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

OVERVIEW REPORT

Prepared by

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Independent Author

Date of Report: June 2012

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

Contents:

1. INTRODUCTION

1.1 Summary of the circumstances leading to the Serious Case Review.

1.1.1 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 was observed to give good eye contact, smile and enjoy feeds and normal activities of daily living. 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.

1.1.2 Baby L's parents had been married for some years as they met in their late teens. Both parents are in employment, although Mother was on maternity leave. They both work for the same family business involving the extended maternal family. The family members are White British with no religious affiliation recorded. The family was understood to enjoy a good standard of living.

1.1.3 Baby L was the first child in the family and had been planned for and wanted. 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.

1.1.4 In the early summer, 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. There were older children in the other family.

1.1.5 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, who lived in the vicinity. For a period of three months Mother and Baby L spent more time with them than in the marital home. Father spent some time staying in the home of mother of half sibling (unborn). That household was in the same part of the city. At some points in time Father was reported as caring for Baby L.

1.1.6 The police were called out on three occasions over a period of two months following the disclosure of the affair to respond to situations, which were identified as of a 'domestic incident' nature. After two of these call-outs Children's Social Care was informed of the incidents. The police also followed up trying to make contact with Mother and to provide advice. Mother, Father and Baby L had not received any services from the Police or Children's Social Care prior to the first call out.

1.1.7 The GP surgery provided appointments to Mother and made a referral for counselling services. Maternal grandmother accompanied Mother on most of the visits to see the GPs and the Therapist. At no point did any agency contact Health visiting services, who carried on providing a universal service unaware of the changes in the family circumstances.

1.1.8 Children's Social Care Duty and Assessment Service were in contact with Mother through a telephone call after notification of the third police call out and receipt of a faxed, handwritten referral from the Therapist. The Duty and Assessment social worker and Team manager closed the referral after providing Mother with advice in a telephone call and did not discuss the information provided or their assessment and decision with any other agency.

1.1.9 After the contact with Children's Social Care Mother saw the Therapist for another session but then failed to attend her next appointment. In the last six weeks of Baby L's life no agency had any direct involvement with Mother other than one routine Health visiting clinic contact at a Children's Centre, where nothing unusual was noted.

1.1.10 A family social event at the parents' home took place one evening, when Baby L was 7 months old, and was described by family members as 'tense'. The event had been organised by Mother, who was not reported by family members to have taken excessive alcohol or any other substances during the evening.

1.1.11 In the early hours of the following morning Mother went downstairs to feed Baby L. Some time later Father found Mother and Baby L 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. Several distressed voices were heard in the background. Maternal grandmother's partner was known to have been at the home as he accompanied Baby L in the ambulance. The first paramedic to arrive called for further ambulance back up, which arrived at 10.02 as well as the police.

1.1.12 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.

1.1.13 Mother was reported as having cut her wrists and neck several times and was described as 'distressed and not talking' during the ambulance trip. Mother was treated in the hospital from 10.15 but according to the UHL IMR (para.3.4.2) did not require suturing and she was discharged in to police custody at 16.00. There was no record of a psychiatric referral. Mother was transferred to the Police Custody suite, where a mental health assessment was subsequently undertaken by a Forensic Medical Examiner, an Approved Mental Health Practitioner and a Duty Psychiatrist, who declared Mother fit for detention and interview in the presence of an appropriate adult. Mother was assessed as a high risk of self- harm.

1.1.14 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".

1.1.15 Mother was charged with murder the following day and remanded in custody. The criminal and Court processes have taken place and 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.'

1.1.16 A letter was sent to key Safeguarding Leads on 31st October to be forwarded to relevant agencies to establish whether the family members had been receiving services. The letter asked for responses to be returned by close of business on Wednesday 2nd November. As new information came to light, on 2nd November another request was made to Safeguarding Leads locally to ensure that all records had been checked.

1.1.17 On November 1st 2011, the Local Authority submitted the formal notification of a Serious Childcare Incident to Ofsted and the Child Protection Operations Team at the DfE was notified and has been kept informed throughout.

1.1.18 The Serious Case Review Subgroup recommended on the 6th December 2011 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 and Ofsted and the DfE was notified thereof. The purpose of the Serious Case Review is as outlined in Chapter 8 (8.5) of Working Together to Safeguard Children 2010, 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.

1.1.19 In the scoping of this Review the Serious Case Review Subgroup recommended that the criteria were met and determined that the timeframe for concluding the Review was June 2012. The criteria

apply to all children, including those with a disability and are set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006:

(1) The functions of a LSCB in relation to its objective (as defined in section 14(1) of the Act) are as follows –

(e) Undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

(2) For the purposes of paragraph (1) (e) a Serious Case Review is one Where –

(a) Abuse or neglect of a child is known or suspected; and

(b) Either –

(i) The child has died; or

(ii) The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the Child.

When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority Children's Social Care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. Local Safeguarding Children Boards should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect; or

- a child has been seriously harmed as a result of being subjected to sexual abuse; or

- a child has been seriously harmed following a violent assault perpetrated by another child or an adult; and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

1.1.20 An inquest was opened and adjourned on 3rd November 2011. Mother pleaded guilty to infanticide at Crown Court and the cause of death was

established as smothering. The inquest did not resume subject to Section 16(5) of the Coroner Act 1988 and the inquest was closed on 18th June 2012.

1.1.21 There has been correspondence between the Coroner's Office and the Leicester City, Head of Service, Children's Safeguarding, Social Care and Safeguarding to share information about Baby L and to seek agreement to invite the family members to participate in the Serious Case Review.

1.1.22 At the time of writing this Overview Report the criminal Court proceedings were taking place. Mother was being treated in a secure environment having been admitted under Section 48(2) of the Mental Health Act 1983. The admission was based on the original diagnosis just after the incident of 'severe depression' and additional findings following further assessments that 'she had experienced symptoms of panic attack and paranoid delusions in the months leading to the incident.' At the conclusion of the Court proceedings, which occurred as this Serious Case Review was finalised, Mother pleaded guilty to Infanticide.

1.1.23 Further information was made available through the family interviews with the Overview Author during the Review process about alleged domestic violence by Father in the early summer of 2011. As a result, the Serious Case Review Panel has referred the new information to be assessed by an interagency Strategy meeting in order to safeguard Half sibling and other children in that household. The outcome of the enquiries and assessment will be reported back to the Serious Case Review Panel. A social work visit to the household to gather further information has taken place.

1.2 Terms of Reference of the Serious Case Review

1.2.1 The Terms of Reference for the Review were set out by the Serious Case Review Subgroup as follows:

1. In relation to the care of the child:

   a) What strengths did the agency/organisation identify?
   b) How well were these strengths recorded, expressed and reviewed?
   c) What concerns did the agency/organisation identify?
   d) How well were these concerns recorded, expressed and reviewed?
   e) How did the agency/organisation respond to these concerns?
   f) How effective was the response of the agency/organisation?

2. In relation to "hearing the voice of the child":

a) How often was the child seen by the professionals involved?
b) Was this frequently enough?
c) In view of the age of the child, was it possible to ascertain her views and feelings? If so, how were the child's views and feelings ascertained? How were her views and wishes recorded?

d) Identify the adults who tried to speak on behalf of the child and who had important information to contribute. What evidence is there that these individuals were listened to?
e) Provide detail on any instances where parents and carers prevented professionals from seeing and listening to the child
f) To what extent did practitioners focus on the needs of the parents? Might this focus on the parents have resulted in the implications for the child becoming overlooked?

3. In relation to Thresholds and Signposting:

   a) To what extent were assessment(s) that were completed in relation to the family 'fit for purpose'? How did the assessment(s) accurately identify need and risk?
   b) How did the agency/organisation give consideration to undertake a Common Assessment Framework?
   c) Provide detail on the needs and risks that were identified and detail whether these were reviewed and managed properly
   d) Provide detail on referrals that were made (or should have been made) to relevant agencies/organisations on the basis of information known to your agency/organisation.
   e) Did the agency/organisation have knowledge of any Domestic Violence in relation to any of the family members? If so, what was the response to this?

4. In relation to the Mental Health needs of the family:
   a) Were any mental health needs identified? If so what action was taken by your agency/organisation to address this?

5. In relation to substance misuse by family members:
   a) Were any needs identified? If so, what action was taken by your agency/organisation to address this?

6. In relation to domestic abuse by family members:
   a) Were any needs identified? If so, what action was taken by your agency/organisation to address this?

7. Provide detail on the ways in which the families' cultural, linguistic, ethnic, religious and disability needs were taken into account by your agency/organisation

8. Provide detail on the extent to which inter and intra-agencies' policies and procedures, and Government guidance was followed in this case.

9. Provide detail on the agency/organisations' management oversight and supervision (of the family and of the worker[s]) in this case. Was the oversight and supervision adequate?

10. To what extent were the decisions, assessments and plans made by your agency/organisation in relation to members of the household, visitors and family robust enough to meet the family's needs?

11. To what extent was the exchange of information appropriate, sufficient and effective:
    a) within your agency/organisation?
    b) between your agency/organisation and other partner agencies/organisations?

12. To what extent was the standard of recording appropriate, sufficient and effective:
    a) within your agency/organisation
    b) between your agency/organisation and other partner agencies/organisations?

13. What recommendations can your agency/organisation make in the light of the facts and the outcome(s) in this case, in order to improve practice?

14. Give examples of good practice that indicate sound intra and inter-agency working.

15. Please refer to any relevant research or lessons learned from other SCRs.

1.2.2 The Panel and Review Authors need to give consideration to other review processes that may be undertaken during the SCR process. How will relevant information be shared to ensure that there is no delay in dual processes?

1.2.3 In respect of the family and family involvement, how is the Panel going to ensure that their views and considerations are taken into account?

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

1.2.5 The time frame for the Review to consider in examining records and interviewing staff had been agreed as 1st July 2010 to 31st December 2011. If, in the process of the Review, any agency were to discover any information of significance outside this time frame the SCR Panel would advise about its inclusion.

1.3 Members of the Serious Case Review Panel

1.3.1 The membership of the Serious Case Review Panel was agreed by the Serious Case Review Subgroup in December 2011 and 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 Nurse Consultant /

Designated Lead for Safeguarding Children and Adults, NHS Leicester City has been consulted by the Designated Doctor for Safeguarding, who is the author of the Health Overview Report.

1.3.2 The SCR Panel members were:

Anne Binney , Independent Chair

Policy Officer ,Leicester Safeguarding Children Board

Manager , Leicester Safeguarding Children Board

Detective Chief Inspector for Safeguarding , Leicestershire Police

Head of Service ,Children's Safeguarding, Leicester City Council

Nurse Consultant / Designated Lead for Safeguarding Children and Adults, NHS Leicester, Leicestershire and Rutland (LLR) PCT Cluster, Leicester City

Head of Safeguarding, University Hospitals Leicester

Senior Lecturer in Substance Misuse, Leicester City Alcohol and Drug Service, Leicester Partnership Trust (LPT) - Advisor to the SCR Panel

Safeguarding Lead, Leicester Partnership Trust

The SCR Panel was supported by the Leicester Safeguarding Children Board Administrator.

1.3.3 The Independent Overview Author, Birgitta Lundberg, was in attendance at all the SCR Panel meetings.

1.3.4 The Health Overview Author attended the SCR Panel on four occasions to observe and to present and discuss the Health Overview Report**.**

1.4 Independent Chair and Independent Overview Author

1.4.1 The Independent Chair of the SCR Panel in respect of Baby L is Anne Binney, who has over 40 years' experience in Children's Social Care, 13 of these at senior management level which included management of front line Safeguarding Services. She retired from a position as Assistant Director responsible for Children's Social Care services in 2010. As well as her social work qualification and registration, she holds an Advanced Certificate in Child Protection Studies and previously chaired an ACPC and LSCB. In addition, Anne holds a Diploma in Management Studies and a Master's degree in Manager and Organisation Development. Since retirement from her full time post, she has worked as an independent consultant, primarily chairing and authoring Serious Case Reviews. Anne Binney is not employed by any of the agencies of the Leicester Safeguarding Children Board.

1.4.2 The Independent Overview Author is Birgitta Lundberg, who has compiled the Overview Report, the Executive Summary and contributed to the Integrated

Action Plan produced by the Leicester Safeguarding Children Board. She is a qualified and GSCC registered social worker and has 30 years' experience of social work practice and management in local authority social care services including 12 years as the manager of child protection/safeguarding and reviewing services. In the past 5 years she has been working as an Independent Social Work Consultant producing Overview Reports and undertaking multi agency Audits. She also writes Safeguarding and Children's Services Procedures and Guidance as commissioned by Tri.x procedures online. Birgitta Lundberg is not employed by any of the agencies of the Leicester Safeguarding Children Board.

1.5 Individual Management Review Reports and Health Overview Report

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

1.5.2 The Health Overview Author consulted with the Nurse Consultant / Designated Lead for Safeguarding Children and Adults, NHS Leicester City in the production of the Health Overview Report about the format of the report and the process of the Review. The Health Overview Report was presented to the SCR Panel and subject to the quality assurance process, which is a part of the SCR Panel's function.

1.5.3 The IMR Authors were as follows:

Consultant Community Paediatrician, Leicester Partnership Trust (LPT)

Named Nurse Safeguarding Children, Leicester Partnership Trust

Adult Safeguarding Lead for Mental Health and Learning Difficulties, LPT

Serious Case Review Officer, Leicestershire Police

Service Manager, Child Protection and Allegations Service, Social Care and Safeguarding, Children and Young People Service

Named Midwife for Safeguarding, University Hospitals Leicester

1.5.4 The Individual Management Review (IMR) reports were provided in several draft versions and the Final reports were submitted as follows:

General Practitioner services, Leicester Leicestershire and Rutland Primary Care Trust Cluster 31st March 2012

Health Visiting services, Leicestershire Partnership Trust 31st March 2012

Improving Access Psychological Therapy services, LCIAPT 25th April 2012

Leicestershire Police 28th March 2012

Midwifery and Accident and Emergency services, University Hospitals of Leicester 10th May 2012

Social Care and Safeguarding services, Education & Children's Services Department 10th May 2012

1.5.5 Three Information Reports were provided to the Review for consideration. The SCR Panel made further enquiries of the report from the ambulance service but did not consider that it required a full IMR report.

1.5.6 A request was sent by the Independent Chair to NHS Direct to verify a phone call by maternal grandmother and Mother after the third police call out and to provide relevant details in an Information Report. This information came to light as a result of the meetings by the Overview Author with family members. The call has been verified and entered in to the Integrated Chronology. An Information report has been requested formally and a brief report has been received (May 29th 2012).

1.5.7 The Action for Children report by the Safeguarding Advisor related to the attendance by Baby L and Mother to a Children's Centre where the Health Visiting clinic was held. Baby L attended with Mother on three occasions during the period.

1.5.8 The other Report related to the East Midlands Ambulance Trust and the attendance by ambulance staff on two separate occasions to Baby L's home address. This will be considered in the Analysis section in conjunction with the Leicestershire Constabulary IMR report.

1.6 Agencies with nil returns

A letter was sent out to all agencies to request a search of records in relation to Baby L and Mother and Father on the 1st November 2011. A number of different ways of spelling family names was included in the request. The following agencies responded that there were no records of any contact with their agency:

- Adult Social Care Services in the City Council
- NHS Walk-in centres
- Youth Offending Service
- Probation Trust
- Connexions service
- CAFCASS

1.7 The Serious Case Review process

1.7.1 On the 6th December 2012 the Serious Case Review Subgroup recommended that the Review should take place as the criteria had been met. The Terms of Reference were agreed and the Panel membership was confirmed. A timeline was agreed for the review process. The Leicester City, Leicestershire and

Rutland Local Safeguarding Children Board procedures for Serious Case Reviews were followed.

1.7.2 A half day Briefing meeting took place between the Independent Chair, the Independent Overview Author and the IMR Authors on the 1st February 2012. The meeting was well attended and the review process and the requirements by Working Together 2010 and subsequent Department of Education additional ministerial instructions in June and September 2010 and Ofsted December 2011 were discussed. The Leicester City Safeguarding Children Board template for IMR reports was examined and there was an opportunity for the IMR Authors to ask questions and seek clarification about the process and their roles in it. Timescales were established and lines of communication with the Safeguarding Children Board Business unit for support and updates were provided. One IMR Author, who was not able to attend, was subsequently briefed in full by the Manager of the LSCB Business unit.

1.7.3 Six SCR Panel meetings took place between February and May 2012, all of which were half day meetings apart from one, which was a full day meeting: 15th February 2012; 5th March 2012; 4th April 2012; 27th April 2012; 11th May 2012 and 23rd May 2012. The Deputy Senior Investigating Officer briefed the first SCR Panel meeting about the criminal investigation and process so far. Regular updates were then provided to the SCR Panel.

1.7.4 The IMR Authors were invited individually to the full day meeting in March. The purpose of that meeting was to evaluate the draft IMR reports and give the Authors an opportunity to present their preliminary findings. The SCR Panel members were able to ask questions for clarification about the information in the reports. Additional information was requested where the Integrated Chronology demonstrated gaps in information. Some of the additional information requests related to professional and organisational practice, which needed to be expanded on or explained more clearly.

1.7.5 The Independent Chair wrote to all IMR Authors confirming any amendments and thanking them for their contributions. Updated versions of the IMRs were subsequently submitted to the Panel within a set timeframe. The IMRs from health agencies were required so that the Health Overview Report could be produced prior to the Overview Report being written. The timescales were tight and there was some pressure on all authors in order to remain within the overall timeline of the SCR.

1.7.6 As the criminal and Court process has been in progress throughout the Review, there was discussion with the Police representative on the Panel about the opportunity to involve the family members in the Review to ensure that they could contribute, if they wished to. It was agreed that a letter with an explanation of the Serious Case Review attaching a leaflet would be sent out to both parents and grandparents; Mother's letter was to go via her solicitor. It was also agreed that a similar letter would be sent to the Mother of Half sibling for information. Invitations to meet with the Overview Author would be extended to Father and maternal and paternal grandparents as long as a Police Family Liaison Officer was present at any meetings and the questions

and discussion with the family members related to matters connected to the Review process rather than the criminal investigation. There was agreement by Panels members that an invitation would be sent to Mother's solicitor to invite Mother to meet with the Overview Author, if she so wished and her health allowed. If Mother of Half sibling expressed an interest to contribute it was agreed that a meeting would be arranged with the Overview Author. The Coroner's Office has been kept informed.

1.7.7 As a result letters were prepared by the Independent Chair of the Panel and sent via the Safeguarding Business Unit, who added the leaflet. At the time of the visits to Father and maternal grandparents it became clear that the letters had not been delivered to the family members as had been intended .The reason for this was an organisational misunderstanding and, in future, the LSCB Business Unit will ensure that a written acknowledgment from the agency delivering the letters will be required.

1.7.8 Several dates were offered for meetings with Father and maternal grandmother, who had expressed an interest in a meeting. The meetings took place in the presence of the Police Family Liaison Officer. For details of Family Involvement see section 2 of this report.

1.7.9 The Independent Overview Author has sent letters thanking the family members for their contribution. An apology on behalf of the Safeguarding Children Board Business unit for the original letters and leaflet not having been provided was included with copies of the original documentation.

1.7.10 The Overview Report was presented to the Serious Case Review Subgroup along with the Health Overview Report, IMRs, the Integrated Chronology, the Integrated Action Plan and the Executive Summary on 12th June 2012 prior to submission to Ofsted.

2. THE FAMILY

2.1 Family composition and Genogram

2.1.1 The family live in a quiet, mixed tenant and owner occupier, residential area on the outskirts of the city. They own their home and are described as 'having strong work ethics'. The parents had been married for some years and were both in full employment within a family business on the maternal side of the family. The extended family on both sides all live within the general area. The family enjoyed a comfortable lifestyle with their own cars and was able to go on holidays. Mother was on maternity leave. Agency records describe a settled home environment with toys and equipment suitable for an infant.

2.1.2 Mother had a close relationship with Maternal Grandmother (MGM), generally, they were in touch on a daily basis, and if not in person they would talk on the phone. MGM described the relationship as not only a mother and daughter relationship but as best friends.

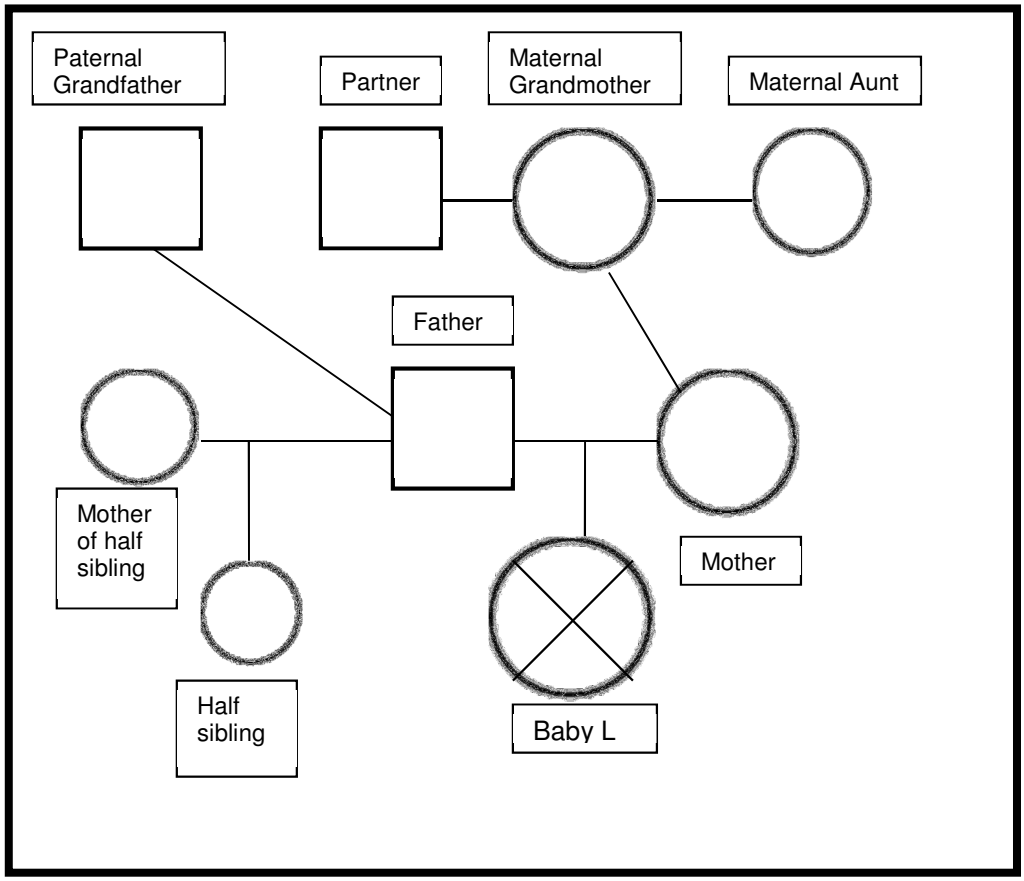
2.1.3

Designation	Age at the time of Baby L's death	Relationship to Baby L	Ethnic Origin
Baby L	7 months	Subject child	White British
Mother	32 years	Mother	White British
Father	35 years	Father	White British
MGM	Not relevant	Maternal Grandmother	White British
MGMP	Not relevant	Maternal Grandmother's partner	White British
MA	Not relevant	Maternal Aunt	White British
PGF	Not relevant	Paternal Grandfather	White British
MHS	Not known	Mother of half sibling	Not known
HS	3 months	Half sibling	Not known

2.1.4 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.

2.1.5 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.

2.1.6 Genogram:



2.2. Community Context

2.2.1 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.

2.2.2 The relationship between Father and his parents was reported by the Family Liaison Officer to have broken down for a period of time just prior to Baby L's birth. As a result paternal Grandparents had not met Baby L prior to the events leading to Baby L's death. Father has been supported by his family subsequently.

2.2.3 The maternal family members were in frequent contact throughout and as previously noted MGM and Mother were in daily conversation. Mother and Baby L stayed with MGM and her family for most of the time between July and September 2011.

2.2.4 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.

2.2.5 The area the family lived is a part of Leicester, which is a large city in the East Midlands with a population of approximately 306,600 and the City Council believes that there may be a population undercount of around 30,000 people, 10% of the city's population. The city is ethnically diverse and the scale of its diversity is unique compared to most other cities in England. There are approximately 79,569 children and young people aged 0 to 18, representing 26% of the total population.

2.2.6 The Leicester Children's Trust was set up in 2004 to provide an integrated strategy of service provision for children and young people in the city. The Trust includes representatives of partner agencies including Health, Police, the Youth Offending Service (YOS), Connexions, Job Centre Plus, School Governors, Voluntary Sector representatives, Leicester Safeguarding Children Board (LSCB) representatives, City Clinical Commissioning Group representatives and local schools and colleges. The Trust has published its priorities in the new Children and Young People's Plan (CYPP) for 2011-14.

The LSCB disaggregated from the Leicestershire and Rutland Local Safeguarding Children Board in September 2009. Under its Independent Chairperson, it brings together the main organisations working with children, young people and families which provide safeguarding services in Leicester.

2.3. Family history and Baby L.

2.3.1 Baby L's parents had known each other since their late teens and their families lived in the same area of the city. There was no information in the agency records of the early history of either parent as no assessments had been carried out in relation to either of them. The absence of agency records demonstrates that there had been no known concerns about either parent as children or adults or their immediate families. The family members therefore had not experienced any direct previous personal contact with services such as the police or Children's Social Care.

2.3.2 Baby L was the first child of Mother and Father. Mother was noted in records as having expressed anxiety about trying to become pregnant prior to the pregnancy with Baby L. Father was present at the birth of Baby L as was maternal grandmother and the birth was difficult but without any serious complications. Mother discharged herself home on the same day that the birth took place. There was no clear explanation in the GP or maternity records about why Mother wanted to leave earlier than recommended. The maternal family thought she had just wanted to come home.

2.3.3 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.

2.3.4 Baby L was described as 'enjoying food and taking bottle feeds well'. In relation to feeding and sleeping patterns Baby L was doing well and Mother reported no concerns about daily routines.

2.3.5 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 Health Visiting service records were the main source for personal information about Baby L, who was consistently described in positive terms as 'doing well', looking well' and 'developing well'.

2.4 Overview of the integrated chronology of events and agency involvement

2.4.1 The intention in this section is not to reproduce the full Integrated Chronology but to draw out significant points in time and provide an account of what is known in agency records about Baby L's life. Some comments will be made to highlight specific issues. The following extracts from the Integrated Chronology are the Independent Overview Author's view of significant information and events which occurred prior to the death of Baby L.

2.4.2 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.

2.4.3 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. The IMRs for Health Visiting and Midwifery services will be considered in more detail in section 3.1 below.

2.4.4 **Missed opportunities**

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:

2.4.5 **The first missed opportunity:**

Early in the morning hours at the end of June 2011 an elderly neighbour called the police as Mother and Baby L had come to them in a distressed state. Mother told the call handler that she was having marital problems and wanted help. Mother stated that 'she had not been assaulted but she had recently found out that her husband was having an affair'. Mother presented

as very agitated. Police officers were dispatched but, as they arrived some time later, Mother had left.

2.4.6 Later the same day Mother contacted the police again as she had returned home and found that Father had locked her out. Mother was concerned that Father might have harmed himself as his car was at the address but he was not responding. Father had been sending her texts during the day saying 'good bye' which she took as indicating an intention to harm himself. As a result the police forced entry to the home and found Father passed out on the upstairs landing having consumed a quantity of alcohol and tablets and with a strong smell of cannabis in the air .There were a number of weapons by Father such as an air rifle and two hunting knives. Other weapons were removed at a later stage from Father's car including a machete. The police took all the items defined as weapons away with them.

2.4.7 The police called the ambulance service, which attended and checked Father out. The police officers and the paramedic concluded on balance that there was no further risk that Father would harm himself and that a Mental Health Assessment was not required. Father appeared apologetic and willing to cooperate.

2.4.8 During the incident Baby L had remained asleep in a car seat with Mother outside the home and had only come in towards the end. Maternal Aunt was also present with Mother. Mother supported Father's explanations about the various weapons that were found and removed. The police officers left Father, Mother, Baby L and maternal Aunt 'to try sort things out' and noted that Baby L looked well cared for and the home was well kept.

2.4.9 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.

2.4.10 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.

2.4.11 The Domestic Abuse Investigation Unit (DAIU) Sergeant reviewed the incident and entered a generic action plan on the crime recording system. A Domestic Abuse Investigation Officer (DAIO) was allocated to contact Mother for a risk assessment to be completed along with a safety plan. Several attempts were recorded as made to contact Mother but without success.

2.4.12 From the contact with the family members the Overview Author was able to clarify that this was the day that Father had informed Mother of a long standing relationship with another woman and that a baby was due from that relationship in two months' time. The information also indicated that the

Mother of Half Sibling (unborn) had demanded that Father informed Mother of the relationship and the expected baby or, if he did not, she would.

2.4.13 Two days after the event Children's Social Care reviewed the referral from the police (CAIU), which had been received as an email with the heading 'for information only.' 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.

2.4.14 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 for example. 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.

2.4.15 ***Author's Comment:***

This was a missed opportunity to consider what was happening in the family in view of the presence of a very young baby, 3 months at that time. The research in the Ofsted report "Ages of concern: learning lessons from serious case reviews" which demonstrates the particular vulnerability of young babies under the age of one year concludes that between 2007 and 2011 of 602 children subject of Serious Case Reviews, 210 were babies under the age of one (35%). The main group of professionals with safeguarding responsibilities to young children is health professionals such as Health Visitors and GPs.

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.

It could be argued that Children's Social Care should have undertaken an Initial Assessment as the information in the referral raised a number of issues of concern such as Mother and Baby L going to the neighbour very early in the morning; Father's own state of mind and the presence of the various weapons, cannabis and alcohol. In addition Mother gave the information to the police officers attending and it was recorded that there was a reason for Father's behaviour in terms of the revelation of the affair. Mother had also been described by the police as 'very distressed.'

The Team manager interpreted the presence of maternal Aunt, the fact that Mother had gone for help and that she had called the police as appropriate actions and 'strengths'. On balance the threshold for an Initial Assessment was not judged as met by the Team manager.

No attempt was made to talk to the police officers involved in their agency decision making to feed back this outcome or check the information that had been shared. The actions of the police might be seen to be ambivalent as they had passed on information in the format of a referral stating that they would take 'no further action' although they were in fact following up by allocating a Domestic Violence Officer to contact Mother and marked the home address for Father as a 'vulnerable adult'*.

The factor that was not taken in to account in the decision made by the social worker and Team manager was the impact on Baby L of the state of reported distress of Mother and the behaviour of Father. The voice of the child was not heard. The concept of 'Early Prevention' should have been an aspect of the decision making as well as collaborative working. The information received should have been shared with the GP and Health Visitor and the welfare and safety of Baby L should have been checked out by a direct follow up contact by one of the front line professionals.

* Leicestershire Police has since moved away from the term vulnerability and now refers to adults who are 'at risk'. The definition is contained within the 'Managing Adults at Risk' Procedures (see below):

An adult is "at risk" if, because of their situation or circumstances, they are unable to protect themselves from harm.

It is necessary to consider both the **situation** and **circumstances** of a case before we can assess risk.

Situation would include environment, employment, family and other relationships, crime and anti-social behaviour levels, and a range of other situational factors.

Circumstances would include personal factors such as Mental Ill Health, Learning Disability, Physical disability, Physical Ill Health, Age and Alcohol or Drug dependency.

2.4.16 The second missed opportunity:

2.4.17 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. MGM was present during the consultation with the GP, who spent a longer than usual time for a consultation with Mother in view of her distressed state. Mother 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 referral was sent three days after seeing the GP.

2.4.18 MGM clarified that Mother did not allow MGM to explain the details of the domestic violence to the GP. On reflection MGM felt that the full information should have been given to the GP but she did not feel able to at the time as Mother did not want anyone to know.

2.4.19 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.

2.4.20 The police received a 999 call believed to have been from Mother but the caller hung up. This was the day before Mother visited the GP Walk in clinic. The call was traced back to Mother's mobile and MGM answered .The police attended MGM's address and were informed that Mother had left her own home two weeks earlier but had returned on the previous day. Not long after her return the parents had argued and Mother had asked Father to leave. Mother had phoned MGM, who came and collected Mother and Baby L. The police recorded this as 'Domestic Incident' and 'standard risk'. The DAIU Sergeant reviewed the report and determined that no further action was needed.

2.4.21 From the meeting between the Overview Author and the maternal family new information, hitherto unknown to the agencies through the Review process, was introduced. This concerned the reports by Mother and MGM of the 'domestic violence/abuse' mentioned to the GP and subsequently partially revealed by Mother to the Therapist and NHS Direct. The day after the above noted incident with Father and the police call out there was an alleged incident described as of 'significant violence leaving visible marks, injuries and bruises to Mother' with Father. This information is subject to further police enquiries.

2.4.22 During the period between the first contact by the police described in section 2.4.4 and the contact with the police in relation to the 999 call as well as the GP contact a time period of 10 days elapsed. No professional saw Mother and Baby L during these 10 days and an appointment for a vaccination for Baby L was not kept. This is the only time in the chronology of contacts that an appointment for Baby L was not kept. It is during this time that Mother had what the maternal family described as 'significant injuries' from one alleged assault which took place shortly after the very first original call out. MGM and her partner were away on holiday abroad when the original incident with Father took place and returned to find the marks and bruises on Mother's arm, leg, body and face.

2.4.23 The maternal family interpreted the distressed behaviour by Mother e.g. the panic attacks, which they gave examples of, and her low moods and thoughts to the revelation of the relationship with the mother of Half sibling and the unborn baby as well as the violent event. The third call out to the police took place around the time of the expected birth of the other baby (Half sibling). Father attended that birth as well.

2.4.24 ***Author's Comment:***

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' as previously mentioned 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 and locally.

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.

The 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.

2.4.25 The third missed opportunity:

2.4.26 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.

2.4.27 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.

2.4.28 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 (17). The subsequent test at the next appointment showed some improvement (down to 9).

2.4.29 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.

2.4.30 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.

2.4.31 The police were told by the adults present that Mother was seeing a Therapist and phone contact was made with the Therapist, while the police were still at the scene. The police provided Mother with contact numbers for Domestic Violence Help lines and suggested that the family should contact the CRISIS team, if needed for mental health support.

2.4.32 The Police Officer in Charge linked the three incidents and made a referral to the Child Abuse investigation Unit (CAIU) and the Domestic Violence Investigation Unit (DAIU) who noted the incident but determined 'No further action' as there had been no crime committed. CAIU sent a referral by email again headed 'For information only' to Children's Social Care.

2.4.33 Two days later Children's Social Care noted that they had received the referral email from the police and recorded it as an 'Initial Contact' which required 'No further action'. There was no conversation with the police CAIU given the past notification and no checks with other professionals such as the GP or the Health Visitor in view of the young age and vulnerability of Baby L. The police information specifically stated that the GP and a Therapist were involved. The involvement of those professionals seems to have led to the judgment that there was no role for Children's Social Care. This decision was not based on any interaction with other professionals to discuss any information or confirm the point of view. There was no evidence in the records that the impact on Baby L of the parents' situation had been considered.

2.4.34 The following day the Therapist consulted with the Administrator in the LPT Safeguarding Team and made a referral to Children's Social Care on the local LSCB multi agency referral form. The referral was hand written and faxed but contained the full information about Mother's state of mind and the information she had given about the domestic violence and Father's affair and Half Sibling's subsequent birth. The referral also said" Mother is aware of this referral and does not want it to be made. I don't know if she has made her husband aware. His knowledge of this referral may trigger his anger ".

2.4.35 At a late stage in the Review process following up information from the family interviews it was revealed that at the same time that the Therapist was making a referral, MGM had made a call out of hours to NHS Direct because

of the distressed behavior and thoughts of Mother .Mother spoke to the call handler and information similar to that provided to the Therapist was given by Mother. The NHS Direct records note the same concerns that were also contained in the Therapist's referral to Children's Social Care. Advice was provided by NHS Direct but no referrals or information was passed on to the Health Visitor or the GP in line with policy and procedures.

2.4.36 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".

2.4.37 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 .

2.4.38 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."

The form had a tick that feedback had taken place when the Team manager signed it off but it is not clear, who had filled that in, as no feedback took place.

If the feedback had led to a conversation with the Therapist, the social worker would have found out more information about the previous referrals from the police, which had been missed, as well as the information about the concerns of Baby L being left alone by Mother.

2.4.39 Mother attended a further session with the Therapist five days after the call from the social worker. Mother told the Therapist that she had been contacted by a social worker and that the call was short and there would be no further involvement. Mother expressed a wish to attend further sessions with Open Mind and another appointment was arranged for three weeks later. Mother did not attend this booked session and was not seen again by the Therapist. The Therapist tried to contact Mother by phone on the day of the appointment without success and left a message with MGM requesting that Mother call back to book another appointment. Mother did not call back.

2.4.40 After the last session with the Therapist there were only routine appointments by Mother with the GP and one '29 weeks assessment' with the Health Visiting service for Baby L, where no mention was made of any concerns. The Health visiting service remained unaware of any issues prior to Baby L's death and no contacts were made with or by other agencies.

2.4.41 ***Author's Comment:***

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.

The referral by the Therapist to Children's Social Care was not given full weight and significant information within the referral was missed. The social worker focused on the aspects of domestic violence but failed to fully pursue the impact of the relationship crisis between the parents. Most research in to domestic violence demonstrates that the risks are increased at the point where relationships break down and additionally there may be conflict about contact to a child.

Baby L was described as spending time with both parents separately but no agency questioned the parents about the arrangements between them for contact and care of Baby L. At the third call out the police established that Mother and MGM were comfortable about Father's practical care of Baby L but they did not go in to detail about the arrangements, although they had been called out to a situation of conflict at the point when Father was returning Baby L to Mother.

The outcome of the police and Therapist's referral to Children's Social Care was 'No further action' with a letter to Mother with advice and information provided .It is noteworthy that after that point Mother and the maternal family made no further attempts to call out the police or take Mother to the GP. Mother attended the last session with the Therapist saying 'everything was fine now' and then made no further contact. The information from both Father and the maternal family is that Mother's behaviour became more distressed and erratic in the weeks leading up to the death of Baby L.

A collection of research articles about 'Domestic Violence and Child Protection' (Humphreys et al 2001) makes the following observation which should be borne in mind by professionals at the point of responding with a NFA letter:

"At its worst, referrals from the police and other agencies in the UK result in ' cover your back' letters from statutory social workers informing parents that they have come to the notice of social services and that the domestic violence in the household is potentially harmful to their children. Such letters, even when they include information about agencies which might be helpful, reinforce women's worst fears about social work intervention in relation to their children and may therefore close down help-seeking and reinforce the abuser's power and control within the family."

2.5 Summary and conclusion of the Integrated Chronology

2.5.1 By merging all the known contacts provided in the IMRs and the Information Reports into the Integrated Chronology, it has been possible to get an overview of the involvement of the different agencies with Baby L and the parents.

2.5.2 The picture, which emerges, reveals that there was a significant range of information available to the agencies, who had been involved, but that the sharing of that information was ineffective. It was not assessed as a whole in the context of the family circumstances with all the professionals as well as the family members and with a clear focus on the impact on Baby L of what was taking place. The information included:

- A report by Mother to the therapist of two separate incidents of domestic violence ,one of which took place as Baby L was held by Mother
- Panic attacks, anxiety and depression in the context of a significant relationship breakdown
- Some references to thoughts of ' being better off dead' prior to the PHQ and GAD assessments and mention of some cannabis and alcohol use
- Similar information to the NHS Direct staff as above
- The behaviour of Father of possible self-harm and the presence of cannabis, alcohol and weapons
- The fact that Baby L was being cared for in different locations, which indicated that the crisis between the parents was unresolved and Baby L was no longer in a settled environment
- Arguments leading to police call outs in the context of 'contact arrangements'.

2.5.3 The different professionals, who were involved, did not work in a collaborative way by alerting each other to new information such as the GPs, the Therapist and NHS Direct and none of them contacted the Health Visitors. The communication in the surgery was hindered by the fact that the record system called SystmOne did not allow access to the Health Visiting service in this practice. The GPs and the Therapist had recorded input on SystmOne, so if the Health Visitors had had access and had looked at the record system, they would have discovered the information.

2.5.4 The response by Children's Social Care on both occasions was not robust on behalf of the child given the very young age of Baby L. In circumstances where a very young baby is reported to have been present in a domestic violence incident the minimum action should be to inform the Health Visitor to allow for a review by the Health Visiting service of their provision and a reassessment of the circumstances impacting on the child.

2.5.5 It was agreed by the SCR Panel that 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.

2.6 Information from the family

2.6.1 The family was invited to participate in the Review and letters were sent out to Father and Maternal Grandparents to be delivered by the Police Family Liaison Officer. A letter for information of the Review process was also sent to the mother of Half Sibling. As Father and maternal grandparents expressed a willingness to meet with the Overview Author in the presence of the Family Liaison Officer, the meetings were arranged. The meeting with Father took place in the paternal grandfather's home and the other meeting was in maternal grandmother's home.

2.6.2 At the time of the meetings it became clear that the participants had not received the letters explaining the process and the purpose of the visits. The meetings therefore spent some time going through the aim of Serious Case Reviews and their function as a process of learning lessons for agencies working with children.

2.6.3 It was explained to Father as well as MGM and her partner that they would be informed prior to the publication of the Review and would be offered a meeting to talk through the reports and the findings. The maternal family was reassured about the anonymisation and the timescales in view of the criminal process and the submission to Ofsted was explained. Father was very concerned about the notion of information about the family being in the public domain even if anonymised. It was explained that the criminal process and Court outcome would leave similar information available but Father remained reluctant to accept the process.

2.6.4 Father was reticent about the information he provided but he explained that he had felt frustrated by the agency responses to the events, which had been reported. Father felt that agencies should have been more focused on the mental health and as he saw it "post natal depression "of Mother and provided help for that. Father described Mother's behaviour at the time as "loss of self-confidence; anxiety; panic attacks and bizarre beliefs that she was being

watched". He had stopped her driving on occasions as he felt that she was not able to do so safely.

2.6.5 Father felt that there had been too much attention paid by agencies to his self-harm attempt and to allegations of domestic violence. Father categorically denied any domestic violence and pointed to the fact that he has no previous record of any kind. Father expressed strong feelings about the fact that he had been scrutinised when it was Mother, who needed help.

2.6.6 Father described the couple looking on the internet for ways of dealing with Mother's problems and considering massage and cannabis to relax. The problems started after the news of Father's affair and the other baby when Baby L was three months old. Father stated that his relationship with the maternal extended family, which had previously been very good, had now broken down.

2.6.7 Father had seen the GP as the best point for help although he felt that the Therapist had spent too much time talking to Mother on the mobile phone. It had not occurred to Father to contact a Health Visitor for support for Mother.

2.6.8 The maternal grandparents expressed their distress at what had happened and their grief at losing Baby L. MGM described the relationship between Mother and herself as very close not only a mother and daughter relationship but 'best friends' as they talked to each other every day.

2.6.9 The maternal grandparents had not been aware of any cannabis use by Mother and as she had stayed with them a significant proportion of the time after the original disclosure of the affair, they had not noticed any cannabis smoking or other substance consumption.

2.6.10 They explained that they had told Mother and Father that they would support them whatever decisions they took about their marriage in the wake of Father's affair. They were not comfortable about it but if Mother had wanted to remain with Father they would have accepted that.

2.6.11 The main concern, which they had not told agencies about because Mother had insisted 'that they must not', was the alleged domestic violence incident, which took place while they were abroad on holiday. On their return MGM had deliberately accompanied Mother to the GP in the hope that the GP would notice the still fading bruises.

2.6.12 MGM gave examples of Mother's distressed behaviour in the weeks over the summer, when she had been staying with them for several weeks and during the autumn. The maternal family related Mother 's behaviour as similar to post traumatic stress behaviour ,sudden panic attacks, curling up in a foetal position and going out and then panicking and not being able to manage Baby L and calling up for help.

2.6.13 The only agencies that the maternal family had considered to seek assistance from were the GP and the Therapist. They had on one of the occasions

phoned NHS Direct for advice but the response had been to insist on speaking to Mother, who had repeated similar information to that given to the Therapist. The family had struggled with Mother's resistance to speak to any agencies. The family had not considered that they could refer to Children's Social Care for support or the Health Visitor.

2.6.14 It had not occurred to any family members that Mother might present a risk to Baby L as she was seen to be fully committed to Baby L and was, in a practical way, caring for Baby L well.

2.6.15 **Author's Comment:**

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.

3. ANALYSIS

3.1 Analysis by Agency including the Health Overview Report

3.1.1 "Working Together sets out how organisations and individuals should work together to safeguard and promote the welfare of children and young people in accordance with the Children Act 1989 and the Children Act 2004. It is important that all practitioners working to safeguard children and young people understand fully their responsibilities and duties as set out in primary legislation and associated regulations and guidance" (*Introduction to Working Together to Safeguard Children, March 2010)*

3.1.2 All agencies providing services to children and families are expected to work within the framework of the legislation, statutory guidance and practice

guidance issued by government. All Local Safeguarding Children Boards are required to have in place Inter Agency Safeguarding procedures easily accessible to all staff and service users. The Leicester Safeguarding Children Board have online open access to their inter agency child protection procedures and all member agencies are expected to have internal agency systems and procedures in place to underpin the Leicester Safeguarding Children Board's procedures.

3.1.3 Safeguarding procedures should be reviewed and updated on a regular basis and all staff should be made aware of how to access and use them through induction, training and supervision.

3.1.4 The IMRs and the Health Overview report in this SCR were required to consider the services delivered within the framework of the current legislation and guidance and in relation to the Leicester Safeguarding Children Board inter agency procedures.

3.1.5 The IMRs and the Health Overview report produced for this Serious Case Review have all addressed the Terms of Reference and set out the history and background of Baby L where there was information in records about the family. Some interviews with staff and professionals have helpfully added to and clarified the information provided in records. The IMRs and the Health Overview Report have drawn the information together and provided some good and some excellent analysis of the services provided to the children and their Mother. The IMRs have aimed to assess what the outcomes were of the services provided for Baby L. Robust questioning about compliance with basic standards and available procedures at the different times is evidenced in the IMRs. Most IMRs have made very useful references to research in order to aid learning. Some specific learning points have emerged for individual agencies and some themes have developed as common across agencies. The sections below will address the agencies separately and then consider the common themes before concluding with an analysis of the review process.

3.1.6 Leicestershire Police IMR

3.1.7 The IMR demonstrates that the IMR Author has examined the available records in depth as the report contains good detail of the incidents as they took place; the reasoning of the officers, who attended, and the subsequent recording and decision making by the officers and line management. The IMR Author has also interviewed a number of staff in relation to the involvement with the family and Baby L. The staff interviews have added to the understanding of the reasoning by the agency.

3.1.8 The IMR makes references to Baby L's demeanour and presentation and general observations by the police officers attending the call outs. This was relevant as the call outs were interpreted as 'domestic incidents'. As a result of the nature of the incidents the police officers and their supervisors decided to make referrals to Children's Social Care via the standard forms, which were emailed to the referral point in Children's Social Care after two of the call outs.

The email on both occasions stated “attached report for your information only”.

3.1.9 The Father on the first call out and Mother on the last call out were also assessed as being ‘vulnerable’ which led to markers on the record system as well as added to the information on the referrals to Children’s Social Care. The referrals contained the full information from the crime reports as these had been ‘cut and pasted’.

3.1.10 The IMR found that the oversight and supervision of the actions taken and decisions made had been thorough and had covered all the aspects of the case for example during the first incident the Force Control Room Inspector had oversight of the case as the officers attended. The crime report was reviewed by several supervisors in respect of vulnerability, domestic abuse and child protection as well as the recovery of a firearm and other weapons. However, it should also be noted that the police system of different supervising officers making decisions in relation to domestic violence incidents and child abuse incidents could lead to some confusion as in this case in the first call out the DAIU Sergeant arranged for a follow up service to Mother but this was not conveyed to Children’s Social Care in the message which said that there was no further role for the police.

3.1.11 The main lesson identified for the agency in the IMR report is to improve its response to circumstances where a decision is made that there is no further role for the police except to send a referral or share information with Children’s Social Care about a child.

3.1.12 The IMR found that the mechanism for sharing information with Children’s Social Care e.g. the email with all the information included but the heading “attached report for your information only” could have been misleading. The process of the Serious Case Review has identified that the response in Children’s Services to the emailed referrals was not robust enough and Children’s Social Care staff limited their actions to checking the police information and did not contact other agencies to share the information and undertake further checks such as with the Health Visitor and the GP.

3.1.13 The Police recommendation has addressed the sharing of information by setting out a proscribed format to be added to emails which reads:

“This information has been assessed by the Comprehensive Referral Desk and disclosed for your consideration and action as appropriate. At this time there is no further responsibility for the police and we will close our record accordingly. Should you require any further information, please contact the Referral Desk on 0116 numbers provided (Adults) or 0116 numbers provided (Children).”

This format has been in place since February 2012 and was reviewed in March 2012 in order to ensure that the practice becomes embedded as standard.

3.1.14 ***Author's Comment:***

The new set wording makes it clear to the person receiving the emailed information what the police will do and how to contact them. It does however raise a query about the spirit of working together across agencies and how agencies collaborate in the process and reflect on information jointly.

The Leicester Safeguarding Children Board principles and procedures as well as all child protection training aims to encourage professionals to talk to each other and share information in a dynamic way. The responsibility to safeguard a child rests with all the agencies and does not stop by passing information without considering the outcome and follow up.

The current expectation is that the referrer should receive a reply from Children's Services about the outcome within a day and, if nothing has happened, the referrer should contact Children's Services within 3 days to check what the outcome was. See Para 2.4.36 above.

The argument between agencies in these circumstances usually centres on whether the information is 'a referral' or 'a contact' or 'for information'. The other significant issue in these discussions is thresholds and workloads, both within the police and Children's Social Care, and how many cases there are of a similar nature, particularly in relation to domestic violence information with children involved.

Whilst the clarity in the new word format of the police communication is helpful there needs to be careful scrutiny of the system to ensure that aspects of working together are not lost.

In some other LSCB areas the notifications sent by the police for children in the youngest age group are also automatically sent to a Health Safeguarding Children team for distribution to Health Visitors and GPs for the identified child. This may be a system which should be considered.

3.1.15 The IMR Author comments on two previous local Serious Case reviews, Child A and Child R, where police involvement in incidents identified as 'domestic abuse' was subject to review. The recommendations from Child R have been implemented but this was after the death of Baby L and the SCR has not been published yet as there is a criminal trial due.

3.1.16 ***Author's Comment:***

As the Independent Author of the SCR Child R and therefore being aware of previous issues and the relevant recommendations, although the report has not yet been published, I can see a marked improvement in practice by the police in the case of Baby L as set out in this IMR.

There are improvements in response, record keeping, supervision and decision making. As noted by the IMR Author the improvements should be subject of regular audit and report back to the LSCB.

3.1.17 The Police IMR commented on the decision making by the police officers attending the first call out, which were also attended by the ambulance staff. This was when Father was found on the landing and was recorded by the police as "vulnerable". The police recording demonstrated that the standard risk assessment procedures had been followed. The police and ambulance staff decided jointly that a Mental Health assessment was not needed and the SCR Panel queried, if the police or the ambulance staff had considered referring their concerns to Father's GP surgery. It was concluded that the police had placed a marker on the home address following the first call out but neither agency had alerted the GP as they had decided that a Mental Health assessment was not required. There were no details in the records by the Ambulance service of the outcome of this call out.

The SCR Panel requested that the two agencies; the police and the ambulance service, should examine their expectations of informing GPs of call outs to reported self-harm incidents where someone is judged to be "vulnerable".

3.1.18 Children's Social Care and Safeguarding IMR

3.1.19 The IMR Author for Children's Social Care has reviewed the records and interviewed three staff involved in the case in person and two staff via a telephone conversation. The approach has been robust and a critical analysis of the actions and decisions of the Duty and Assessment Service, DAS, which is the overarching front door service for Children's Social Care, is in evidence.

3.1.20 The Duty and Response team is the part of DAS which screens all referrals and makes the initial decisions about what should happen next .So for example some referrals may lead to signposting to other services, some may be referred for consideration for a Common Assessment Framework service or some may be subject to further action by the Duty and Response team. This team consists of 8.5 full time equivalent Social Work posts and 7 full time equivalent Child Care Practitioner posts. At the time of this case activity there were two Team managers in post as well as eleven qualified social workers and eight Assessment workers in the team. The volume of work for this team can be illustrated by the numbers of contacts during the five month period of this case which was approximately 900 per month and 640 referrals. The two referrals from the police and the referral from the Therapist were dealt with by this team. The staff involved in this case was qualified and had received relevant up to date training.

3.1.21 The IMR clarifies that Baby L was never seen by anyone from Children's Social Care as the only contact with the family was a telephone conversation with Mother in relation to the referral from the Therapist and the second police referral notification. At that point Mother and Baby L were staying with MGM.

3.1.22 The IMR Author is critical of the recording of the reasoning for the two referrals from the police to be noted as 'Advice and Information' with no further action taken. The referrals should have led to cross checking with the professionals mentioned in the referrals e.g. the GPs and the police officers, who dealt with the case. In view of the young age of Baby L the Duty and Response team should have contacted the Health Visitor partly to seek information but also to give the information about this young child. Careful consideration should also have been given together with the Health Visitor to undertaking a CAF offering support services to Baby L and Mother.

3.1.23 The IMR has drawn out the fact that both the social worker and the Team manager missed significant information contained in the referral from the Therapist about Baby L. Mother had told the Therapist that while having one of the panic attacks she may have left Baby L alone and unattended for a period of time. This information had not been taken into account in the assessment and decision making process.

3.1.24 The IMR noted that the recording of the decision making was minimal and was hindered by the Information Case record system, ICS, and the system for storing information. The Social Worker, who dealt with the third referral, noted that there had been two previous contacts where no further action had been taken. The detail of those contacts on the historical records database (EDRMS), a separate database to the recording database could not be found. No attempt was made by the social worker to contact the police to ask for information about the previous notifications. A Team Manager clarified that on some occasions during that period there was a backlog of filing of information on EDRMS but in this case, it should not have been a problem as the two previous referrals had been emails sent by the Child Abuse Investigation Unit.

3.1.25 The social worker talked to Mother about the risk of harm to young children if they witnessed domestic violence and noted that a child could be harmed accidentally by a violent partner. The social worker stated that "Mother had understood this advice and that Children's Social Care would have to take action, if there were any more reports of violence or incidents." The social worker had explained that it would mean a home visit and checks with other agencies.

3.1.26 ***Author's Comment:***

While it was good practice to explain the role of Children's Social Care to Mother the explanation must not be offered as a possible threat of action. The referral had stated that Mother was fearful of Father's reaction to a referral and consequently Mother was reluctant to agree to the Therapist making the referral in the first place. A brief contact over the telephone was not the appropriate method to convey complex information and make any assessment. The referrer was a Therapist and the presence of mental health issues should have been clear to the social worker and the Team manager even without seeking further information.

"Women with mental health needs are often reluctant to seek help because of fears that they will be judged as inadequate mothers and their children will be 'taken away' (Stanley et al 2003)".

Mother withdrew from contact with the agencies shortly afterwards having attended one booked session with the Therapist a few days after the conversation with the social worker.

3.1.27 The social worker and the Team manager making the decisions had focused on the domestic violence aspects being reported by the referrers. Their brief assessment of the information provided had missed some significant aspects relating to Baby L and failed to pick up on the mental health aspects with Mother. They had overestimated the benefits and strengths of the support provided by the extended maternal family.

3.1.28 The assessment prior to deciding to take no further action had been superficial and had failed to consider the impact on Baby L given the crisis that the two parents were experiencing. The accumulated concerns raised by the time the social worker was tasked with contacting Mother should have led to an Initial Assessment with cross agency checks and a home visit with the social worker seeing Baby L. The family members and extended family should have been contacted as well.

3.1 29 There was no attempt to clarify any information by contacting the referrers or sharing the information with the Health Professionals already involved with the family e.g., the Therapist, the GPs and Health Visitors. When the subject child of a referral is under six months old it should be an automatic reflex to think Health Visitor as this service will have some knowledge of and access to the child.

3.1.30 ***Author's Comment:***

The reasons given in the IMR by the Team manager and social worker for their assessment were based on the mistaken assumptions that:

- 'separation means reduced risk';
- 'extended family support is always helpful and will protect a child' and
- 'the GP and Health Visitor were aware of the same information as Children's Social Care and had not made referrals'.

To illustrate the point the IMR Author draws out some quotes from the booklet "Ten Pitfalls and how to avoid them. What research tells us" (Broadhurst et al September 2010 NSPCC).

"Pitfall 1 refers to an initial hypothesis being formulated on the basis of incomplete information and it is assessed and accepted too quickly. Practitioners become committed to this hypothesis and do not seek out information that may disconfirm or refute it.

The leaflet goes on to say "a substantial body of research evidence has clearly identified the tendency for 'early evidence bias' in human decision making that is a first summing up of a situation strongly influences the analysis of subsequent or new information" (Munro 1999; Garbill 2005; Burton 2009)."

The learning point is that assumptions should not be made and questions should be asked proactively of referrers especially where young infants are involved, as they are particularly vulnerable.

3.1.31 The IMR concluded that the current referral procedure in the LSCB procedures sets out clear expectations about checking information with other agencies and responding to the referrer following receipt of a referral. The practice in the case of Baby L had fallen short of the expected standards and had led to services not being provided to Baby L and the parents at a point when they should have been.

3.1.32 The IMR recommendation for Children's Social Care is focused on improving the referral screening process and particularly to embed good practice to take account in the decision making of the full case history.

3.1.33 The recommendation made must be strictly followed up by management action to underpin good practice so that the obstacles identified in the report, when trying to find the two previous referrals, are addressed. The action should include regular audits of referral paths and supervisory checks.

"Analysis of Serious Case Reviews clearly suggests that outcomes must be fed back to referrers and in cases of no further action, universal services need to be notified so that they can remain vigilant to further concerns" (Brandon et al 2008).

3.1.34 The IMR gives an account of the actions that have been put in place to improve services and promote good practice.

- An audit of the screening process for referrals will be undertaken by the end of April 2012.
- The audit will include examining that referrals are signposted to Early Intervention and Prevention services and CAF
- The IMR will be disseminated along with the booklet about Pitfalls with practitioners and managers and discussed in team meetings
- The Service Manager Child Protection has been working with the Head of Children' Safeguarding Leicester City, Leicestershire and Rutland NHS to improve engagement with GP's within Child Protection multi-agency activity.

3.1.35 Health Agencies IMRs and the Health Overview Report

3.1.36 The purpose of the Health Overview report is to collate and draw together the information from the IMRs which have been undertaken by different health

agencies involved with Baby L and the family and provide an overview of the issues and lesson to be learnt for the Health community**.** The Health Overview Report has drawn together four IMR reports and one Information Report from EMAS (East Midlands Ambulance Service) as follows:

- Mental Health Services
- Midwifery Services and Accident and Emergency
- Health Visiting Service
- GP Practice

NB. A late request was made to NHS Direct to recheck their records and provide an Information Report as a contact was reported. This followed on from some additional information provided by MGM to the Overview Author about a telephone contact in the late summer. The entry has been added to the Integrated Chronology.

3.1.37 The Health IMRs provided good contextual information as well as information about the services that had been provided. The IMRs were robust in their scrutiny of the records and in pursuing their enquiries in staff interviews .The Health Overview Author followed up where matters needed further clarification with the IMR Authors.

3.1.38 The IMRs and the Health Overview report all provide useful references to research and explore the impact of the services on Baby L and Mother and consider what could have been done differently and how services could be improved in future.

3.1.39 ***Author's Comment:***

The Health Overview report and the IMRs all provide information about the community, the organisation, management and quality control systems and training.

The information was interesting but the issue of the role and capacity of the Health Visiting services and the relationship between the Health Visiting services and GP practices and individual GPs was the most relevant aspect in relation to Baby L.

The communication and information sharing including the record systems were the areas identified as of most concern. The particular issue that stands out was the lack of involvement by health colleagues with the Health Visiting Services in view of the young age of Baby L.

3.1.40 The information about Baby L recorded two routine checks where Baby L was seen by the GP and seven contacts by the Health Visiting service ,three at home and four in clinic. All contacts were universal routine contacts in line with "Children's Community Health Services, Health Visiting and School Nursing Healthy Child Programme Performance Indicators."

Baby L was not recorded as seen otherwise but all the health professionals recalled that Baby L had attended appointments with Mother and usually MGM present as well.

3.1.41 Mother was seen by different health professionals each time except the Therapist, who was the only professional, who was a consistent contact with two appointments and a number of telephone contacts.

3.1.42 The themes which are identified in the IMRs and the Health Overview report can be summed up as:

- Communication and effective information sharing between health professionals within the health community and with other agencies must improve.
- Health professionals must consider the needs of the child rather than focus on the adult /parent's needs in isolation, they must actively assess the impact of the adults parenting capacity on the care and welfare of the child.
- Health professionals must consider the impact on the child where there are concerns about the parent's mental health, domestic abuse and substance use

3.1.43 The GP IMR report, the Mental Health services IMR report and the Health Visiting IMR report all address the recording systems of the different professionals and the electronic SystmOne. They all conclude that the professionals, who had access to the system, did not record all the relevant information for example ; the GP, who discussed the need to refer to Children's Social Care with the Therapist following Mother's disclosure of domestic violence with Baby L present, did not record the discussion. A record of the discussion was made by the Therapist only.

3.1.44 The Health Visiting IMR highlighted the communication difficulties in relation to the use of SystmOne. Health Visitor contacts with the family of Baby L were recorded on the electronic child health record on SystmOne. The electronic record system was used by the GP practice with whom the family were registered. That GP practice had not approved a reciprocal share for medical records with the Health Visiting service. The Health Visitors therefore were not able to view the medical records of the people they were working with, but the GPs could view the Health Visitor records. The practice of reciprocal sharing of SystmOne records varies across the city, dependent on the GP practice involved, as some allow full access to the records. Where the access has been restricted this is explained as due to a difference in interpretations of the Data Protection Act 1998.

The SCR Panel concluded that in line with Working Together 2010 the concerns about a child should always override constraints about information sharing and if an agency is in doubt in any situation legal advice should be sought.

3.1.45 The GP records of the second consultation with Mother, which focused on Mother's mental health, had not been recorded to a good standard. On interview the locum GP recalled that Mother's mental health was assessed and treatment options were discussed and long term medication was prescribed. There was no record to demonstrate that the implications of potential post natal depression for Baby L had been considered. There was no follow up arranged to review progress with the prescribed anti-depressant medication and according to family information Mother only took it for a few days.

3.1.46 ***Author's Comment:***

The GP IMR commented that the GP, having been consulted by the Therapist, had signposted the Therapist to the Safeguarding team appropriately to discuss the disclosures by Mother of domestic violence and to discuss making a referral to Children's Social Care. The GP IMR Author and the Health Overview report do not clarify that the GP had an equal responsibility to assess the information and make a referral to Children's Social Care.

This was also the point where neither the GP nor the Therapist made any attempt to share the information with the Health Visitor.

3.1.47 The GP IMR raised the fact that GPs have identified increased difficulties in effective communication and case discussion with Health Visitors since they were relocated in 2007 away from GP practices in to community provision such as Children's Centres. The perception that it is difficult to communicate is based on a notion that it is difficult and time consuming to identify the correct Health Visitor to communicate with. The IMR Author concluded that this notion might have affected the consideration of the role of the Health Visitor in the case of Baby L.

3.1.48 The Health Visiting IMR concluded that their service was unaware of any risk factors during their work with Baby L and comments that "The assessment process has only meaning when all information is pooled together and allowed to contribute to an overall multi-dimensional picture. It is widely documented that "child abuse occurs at times of critical stress in the relationship of vulnerable parents" (Reder et al 2009). The importance of sharing information appropriately across agencies to support early intervention and safeguarding is crucial."

3.1.49 The Mental Health IMR clarified that the Therapist should have contacted the Health Visitor at the same time as the referral to Children's Social Care was made. It would seem logical that the Therapist and GP should have considered contacting the Health Visitor at the same time as they discussed referring to Children's Social Care in view of Baby L's young age.

3.1.50 The Therapist telephoned Children's Social Care to enquire how to send the referral and followed the call up with a faxed hand written multi agency form.

The Mental Health IMR considered the interagency procedures expectations about the referral process and feedback from Children's Social Care within the specified timescales. The IMR Author made clear that the Therapist should have sought feedback and not have accepted the report back by Mother only. The IMR Author notes the lessons as follows:

"The Biennial Analysis of Serious Case Reviews (2005-07) discussed the need for staff to remain objective and be able to clarify facts. Lord Laming (2003) in his report into the inquiry into the death of Victoria Climbié raises the concern of staff remaining "Respectfully uncertain" when working with families where the safeguarding of children is a concern."

3.1.51 The Health Overview Report made three additional recommendations to those made in the IMR reports. The IMRs had addressed the immediate service areas and the Health Overview reports additional recommendations widens the learning from this SCR to include learning and changes in procedures and practice across the GP services in the city. A report from sessions with Health Visitors and school nurses has been provided to the Review to evidence that the implementation of the recommendations is taking place. The recommendations are specific and clear timescales need to be set in the Integrated Action Plan to ensure that the changes are followed through to embed in practice. Progress should be reported back to the LSCB SCR Subgroup and any obstacles to implementing the changes in procedures and practice should be resolved through the LSCB system.

3.1.52 The Health Overview report demonstrated that the issues and recommendations raised have been gradually implemented in the course of the Review to ensure that the learning from this Review is acted on:

- The GP practices involved with this SCR have had updated child protection training including the need to 'Think child, think parent, think family 'a guide to working with parental mental health and child welfare. (SCIE Guidance 2009).

- The link between domestic abuse and violence and the welfare of children, especially vulnerable young infants, has been raised in the training. The need to consider the impact on the child has been reinforced.

- The two GP practices involved have updated their Child Protection policies and have Safeguarding Leads in place.

- The GP practice and the Link Health Visitor have recently reviewed communication as the health visiting team is based away from the surgery setting. The Link Health Visitor and the GP are now using the electronic patient record to send "tasks" or share key information, in addition to face to face communication and regular meetings.

- Learning from this Review has been incorporated in mandatory training across the GP and Health Visiting services particularly in relation to the

need to communicate and to consider the needs of the child when there are issues of mental health, domestic violence and substance use concerns in relation to a parent.

3.1.53 The IMR which addressed Midwifery services and the admission to the Emergency Department at the time of Baby L's death considered some lessons about the handling of such an emergency, which had not been explored fully in the Health Overview report.

3.1.54 The IMR noted that the Mental Health Care Pathway was not documented as having been followed as it should have been. This would have required a psychiatric assessment by the Deliberate Self Harm Team prior to Mother being discharged into police custody. Staff also became concerned as relatives were not allowed to see Baby L by the police.

3.1.55 ***Author's Comment:***

The UHL IMR report made a recommendation for the Emergency Department mental health procedures to be reviewed in light of this case. The Review should involve the police in a discussion about best practice for future cases where both agencies are involved.

3.2 Analysis by theme.

3.2.1 The Terms of Reference for this Review identified a number of themes to be examined:

- Hearing the voice of the child
- Thresholds and sign posting
- Domestic abuse, mental health issues, substance use
- Recording and Management oversight - procedures
- Information sharing –within agencies and between agencies

The themes have been considered in the IMRs, the Health Overview Report and the Information reports in relation to the specific agencies and have been addressed as such in the Analysis by Agency above.

3.2.2 The overview of all the information that has been made available to the Review including the SCR Panel discussions, which were minuted , and the contribution by the family members has led to some additional themes emerging which can be set out as:

- Assessment - understanding the impact on the child of a parental relationship crisis
- Challenging assumptions about 'supportive families' and safety
- Understanding and valuing different professional roles
- Commitment to a proactive collaborative safeguarding culture

A number of the themes are interlinked and the lessons are connected as the overall aim should be to promote better collaborative working to improve the outcomes for children and in particular to safeguard children more effectively in future.

3.2.3 **Hearing the voice of the child**

The recording by the Midwifery services and Health Visiting services provided the main information about Baby L, the care by and interactions with Mother, and general health and social development. As the professionals in these services were not approached at any time about the changing circumstances of the parents' relationship and therefore of the impact on Baby L, they were not in a position to fulfill their roles as the front line practitioners advocating on behalf of very young infants.

3.2.4 A number of other professionals were involved over a fairly short period of time from Baby L being three months old to seven months old, and no one professional considered contacting the Health Visiting service. The professionals involved were police officers, GPs, a therapist and social workers and Team managers. No system was in place to automatically alert Health Visiting to any changes as in this case there was no access to SystmOne for the relevant staff.

'The agencies were all acting within their immediate remits and failed 'to look at aspects of the children's needs outside of their own specific brief ' often referred to as 'silo practice'.(Brandon et al 2009)'

3.2.5 The family was asked by the Overview Author, if they had considered seeking help from any agency at any point. The answer was focused on contacting the GP in relation to Mother or the police in relation to Father. They had also contacted NHS Direct over a Bank holiday period as they perceived that the main problem was Mother's mental health as Mother had talked about thoughts of self-harm.

3.2.6 The family had not considered that the circumstances presented any risks to Baby L as they saw the problem as the concerns for Mother. They had not considered contacting a Health Visitor as they perceived that service as being concerned with practical matters of weight and immunisations rather than support for Mother and Baby L and a means of accessing other services.

3.2.7 The professionals, who came in to contact with the family and Baby L, were also focused on the behaviour and presentation of the adults. The child's voice was not heard as the impact on Baby L of what was happening to the adults was not being assessed in a multi- agency holistic way by anyone. Baby L was observed to look well cared for and the home surroundings were interpreted positively by individual agencies, the police for example.

3.2.8 The Therapist was concerned for Baby L's welfare in relation to the reported domestic violence and Baby L being held during one incident. The Therapist was also worried as it seemed that Mother had left Baby L unattended for a

period of time during a panic attack. As a result a referral to Children's Social Care was made but the Therapist did not follow the action through by checking the outcome. The GP, who discussed the case with the Therapist, did not make a referral although the GP had the same responsibilities to Baby L as the Therapist.

3.2.9 ***Author's Comment:***

Considering a study called 'The Child, The Family and The GP: Tensions and conflicts of interest in safeguarding children'; H.Tompsett et al (April 2009 Dcsf) which aimed initially to 'investigate potential 'conflicts of interest 'where parents and children were both patients of the GP and to identify strategies for managing these conflicts, we can note one of the conclusions of the study that:

GP participation in the Safeguarding agenda must be addressed not only in terms of training and awareness raising but in terms of accountability and the responsibility to share information and make referrals where there are concerns about the welfare of children**.**

3.2.10 **Challenging assumptions about 'supportive families' and safety**

The records in the agencies describe the home of Baby L and the family and the maternal grandparent's home as comfortable, well cared for and well equipped. The material family circumstances and the status of the parents as employed and with a comfortable lifestyle appear to have influenced the professionals to view the background situation too positively and without challenge.

3.2.11 The Children's Social Care records and staff interviews reveal that the family was assumed to be 'safe ' and supportive .The fact that Mother was, at the time she was spoken to by the social worker, in the maternal grandparents home and talking about the relationship being over, was accepted without challenge.

3.2.12 Mother's actions to call the police and the maternal grandparents for support whenever it was needed was also interpreted as a 'strength '.Mother's version of events and the information volunteered was accepted without checking it out with other professionals ,who had been involved.

3.2.13 The fact that Mother's requests for support were inconsistent was not picked up by the professionals as the professionals were different each time with the exception of the Therapist, who saw Mother on more than one occasion. Mother fluctuated between asking for help and then declining involvement, for example with Children's Social Care. Both Father and Maternal grandmother described Mother as "having good days and bad days".

3.2.14 The close knit family system was seen as a safety net when in fact it may have hindered Mother from sharing information .The crisis brought on by

Father's relationship with another woman and the birth of Half sibling was not only a crisis for Mother alone but for the whole family system due to the social and work ties among the adults.

3.2.15 The intervention, that an Initial Assessment would have brought about, in line with the dimensions of the Assessment Framework for Children in Need (2000) ,would have opened up the information across the agencies in partnership with the family and with a focus on Baby L's welfare in the middle of the adult crisis .

3.2.16 **Domestic abuse, mental health issues, substance use - assessments**

The presence of a cluster of problems was hinted at in the information that had been recorded in the different agencies in relation to Mother and Father in the three missed opportunities identified:

- A serious relationship breakdown in the marriage with distressed behaviour by both parents
- Father being found with alcohol, cannabis, tablets and weapons by police call out
- Two specified incidents of domestic violence reported by Mother to the Therapist
- Baby L being present at one of the domestic violence incidents
- Mother seeking mental health support with anxiety, panic attacks, depressed thoughts
- Mother reporting cannabis use and alcohol use to 'relax'
- The Therapists concerns that Baby L may have been left alone during a panic attack

This accumulated information was present in the police referral notification and in the Therapists multi agency referral form, which were provided to Children's Social Care.

3.2.17 The response to the referral from the Therapist by Children's Social Care focused on the information about the reported domestic violence and the breakdown of the marriage. Some of the information in the referrals was missed and no attempts were made to question or verify any of the information by talking to the other professionals involved with Baby L and the parents. No attempt was made to check Mother's assertion that the maternal grandparents were able to offer long term support.

3.2.18 An exploration of research studies around the world into parents killing their children and in particular filicide combined with suicide called "The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness; Centre for Suicide Prevention'' (the University of Manchester June 2009) reveals that there are some common themes that emerge from the studies.

The themes which emerge are that

- mothers are more likely to kill an infant and then attempt suicide
- a history of domestic abuse including controlling behaviour

- times of separation after relationship breakdown are high risk
- contact arrangement disputes are high risk
- the presence of mental health problems, particularly depression, is high risk
- the presence of alcohol and/or substance use/misuse is a high risk

The research literature has not agreed a definition of filicide –suicide but it is usually a biological parent killing a child or children and then attempting to kill themselves sometimes for altruistic motives and sometimes for revenge.

The study also notes that:

'International research consistently reports that infants are at greater risk of filicide than children in other age groups, with infants being particularly vulnerable to maternal filicide in the first few months of their lives. The first few months following childbirth is an important time for intervention, with the health professional's active involvement with new mothers.'

The study adds:

'With the Infanticide Act 1922 amended in 1938, English law took into account the unique mitigating circumstances which differentiate this act from other killings. In this context, infanticide applies only to women who have killed their own child as a consequence of the effects of childbirth. It is not possible, therefore, for a man to be charged with infanticide.'

The most common cause of death for neonates is suffocation (27%), drowning (22%) and exposure (14%) (Crittenden & Craig, 1990).

The study quotes a distinction in the risk profile between cases where the parent also attempts to harm themselves:

'Whilst personal attachment towards family members, marriage and parenthood are usually protective factors for suicide, this is not the case in filicide-suicides (Friedman, 2008; Gross, 2008). Therefore the risk profile for filicide-suicide and suicide is different.'

3.2.19 At the time of the referrals to Children's Social Care there had been no concerns by any agency that Mother presented a risk of harm to Baby L and Mother had not made any threats to harm Baby L .The concerns had been interpreted as domestic violence incidents.

3.2.20 Mother had however revealed thoughts of self-harm to the Therapist. The call by maternal grandmother to NHS Direct around this same time, where Mother also spoke to the NHS Direct staff, referred to Mother having discussed similar thoughts with her family, who were said to have dissuaded her. During this call Mother also said she occasionally used cannabis.

3.2.21 The professionals involved did not combine the various strands of concerns and assess the interaction between these strands on Mother and her capacity to safely parent Baby L and put Baby L's needs first.

3.2.22 The effects on Mother's emotional capacity to care for Baby L with the uncertainty of the future for them, given Father's other relationship and the new child there, was not taken in to account in any assessments made by the professionals. The extent of the impact of Father's actions on the family had not been recognised and was not assessed in relation to Baby L's welfare.

Author's comment:

If an Initial Assessment based on the interactions of the three dimensions of the Assessment Framework (2000) had been carried out and had involved the core agencies and the extended family the outcome for Baby L could have been different.

The LSCB Interagency procedures for Domestic Abuse /Violence (Chapter 5.12 Section 6 Referral to Children's Social Care) should have been considered as Baby L had been present and there had been several contacts. The chapter states:

"Normally, one serious or several lesser incidents of domestic violence where there is a child in the household means that Children's Services should carry out an Initial Assessment of the child and family, including consulting existing records."

An assessment would have uncovered the information noted above and, although the family and Mother had not been forthcoming, it is very probable that more information would have been available from the family and Mother, if they had been supported to understand that the focus of the services was the welfare of Baby L.

The circumstances may have been best dealt with through a Family Group Conference format to support the extended family to resolve some of the issues alongside services being provided to Mother and Baby L.

3.2.23 **The referral process –thresholds, recording, supervision, professional roles and information sharing**

The Leicester Safeguarding Children Board inter agency procedures set out clear expectations of how referrals should be made, responded to and recorded by all agencies. A multi-agency referral form is used by professionals to make referrals which are either faxed or emailed. The form should be filled in clearly and contain as much of the requested information as possible but should not be delayed if information is not known.

3.2.24 The procedures are quite explicit that Children's Social Care should acknowledge receipt of the referral within one working day and, if this is not done, the referrer is expected to query what has taken place within three working days. (See para.2.4.37 above for a copy of the procedure).

3.2.25 The IMRs identified that there were a number of issues in the different agencies around the referral process which reflect different agency perspectives on the roles and responsibilities in the process as well as the perennial question 'when is it a referral or a contact or 'for information'?

3.2.26 When the Therapist sought advice from the GP, the GP advised the Therapist to make the referral to Children's Social Care and to consult with a named or designated member of the Health Safeguarding team. The Therapist was only able to speak to the Health Safeguarding team Administrator about how to proceed rather than to have a consultation with a named /designated professional. The referral was then made some days later. This was not good practice as the delays might have made a difference and the interagency procedures are clear about avoiding delay.

3.2.27 The GP practice was also responsible for Baby L and the GP could have made the referral rather than delegate it to the Therapist or they could both have made a referral. The GP would have had other information to be shared as well as the information from Mother to the Therapist.

3.2.28 The response to the referral in Children's Social Care has been acknowledged as poor practice as information was missed and past history was not accessed. The question that arises is whether the Social Care staff did not give the information from the Therapist the weight that they should have done, particularly as they failed to identify the mental health aspects.

3.2.29 Interagency working requires the different practitioners across the agencies to have an understanding of each other's roles and responsibilities and to respect each other's professional knowledge and judgment in any specialism. Different roles and remits should not raise barriers to working together but rather combine the specialist knowledge and perspective that the different practitioners bring to the task of safeguarding to improve the response to children.

3.2.30 Interagency training is the traditional route for learning about other practitioners and agencies and exploring roles and responsibilities. In many agencies the training in safeguarding has more recently been provided on a single agency basis for reasons of cost in releasing staff, which does not have the same effective impact on learning about colleagues and agencies.

3.2.31 Training is one mechanism for learning and other ways of understanding the roles and responsibilities can be covered through good line management and good professional supervision processes.

3.2.32 The police decision making in this case was well recorded and assessed through the line management structure. The decision to send a notification to Children's Social Care was made as the police considered that Baby L's future care might be impacted on by the parents' relationship breakdown.

3.2.33 The police, the GP and the Therapist all passed on information and concerns relating to Baby L as referrals and 'for information' but none of the referrers had a conversation with Children's Social Care to follow up the information or query the outcome as expected by the interagency procedures. This begs the question about the commitment to working together in collaboration to safeguard children as the professionals appear to have ended their involvement in the process by passing information on to Children's Social Care expecting this agency to take over the responsibility for Baby L's welfare.

3.2.34 The SCR Review reveals a process where the interactions between the various professionals have been minimal. It is particularly concerning as no one within the health community or from the other agencies made any attempt to communicate with the Health Visiting service, which was the primary front line service for Baby L.

Working Together (2010) is clear that "to achieve good outcomes for children all professionals with responsibility for provision of services and assessment must work together according to an agreed plan of action".

3.3 Analysis of the Review process and Family involvement

3.3.1 The review process has been managed within the time frame expected by Working Together 2010 and the Panel meetings have been quite well attended .The administration of the Review by the Safeguarding Business unit has been excellent with the Manager and Policy Officer working closely with the Independent Chair to chase up authors and distribute the documentation. Templates were in place and were used by all agencies. An Administrator kept minutes of meetings and organised correspondence and documents.

3.3.2 The discussions in the Panel meetings were helpful in order to clarify issues and request additional information. The additional member of the Panel acting as an Advisor with a specialism in relation to substance use and mental health issues was very helpful and allowed the Panel to reflect on the case and improved the learning process of the Review.

3.3.3 The agreement by the Police and the Corners Office to give the go ahead to speak to the family was helpful and has added to the learning of the Serious Case Review. It was not possible to speak to Mother in view of her health but she was informed of the process and offered the opportunity to contribute.

3.3.4 The contribution from Father and maternal grandparents enhanced the process as it allowed the Panel to understand their reasoning better when trying to deal with the family crisis.

3.3.5 The learning for the agencies is partly about how families in the community perceive where they might get help from in a crisis. When the problem was seen by them to be about domestic abuse they viewed the police as the relevant agency, whereas when they thought it was mental health, the GP and NHS Direct was the point of reference.

3.3.6 The family had not considered Health Visiting as a service that might help them partly because they had not defined the problem as primarily related to Baby L. Mother was the focus. Their view of health visiting was limited to practical tasks rather than a support service to Mother as well.

3.3.7 The family had not considered asking for support from Children's Social Care and Mother was reluctant for a referral to be made to them by the Therapist. The maternal grandparents reflected the view that Children's Social Care's main function was to remove children from their families where there was abuse. They did not have an expectation that Mother and Baby L could have received help from them.

3.4 Summary and conclusions

3.4.1 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.

3.4.2 Mother had no previous history of mental health problems and this was the first child. There was no known reported previous history of cannabis use and the Review has not been able to determine the extent of the cannabis use as the only person to answer the question would have been Mother. There was no evidence of extensive cannabis use as, during the period that Mother was staying with maternal grandparents, they had not noted any. Father explained that the use was 'medicinal' to help Mother with the panic attacks.

3.4.3 The early period of Baby L's life, the first three months, was uneventful and Baby L made good progress. All interactions between Baby L and Mother were observed and recorded by the Midwifery services, the GP and the Health Visiting services. The observations were positive and all milestones were met.

3.4.4 The crisis in the early summer, which fundamentally changed the family, was the turning point. In view of the information, that has been available to this Review about agency involvement, it is clear that there were three missed opportunities when services should have been provided, which might have prevented Baby L's death:

- The first police call out to Father being found on the landing with various weapons and the referral to Children's Social Care
- The visit to the GP when the referral was made to the Therapist for mental health concerns with anxiety and panic attacks
- The referral to Children's Social Care by the Therapist and the referral from the police in relation to the third call out

3.4.5 The three missed opportunities identified in the Review should have led to involvement by Health Visiting services and Children's Social Care services. The involvement of the Health Visiting services could have come by several different routes:

- The SystmOne information system should have been available to the Health Visiting service.
- The GP should have consulted with the Health Visitor in question.
- The Therapist should have informed the Health Visitor.
- NHS Direct should have informed the Health Visitor.
- Children's Social Care should have liaised with the Health Visitor in connection with each referral.
- If Children's Social Care had considered Early Intervention and a CAF they would have contacted the Health Visitor.
- If Children's Social Care had considered an Initial Assessment in line with the LSCB Domestic Violence procedures, they would have contacted the Health Visitor.

3.4.6 If the Health Visiting service had been informed they would have had to review their provision of service to Baby L, which was in the category of 'universal services' as that was the need that had been assessed in the first three months of Baby L's life. In view of the information available from the Therapist it is probable that the category of service would have changed. The Health Visitor would have engaged with Mother and Baby L more proactively as a targeted service and would have consulted with Children's Social Care.

3.4.7 The involvement of all the agencies should have been more comprehensive in the assessment of Baby L's experience as the information about domestic violence, mental health issues and cannabis together with the fact that Mother and Baby L were moving between households should have been combined. The impact on Mother's capacity to meet Baby L's needs should have been considered.

3.4.8 The policies and procedures for making Referrals to Children's Social Care, to the Think Family /Whole Family approach, which includes chapters about mental health and substance use issues, and the Domestic Abuse/Violence chapter, are all in place in the Leicester Safeguarding Children Board interagency procedures. The evidence in this Review is that the various agencies did not follow the policies and procedures in the referral stages. Even when a referral was made it was not followed up to check that it had been received and acted on. Children's Social Care did not send out acknowledgments of referrals as required.

3.4.9 Assessments about the needs of Baby L were made by the police when they passed on the information to Children's Social Care as referrals stating that 'there was no further role for their agency'. The assessments were based on the presenting information from the call outs to the family. Given the vulnerability of Baby L due to the young age the police should have followed the referrals up with a check with Children's Social Care to ensure that the referral had been assessed. There may not have been a crime committed or a direct role for police investigations but there was a joint responsibility in relation to child protection for Baby L's welfare. If the police had decided that this was a referral for Children's Social Care to undertake an assessment as a

single agency assessment then it would have been good practice for that decision to have been taken jointly.

3.4.10 The assessment of the referral from the Therapist by Children's Social Care was seriously flawed as information had been missed and previous contacts were not taken in to account. The social worker and Team manager did not make contact with the referrer and no checks were undertaken with any other agencies. As a result the decision to speak to Mother in a phone call meant that Baby L was never seen by Children's Social Care.

3.4.11 Having accepted Mother's refusal for a service the case was closed by sending out some domestic violence information and no other agency was informed. The fact that Mother was reluctant to accept any service and had expressed a fear, as evidenced in the Therapists referral, of Father's reaction of anger, should have led the social worker to reassess the risks and safety for Baby L. At this point the social worker should have shared the information with the Health Visitor and the Therapist as the original referrer.

3.4.12 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. 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.

4. LEARNING

4.1 Lessons to be learnt

4.1.1 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 .

4.1.2 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.

4.1.3 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.

4.1.4 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.

4.1.5 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.

4.1.6 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.

4.1.7 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?

4.1.8 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.

4.1.9 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.

4.1.10 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.

4.2 Implementation of learning

4.2.1 All the IMRs have provided evidence in the reports of actions taken in response to their recommendations. The learning, where actions are planned, such as audits, is set against clear timescales.

4.2.2 The Overview Author has noted that learning from previous local Serious Case Reviews, such as Child A and Child R, is in evidence in this Review. The police have demonstrated learning in record keeping, supervision and decision making as well as in recording details of the presence of the child.

4.2.3 The CCG GP Safeguarding Lead and the Nurse Consultant / Designated Lead for Safeguarding Children and Adults have embarked on work with Health Visitors, School Nurses and GPs in session across the city .The notes from the sessions have been made available to the SCR Panel and demonstrate good progress and a willingness to learn from the Reviews. The

use of the information system SystmOne has been addressed with the specific GP Practice and the Heath Visitors and other mechanisms to work together have also been put in place, for example, regular meetings and clinical supervision sessions.

4.2.4 Each agency is required to provide feedback from the IMR and the Serious Case Review process to the personnel specifically involved in the case. The dissemination of the key learning will be targeted to the staff and managers in all the member agencies of the Leicester Safeguarding Children Board. Reports will be published on the LSCB website.

5. RECOMMENDATIONS and ACTION PLAN

5.1 Recommendations by the Overview Author

5.1.1 The recommendations from the Individual Management Reviews and Health Overview Report are set out in the Appendices below. The recommendations by the Overview Author are intended to compliment the recommendations in the IMRs and HOR and to address the agencies collectively. The intention is to improve interagency work to safeguard children and promote their welfare in the city.

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 .

5.2 Progressing Recommendations and dissemination of learning

5.2.1 As the Commissioner of the Serious Case Review, the SCR Sub Group will monitor the resulting Action Plan. At its monthly meeting, progress will be monitored with colleagues from the key agencies represented on the group.

5.2.2 Dissemination of the learning will be achieved by a number of means:

- Any future relevant inter-agency Training and Learning content will incorporate the learning from this case.
- Two half day workshops for multi-agency groups will take place in September 2012 to disseminate the findings.
- The key messages will be shared with partners at a full Board meeting, with the expectation that Safeguarding Leads will then disseminate these messages within their own agencies/organisations.
- Key learning will feature in the LSCB's own 2 monthly Research Digest of the safeguarding messages that are most relevant to the range of

disciplines covered by the Board. Briefing packs will be made available to Safeguarding Leads to assist in the sharing of key messages.

- The learning will be shared with County colleagues at a range of joint business meetings (Procedures and Development sub group LLR, the Joint City and County SCR sub group, etc)
- The learning will be shared with colleagues in Adult Services via the mutual attendance on each other's SCR sub groups and Board meetings.
- The LSCB website will feature the report outcomes on its "Latest News" section and also on its "Information for Practitioners" section.
- The Procedures and Development sub group LLR will consider whether any amendments/additions are required to LSCB procedures in the light of the learning from the case.
- Local media will be used as part of the publication process to highlight key issues.

5.3 The Integrated Action Plan

5.3.1 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.

5.3.2 Each agency and the Lead for an action are expected to report regularly to the Safeguarding Business Unit Policy Officer and to provide evidence for the records to confirm progress and completion.

5.3.3 The Policy Officer informs the Serious Case Review Sub group regularly of the progress of an Action Plan and all completed actions are referred on to the Safeguarding Effectiveness Group (SEG).

5.3.4 The task of SEG is to evaluate the impact and effectiveness of the implemented recommendation/action. The evaluation may take the form of an audit, single or interagency, or a Questionnaire involving the relevant practitioners and service users. SEG will consider, if the implementation has met the original aims and achieved the intended outcome. The LSCB will therefore be able to track progress and address the learning from Serious Case Reviews.

The Integrated Action Plan is contained in Appendix 2.

Birgitta Lundberg
Independent Overview Author
June 2012.

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