Leicester Safeguarding Children Board

SERIOUS CASE REVIEW
Relating to Baby L

Date of birth: 2011
Date of death: 2011, aged 7 months

Ethnic Origin: White British

EXECUTIVE SUMMARY

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Please note: The report has been anonymised and subject to redaction to protect the identities and privacy of family members and professionals involved.

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1. Introduction:

This is a summary of a Serious Case Review undertaken by Leicester Safeguarding Children Board (LSCB) following the death in 2011 of Baby L aged 7 months. The decision to proceed with a Review was taken in December 2011 by the Independent Chair of Leicester Safeguarding Children Board, Dr. David N. Jones.

The purpose of a Serious Case Review is outlined in Chapter 8 (8.5) of the Working Together to Safeguard Children 2010 Guidance, namely to:

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work, individually and together, to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child dies or who is to blame. These are matters for coroners and for criminal courts. In production of this report, agencies have collated sensitive and personal information under conditions of strict confidentiality.

The findings of the Review have been reported to the Office for Standards in Education, Children's Services and Skills (OFSTED) and to the Department of Education Safeguarding Group as is required.

Father and maternal grandmother and members of the maternal family have contributed to the Review process. The family members were invited to participate in the process and father and maternal grandmother were able to meet with the Overview Author. In view of the ongoing criminal processes a Police Family Liaison Officer was present and the conversation explored what lessons the family thought might be learnt by agencies from the Review.

Mother has been informed of the Review process in writing and has been invited to contribute to the process. In view of Mother's health a meeting has not taken place as yet.

A criminal process is taking place and is nearing its conclusion. Mother was arrested at the time of the death of Baby L and charged with murder. Mother was subsequently admitted under Section 48(2) of the Mental Health Act 1983 to a secure environment.

On the 8th June 2012 Mother's plea of guilty to Infanticide was accepted. A sentence of a Section 37 Hospital Order with a Section 41 (Restriction Order) under the Mental Health Act 1983 was passed .This means that doctors must seek permission from the Ministry of Justice prior to a discharge from hospital care. The cause of death was reported in Court as 'smothering.'

Information in this report has been anonymised to protect the privacy of family members including references to the gender of Baby L.

2. The Reasons for the Serious Case Review

Baby L was a seven month old baby, who was described in records as well cared for, healthy and reaching all developmental milestones. Baby L lived with both parents in their own home in a residential area on the outskirts of the city. The home environment was noted to be comfortable and well kept. Baby L's parents had been married for some years and this was their first child.

The extended families of both parents lived nearby and were all in regular contact both socially and at work. Mother and maternal grandmother were in daily contact and had a positive, supportive relationship.

The first three months of Baby L's life were settled and all universal services, such as Health visiting and GP services, were provided and attended. All immunisations and developmental checks had been undertaken. The records noted observations of a 'good attachment and interaction between Baby L and Mother'. There were no

records of concerns about Mother's wellbeing or that of Baby L. Routine screening for post natal depression had been undertaken and no concerns were noted.

When Baby L was three months old, Father informed Mother that he had been involved in another relationship for some years and that a baby was expected in two months' time. The woman in question was a part of the family social circle and therefore known to Mother.

The relationship between Mother and Father was thrown in to crisis and Mother was reported as very distressed. From this point Mother spent an increasing amount of time staying with maternal grandparents.

During the following four months until the death of Baby L a number of contacts took place with agencies which have been explored in this Review and are referred to in section 5 below.

When Baby L was 7 months old the incident leading to Baby L's death occurred the morning after a family social event. Mother had gone downstairs to feed Baby L early in the morning and when Father came down later, he found Baby L and Mother in the lounge.

A 999 call was received at 09.50 requesting an ambulance and the call was cut off. The Emergency Operations Centre returned the call and details were provided on how to assess Baby L's breathing and how to start resuscitation until the arrival of paramedics at 09.56. The first paramedic to arrive called for further ambulance back up, which arrived at 10.02 as well as the police.

Baby L was described as 'being in cardiac arrest, unconscious and not breathing' and Mother as 'having cut her throat and wrists' by the paramedic attending and making the further callouts.

Baby L's death was recorded at 10.26 and the Safeguarding Office at the hospital and the Local Safeguarding Children Board were notified. The full examination of Baby L could find no obvious wounds or bleeding and resuscitation was tried with no response. The relatives present were not allowed to see Baby L at the hospital on

the instructions of the police. The post mortem recorded "the cause of death 'inconclusive' as there was no natural or unnatural cause of death but that the account given by Mother to the emergency services staff was consistent with the findings that Mother apparently caused the death of Baby L".

At the time of Baby L's death there were no services being provided to Baby L or Mother other than universal services like Health Visiting and GP services.

3. The Serious Case Review Process

The Serious Case Review Subgroup recommended that the criteria were met for a Serious Case Review and the Independent Chair of Leicester Safeguarding Children Board accepted the recommendation by the Subgroup. A letter was sent to all member agencies of the Leicester Safeguarding Children Board to notify agencies of the decision and to request that all records should be located and secured. Preparations should be started to undertake Individual Management Reviews (IMRs) in each agency where there had been any services provided to Baby L and Mother and Father.

The scope of the Review should include consideration of the Leicester Safeguarding Children Board Interagency Child Protection Procedures and should cover information about Baby L and Mother and Father. Information about the extended family should be referred to where relevant to the Review and in order to understand the historical context of Baby L's family.

The timeframe of the Review should cover information between July 2010 to December 2011. Historical information could be included if the SCR Panel determined that it was relevant to the Review.

The Terms of Reference for the Review were agreed by the Serious Case Review Subgroup. A Serious Case Review Panel was commissioned to undertake the Review and an Independent Chair of the Panel and an Independent Overview Author were appointed.

The Terms of Reference of the Review were set out by the Serious Case Review Subgroup and are set out in full in the Overview Report .The Terms of Reference applied to all agencies involved. They covered the contents of the services provided as well as how managers and practitioners delivered those services. How and why decisions were made and actions carried out and in particular how effective the agencies were in responding to Baby L.

The membership of the Serious Case Review Panel consisted of senior managers and/or designated professionals from the key statutory agencies who had had no direct contact or management involvement with the family of Baby L and were not the authors of the Individual Management Review reports. The Independent Chair of the Panel and the Independent Overview Author are not and have not been employed by any of the member agencies of the LSCB.

The Review was expected to be concluded for submission to Ofsted in June 2012.The publication of the Review will have to wait until any criminal processes have been finished.

The LSCB expected all agencies to undertake their IMRs within the timeframe and in line with the local procedures .The SCR Panel would monitor progress and perform a quality assurance role in relation to the Individual Management Reviews and their progress.

All agencies were expected to address any findings which highlight an urgent need to make changes, whether to policies and procedures or to practice .An agency should not wait until the Review process has ended, if there is a need to intervene and make changes to improve services.

An Integrated Action Plan was produced to capture the recommendations made by all agencies and the Overview Authors .The Action Plan will be monitored by the LSCB on a regular basis to ensure that recommendations are implemented and maintained.

The authors undertaking the single agency reviews and producing the Individual Management Review reports and the three Information Reports were senior managers and/or senior practitioners, who had not had direct contact or management involvement with the family of Baby L. Similarly the Health Overview Report Author had not had any direct contact or management involvement with Baby L.

A series of SCR Panel meetings took place between February 2012 and June 2012 in order to progress the Review.

4. The Family

The family is of White British origin and they live in a mainly White British area of the city. There were no records indicating any specific religious affiliation for the family. The family members were not known to the police in the area prior to the early summer of 2011. There are no known records of any past involvement with Social Care services of either parent or close family members. Baby L was not recorded as attending any community resources other than the Health Visiting clinic at a Children's Centre.

The picture that emerged from agency records and the meetings with the family members is one of a supportive network of maternal and paternal family members all living within a reasonably easy distance of one another. Frequent contact, not only socially, but also at work maintained the close links and provided support. The family led a busy life with a network of friends and an active social life in frequent touch with the extended family.

Mother was reported by MGM to have been going out and visiting friends with Baby L in the first three months of Baby L's life .Mother was described as generally happy and active during this period without any signs of concern. The area the family lives in has a Sure Start Children's Centre and a dentist and doctor's surgery nearby. There is a small shopping centre nearby. There is a primary school and secondary school in the area.

Baby L and the interactions between Baby L and Mother were consistently described in a positive way with descriptions of warm and affectionate interactions and appropriate responses by Mother to Baby L.

Baby L was always noted to be well dressed, meeting all developmental milestones and seeming to be content. No concerns were noted about the care or development of Baby L at any point.

The information, when Baby L was three months old, that Father had another long standing relationship where another baby was due caused a crisis not only between Mother and Father but within the whole family system. The maternal family expressed support to Mother whatever decision she wanted to make for the future.

During this Review it has emerged that a number of events took place where the maternal family had serious concerns for Mother and therefore Mother stayed with them with Baby L for significant periods of time.

5. Summary and conclusions of the Integrated Chronology

The Integrated Chronology of the involvement of the agencies with Baby L has been analysed in the Overview Report and examined in detail. Although the Terms of Reference stipulated the time frame to be examined as July 2010 to December 2011 there was no information of any significance pertinent to the Review prior to June 2011. The records prior to June 2011 demonstrate routine contacts with the GP services for the pregnancy and minor ailments for the parents.

Contacts between Baby L and Midwifery and Health Visiting services, which were categorised as ‘universal services’, took place and were recorded. The Midwife visited the home and saw Baby L five times after the birth before handing over the care to the Health Visiting services. The Health Visiting services saw Baby L at home on three occasions and in clinic on four occasions including the last clinic visit three weeks before the death of Baby L.

There were **three missed opportunities** where agencies should have made different decisions and taken other actions, which could have led to a different outcome for Baby L. They were in brief:

The first missed opportunity:

Late June 2011 Father informed Mother of his extramarital relationship and that another baby was expected. Mother subsequently called the police in a distressed state having gone for assistance to a neighbour. Later that day the police were called again to the home as Father was locked in believed to be at risk of self-harm. At this point Baby L was three months old. Father was found with a number of weapons and substances.

The incident was resolved at the time but the Police Officers, who had attended the incident, assessed the risk as 'medium' and filled in the required forms CR1 2/12a and a Domestic Incident Crime report. The crime report was reviewed by the Inspector of the Comprehensive Referral Desk (CRD) as the Officer in the Case (OIC) had entered a 'vulnerable' code in respect of Father against the home address with a history marker and submitted an intelligence log.

The Child Protection Specialist Sergeant reviewed the report and requested that a referral be sent to Children's Social Care for their attention. The form was headed 'for your information only' and included the full information from the crime report.

Two days after the event Children's Social Care reviewed the referral from the police. The referral went on to note that 'it had been reviewed by a Sergeant in the Child Abuse Investigation Unit who had decided there was no role for the police Child Abuse Investigation Unit'. The police referral went on to outline the events in full.

The referral was screened by the Duty and Assessment Team Manager who recorded it as 'advice received and no further action'. Children's Social Care did not contact any other agencies for checks nor was the information shared with the Health visitor. The referral was in the form of an email and no action was taken to

speak to the referrer, e.g. the police, to discuss it or to feed back the outcome and decision taken.

The information about the incident should have been shared with the Health Visitor by Children's Social Care even if they did not intend to undertake an Initial Assessment. A CAF could have been triggered by the Health Visitor. At the very least the Health Visitor would have had to review and reassess their agency's level of involvement with Baby L in light of the information and would therefore have made contact with Mother to talk through the information. As it was the Health Visiting service was unaware of any changes in the circumstances of Baby L.

The second missed opportunity:

Seven days after the incident with Father, Mother telephoned requesting a late appointment with the GP surgery so that MGM could accompany her to the surgery. Mother described herself as 'a bag of nerves'. No appointment was made but four days after that Mother was seen by a GP in the surgery Walk in Clinic accompanied by maternal grandmother.

Mother was in a very distressed state and disclosed some 'violence' and marital problems and described panic attacks that she was experiencing .The agreed outcome was that Mother was referred to the Open Mind counselling service.

The GP included the information from the consultation in the referral to the Therapist and entered information on the record system SystmOne but the GP did not contact or consult with the Health Visitor. The Health Visiting service did not have access to the information recorded on SystmOne in this GP Practice at that time. The Health Visitors remained unaware therefore of the concerns in Baby L's family.

During this period there were contacts with the GP and the police. The family and Mother chose to divulge some information to the GP and to the Therapist about domestic violence by Father but the full information about what was happening in the relationship was not reported to the agencies. However, this information about 'violence' was not passed on by the GP to alert the Health Visiting service. The

Health Visiting service was the main professional group whose specific role it was to have a clear focus on the welfare of Baby L. They should have been informed of the changing home circumstances.

Baby L was moving between the home address and maternal family's address as well as spending some time being cared for by Father. A home visit and direct contact by a Health Visitor to review the universal service provision might have provided Baby L with a professional with a remit to represent the point of view of Baby L and to consider the impact of the crisis that the parents were going through.

The Ofsted report 'Ages of Concern' (2011) highlights findings from Serious Case Reviews where often the only professionals involved with very young infants are the Health Visitors and GPs .The importance of those two groups of professionals to recognise the need to communicate with one another proactively particularly about young infants is emphasised in the report as a matter raised by SCRs nationally.

The overall response by professionals was focused on the behaviour of the adults and their expressed distress. The records demonstrate that the GP and the police were observing that Baby L 'seemed well cared for' but they were not actively considering what the impact of the behaviour of the adults was having on Baby L's daily life and emotional wellbeing.

Leicester Safeguarding Children Board procedures manual has a chapter (4.1.) which sets out principles and procedures called the "Think Family / Whole Family approach Protocol " to promote collaborative inter agency working where the impact on the child is the focus. These principles, procedures and guidance were not followed in this case.

The third missed opportunity:

When Baby L was five months old and a month after the contact with the GP, who referred Mother for counselling services, Mother attended the first appointment with the Therapist .The appointment coincided with reports of the birth of Half Sibling, which Father was present at.

Mother disclosed in the first session that she had experienced physical and psychological abuse from Father including two occasions of domestic violence according to the Therapist's records. On one of those occasions she reported that she had been holding Baby L. The Therapist explained that she would have to discuss this information with the GP and the LPT Safeguarding team. Mother also reported depression, anxiety and panic attacks and described that she and Baby L were moving between their own home and that of MGM. Mother's description of one of the panic attacks caused the Therapist to be concerned that Baby L appeared to have been left alone and unattended for some time.

The Therapist assessed Mother's mental health against the Patient Health Questionnaire (PHQ) scales and a Generalised Anxiety Disorder Assessment (GAD) was undertaken. The assessments provided a base line and the score at the time equated with 'moderately severe symptoms' of depression and anxiety

Mother agreed to her information being shared with Children's Social Care, although with some reluctance, as the Therapist pointed out that she had a responsibility in relation to reports of domestic violence in order to safeguard the child and Mother. There was no mention of the Health Visitor by the Therapist or by Mother.

In the early evening the following day the police were called out to a disturbance outside MGM's home, where Father was agitated and shouting having called around to drop Baby L back to the care of Mother. Father was described in records as quite 'confrontational 'with the police.

As a result of this call out the police made a further referral to Children's Social Care with full information and linking back to previous call outs. The email was headed 'for information'. The referral was noted but no action was taken.

The maternal family called NHS Direct at this time too and Mother gave information similar to that given to the GP and the Therapist .Advice was offered but no information was provided to the Health Visitor of GP about the contact. There were references to thoughts of self-harm.

The following day the Therapist made a referral to Children's Social Care using a faxed multi-agency referral form. The Team manager Children's Social Care allocated the task of following up the Therapist's referral with Mother to an experienced social worker, who made telephone contact with Mother. The social worker offered Mother advice and arranged to send a booklet about domestic violence to Mother. Mother told the social worker that she did not want to accept support at this time. The social worker explained that if there were any other incidents of concern Children's Social Care would "have to take action to safeguard Baby L".

The social worker and the Team manager closed the referral from the Therapist and did not undertake any checks or consult with any other professionals. They did not share the information with the Health Visitor and GP, although the age of Baby L would mean that the Health Visiting service would be involved. There was no consideration to undertake a CAF assessment in view of the fact that this was a referral in addition to the two notifications from the police in a fairly short space of time. If they decided that the threshold for an Initial Assessment had not been met they should have considered whether there was a need for Early Prevention support services through the Common Assessment Framework route, which would have engaged the Health Visitor .

The social worker and the Team manager, who endorsed the social worker's recommendations, did not take any action to speak to the referrer or to feed back the outcome of the referral as is expected by the Leicester Safeguarding Children Board inter agency procedures manual chapter 3.2 Referrals to Children's Social Care services: "The duty social worker should acknowledge a written referral within one working day of receiving it. If the referrer has not received an acknowledgement within 3 working days, he/she should contact the manager in the Children's Social Care Services team again.

- Feedback on the outcome of a referral should be provided to the referrer, including where no further action is to be taken.

- In the case of a referral by a member of the public, feedback should be provided in a way which will respect the confidentiality of the child."

This last opportunity was a significant missed opportunity. Several agencies had by now built up information, which an assessment in a multi-agency format such as an Initial Assessment would have linked together and also included agencies so far left out of the loop such as the Health Visitors. The information about domestic abuse was emerging and Father and the maternal family were expressing serious concerns about Mother's mental health to each other but not explicitly to agencies.

An Initial Assessment should have been undertaken by Children's Social Care at the point when the referral from the Therapist was received. It would then have followed that information would have been actively shared and discussed between the agencies and not only would the Health Visiting service have become involved but the extended family and Father would have been spoken to. A multi-agency assessment focused on safeguarding and promoting Baby L's welfare could have led to a different outcome for Baby L.

The revelation of Father's long standing affair with another woman and the unborn Half Sibling had caused a significant crisis for Mother but also for the extended family system. The extended family was close knit as they not only lived within easy reach of each other, socialised regularly, communicated daily and a number of them worked within the same workplace.

As the family system tried to manage the new relationships and struggled to do so, the agencies looking on from the outside saw a 'supportive and close family 'which was interpreted as a 'strength' which reduced the need for services.

The information about Mother's and Father's state of mind and the impact of the crisis on Baby L was missed as information was suppressed within the family trying to cope.

Mother's presentations to agencies were inconsistent and each contact apart from with the Therapist was to different professionals including the GPs, so there was no continuity in the responding professionals either.

The information in the agency records did not reveal the extent of the crisis within this family. There are lessons from this Review for how professionals ask for information and assess the relationship of families in their overall context in order to understand the position of the child in question in the family system.

6. The Conclusions of the Independent Overview Report

In light of all the evidence available to this Review the SCR Panel and Overview Author agreed that the death of Baby L could not have been predicted.

The overall conclusion of this Review is that the three missed opportunities were points in time where the relevant agencies should have been sharing and discussing information with each other and the extended family to assess the needs and safety of Baby L. Further details of the findings are in section 3.4 in the Overview Report.

The systems were in place except for the Health Visitors but the information was passed over by professionals without any proactive two way involvement to discuss the information in line with the current guidance and procedures. As a result Baby L did not receive the services, which should have been in place and which might have prevented the death of Baby L.

7. Lessons to be learnt:

A number of lessons to be learnt have emerged from this Serious Case Review which must be followed up to ensure that practice improves and where practice has already been addressed as a result, mechanisms must be in place to embed and maintain the improvements .

The most obvious lesson relates to the vulnerability of very young babies, which is underpinned by research findings in the Ofsted report ‘’Ages of Concern’’ 2011 and other research quoted in this Overview report. All agencies that come across very young babies must assess the impact on the child of the behaviour of the adults around the child. An assessment of the factors affecting the parenting capacity of the parent/ carer must take place to determine if the child’s needs are met and the child is safe.

As the youngest age group has a universal service from Health Visitors in the community, all other agencies must share information with Health visiting services effectively when there are any concerns. The lesson is not only for agencies other than health agencies but also, specifically for health colleagues to address, so that systems, which are in place, are accessible and can be used.

The police have a system for reporting information and referrals to Children’s Social Care in relation to children through the Comprehensive Referral Desk (CRD) .The lessons have already been taken onboard in relation to the wording on the referral form as noted in this Review.

However, there is no system in place for passing copies of the same information to the Health Safeguarding teams as there is in many other LSCB areas. The police have duties in relation to safeguarding children as set out in sections 10 and 11 of the Children Act 2004 (the Working Together 2012 consultation document confirms these duties) to share intelligence about children during the course of carrying out their duties. The volume of referrals is not clear but, if an age criteria set at young children under the age of 2 years old for example, was agreed then the most vulnerable group would be provided with the service. The notifications could be specifically in relation to ‘Domestic Incident’ call outs.

It would be the task of the Health Safeguarding teams to identify the Health Visitor and GP for the child and pass the information on. In this way the gap in sharing information identified in this Review should not occur again.

The Review has identified that the current procedures and guidance for making referrals to Children's Social Care and responding to those referrals are not working as well as they should be. The reasons for the passivity of referrers and the lack of follow up back to referrers appear to be varied. The referral process has already been subject of audit exercises in relation to the screening of referrals within Children's Social Care as a result of this Review and any actions arising from the audits will be implemented. There are however lessons for all the agencies in this case as the process of making referrals and sharing information should be proactive and agencies should take a collaborative approach to working together rather than just passing information over to each other. There is a need to undertake multi-agency audits of referrals to determine if there are ways to improve the process across the agencies.

The response by Children's Social Care and the police to providing women with information packs around domestic abuse and violence is helpful. However, where the information is sent out with a letter to inform a Mother of the notification of an incident and that the Children's Services will take no further action the impact on the Mother may not be what was intended. The social workers approach to the conversation with Mother over the telephone and the follow up letter may have caused Mother to cease approaching agencies as no other contacts followed. When the decision is made by a social worker and manager to close a referral and follow it up by a standard letter there is a need to reflect on the wording particularly when dealing with a first time mother and a very young baby.

A query arose during the Review about the practice by ambulance staff and the police in notifying GPs of call outs that involve incidents of self-harm and adults who are identified as 'vulnerable'. It was not possible to establish what took place with the call out to Father as the ambulance staff records were too brief. The SCR Panel requested that this matter be followed up to clarify if there was a system in place and, if not, if it would be good practice to consider one?

The IMR for the Emergency Department identified a learning point for the events following the death of Baby L about the management of Mother in line with the agreed mental health pathway and the liaison between the police and hospital staff.

The IMR has recommended an audit to consider compliance with the recently introduced mental health pathway and comments that: “It is important to share this finding with police colleagues, to enable both agencies to reflect whether discharge into police custody was too quick in this case.” It may be helpful to involve the police at an early stage in any review rather than share the findings at the conclusion.

The full Review information has revealed that the professionals involved were aware of Baby L and commented on presentation, health and observed interactions between Mother and Baby L. The child was therefore present in the records, especially the police records, in relation to the three missed opportunities. The aspect that was not in evidence, and is a lesson to take forward, is the lack of recognition by all the professionals of the meaning and impact of the experiences of the parents for Baby L.

The context of the breakdown of the marriage following Father’s revelation of the long standing affair with mother of half sibling and the arrival of half sibling and the effect on Mother and therefore on Baby L was not recognised fully. The additional information which came out in small pieces about domestic violence added to the effect on Mother’s parenting capacity .The anxiety and panic attacks also affected her ability to safely care for Baby L. Given the young age of Baby L there were no visible signs of the unsettled environment and Mother‘s state of mind. The professionals need to reflect the learning from this Review about taking all aspects in to account and carefully viewing the aspects from the perspective of the child particularly when the child is too young to raise its voice.

8. Recommendations and Action Plan

The recommendations by the Overview Author are intended to compliment the recommendations in the IMRs and Health Overview Report and to address the agencies collectively. The intention is to improve interagency work to safeguard children and promote their welfare in the city.

The Integrated Action Plan has been drawn up and agreed by the agencies involved in this Serious Case Review. There is process in place to monitor the Action Plan and report to the agencies and to the Leicester Safeguarding Children Board about progress and to resolve any difficulties.

The full recommendations and the Action Plan are available in the Overview Report.

The recommendations by the Overview Author:

Recommendation 1:

The Leicester Safeguarding Children Board should urgently review and update Information Sharing procedures and protocols to produce one clear, up to date set of standards for all agencies to share, exchange and check information where there are any concerns about the welfare of children. The new Protocol should be widely disseminated within all agencies that provide services to, and work with, children or adults, who are parents or carers.

Recommendation 2:

A Leicester Safeguarding Children Board Working Group involving the core agencies: Police, Health and Children's Social Care supported by a Board Policy Development Officer should undertake research of best practice in other LSCB areas of mechanisms for sharing information effectively with colleagues in the Health Visiting service and with GPs in relation to police attendance at 'domestic incidents' where young children are present or are members of the household. This should include 'unborn' children.

The Working Group should ensure that a system is in place within three months. The Quality Assurance Group should ensure that regular audits of the system take place and report back to the LSCB.

Recommendation 3:

The current interagency referral procedures should be subject to a frontline interagency audit of cases involving children under the age of 1 year old to examine if:

- Information was shared with or by Health Visitors and GPs
- The referrer was responded to by Children's Social Care
- An assessment was made of parenting capacity
- The impact of the concerns on the child was addressed

The findings and the learning from the audit should be disseminated across the agencies.

Recommendation 4:

In order to promote Early Prevention intervention and support, Children's Social Care should routinely consider what agencies and services should be informed/ signposted when the decision by Children's Social Care is to take "no further action".

Recommendation 5:

The UHL Emergency Department mental health procedures Review should involve the police in a discussion about best practice for future cases where both agencies are involved.

Recommendation 6:

All training programmes, single agency and interagency, should be expected when commissioned to ensure that the vulnerability of the youngest age group is addressed in the training.

Recommendation 7:

Managers and supervisors should be expected to reflect in their decision making that the impact on a young child has been taken into account particularly when the parent/s have a cluster of problems related to domestic violence, mental health issues and substance misuse. Therefore:

Each agency should undertake regular internal audits of decisions made to close a case /take no further action /not accept a case/not refer, where a child under the age of two is involved and the cluster of problems of domestic violence ,mental health issues and substance misuse are present.