Leicester Safeguarding Children Board

SERIOUS CASE REVIEW IN RESPECT OF CHILD R

Date of birth: 2010
Date of death: 2011, aged 10 months

Ethnic Origin: Dual Heritage

EXECUTIVE SUMMARY

January 2012

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1. Introduction

1.1 This is a summary of a Serious Case Review undertaken by Leicester Safeguarding Children Board (LSCB) following the death in 2011 of Child R aged 10 months. The decision to proceed with a Review was taken in July 2011 by the Independent Chair of Leicester Safeguarding Children Board, Dr. David N. Jones.

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

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

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

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

1.5 Mother and step Grandmother have contributed to the Review process. Family members were invited to participate in the process and Mother and maternal step Grandmother were able to meet with the Overview Author.

In view of the ongoing criminal processes a Police Family Liaison Officer was present and the conversation explored what lessons the family thought might be learnt from the review.

1.6 Mother's partner has been arrested on suspicion of murder. Conditional Police Bail has been set and a criminal investigation is in progress.

1.7 Information in this report has been anonymised to protect the privacy of family members including references to the gender of children and the subject children are referred to as Child R and Sibling.

2. The Reasons for the Serious Case Review

2.1 On a weekday morning in 2011 Child R was living with Sibling, who was just over two years old, and Mother in a two bed roomed end terrace house, which had been described as 'without carpets, dirty and untidy and with limited food in the house'. Mother's partner had moved in to live with them 5 weeks earlier having started a relationship with Mother some months earlier.

2.2 Mother had started a college Learn Direct literacy and numeracy course which she attended daily. Mother's partner looked after Child R and Sibling while Mother went out. That day Mother phoned at 12.16pm to say that she was going to meet a male friend for lunch and then come home.

2.3 At 12.51pm a 999 call was received by the East Midlands Ambulance Service (EMAS) for a 10 month old baby who was reported to have 'gone limp and had difficulty in breathing'. The caller was a male, who identified himself as the step father of Child R. A Community Paramedic and a Double Crew Ambulance were immediately dispatched to the address.

2.4 Child R was reported on examination at the Accident and Emergency department to have multiple injuries as follows:

- Fractured left clavicle
- Bruising to head, neck and ear
- Multiple Intra Retinal haemorrhages to both eyes
- 2 head injuries resulting in brain bleed
- Cardiac arrest

2.5 Child R was pronounced dead in the afternoon the following day.

2.6 The Police and Children's Services were informed by the local emergency Hospital Safeguarding team of the circumstances shortly after the emergency admission and action was taken to safeguard Sibling, who was being cared for initially by members of the maternal extended family. A Section 47 Enquiry was started in relation to Sibling including a child protection medical assessment. Sibling was placed in a foster placement under Section 20 of the Children Act 1989 with Mother's agreement and was then moved to be cared for by Maternal Grandfather and his partner at the end of August 2011.

2.7 Two days after the death of Child R an Interim Care Order was granted to the Local Authority in respect of Sibling and an Initial Child Protection Conference was held within fifteen working days. Although Sibling was not made the subject of a Child Protection Plan as the Care proceedings process offered protection, the Child Protection Conference made recommendations for further assessments and in particular a comprehensive assessment of Mother's parenting capacity.

2.8 At the time of the events leading to the death of Child R, the two children were receiving universal services from the Health Visiting service and the

GP service. They were not subjects of Child Protection Plans or Care proceedings and had never been prior to the death of Child R.

2.9 The Children's Services Duty and Assessment Service (DAS) had closed an Initial Assessment four days earlier following two referrals during the previous two months by the East Midlands Ambulance Service (EMAS). The referrals had arisen after Sibling had been taken to the Accident and Emergency department by ambulance in connection with injuries and the Paramedic staff had reported serious concerns about the conditions in the home. The referrals were made through the EMAS Safeguarding Referral Line, who referred to Children's Services.

3. The Serious Case Review Process

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

3.2 The scope of the Review included consideration of the Leicester Safeguarding Children Board Interagency Child Protection Procedures and covered information about Child R, Sibling and the significant adults in the children's lives e.g Mother, Birth Father and Mother's Partner. Information about the extended family was referred to where relevant to the Review and in order to understand the historical context of the children's family.

3.3 The timeframe of the Review covered information between the dates of January 2008 and August 2011 specifically. Historical information could be included if the SCR Panel determined that it was relevant to the Review.

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

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

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

3.7 The LSCB expected all agencies to undertake their IMRs within the timeframe and in line with the local procedures .The SCR Panel monitored progress and performed a quality assurance role in relation to the individual management reviews and their progress.

3.8 All agencies were expected to address any findings which highlighted an urgent need to make changes, whether to policies and procedures or to practice. All agencies were clear that they should not wait until the review process had ended, if there was a need to intervene and make changes to improve services.

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

3.10 The Terms of Reference were set out as follows:

1. In relation to the care of the children:

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 were the children seen by the professionals involved?

b) Was this frequently enough?

c) In view of the ages of the children, was it possible to ascertain their views and feelings? If so, how were the children’s views and feelings ascertained? How were their views and wishes recorded?

d) Identify the adults who tried to speak on behalf of the children 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 children

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 children becoming overlooked?

3. In relation to Thresholds and Signposting:

a) To what extent were the 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 Domestic Violence in relation to any of the family members? If so, what was the response to this?

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

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

6. 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?

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

8. To what extent was the exchange of information appropriate, sufficient and effective:

a) within the agency/organisation?

b) between the agency/organisation and other partner agencies/organisations?

9. To what extent was the standard of recording appropriate, sufficient and effective:

a) within the agency/organisation

b) between the agency/organisation and other partner agencies/organisations?

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

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

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

3.12 A series of SCR Panel meetings took place between August 2011 and January 2012 in order to progress the Review.

4. The Family Background

4.1 The family all live in the area of Leicester except Birth Father's family, who live in the London area. Birth Father also has links in the West Country. The maternal family members are in contact with one another on a regular basis and the information in records and from the family describes relationships as supportive but sometimes 'volatile' when disagreements occur. Mother reported that Maternal Grandfather and his family, which includes two step siblings, were in regular contact at weekends often caring for Sibling and Child R.

4.2 The ethnicity of Child R and Sibling was recorded as 'dual heritage'; Birth Father is recorded as Black Caribbean and Mother as White British.
Mother's partner who lived in the household at the time of the death of Child R was recorded as White British.

4.3 There were no records indicating a religious affiliation for the family members.

4.4 Mother and the children lived in a two bedroom house in a Social Housing Scheme tenancy in a predominantly white working class area of the city. There were accessible community resources, such as shops and libraries .Children's Centres were located in the area as well as Community Centres.

4.5 Child R and Sibling were not recorded as attending any community resources other than the Health Visiting clinic at a Children's Centre. Mother had not felt that any support services had been needed other than assistance with applications for financial support such as charity applications for new carpets.

4.6 Child R was described in records and by Mother and step maternal Grandmother as 'a contented baby, who was developing well'.

4.7 Sibling is described in his current placement as a lively and friendly two year old, happy to sit and draw and talk about the activity. Sibling has settled well with maternal Grandfather.

4.8 Mother experienced an unsettled childhood with many changes of carers and schools. Her parents separated when she was very young and between 1990 and 2006 Mother and her siblings were subject of a range of concerns from neglect, alcohol and drug misuse, domestic violence and non school attendance. At one point Mother was reported to have been struck by her own mother, maternal Grandmother, but the complaint was withdrawn.

4.9 Birth Father, who is the biological father of both Child R and Sibling, had a history with domestic violence offences in 2007 against a previous partner.

There were no children in that relationship. Birth Father and Mother had a relationship that fluctuated but in reality he lived with Mother for the period from the pregnancy and birth of Sibling in 2008 to December 2010.

4.10 There was a dispute about the paternity of Child R as Mother was unsure of who the father was .A DNA test has confirmed paternity as Birth Father. Birth Father was not referred to in depth in any records, except the Probation IMR, although he is noted as being present with Mother and Sibling on several occasions in other agency records. The few descriptions there were report that he interacted well with Sibling and Child R. Mother reported to the Overview Author that he was a 'good father' when Sibling was a baby but as Sibling became older treated Sibling more as a 'friend rather than a child.'

4.11 Mother's partner who had joined the household five weeks prior to the death of Child R has no known history of any significance and he was referred to by Mother as a friend. Maternal step Grandmother commented that the family had felt that he had 'been immature' and had moved in to the household very quickly. The family had not picked up any signs of concern and had thought that he seemed to have a good relationship with the children.

5. Summary and conclusions of the Integrated Chronology

5.1 By merging all the known contacts provided in the IMRs into the Integrated Chronology, it has been possible to get an overview of the involvement of the different agencies with the children and the significant adults. A picture emerges of a vulnerable young Mother, who is struggling to meet the needs of the children in relation to basic routines and safe caring. The environment when Birth Father was present appears to have been more settled for the children in terms of basic routines and care. However, the

reports of ‘domestic incidents or noise disturbances’ and Mother’s own account of the relationship indicate that there were many arguments and fights involving physical violence between Mother and Birth Father.

5.2 There were repeated references in the records of requests for financial assistance with furnishings such as carpets and at the same time all the agencies noted the deteriorating conditions of the home but no one considered the impact on the children of the signs of neglect.

5.3 It becomes apparent that there were a number of missed opportunities for the agencies to share information and work collaboratively to assess the needs of the children and promote their welfare through consultation, referral and/or Assessments:

- The referral in 2008 from Probation in relation to risks of domestic violence by Birth Father should have led to a pre Birth Assessment meeting between the relevant agencies to draw up a Care Plan for the birth of Sibling.
- The Initial Assessment by Children’s Services and the involvement by Health Visiting were focussed on the accommodation issues rather than Sibling.
- The joint homevisit late April 2009 by the Student Social Worker and the Health Visitor should have led to a review of the risks in relation to the domestic violence information about Birth Father, which would have led to sharing information with the police.
- The police should have referred the domestic violence report in early May by Mother and checked with Children’s Services. Information sharing between the agencies at this point would have led to a better informed assessment of the impact on Sibling of the care by Mother and Birth Father.
- At the point of closing the case of Sibling in early July 2009 when Sibling was 4 months old Children’s Services should have updated all

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agency checks and reviewed the case. The Student Social Worker transfer summary concerns about the domestic violence assessment should have been addressed.

- Mother presented on three occasions at the GP surgery to be treated for 'post natal depression'. The Patient Health Questionnaire scale to measure depression was used and treatment prescribed. There was no consultation or information sharing across the health agencies about the impact on Mother's capacity to care for Sibling.
- There were two domestic violence call outs to the Police in November 2009 leading to a Harassment Warning being administered to Birth Father in late December 2009. There was no information sharing with other agencies although, at this time, Mother was reported to be pregnant again.
- Child R was born in August 2010 and no pre Birth Assessment was undertaken although Birth Father was still present in the household, the paternity was uncertain and the domestic violence risks had not been addressed. Children's Services were not aware of the birth as no referral had been made by the GP or Midwifery/Maternity services.
- In August and September 2010 the Health Visiting Service noted the 'lack of carpets and uneven floor' as a concern and did not consult about the information from Mother about 'leaving Birth Father 'or consider the impact on Sibling and the newborn Child R.
- In December 2010 there were call outs by Mother to the police on two consecutive days in relation to the relationship with Birth Father ending. As previously noted this was the risk factor in relation to the domestic violence behaviour by Birth Father in the past. A referral should have been made to Children's Services and agency checks should have been undertaken.
- The homevisit in January 2011 by the Health Visiting Nursery Nurse was a point at which a referral should have been made to Children's Services as there were signs of neglect including a drop in the weight

of Child R. This was a missed opportunity to assess Mother's parenting capacity either through a CAF or a Core Assessment.

- During May and June 2011 there were increasing concerns about the state of the home and the impact on the children. The neglect described in records was not recognised as such and agencies failed to work together to pool information to promote the welfare of the children.
- The two presentations in the A and E department of Sibling with head injuries were dealt with without considering the wider implications about the care being provided to two very young children by Mother except by EMAS, who made safeguarding referrals appropriately. It was a missed opportunity by Children's Services that the assessment that followed the first referral was not followed up fully and the second referral was lost.
- If the agencies had been more probing and proactive in their assessment of Mother at this point the presence of Mother's partner would have become known. The fact that Mother was attending a course leaving the children in his care would have been considered.

5.4 Collectively the agencies failed to focus on the children's needs as the main issues which were addressed related to accommodation and the state of the home. The impact on the children's lives was missed. The significance of Mother's own background history and its impact on her capacity to safeguard the children was never addressed as the assessments that took place focussed on accommodation and the relationship with Birth Father, although the threat of domestic violence by him was never fully explored. As information was not shared collaboratively in the weeks prior to Child R's death the presence of Mother's partner was not recognised or the fact that he was left to care for the children while Mother attended the Learning course.

6. The Conclusions of the Independent Overview Report

6.1 In light of all the evidence available to this Review the SCR Panel and Overview Author agreed that the death of Child R could not have been predicted or prevented. There were no signs of danger in relation to Mother's partner; there was no record of previous convictions; no soft intelligence and no reports by other women about any domestic violence. The family members according to SMGF had not picked up any warning signs. The school record of Mother's partner did not indicate any signs of violence apart from one incident in school as a teenager but that was not a major incident. In short, there were no warning signs and Mother's partner had only been in the household for 5 weeks prior to the event.

6.2 Having considered the information available to this Review it was, however, predictable that Child R and Sibling would need additional services as Children in Need during their childhood. Mother's capacity to meet their needs, socially, emotionally and developmentally without extensive support was doubtful .It is unclear if Mother would have been able to put the children's needs before those of her own to cooperate with such services. The children would have remained vulnerable to persons posing a risk to children as Mother was willing to allow a range of people to look after them. In many ways, in view of her own background history and pattern of casual relationships Mother remains vulnerable to risky adults herself.

6.3 There would have been services in place for the children and the family, if referrals been made and acted on when they should have been, for example, in January 2011 or following the presentations to the A and E department of Sibling. We can only speculate whether the presence of regular services input and contacts by professionals would have served as a deterrent to Mother's partner.

6.4 The Review of the tragic death of Child R was asked to consider a range of questions in the Terms of Reference about the services provided to Child R and Sibling. The Individual Management Reviews, the Health Overview Report and the Independent Overview Report examined the information and assessed it with reference to national legislation and guidance and to the local Leicester City, Leicestershire and Rutland Safeguarding Children Board Interagency Child Protection Procedures.

6.5 The Overview Author concluded that there were a number of missed opportunities to provide services to Child R and Sibling and to assess their needs in a multi agency format. Services could have been provided to promote the welfare of both children on a number of occasions. For example, pre Birth assessments to plan and prepare for their births and subsequent care might have safeguarded them from the impact of neglect, such as Sibling's delayed speech development. If services had been provided to support the family it could have made the children less vulnerable to being left with unsafe carers,

6.6 Although a pre-birth assessment would not necessarily have led to services over a long period of time, a good assessment would have provided the base for future interventions by providing background information and assessing the parenting capacity of Mother and Birth Father thus setting the scene for addressing the children's needs in the future.

6.7 In order to undertake good assessments agencies must share information and work together as stated:

"Effective information sharing is key to delivering better, more efficient services co-ordinated around the needs of children, young people and

families. Building understanding and confidence in information sharing is essential to support early intervention and preventative work as well as for safeguarding children and promoting their welfare. Most decisions to share information require professional judgement .Practitioners must feel confident about when and how information can be shared legally and professionally, and that they will have the support of their managers and organisations."

The Governments Response to Lord Laming: The protection of children in England; an action plan, May 2009 (62.page7)

6.8 Information sharing had not been effective in this case and it was noticeable that all agencies had been remiss in undertaking checks with other agencies or in undertaking checks within their own agency. The purpose of undertaking 'agency checks ' is to establish, which agencies are involved with a child, to confirm and share information and to proceed to plan any services and interventions jointly.

6.9 It should be standard practice to check any record / information systems in all agencies for background history of a child and relevant adults to ensure that needs are assessed and services are provided based on full and accurate information.

6.10 The evidence in the IMRs of a child centred service is weak. The Health Visitors, who provided services to both the children, had noted all the routine developmental checks and services to the children. They had recorded some comments about the conditions in the home and had focussed on exploring practical solutions with Mother. The aspect that was missing was an assessment, with conclusions, about the impact on the children of the environment they were living in. A child focussed service should regularly review and assess the meaning, the impact, for the child's welfare of the circumstances surrounding the child.

6.11 In fact the children were seen by various agencies, although this was not always recorded as it should have been, for example, by the police when called out to domestic incidents.

6.12 Children's Services visited a month before the death of Child R and met Child R for the first time. Concerns about the home environment were recorded and should have been followed up as recommended. The concerns, that were expressed, focussed on the need for practical Family support services to improve the physical surroundings rather than the impact on the children of the care provided by Mother.

6.13 There was no evidence that services had systematically addressed the needs of Child R and Sibling in relation to their dual heritage. Matters of personal care such as skin care and hair care should have been discussed with Mother. There were anecdotal references to Birth Father preparing food for Sibling and talking about his own family but there were no records of any contact with the extended paternal family once Sibling was born.

6.14 There were similarly anecdotal references to Mother and one of Mother's friends making remarks, which were viewed by professionals as racist about the children. There would have been serious concerns about the children's welfare if this had been a part of their life experience. It is not possible to comment further other than to raise the issue that when professionals undertake assessments of children of dual heritage, they must include culture and attitudes by parents and adults connected to the children in their assessment not only in relation to children's needs but in terms of any risks to them.

6.15 Policies and procedures were in place in relation to sharing information, making referrals and undertaking assessments. Policies and procedures were not universally complied with particularly in relation to information checks as noted above.

6.16 The IMRs do not offer explanations about why staff were not complying with undertaking checks but recommendations, for example by the Police to undertake a gap analysis with a view to identify the reasons for the lack of compliance, are being implemented. The IMRs concluded that the staff were not experiencing heavy workloads at the time, similarly the information systems were not too complicated or time consuming. The question about the lack of basic good standards with checking records and information systems for staff and managers may be more about a cultural commitment to the importance of including full and accurate information in decision making and assessments. Professionals need to understand the importance of keeping accurate, up to date records as a matter of being accountable to the service users e.g. the children and families as well.

6.17 The issue of a shared understanding by agencies of making referrals to Children's Services has been raised in the Review although there were procedures in place in the LSCB Interagency Child Protection Procedures with a chapter setting out how to refer to Children's Services and how the referral should be received. Whether the referral procedures were not understood for example by the Health Visitors, who should have made a referral in January 2011, or whether the procedures were not being used in general was unclear. Based on the available information in the IMR it was more likely that the Health Visiting staff did not consider making any referrals as they did not recognise the circumstances described by the Nursery Nurse as Neglect, which should have been acted on.

6.18 There are chapters in the LSCB procedures about Neglect and Domestic Abuse / Violence which provide Practice Guidance and set out how to make referrals and what to consider in any assessments. In relation to both subjects the professionals in this case do not appear to have been familiar with undertaking full assessments in relation to either subject.

6.19 For example, Birth Father's domestic violence offences were never fully assessed for possible risks to Child R, Sibling or Mother. This was pointed out in the Transfer summary by a Student Social Worker on placement in 2009 but the recommendations were not followed up. Both at the birth of Sibling and at the birth of Child R a pre Birth assessment should have been undertaken. Birth Father was living with Mother at the time of Sibling's birth and was still in the household at the time of Child R's birth. The uncertainty about paternity would have increased the risks to Child R.

6.20 The only example of good practice that can be identified as having gone beyond expected good standards of work related to the EMAS staff member. The EMAS paramedic attended the home on two occasions and followed up by making safeguarding referrals in accordance with the agency procedures. As it was realised that there had been no changes in the home between the two visits the staff member made a point of querying what had happened to the first referral and made a second referral.

7. Lessons to be learnt

7.1 Pre-Birth assessments should be undertaken as child focussed multi agency assessments of the members of the family and any existing support systems. The assessment of the parenting capacity of the adults

caring for the child should include good background histories. The outcome of the assessments should be that Care plans and Child in Need plans are agreed and reviewed regularly, whether the services are to be provided as Family support ,Child in Need or Child subject of a Child Protection Plan.

7.2 The decision making by staff and managers in relation to transfer summaries, recommendations for case closures, decisions about levels of risk or case priority and making referrals should be undertaken based on up to date information. The child's circumstances should always be reassessed and reviewed to take account of any new information. The impact on the child's well being of the proposed decision –whether to close a case or to refer it for example – should always be stated along with the reasons for the decision taken.

7.3 The Review identified the need to improve some information sharing systems such as the EMAS referral form, its contents, and how it is passed to staff in the A and E department. The other part of the system that needs to be clarified and improved is how the referral information is received and used in the A and E department by doctors and nursing staff to inform the medical assessment of the child.

7.4 How information was shared within agencies, such as between the GP and the Health Visiting Service, and between agencies has highlighted the need for all professionals to consider not only how they pass information on but how it is also received. Information sharing should be a participative process with an exchange of views and information with room for questions to be asked.

7.5 The Review has identified that there was practice guidance in place about Domestic Abuse and Neglect during the time frame of this Review. The

front line staff and managers did not recognise the need to assess the children's welfare, and their possible needs to be safeguarded, in the context of the information that was available about domestic violence. Similarly they did not recognise the signs of neglect and consider the impact therefore on the children's welfare. The lessons to be learnt are that supervision and training of both front line staff and managers must incorporate the principles of multi agency working in assessments of all kinds in order to identify when there are signs of abuse and neglect.

8. Recommendations

8.1 An Integrated Action Plan was produced. A number of the actions have been implemented while the Serious Case Review has been in progress and the Integrated Action Plan is monitored regularly by the LSCB.

8.2 The recommendations from the Individual Management Reviews and Health Overview Report were set out in full in an Appendix to the Overview Report. The recommendations addressed the main findings of the Overview report.

Recommendation 1.

Any current Pre Birth Assessment protocol should be reviewed and an up to date interagency Protocol should be developed which reflects the learning from this Review .The Protocol should be made available on the LSCB website and should be included in the Interagency Child Protection procedures.

Recommendation 2.

Current single agency and interagency training programs in relation to Neglect and Domestic Abuse / Violence should be reviewed to incorporate the learning from this Review.

Recommendation 3.

The uptake and attendance of Safeguarding training courses, whether single agency or interagency, should be reviewed to ensure that the training 'Recognising the signs and symptoms of neglect and abuse' is targeted to front line staff , front line managers and supervisors in all agencies .

Recommendation 4.

An interagency review exercise should take place to examine the understanding across agencies of the 'threshold criteria 'for making a referral to Children's Services to determine whether there is a shared view of the criteria and the referral process. The Review exercise should aim to highlight good practice examples as well as any gaps or problems to be addressed.

Recommendation 5.

The systems for sharing information about safeguarding concerns between EMAS staff and A and E department doctors and nursing staff should be reviewed. A protocol should be developed between the services to ensure that information is recorded and shared effectively so that the relevant information is taken into account when assessing a child.

NB. 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.

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Independent Overview Author
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