutions were successful.

18.15 There have been 16 meaningful contacts and referrals to children's social work services between 2010- 2020, either in the aftermath of violence from Adult HM, or the seeking of information on whether he poses a risk to children. Two of these contacts were to social work services within Doncaster Council (2010 and 2012) with the rest being to Doncaster Children's Services Trust.

18.16 Doncaster Children's Services Trust undertook Child in Need assessments in respect of four different families covering 8 children in total. There were 2 other incidents where information suggests an assessment may have been appropriate, but no record is available. All of the incidents identified Adult HM as being within the family home and all but one clearly in a relationship with the mother of the children.

18.17 In all the assessments Adult HM was reported to have moved into the family home within weeks of the relationship developing, and within a few weeks of being resident in the family home he is reported to have been controlling of the mothers. The children spoke to the Social Workers in two of the assessments about Adult HM swearing directly at the children and in two assessments he is known to have hurt the children physically.

18.18 A consistent feature of the assessments is the lack of triangulation in respect of Adult HM's presence in multiple families and the chronological impact of his behaviours and abuse on women and children. The information is available on the Children's Social Care database is not noticed by practitioners who do not flag him as a key person of concern. The Risk to Child (RTC) marker should have been used (there was no policy in place regarding their use prior to the review). Instead, the practice across all of the assessments is one where the Social Worker considers Adult HM as being no longer a risk as he has left the family home and as such, the risk has been mitigated.

18.19 This review has identified that once Adult HM is known to have caused harm in a family, he leaves the family home, on occasions this has been through being in custody but mostly he has moved onto another relationship within weeks of the last one.

18.20 The final assessment was carried out in 2019 by Doncaster Children's Services Trust started on the 30th April and completed within the 45-day statutory time scale being stepped down to Early Help.

18.21 The assessment involved two children and their mother, who Adult HM had started a relationship with, moving into the family's home very shortly afterwards.

18.22 The assessment took place as a result of contact from the school of one of the children following the child having spoken to her parenting worker about Adult HM having locked her in her bedroom, taking the light bulb out, swearing at her and being controlling with her mother. The incident appears to be an example of the type of behaviours Adult HM was exhibiting within the family setting and towards the child.

18.23 Police information would suggest that Adult HM was involved with this family for approximately seven weeks. Evidence therefore suggests that Adult HM commenced his relationship with Adult GF within weeks of this assessment being completed.

18.24 In one particular case concerning an ex-partner Adult HM's violence was also directed independently to her 2 children, this led to an assessment carried out by Doncaster Children's Services Trust but did not include Adult HM as he had left the family home. It appears as with other assessments carried out by Doncaster Children's Services Trust it was seen as a protective factor that Adult HM was no longer in the family home.

18.25 The harm experienced by these children did not result in a decision by Doncaster Children's Services Trust to instigate a section 47 Child Protection enquiry, instead a Child in Need assessment under Section 17, was undertaken; this despite the fact that the mother had been the victim of domestic abuse on numerous occasions with various partners. Children's social care viewed this mother as a victim of her own circumstances. The section 17 assessment stated that the mother *''makes poor relationship choices''* and *'omits to consider the impact of her choices on her children'*.

18.26 The social work approach to assessment once the perpetrator of domestic abuse has left the family has been to view the risk to the children as having been removed.

18.27 At the time of Child G's death Adult HM had no markers or flags on the children's social care record in Doncaster Children's Services Trust identifying that he was a risk to children notwithstanding the incidents which had been considered by social work over the years.

18.28 This issue was identified for action by the Rapid Review:

Learning

The analysis and assessment of the need, harm and risk to children needs to be based on the full information picture available of all those involved.

Information sharing when required between social work services and other safeguarding partners needs to be fulsome, effective, efficient, and supported by professional curiosity.

Perpetrators of abuse must be readily identifiable within children's records and their current risk to children visible.

Children's social work must consider and be responsive to the true impact of violence and domestic abuse on a child's lived experience, being professionally conscious of bias when an adults needs are potentially significant and overwhelming.

Response to Learning

Child focused risk assessment in domestic abuse cases

Since December 2020 - The EVOLUTION prompts tool now used by all Social Workers in the Front Door of Children's Social Care. Social Workers carefully consider need, harm and risk factors relating to domestic abuse at the point of screening referrals and responding to information sharing requests.

Young people involved in domestic abuse incidents (where applicable) are screened and then referred to the Child Exploitation Team to add to the Vulnerability Assessment Tracker (VAT) for scoring (red, amber and green) and presentation to the Multi-Agency Child Exploitation meeting (MACE). MACE takes place weekly for those identified as Red, 3 weekly for Amber and 12 weekly for Green. Young people who are rag rated green are immediately linked into the Early Help offer, Family Solutions and also the Encouraging Potential Inspiring Change Programme (EPIC) for preventative services.

All Social Workers are encouraged to adopt an inquisitive approach to assessing the impact of domestic abuse for children with particular attention paid to the contributing factors of drugs, alcohol, adult and parental mental health and criminal profiles of the adults concerned. This approach is adopted when screening for all professional referrals, police notifications and members of the public reporting concerns relating to children.

Response to Learning

Information sharing at the front door of Children's Services

The requirement for agencies to submit a cumbersome referral form as part of the request for information sharing has now been removed. This has been replaced by a more proportionate and timely response through an email request template. The new template clearly supports the officer requesting the information and those responsible for the response to be clear concerning the request for information, why the request is being made, and the outcome required. Historical or relevant factors such as need, harm and risk associated to children or adults are required.

- Single Point Of Contacts (SPOCs) are in place to assist with information request and by Probation directly from court
- The Multi-agency threshold document has been refreshed and levels of need descriptors are at the consultation stage with partner agencies. This is to achieve a consistent application of threshold decision making in regard to need, harm and risk
- The National Probation Service is now a key member of the Multi-agency Child Exploitation meeting (MACE) for children and a close link for all vulnerability factors
- Development work is currently underway to move towards a Multi-Agency Safeguarding Hub at the front door of children services

Since January 2021, the leadership team have commissioned a series of workshops for all social work staff alongside Probation Officers to ensure that assessments are timely, robust, and analytic and appropriately address identified risk factors, focusing particularly on the use of history information used wisely in assessments.

Doncaster Children's Services Trust continue to develop their commitment to improve operational practice in case work and ensure quality case summaries, chronologies, genograms and ecomaps are up to date on children's case files.

Response to Learning

The newly appointed Head of Service for Quality Assurance is tasked with updating the Quality Assurance framework and operational guidance in respect of:

- Review of the current Trust Domestic Abuse Policy, Practice and Guidance
- Reviewing and strengthening the role of Domestic Abuse Navigators (DANs) (based on confirmed establishment)
- Review the role of the Domestic Abuse Champions within Doncaster Children's Services Trust and subsequently across the partnership
- Review and strengthen the use of the DASH risk assessment tool
- Agreement and implementation of victim and child Domestic Abuse risk assessment tools
- Mapping of Domestic Abuse offer across Doncaster for victims, children and perpetrators
- Review of role and function of Domestic Abuse Hub
- Review of the processes, effectiveness and interface between Multi-agency Risk Assessment Conference (MARAC) and Multi-agency Public Protection Arrangements (MAPPA)
- Learning from Joint Targeted Area Inspection, Audits, Domestic Homicide Reviews and Learning Reviews and National Evidence based practice
- Review of Operation Encompass and its effectiveness
- Review and development of Domestic Abuse performance information available to the partnership
- Review and develop training programme available to the partnership and what the 'mandatory' training should be
- Review of role of Independent Domestic Violence Advisors and Domestic Abuse Counselling workers to ensure right families are identified.
- Develop internal programme of training to improve assessments of risk and impact of Domestic Abuse

Domestic Abuse Strategy

18.29 The Doncaster Domestic Abuse Strategy was published on 31st January 2017, commissioned as a result of four domestic homicide reviews that occurred over the course of 4 years. In response the strategic leaders moved proactively to have strong control and oversight on a collaborative response to domestic abuse.

18.30 The strategy was written as a 5 year developmental plan, and is a positive document with an excellent governance structure that included a robust quality assurance framework inclusive of deep dive auditing by a multi-agency group to evidence the impact of the strategic practice across the partnership. This would also test how various services were responsive in identifying and reducing need, harm and risk with the opportunity to structure services accordingly and where innovation could grow. The learning loop of the quality assurance framework was key to the success of this strategy.

18.31 There was a Chief Officer Group that was central to the strategy and would drive the implementation. However, the Chief Officers Group (COG) was stood down in July 2018 some 18 months after publication.

18.32 This decision was made by the Safer Stronger Doncaster Partnership who agreed that oversight of the strategy and performance against it would be held by its Domestic and Sexual Abuse theme group. The review was advised that the Domestic and Sexual Abuse Theme Group led on the key actions and presented regular reports on progress to the SSDP and provided the vehicle for accountability at a strategic level.

18.33 There is an acceptance that the decision and the standing down of the Chief Officer Group reduced the level of focus and accountability at the strategic level and with it the strategic oversight of some key services was lost.

18.34 The changing of the governance structure meant that the connectivity across the partnership was diluted, there was no performance information or partnership data available upon which to commission or decommission services or to provide the strategic picture of harm. There was no clear identification or line of sight of children and young people living with Domestic Abuse in their homes.

18.35 Perpetrators of Domestic abuse, other than the High risk offenders who were discussed at Multi-agency Risk Assessment Conference (MARAC) were not readily identifiable to the partnership nor routinely discussed within a multi-agency forum to consider risk mitigation of a perpetrator. The review has recognised and welcomes the inception of a Multi-Agency Tasking and Co-ordination (MATAC) in respect of domestic abuse perpetrators.

18.36 These issues were recognised by the statutory safeguarding partners through engagement with the review and immediate actions were taken by senior leaders within the partnership to address the issues.

Learning

The importance of strong, relentlessly focused partnership governance and leadership is essential in the delivery of a multi-agency strategy Domestic Abuse Strategy.

This leadership is necessary to ensure the delivery of the strategy, an understanding of the profile and details of harm caused by Domestic Abuse, the delivery of a quality assurance and performance framework and to ensure provision of appropriate services to meet the needs of children impacted and affected by domestic abuse.

Response to Learning

The Chief Officer Group has been re-instated and will oversee the delivery of the Domestic Abuse Strategy.

A positive and responsive decision to reinstate the Chief Officers Group, has resulted in the development of a domestic abuse performance dashboard to ensure a clear line of sight in respect of the profile of domestic abuse.

The Chief Officers Group have set 6 strategic priorities:

- Develop a whole partnership Domestic Abuse data and intelligence dashboard

Response to Learning Cont'd

- Map current Domestic Abuse systems and processes from the front door and partnership associated pathways
- Map all children living in households where there are incidents of Domestic Abuse to ensure that there is a strong line of sight across the partnership and risk stratification and support plans in place
- Develop a Domestic Abuse quality assurance, insight and audit assurance framework which includes workforce and practice development areas
- Review the Commissioned and Contracted of Services to ensure that the available funding is pitched in the right place and delivering favourable outcomes.
- Review and refresh the DA strategy and action plan for (2021-24).

Doncaster Council have funded a new post of strategic lead for Domestic Abuse who commenced in post in March 2021.

An ongoing program of mandatory Domestic Abuse training has been developed and rolled out across the partnership

Alongside the Domestic Abuse strategy sit two key documents, namely the local transformation plan and a longitudinal study undertaken in respect of the Growing Futures initiatives **(see below)**

19 Doncaster Multi Agency Risk Assessment Conference (MARAC)

19.1 As part of its consideration of the response to domestic abuse the review attended the Doncaster Partnership Multi Agency Risk Assessment Conference (MARAC) as well as meeting with the chair and those leaders who oversee the process.

19.2 The review was impressed with the way the meeting was chaired and the processes which enabled the conference to function in a very business-like manner. The numbers of cases being routinely discussed at the meeting was high with significant levels of risk being identified and actions planned for mitigation.

19.3 All safeguarding partners were represented although the review raised concerns at the attendance by Doncaster Children's Services Trust in terms of representation of children by a non-qualified social work voice.

19.4 The review believes that attendance by case holding Social Workers relevant to each individual Multi-agency Risk Assessment Conference (MARAC) discussion is important and best practice for children. Discussions were held during the life of the review with stakeholders in relation to this. As part of the learning methodology the lack of qualified social work representation was escalated to Doncaster Children's Services Trust and the Director of social work took appropriate action.

19.5 The use of video conferencing has become part of the new normal throughout 2020 and 2021 due to the Covid 19 pandemic. This use of technology would afford social work services the opportunity to attend such meetings as Multi-agency Risk Assessment Conference (MARAC) whilst reducing the pressure on their time through having to attend

in person. It is the social work advocacy of the child's voice and lived experience which is critical.

20 Risk to Children Markers (RTC)

20.1 The Rapid Review which was carried out following the death of Child G identified there was an issue concerning the use of Risk to Children markers within the Doncaster Children's Services Trust case files system. An action was identified to issue practice guidance concerning the use of Risk to children markers (RTC) as opposed to 'Hazard' warning markers for known violent offenders. The review supports this original action having found the use of Risk to Children markers against known violent offenders and perpetrators of domestic abuse was not consistent.

Response to Learning

The leadership team responded effectively, and Doncaster Children's Services Trust now has a permanent seat at the table in respect of Multi-agency Risk Assessment Conference (MARAC) and Multi-agency Public Protection Arrangements (MAPPA).

MARAC attendance is by a social worker from the Assessment Service on cases that are not open. Team managers and social workers attend MARAC on allocated cases for their children.

There has been an increase in cases scheduled at MARAC which has now moved from a fortnightly meeting to weekly in order to manage the workload and risk more effectively.

Doncaster Children's Services Trust have introduced an initiative called Family First where if the decision of the social work service at the front door is for an assessment to be completed a meeting is held with the family within the first seven days of the assessment and a further meeting with other relevant partners within 15 days. If a targeted approach is the outcome of the assessment, then Early Help and the family are already involved. This ensures a lead professional is identified and Team Around the Family coordination continues thereby ensuring an integrated response. This applies to all referrals for domestic abuse.

The Principal Social Worker attends MAPPA 2 meetings and provides professional advice and guidance in relation to safeguarding children. They also take responsibility for ensuring that any new Risk To Children (RTC) markers are added to the children case management system, and that existing markers are updated where needed. The Head of Service for the Assessment Service or the Principal Social Worker attend MAPPA 3 meetings.

Training for all social workers in the work of MAPPA will be commissioned during 2021.

Guidance has been circulated (Sept 2020) concerning the use of Risk to Children markers within Doncaster Children's Services Trust and also more widely across early help services via Doncaster Council.

It is now the responsibility of the child protection chair attending MARAC to ensure RTC markers are added to a child's case file and updated as appropriate when new information comes to light through the meeting.

20.2 We would identify the opportunity for Multi-agency Risk Assessment Conference (MARAC) to forge a strong relationship with the new Multi-Agency Tasking and Co-ordination (MATAC) in respect of domestic abuse perpetrators which is highlighted within the police section of this report. (Recommendation at Appendix 4)

21 Growing Futures Project and Domestic Abuse Navigators (DANS)

21.1 Alongside the Domestic Abuse Strategy sits two key documents, namely the local transformation plan and the longitudinal study undertaken in respect of The Growing Futures Project.

21.2 *The Mental Health and Well Being, Local Transformation Plan 2015 -2020* addressed how the partnership would respond to domestic abuse based upon concerns that domestic abuse and violence was noted as a significant feature for children and young people in over 30% of all referrals to Doncaster Children's Services Trust. The document noted that domestic abuse was usually firstly identified at a relatively high level of risk by either the police or social care and not commonly identified by universal and Early Help services, with most of these responses focused on either victims or perpetrators, and not on the children and young people in the family.

21.3 It was noted that the immediate efforts to reduce short term risk did not always reduce risk in the long term, and at times led to a repeat victimisation with different partners in new relationships, with a worry that young people went on to become victims or perpetrators in their adult life. The document noted that there were very few interventions focused on children and young people directly, and even fewer focused on the recovery of victims and their children together, in order to achieve sustained reduced risk of victimisation.

22 The Growing Futures Project

22.1 The Growing Futures project was formed as a partnership approach and way of working led by Doncaster Children's Services Trust which aimed to improve the outcomes of families, particularly children and young people, affected by domestic violence and abuse (DVA) through transforming the services that work with them.

22.2 It was funded from April 2015 to September 2016 by Round 1 of the Department for Education's (DfE) Children's Social Care Innovation Programme (Innovation Programme) and was operational between September 2015 and March 2017. Although the Innovation Programme came to an end in March 2017, some of the activities implemented under the approach have been incorporated into Doncaster Children's Services Trust's business as usual. In particular, the whole family approach to domestic abuse that was led by a team of Domestic Abuse Navigators (DANs) continued.

22.3 Growing Futures was designed to address significant historical difficulties with multi- agency working and poor levels of trust between service users and services. Its specific aims were to:

- Reduce the emotional harm caused by domestic violence and abuse to children and young people
- Directly support recovery from domestic violence and abuse for victims and their children
- Significantly reduce repeat victimisation
- Challenge the acceptance of domestic violence and abuse in families and their communities

- Break the pattern of domestic violence and abuse as it re-presents in children and young people.

22.4 An initial evaluation of Growing Futures was conducted between May 2015 and September 2016 by Opcit Research. The evaluation provided proof of concept for the Growing Futures model. For instance, the evaluation report (published in March 2017) focused on the impact of the new model of working with families, as delivered by Domestic Abuse Navigators (DANs), and processes which supported the model. It identified that Growing Futures was having a positive impact on Doncaster Children's Services Trust relationships with families and communities, multi-agency working and on some of the families who were supported by Domestic Abuse Navigators (DANs).

22.5 It was originally planned that there would 12 Domestic Abuse Navigators (DANs) in place. However, only 10 were appointed. Eight of these appointments filled DAN roles whilst two appointments became Domestic Abuse Navigators (DANs) managers.

22.6 Key findings from this evaluation included:

22.7 Growing Futures had a sustained impact on the delivery of services children and families receive. The primary change to service delivery which continued to have a sustained impact for families was the role of the Domestic Abuse Navigator, which has been adopted as part of everyday service delivery by Doncaster Children's Services Trust following the end of the Growing Futures funding period. There was consensus that the whole family model in Doncaster should be underpinned by the role of the Domestic Abuse Navigator, whose intensive work with the whole family was viewed as important for building lasting relationships and helping to overcome entrenched behaviours which result in domestic abuse.

22.8 There was evidence from interviews and casefile reviews that the whole family model of working had been implemented by other professionals. Stakeholders and Social Workers reported that Domestic Abuse Navigators who had been in place for a number of years could offer more experience, which was viewed as positive for families.

22.9 There was a wealth of evidence to suggest that the whole family approach through Domestic Abuse Navigators direct intervention work and efforts to consider all family members' wishes and feelings at different stages in a family's support from children's social care services had been sustained.

22.10 Qualitative consultation with stakeholders, social care staff and Domestic Abuse Navigators was positive about sustained increases in wellbeing and resilience for children and family members as a result of Growing Futures. Work continued to be developed which may not have occurred without the Round 1 Innovation Programme investment.

22.11 Further work which might not have been developed without the investment of the Innovation Programme includes a Family Risk Assessment tool to complement the Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH).

22.12 However, it was not clear the extent to which this was being used. Stakeholders also reported that Doncaster Children's Services Trust domestic violence and abuse related policies and Domestic Abuse Navigator practice guidance would need to be refreshed.

22.13 Documentation showed that the Domestic Abuse Chief Officer Group, a multi-agency subgroup, were taking steps to develop and coordinate strategies to tackle domestic and sexual violence and abuse and the Practice Guide and Outcomes Framework was updated

in April 2017. A final addition was the creation of domestic abuse champions which have been placed in each of the four geographical localities of Doncaster Children's Services Trust.

22.14 However, in 2020 there was a significant reduction in the number of Domestic Abuse Navigators, from eight to four. This was not regarded as problematic, with Domestic Abuse Navigators, Social Workers and stakeholders reporting at the time that they were still able to provide high levels of support to the families they worked with.

22.15 Domestic Abuse Navigators had the capacity to provide support to high-risk rather than Medium to the low-risk families. It was envisaged that Medium and Low risk family support would be provided through the upskilling of other professionals concerning the whole family model of working. However, it is not clear if the upskilling of other professionals took place.

22.16 The Family Risk Assessment tool that was to be developed in order to complement the use of the compliment the Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH), was not produced, resulting in the over reliance on DASH as the sole risk assessment tool where domestic abuse was concerned. Without a family or child specific risk assessment tool in place the upskilling of professionals to provide a consistent approach to supporting children and families experiencing domestic abuse simply did not take place.

22.17 The decision to reduce the DAN's workers was one taken by Doncaster Children's Services Trust and was in response to financial constraints, this decision was specifically impactful given that the DAN's service was the only targeted domestic abuse service working directly with children.

- In 2017: the service consisted of 2 x team managers, 8 x DAN's practitioners and 2 x perpetrator engagement workers.
- By 2019: the service was reduced to 1 x team manager, 4 x DAN's practitioners and 1 x perpetrator engagement worker.
- In 2020 (March): the service consists of, 1 x team manager, 2 x DAN's practitioners and no perpetrator engagement workers.

Learning:

The Domestic Abuse, Stalking and Honour Based Violence (DASH) is an adult based risk assessment tool used primarily by the police following attendance at a domestic abuse incident. The tool identifies adult risk, but caution needs to be applied when relying on it as a tool to understand a child's lived experience of domestic abuse.

Many Local Authorities Children's Services have adopted the use of a child specific assessment tool in relation to domestic abuse incidents such as the Barnardos Rim and Ram tool which provides much better line of sight concerning a child's lived experience, affording quality assessments that lead to proportionate and protective multi-agency intervention to safeguard children.

Reduction in funding for the DAN's service has impacted the ability of Doncaster Children Services Trust to deliver the services to a level it would have wished to have done.

Response to Learning

The Barnardo's Rim/Ram assessment tool has been introduced in both the front door of children's social care and within the assessment teams to strengthen analysis.

The strategic leadership group have secured future investment in the service to maximise the strength of the Domestic Abuse Navigator Service (DANS) offer by commissioning two new Domestic abuse Navigators, one perpetrator worker and one additional business support worker.

23 Family Voice

23.1 An important part of this review process has been the conversations with family members, at the time of the field work for this review the police investigation meant that reviewers were unable to meet with Adult GF's extended family. As reviewers, we have however had the opportunity to meet with two of Adult HM's family and with the foster carers who looked after Child G's two siblings in the aftermath of his death.

23.2 *Foster carers*

23.3 Child GF1 and Child GF2 were placed with Doncaster Children Services Trust a family of experienced foster carers following a short stay with their maternal uncle and his wife when Adult GF was remanded in custody pending trial. Reviewers took the opportunity to learn about Child G and his siblings experience through the lens of the carers who spoke eloquently and lovingly about the children.

23.4 The Foster Carers spoke of the strong attachment between the children and particularly about Child GF2's parental instinct for their little sibling, they were able to share their worries about the impact of Child G's death on Child GF2 in particular and the sense of loss and protection of their mother. The carers believe that Child GF2's position within the family was one of a young carer and protector of their brother and their worries about Child GF2 holding a sense of responsibility for not preventing Child G's death was a significant feature of the conversion.

23.5 Reviewers where able to raise the need for immediate psychological first aid for Child GF2 in particular given their protective role. With the permission of the director for social work, one of the reviewers facilitated a meeting with the social work practitioners and line managers (including the Independent Reviewing Officer and Principal Social Worker). Through the active sharing of practice wisdom and the insertion of some urgency around Child GF2's mental health needs, swift action was taken to ensure the right therapeutic support was provided without further delay.

23.6 The children's looked after review process for both Child GF2 and Child GF1 were subsequently strengthened to ensure that the multi-agency groups provided the right support within the margins of legal proceedings.

23.7 For Child GF1 the carers reported on the rapid and significant improvements in speech and confidence. They reflected on how much Child GF1 had flourished and discussed how they had felt this was due to the level of security that Child GF2 had provided for Child GF1, consequently Child GF2 experienced a fair amount of unrest when Child GF1 had family time contact with her paternal grandmother.

Learning

Children should be provided the proportionate psychological first aid as soon as is right for them. Services must be robust in their planning so that court proceedings (criminal or civil) do not prevent the progress of good mental health when children experience trauma.

23.8 Adult HM's siblings

23.9 Adult HM is the younger brother of his three older siblings. Reviewers had the privilege of spending time with two out of the three siblings who spoke openly about their life experience and their love and commitment to their brother, particular their love and protection of his biological children.

23.10 His siblings talked with us about their support for Adult HM throughout all of his life and his particular closeness with his eldest sibling, who left home as a young teenager and lived independently by the time Adult HM reached his adolescent years. As a sibling group they had been united in their support of each other as they endured a childhood where domestic abuse, coercive control, and abuse was a feature. Both siblings spoke of a childhood where professionals had substantial involvement throughout their life and believed that professionals did not know how to step in and protect them properly. Adult HM was supported by school staff in his adolescent years as the multi-agency group agreed the step down from a Child Protection plan.

23.11 They spoke of Adult HM's difficulties with drug abuse over the years and his devastation at the breakup of his marriage, that followed Adult HM having one relationship after another. They were forthcoming in their views that they knew their brother to be a 'nightmare' at times, but believed him to be very, very good with children. They took the stance that he would never hurt a child, a view that despite their ability to think about the impact of domestic abuse in their own childhood had on them and their knowledge about Adult HM's temper, they continued to hold.

23.12 Reviewers were curious about the level of help and support to Adult HM over the years, particular given his significant involvement with Probation Services. Both siblings believed this to be ineffective and experienced the services as dismissive of their views on Adult HM. They spoke of arranging drug rehabilitation in an attempt to support their brother and of the little amount of help and support they believed they were given.

23.13 Adult HM's siblings stated they were pleased about the relationship between Adult GF and their brother, considering Adult HM to be a good influence on them as a family unit. They gave examples of how Adult HM took it upon himself to place some boundaries around the type of food the children eat and to be clear with Adult GF about the need to cut down on the amount of junk food consumed by them all. Both spoke of getting to know Adult GF as a local girl who had children by different fathers. The spoke of how they had come to know that Adult GF self-harmed at times and felt depressed. They believed that Adult HM had looked after her and her children, they did not believe that he had it in him to have murdered Child G.

23.14 Reviewers were able to explore their lived experience growing up in their community and what they believed to be the impact of domestic abuse on children. Both siblings where forthcoming and reflective about great things within their community and of a sense of

identity. However, they also spoke about the fact that people in the community often knew when violence happened in a family.

23.15 At one stage when asked about their thoughts on how violence in families manifests itself, one of the sibling's response was that for some communities Domestic Abuse *'is no longer shameful'.*

23.16 Reviewers were able to explore what they, as family members and parents, hoped to be the outcome of this review. Both were able to state clearly that there is a need for there to be less tolerance of abusive behaviours. Action about abuse and domestic abuse needed to be stronger and there was a need to support their community with the impact of drug and alcohol abuse.

23.17 They were clear in their wish for the public services to be more proactive and locally based so that support is targeted and easily obtained.

Learning

The review gained the view that Domestic Abuse and Violence may be considered as no longer shameful within some communities of Doncaster which the safeguarding partnership may well wish to explore further.

24 Partner and Partnership Knowledge July/August 2019: Adult GF & Adult HM

24.1 In considering the Terms of Reference for the review it is important to understand the partnership perspective and knowledge of Adult GF & Adult HM at the point they commenced their relationship.

24.2 Using the evidence and knowledge from the South Yorkshire Police murder investigation into the death of Child G it is fair to conclude that Adult GF and Adult HM commenced a relationship in the early summer of 2019. It is also appropriate to conclude that Adult HM moved into the family home with Adult GF, Child GF2, Child GF1 and Child G at the beginning of August 2019 within approximately 7 weeks of leaving another relationship where domestic and direct child abuse had featured. As has been identified this previous relationship and the abuse within it was subject to a Child in Need assessment by Doncaster Children's Services Trust.

24.3 As has been identified there was little professional knowledge across the partnership at the point of Child G's death concerning Adult GF other than the normal health and educational material concerning a single mother attempting to parent her three children. The review has found nothing to contradict this view and confirms that there was no information within the partnership, which would have raised even the slightest of concerns about Adult GF or the safety of her three children.

24.4 Adult HM was however very different. There was a wealth of information and knowledge concerning his life story, his propensity for violence against partners, children and strangers and the escalating risk he posed to those he formed relationships with their children and the general public.

24.5 This knowledge has been seen for the first time in an holistic and fulsome manner by the review but as has been discussed within the report already was not considered in its entirety at any point when a partner or partners were attempting to identify the risks he posed to society.

24.6 It is interesting to succinctly identify where the knowledge sat when Adult HM started his relationship with Adult GF to reinforce many areas of learning that this report has identified and which the partnership has acted upon.

24.7 Doncaster Children's Services Trust held large portions of his hidden life story. His early life was held within original paper files which had been migrated to a data format (through being scanned) which were provided to the review by the Trust and analysed. This early life story held the key to understanding Adult HM the man as he moved from one relationship to another. The Trust also held information in easily accessible data format on the children's case file system in respect of his behaviours towards his ex-wife and subsequent partners through the lens of child and family assessments carried out as the result of his violence in the respective homes.

24.8 The Multi Agency Risk Assessment Conference (MARAC) held information concerning the risk he posed through domestic abuse across different partners and the understanding of the risks irrespective of the criminal justice process outcomes.

24.9 South Yorkshire Police held information concerning his offending, convictions and violence from his adolescence to the present day. The records identify the escalating nature of his violence over the years, his use of weapons and a continual cycle of abuse of partners and their children through domestic abuse. When the relationship with Adult GF started and Adult HM moved into the family home the force did not know this information nor would they have been aware the South Yorkshire Community Rehabilitation Company would have been interested. The force however did have the opportunity to positively identify this on the 11th August 2019.

24.10 The National Probation Service and South Yorkshire Community Rehabilitation Company held significant understanding of his behaviours including clear evidence of his lack of interest in addressing them in particular his use of violence in relationships and ongoing use of alcohol and drugs. The case notes from both Probation Services identify a constant changing of female partners and a success of moving into the homes and lives of vulnerable women and their children. Examination of the records show on occasions it was impossible to pin down who he was in a relationship with and where he was living. This in itself is valuable information to a professionally curious safeguarding professional when attempting to analyse risk.

24.11 What was unknown at the time Adult HM commenced his relationship with Adult GF and moved into the family home were two key pieces of knowledge:

- A holistic and fulsome partnership picture of Adult HM, the person and his continual and longstanding abuse of women and children through domestic abuse built on the safeguarding partners individual and joint knowledge which would have identified the risks he posed to Adult GF, her three children and members of the public

- The very fact that he had started the relationship with Adult GF and had moved into the family home with direct care and control of Child GF2, Child GF1 and Child G

24.12 One could argue that if the first had been in place it could have generated effective partnership working which may well have identified the second.

25 Terms of Reference: Answers from the Review

25.1 What opportunities existed to intervene within the partnership that could have prevented the death of Child G?

25.2 Feedback from the partnership when considering the initial draft of this review report included a suggested change to the question posed within the Terms of Reference. The suggestion was:

25.3 Were there opportunities to intervene that may have prevented the death of Child G?

25.4 The review believes the following answers both.

25.5 When considering the potential answers to this one needs to recognise firstly that Child G during his short life was not considered to be at risk or on the radar of concern to the Doncaster Safeguarding Partnership or any partner with responsibilities for safeguarding and promoting the welfare of children.

25.6 Child G was known to health services through the provision of normal Early Years health services. He was also known to the staff running the sessions he attended at a local outreach centre run by the Family Hub and at the Primary School through the attendance of his siblings. None of these interactions raised any cause for concern.

25.7 Child G was not seen by the police when they attended the incident on the 11th August 2019 and the South Yorkshire Community Rehabilitation Company who were supervising Adult HM in 2019 were not aware of Adult HM's relationship with Adult GF or that he had moved in to live with her and the three children in August 2019.

25.8 The police investigation has identified he suffered repeated and visible injuries during 2019 but none were seen by or identified to a safeguarding practitioner. It is clear that his mother, Adult GF, deliberately avoided seeking medical help for him and wished to avoid interest from social work services.

25.9 Members of the public on more than one occasion recognised visible injuries to Child G and challenged Adult GF concerning them on occasions suggesting she consider medical support. No one from the community raised a concern regarding Child G's injuries to any service who could have intervened.

25.10 Given this factual precis it is apparent that **no** safeguarding professional had the awareness of Child G's lived experience and as such had **no** cause to intervene in order to protect him. (The safeguarding issues and learning emanating from the professional interactions in and around Child G during his life have been identified within the report).

25.11 However, the review would suggest that opportunities did exist for the partnership to have been potentially more aware of Child G and the risk in particular Adult HM posed to him and this may have created opportunities to intervene and protect him during the Autumn months of 2019.

25.12 The necessary conducting of an in-depth assessment of Adult HM was never achieved (prior to the review), although the knowledge was held within individual partners which would have enabled a much clearer view of the escalating risks he posed especially to his partners and their children. Adult HM was discussed at Multi-agency Risk Assessment Conference (MARAC) on more than one occasion as a High risk offender of domestic abuse for specific incidents but did not lead to a higher level of partnership awareness of his continual and escalating behaviours.

25.13 Risk assessments of Adult HM by both Probation Services routinely graded him at a lower risk than his potential for harm suggested based on a partial understanding of his behaviours and his offending. He was assessed as High risk to partners on one occasion following a violent incident but remained as Medium to children. Efforts were made by

particular practitioners to create a wider partnership-based view through information sharing but this was not successful for reasons already identified.

25.14 On the 15th October 2015, Adult HM was convicted of an offence which could have enabled him to be managed at Multi-agency Public Protection Arrangements (MAPPA) 2, category 2. There were other incidents of violence and behaviours where consideration for escalation to be managed at this level by the partnership could have been made.

25.15 If Adult HM had been accepted for management in this way (or managed in another integrated partnership manner) it could have elevated him in the consciousness of the partnership, and he may have been recognised as the extremely violent offender that he was.

25.16 This would have enabled partnership support to the management of him by the National Probation Service (who would have owned him under the Multi-agency Public Protection Arrangements (MAPPA) guidance at level 2 category 2) and would have enabled the partnership to create the full information picture upon which risk assessments could have been based.

25.17 Integrated partnership involvement in his management such as is afforded by the Multi-agency Public Protection Arrangements (MAPPA) process may have enabled the partnership to recognise that Adult HM had entered another relationship and that he was living with Adult GF and the three children. Experience suggests that management in a partnership manner would have identified intelligence gaps which the partnership would have been actioned to fill.

25.18 The review recognises the partnership is responding to the challenges posed by domestic abuse offenders such as Adult HM through the creation of Multi Agency structures and meetings which will provide the consciousness, partnership knowledge and prevention focus the review believes Multi-agency Public Protection Arrangements (MAPPA) 2 or other partnership forum may have provided.

25.19 The police incident of the 11th August 2019 should have triggered the submission of a Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH) form and notification to Children's Social Care but this would likely not have filtered through to the South Yorkshire Community Rehabilitation Company who were supervising Adult HM at the time, although it may have alerted the Primary School through operation Encompass where the siblings of Child G attended.

25.20 If the partnership had been able to see the developing situation around Child G in the Summer and Autumn of 2019 it could have led to the sharing of information with Adult GF directly through the application of Claire's Law: specifically, the 'right to know'.

25.21 The answer therefore is in two parts:

1. The review identifies that the partnership did not have a direct opportunity to prevent the death of Child G.

2. Closer more integrated partnership working in the preceding years concerning the management of the risks posed by Adult HM may have created the visibility of Child G and the risks posed by Adult HM which could have enabled them to intervene to protect him from the abuse he was suffering during the latter months of 2019.

25.22 ***How effective is the Doncaster partnership in safeguarding and promoting the welfare of children, particularly through the use of information and intelligence to identify need, harm and risk?***

25.23 Doncaster Safeguarding Partnership and its partner organisations routinely and successfully work to safeguard and promote the welfare of children.

25.24 This review has identified areas of learning particularly in relation to the use of information and intelligence as well as closer multi agency working which would have (in the case of Child G) and can create greater opportunity for the safeguarding partnership to identify need, harm and risk earlier and to focus on the offending and behaviours of prolific domestic abuse offenders who cause harm to their partners and the children who live with the abuse.

25.25 The partnership recognises it has opportunities to work in a more integrated and cohesive way to ensure information wherever it is held is available to any safeguarding professional who is tasked to identify need, harm and risk or those required to carry out assessments or offender-based risk assessments.

25.26 Closer partnership working can enhance the opportunities for recognising prolific offenders of domestic abuse and drive the joint working required to deliver effective preventative strategies to safeguard and promote the welfare of children.

25.27 In line with the methodology of the review the partnership has embraced many of the areas of learning identified which will enhance its ability to work in a more effective, cohesive and integrated partnership manner and to ensure information and intelligence is available and used to enhance the protection of victims of domestic abuse and the safeguarding of children.

25.28 ***Considering the effectiveness of the various risk assessment tools and approaches in use across the safeguarding partnership, to establish the strength of the multi-agency approach to maintaining public safety, in relation to children and families.***

25.29 The review has found no evidence that any specific risk assessment tool has prevented the identification of need, harm or risk to families and children.

25.30 The reliance on Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH), which is an adult based tool, at the front door to children's services does not provide a fulsome picture of the lived experience of children within domestic abuse. This issue has been raised as part of the review and has been acted upon Doncaster Children's Services Trust who have introduced the Barnardos RIM RAM child focused risk assessment tool within the developing Multi Agency Safeguarding Hub.

25.31 No professional during the review raised any concerns about their understanding of each other's risk assessment tools or the language concerning levels of risk.

25.32 Opportunities have been identified within the review for individual organisations' risk assessments to be discussed alongside each other in emerging partnership forums to ensure as wide an understanding of need, harm and risk as possible across the multi-agency landscape upon which to base preventative strategies and safety planning.

25.33 The completion of particular risk assessments, and on occasions tensions between the outputs of them, have been identified within the report. Learning has been identified, accepted by individual partners, and activity to generate improvement commenced.

25.34 As reviewers we are mindful that any assessment tool used by professionals is only as good as the information used within them and the analysis of such information in the context of need, harm and risk.

25.35 It is the application of robust professional curiosity and courageous practice executed with conviction to address need, harm and risk which ensures the impact of any tool used across a partnership to keep children safe.

26 Concluding statement

26.1 There can be no doubt that strong leadership goes alongside highly effective approaches to performance management and quality assurance. Their inter-relationship is vital for the kind of continual improvement seen in outstanding children's safeguarding partnerships.

26.2 Senior leaders must therefore ensure that they create an environment that looks beyond the required statutory returns, to enable them to be sighted on timely decision making for the care and protection of children.

26.3 Given Child G's short life, we are all charged with the personal and professional responsibility to learn the lessons presented in this review and acknowledge them without prejudice.

26.4 Domestic abuse in our lifetime presents us with a plague of damage to children, which is often unseen until this manifests in their physical, mental and emotional development as they grow up. The role models and the proactive protective adults that surround our precious children are so very important if we are to realise a safe and better society for all.

26.5 We must do all we can to make our children of today our safe adults of tomorrow. They are our future leaders, mothers, fathers, sisters and brothers. It is our duty to make sure that we do all we can to make society a safe and aspirational place for them. It is clear the senior leadership of the safeguarding partnership agree and are committed to delivering the learning of this review and striving for continual improvement in safeguarding practice.

26.6 Good professional practice across the various agencies comes from professional curiosity, courage and reflection where actions are informed by intelligence and solid evidence-based judgements that have outcome focused actions with children at the heart of everyone's practice.

26.7 It has been a humbling experience to have undertaken this review and our thanks and praise goes out to those practitioners who allowed themselves to walk back through their contextual lived experience of involvement with Child G, his family and associated others. The review itself has been a challenging, thought provoking, and dynamic experience for those involved.

26.8 We particularly extend our thanks to the cooperation and courage shown by Adult HM's extended family who were able to offer a valuable perspective on life growing up in Doncaster.

26.9 As reviewers we leave you with the stark expression of Adult HM's own family member, when asked about her thoughts on how violence in families manifests itself, her response was that for some communities Domestic Abuse is no longer shameful.

26.10 To ensure that children are protected and that lessons are learnt from the murder of Child G, the multi-agency partnership alongside the community must never forget that Domestic Abuse cannot slide into normalisation and must not be tolerated. The risks are too high for our children and their mothers.

26.11 Professionals must remember that children do not just witness domestic abuse they '***live it'***.

Appendix 1

Biographies of Reviewers

Anne Coyle

Anne Coyle is a professional Social Worker having specialised in the field of children's services for over 27 years. With a sound foundation in the protection and safeguarding of children. Anne is a leader who practices the courage of her convictions with the confidence to act in accordance with what works and works well for children and families.

Her execution of leadership roles has resulted in the turning around of poor organisations through her politically savvy leadership style, knowing how to balance the demands of a directorship with local government.

Anne is also a serious case review author, having undertaken several independent enquiries and published case reviews across various organisations in the UK.

Anne is currently commissioned as the Interim Director of Children and Families for the London Bourgh of Hackney, with a workforce of 355 FTE and a budget of approximately 50M.

Nigel Boulton MA

Nigel served as a police officer for 31 years. He spent most of his career as a Detective serving for 11 years as a Detective Superintendent leading and managing the investigation of Homicide and Serious and Organised Crime enquiries. He worked extensively across the UK and abroad.

Nigel designed and delivered the original concept of Multi Agency Safeguarding Hubs, the true design of which draws on his experiences dealing with risk assessment and decision making in relation to extremely sensitive intelligence.

Since finishing service, he has run his own consulting company and associates network specialising in the design and delivery of true Multi Agency Safeguarding Hubs (MASH) which together with his social work partner he has continued to develop its evolution.

He is also partner in a safeguarding company which provides safeguarding expertise across social work, policing and health sectors including the provision of social work practice improvement through a unique *'live learning'* model. The organisation also works alongside the internationally renowned inclusive theatre company Chicken Shed to raise the voice of the child by way of performing and creative art.

As well as providing consulting services he has supported the Local Government Association peer review process as a specialist peer in relation to safeguarding.

Appendix 2

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Appendix 3

Learning: Consolidated list

Education Health and Early Help

Doncaster's schools, health services and Early Help are ideally positioned to enhance family-based knowledge especially awareness concerning children's paternity through a relentless focus on children, the application of professional curiosity and the conscious use of practice wisdom. Such curiosity should be applied when seeking to understand a child's paternity and to understand who else maybe in the family home.

South Yorkshire Police

When attending any report of domestic abuse or violence officers must make best efforts to identify all those involved both victims and perpetrators including those who may have left the scene and ensure all information and intelligence is shared in line with local safeguarding policies with their local Authority children's service.

Where domestic abuse or violence is reported, or suspected police officers and staff need to always be professionally curious to a point where they satisfy themselves (or not) that any potential victim is safe both at the time and when their contact with that person or their dependents finishes. This on all occasions MUST include all children and young people. Children and young people should be engaged with to a point where the officers can satisfy themselves of the identity of the child and that they are safe and well.

Officers should be professionally curious and be prepared to challenge any narrative provided by either a potential victim or perpetrator. They should be aware of the potential for unseen levels of coercive control which may be in place within relationships both between the adults and any children or young people who are within the family unit.

Police officers should be knowledgeable and confident in their use of powers of entry to premises in order to ensure the safety of victims, children and young people where domestic abuse and violence is or has occurred or is reasonably suspected to be or has been taking place.

The Domestic Violence Disclosure Scheme 2016 (Clare's Law)

Opportunities exist within the partnership for The Domestic Violence Disclosure Scheme 2016 (Clare's Law) to be used in a more preventative way focussing on the 'Right to Know' by 'partners' within relationships through the more detailed identification and analysis of repeat offenders thereby enhancing the current use of it through Multi-agency Risk Assessment Conference (MARAC) following an incident of violence or abuse.

National Probation Service & South Yorkshire Community Rehabilitation Company

Risk Assessments and Information Sharing

Risk assessments are dynamic and require regular review and monitoring. Their effectiveness is increased when professionals consider all available information including relevant life history, their offending, behaviours and when triangulated with previous records alongside partnership information.

Assessment should attempt to recognise the voices of those around the individual both adults and children and include the widest possible partnership knowledge.

Professionals need to be curious and courageous in their management of offenders, seeking to utilise all the available information described to produce the most holistic assessment of need, harm and risk as possible.

Compliance and timeliness concerning the completion of risk assessment tools is essential in professional practice and requires constant management oversight and quality assurance. Risk assessment needs to be dynamic and timely in line with changing circumstances.

Information sharing is important to good assessment practice. Professionals need to consider information concerning an individual in a wider sense looking to establish the broadest understanding of the behaviours, risks and context upon which to assess risk and make decisions concerning supervision, management and case direction.

A more curious approach to information sharing, (when both requesting and providing) and analysis ensuring focus is not directed to the immediate concerns around an individual nor only on the immediate and obvious family context.

Processes and practice across the Doncaster Safeguarding Partnership should facilitate effective and efficient information sharing across the whole partnership in multiple directions in harmony with legislation and best practice guidance.

Management and Professional Supervision

Management and professional supervision should be frequent, impactful, and well recorded. It should support the professional and provide unbiased, experienced, and clear insight into the supervision or management of the individual.

Staff and managers should be aware that any key event or concerning issue within a case should trigger the insight of management oversight and supervision.

Management needs to be understanding of individual casework through oversight, supervision, and audit to the point where they will intervene to ensure compliance, dynamic practice improvement and interventionist support to protect staff.

Management oversight, supervision and case audit should be considered as core practice requirements.

Children and Young People

Children need to be identified, considered and their lived experience understood when assessing the risks posed by an individual who violently offends within personal relationships.

Professionals need to recognise all children in their risk assessments and make clear what interventions need to be in place to reduce the harm posed by offenders.

When considering the risks to children it should be recognised, they experience serous and significant harm both visible and not, through the impact of Domestic Abuse therefore the risks to them need to be acknowledged as potential victims. There needs to be a recognition that children and young people suffer the consequences of it in terms of their development and emotional wellbeing, they do not just witness it they ‘live it’.

Risk Assessment Tools

Tensions which arise from the results of differing risk assessments should cause professional concern and discussion.

Professionals and managers should use these tools to trigger management oversight discussion to further explore these tensions and amend risk management plans accordingly.

Safeguarding partners should look for new opportunities to enable multi agency discussions regarding the range of different risk assessment tools in use across the partnership to better understand what each is identifying as well as the tensions and differences between them.

Consideration by the partnership of the outcomes of multiple risk assessment tools as an integral part of the response to domestic abuse provides the opportunity to add significant value to understanding true risk posed by offenders of domestic abuse and support safety planning for adult victims and children.

Multi Agency Public Protection Arrangements

The multi-agency partnership should recognise the strength in working together in an integrated manner to manage offenders who pose a significant risk of harm to others, they must understand that the NPS cannot do this alone. The NPS and its partners need to recognise the benefits in the wider use of the categories and levels of the Multi-agency Public Protection Arrangements (MAPPA) guidance.

Decisions as to where an individual should be managed within Multi-agency Public Protection Arrangements (MAPPA) should be based on a full history of offending and behaviours and kept constantly under review through professional practice, management oversight and supervision. Key contextual and behavioural changes should prompt re-evaluation.

Recording of Case Notes

Case notes are not only descriptive of events but provided considered analysis of information to provide an accurate understanding of a case.

They should include reasons for key decisions and enquiries made to triangulate and challenge information.

Professionals must review these case notes over time to establish patterns of risky behaviour and review risk assessment and management plans as required. This is particularly pertinent during episodes of case transfer between professionals when experiential knowledge of an individual may be lost.

Addressing Behaviours and Compliance with Orders

Professionals and those who manage them should ensure there is routine oversight and assessment of achievement against Community Orders and Licence conditions, to ensure impact is captured and revisions put in place to further manage risk and promote desistance from offending behaviour.

Doncaster Children's Services Trust (DCST)

The analysis and assessment of the need, harm and risk to children needs to be based on the full information picture available of all those involved.

Information sharing when required between social work services and other safeguarding partners needs to be fulsome, effective, efficient, and supported by professional curiosity.

Perpetrators of abuse must be readily identifiable within children's records and their current risk to children visible.

Children's social work must consider and be responsive to the true impact of violence and domestic abuse on a child's lived experience, being professionally conscious of bias when an adults needs are potentially significant and overwhelming.

Domestic Abuse Strategy

The importance of strong, relentlessly focused partnership governance and leadership is essential in the delivery of a multi-agency strategy Domestic Abuse Strategy.

This leadership is necessary to ensure the delivery of the strategy, an understanding of the profile and details of harm caused by Domestic Abuse, the delivery of a quality assurance and performance framework and to ensure provision of appropriate services to meet the needs of children impacted and affected by domestic abuse.

The Domestic Abuse, Stalking and Honour Based Violence (DASH) is an adult based risk assessment tool used primarily by the police following attendance at a domestic abuse incident. The tool identifies adult risk, but caution needs to be applied when relying on it as a tool to understand a child's lived experience of domestic abuse.

Many Local Authorities Children's Services have adopted the use of a child specific assessment tool in relation to domestic abuse incidents such as the Barnardos Rim and Ram tool which provides much better line of sight concerning a child's lived experience, affording quality assessments that lead to proportionate and protective multi-agency intervention to safeguard children.

Reduction in funding for the DAN's service has impacted the ability of Doncaster Children Services Trust to deliver the services to a level it would have wished to have done.

Family Voice

Children should be furnished with the proportionate psychological first aid as soon as is right for them. Services must be robust in their planning so that court proceedings (criminal or civil) do not prevent the progress of good mental health when children experience trauma.

The review gained the view that Domestic Abuse and Violence may be considered as no longer shameful within some communities of Doncaster which the safeguarding partnership may well wish to explore further.

Appendix 4

Recommendations (not identified within learning paragraphs)

1. Doncaster Safeguarding Partnership to consider creating a Multi-Agency Practice Champions (Ambassadors) Group as suggested by attendees of the Practice Learning Event. This will provide the practitioners to support the embedding of sustainable improvements in single and multi-agency practice.

2. Doncaster and Bassetlaw Hospitals NHS Foundation Trust reviews its Referral To Hospital and Safeguarding policy's in respect of children who miss appointments: in particular to ensure they are fully in harmony with current national thinking and language concerning *'was not brought'* and *'did not attend'.*

3. Doncaster Safeguarding Partnership to consider opportunities to embed Multi -Agency discussion of different organisations risk assessment outcomes in respect of defined cohorts of domestic abuse perpetrators within standing agendas of both the new Multi-Agency Tasking and Co-ordination (MATAC) forum and the established Multi-agency Risk Assessment Conference (MARAC) meeting. This offers the chance to add significant value to the overall understanding of the true risk posed by offenders of domestic abuse, support safety planning for adult victims and reduce harm and risk to children and young people.

4. Doncaster Safeguarding Partnership to consider the opportunities for the existing Multi-agency Risk Assessment Conference (MARAC) meeting and processes to forge a strong relationship with the new Multi-Agency Tasking and Co-ordination (MATAC) meeting in respect of defined cohorts of domestic abuse perpetrators.

5. The National Probation Service (at a national level) considers a review of its violence predictor tools and the weight given to (or not) prosecutions when they are withdrawn or do not succeed especially given the well evidenced issues concerning gaining convictions for domestic abuse and violence incidents and the importance of other types if case disposal in line with victim wishes.

Appendix 5

Reflective feedback from Learning Event (Practitioners)

- I feel Inspired by others around me as I listen to those professionals who have had direct contact with children.
- A running theme through the day was to be professionally curious (nosey) and ask qualitative questions. Ask those questions that you think are unaskable – what is an unaskable question, is there actually such a thing?
- A learning point for me is that practice wisdom is very important and the use of a genogram with the Service User to look at family and relationships is a great way to explore the life and experiences of a Service User. It also promotes qualitative conversation focusing on Need, Harm and Risk.
- We all need to think "What is the child thinking?", "What is it like to be in their shoes? Practicing in this way is child centred.
- The whole day encouraged and embraced members of the group to speak openly about their experiences, thoughts and feelings. I have to admit I was apprehensive about attending but I am so glad that i did and now others in our organisation will learn from this event too. A month on there have been a number of conversations and discussions; some that I have been involved in, already acted upon regarding operational processes and practice development. These have been and will continue to be worked on and disseminated to all staff to support our learning and practice.
- Communication really is key. We need to be speaking to each other more. For example, if we have concerns regarding a child who attends Family Hub sessions we need to be checking if they have older siblings. If they do, have a conversation with the school the other children attend. See what thoughts and feelings they may have about the family.

- I was reminded of how childhood trauma effects the adult. Due to my Early Years background and experience of working with families I do have a good understanding about this but to actually see a case that demonstrates this really brought it home. It made me question – Are we doing enough to try and break the cycle.

- I think that all Family Hub staff should attend the ACE training.

- Children are at the heart of everything we do. This can be forgotten as adults have the 'voice' but we need to make time to listen to what they children of these families are trying to say. As we discussed on the day, it is so easy to get bombarded with the adults' thoughts and problems and forget about the children who are sat quietly in the corner. (Family Hub and Early Help practitioners).

- It was very eye opening for me in reflecting on my own practice. Although it was difficult to see the pictures of the children, it was really helpful as particularly in my position, not working directly with children, I can lose sight of them.

- The importance of professional curiosity with other professionals and service users or families. I was reflecting on why I perhaps avoid more personal questions.

- The importance of sharing information, this can at times be difficult due to time or confidentiality. However, the event reminded me of the importance of this. There's room for improvement/changes in current local safeguarding practices and processes.

- The importance of taking the time to reflect.

- Use professional curiosity more and ask more questions with both service users and professionals, and to feel more confident in doing so.

- Pick up the phone more to contact other agencies for advice and information or share information with them.

- Feedback the challenges and examples more frequently to managers in the current processes or experiences when it comes to safeguarding. In the meantime, to reflect on how I can access the right information by ringing and asking the right questions.

- To try to take more time in reflecting and discussing challenges or suspicions with colleagues and in supervision. (Probation and CRC).

- I felt very positive that communication and recording of low-level concerns needs to be and will be developed in Doncaster.

- There are many families in our community who don't know that what they are living through is not acceptable or appropriate and have a 'this is normal' view of domestic violence, substance misuse and attitudes towards education and other professionals. If we are to identify and safeguard children in these situations, then the way we communicate and record low level concerns has to be efficient and fit for purpose.

- Historically, low level concerns such as missed appointments, not attending non-statutory provision etc would not trigger opening an Early Help assessment and those agencies would be unlikely to know which other agencies were involved or had concerns. Likewise, agencies such as schools and Family Hubs etc need to have information about adults who are deemed a risk to children. From school's experience, there have been too many times when other agencies have refused to share information with us that would have been helpful to protect children. I appreciate everyone's concern around confidentiality and of course limits during police investigations. However, schools need to have access to this information to ensure that we are proactive and not reactive. (education)

- We will put more emphasis on proactively developing the relationships with other agencies involved with our families - Family Hub, health visitors, secondary schools, probation and police. This emphasis needs to be directed from the managers in all agencies to ensure the expectation of this is clear and time and resources available. (education)

- Professionally, it did make me question whether the National Probation Service work in a bit of a ‘silo’ of our own making. I do not mean that we do not care about safeguarding or play our part in this, but I did wonder whether we were quick to leave the focus of this onto Social Care, once we had ‘done our bit’ by making a referral and liaising with Social Workers. It got me thinking that as an organisation, we need to be more embedded in the Safeguarding world, rather than being an organisation that is sometimes on the periphery. (probation)

- The learning for me was about being out there, in the community, talking to people, gathering what Nigel called Community Intelligence. This would help us make the links between families, seeing where men (in the main) are moving from relationship to relationship in which they are abusive. Of course, structures are in place that will support this, Multi-agency Risk Assessment Conference (MARAC) etc, but it seems to me that there is no substitute for being on the ground. Better links need to be made with schools is one thing that I will take away and push for. I also think that we need to have a presence in MASH Teams, we seem to be the missing piece of the jigsaw. This might need the NPS to be more innovative in how we work.

- The importance of Adverse Childhood Experiences cannot be underestimated in shaping today's adults, although I knew about this, the day reinforced me knowledge and my learning. (probation)

Those who participated in The Learning Event expressed a desire to form a practice champions (Ambassador) groups across the partnership and to be a multi-agency dynamic partnership group that would drive the implementation of the learning should the partnership wish to engage with this style of improvement.