Child LK "Rose" Serious Case Review Learning Brief
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Lancashire SCB commissioned a Serious Case Review (SCR) regarding a child to be known as "Rose" (LK) who died in 2017 aged 8 months.

Case summary

Rose lived with her Mother and sibling "Daisy" age 2 at the time of her death. The prelude to the timeframe of the review was a serious assault many years ago on a young child, who fortunately survived. The Mother of Rose and Daisy was involved in the care of that injured child and after initially denying responsibility for the harm caused made partial admissions, including to professionals, to having caused the injuries. Unfortunately, there was insufficient evidence to charge Mother at that time.

Mother became pregnant with Daisy in early 2015 and services immediately became involved due to the risk of physical abuse after the historical incident with the other child. Mother gave the appearance of cooperating with professionals but was using disguised compliance. She was judged as a changed person, making progress, who could be trusted to care for her daughter at home. Father of Daisy had learning difficulties and some alcohol related convictions. Despite Mother's known background of harming another child, Father was assessed as a higher risk and granted only supervised contact.

By 2016 Mother was living independently with Daisy on a care order with home placement. Unknown to services Mother resumed the relationship with Father which breached the home placement agreement regarding Daisy. Mother became pregnant (with Rose) but concealed the pregnancy. Father's claims about the pregnancy were disbelieved by the professionals he told, who made no enquiries other than asking Mother who denied she was pregnant.

Rose was a premature baby - she was born around 24 weeks in 2016. The pregnancy was concealed until this point. Legal advice was obtained by children's social care regarding sibling Daisy's future, and Rose's once it was known she would survive.

Eventually in February 2017 a care order was granted for Rose but with the decision that both children, a toddler (Daisy) and a baby (Rose) born premature with complex needs, would live with Mother on a home placement with a robust plan of support. This included commissioned overnight support workers staying at the address.

The overnight support was soon amended to just evenings at a time when some concerns had been raised regarding Mother's lifestyle. Unfortunately, in April 2017 within only a short period of the new support arrangements, the support worker had left for the night when Mother called an ambulance reporting Rose was unwell.

Rose was found to have suffered a serious head trauma suspected to have been caused non accidentally. Rose sadly died and Mother was arrested. In 2018 Mother was charged and subsequently convicted of the murder of Rose and the non-recent serious assault on the other young child which occurred years before.

Key learning themes from this review are found on the next page.

Learning Themes

The review highlighted the following learning themes:

- A child's lived experience should be reflected in assessments and work undertaken with a family. Professionals should be mindful of being influenced and manipulated by parents/ carers; desired outcomes for the child should be the key focus for professionals;
- Disguised compliance should always be considered as a key area of concern when assessing risk to a child, even in cases where families appear to be making progress and where there is full cooperation;
- When agencies become aware of a concealed or denied pregnancy there should be a robust response to assess future need, care and support and assessment of risk. The LSCB have recently updated the concealed and denied pregnancy protocol to support agencies with this. If you have questions regarding concealed and/or denied pregnancies contact your agency safeguarding lead;
- Responses to minor injuries in looked after children – professionals should ascertain whether explanations of injuries (however minor) are plausible and minor injuries should be viewed collectively with other information about a child which together could give cause for greater concern;
- When undertaking assessments, all professionals should ensure they are comprehensive documenting all risks that have been considered, all possible agencies (including non-statutory organisations) have been asked for information and relevant family members have contributed to the process and their views have been fully considered;
- Professionals should ensure mothers/ fathers/ guardians are treated equally and concerns or information should be processed in the same way;
- Meaningful engagement of GP services throughout all safeguarding processes;
- Agencies should try, where possible to maintain the consistency of professionals working with families especially on complex cases;
- Professionals working with children on home placement agreements should regularly discuss these cases in supervision to ensure new risks are not overlooked and the support being provided is appropriate. The CLA Review should also be utilised in this way;
- Accurate and timely recording of legal information (including discussions) is paramount;

Conclusion

The findings of this SCR identified missed opportunities which if acted upon or responded to differently may have altered the outcome of the case. However, working with families in complex circumstances was recognised as being continually challenging, made more difficult when individuals who professionals are working hard to support, have intent to manipulate and deceive. In response to the findings the LSCB has devised an action plan which includes ways by which services and practice may be enhanced and developed.

The full SCR report is available on the LSCB website.