Lancashire Safeguarding Children Board Learning Brief

Child LE Serious Case Review
To be published 14 June 2017

Case Summary

Lancashire LSCB has published a Serious Case Review (SCR) about a child known as Child LE who died shortly after birth following a concealed pregnancy. In the 11 weeks leading up to LE's death, there were a number of issues with multi-agency working which contributed to ineffective safeguarding of Child LE and siblings.

The review highlighted the following key learning points below:

1. Professionals should always consider a psycho-social assessment and referral to children's social care if a woman has concealed or denied her pregnancy. The LSCB will be developing a multi-agency protocol to support professionals and agencies with this.
2. A mental health assessment should always be considered (decision making clearly recorded) for all women who are parents who have been referred for but have never engaged with mental health services (as an adult or child) and who continue to suffer with mental health issues. Mental health concerns should also form part of a risk assessment of the vulnerabilities within the family unit.
3. Parenting capacity should form a key part of risk assessments. Practitioners should always include parental histories including trauma and abuse as part of this assessment and consider the effect this may have on the parent's capacity to care for and safeguard their children (and themselves). Being mindful of the cumulative impact on risk of harm to a child when different risk factors are present in combination or over a period of time.
4. All agencies need to ensure fathers are included as part of assessments and their presence or absence recorded at appointments. Where a partner who is not the father is a member of the household they should also be included.
5. Routine enquiry for domestic abuse should be completed at every contact – records should indicate whether father/ male partner is present and routine enquiry not undertaken; professional curiosity should be utilised to establish the family dynamics enabling other support services to be considered (if appropriate).
6. Child protection decisions should always be based on all the information that is available at the time. Where a professional feels the wrong decision has been made and inter-agency discussion does not resolve this then the LSCB disagreement resolution policy should be utilised to escalate inter-agency concerns and disagreements.
7. Following an allegation of physical or sexual abuse being made, even if it is retracted, there should be evidence children and young people have been listened to, that their views are respected. Evidence and research about why children and young people may retract allegations (sometimes on numerous occasions) should also be used to inform decision making and planning. Holding a strategy discussion (even if the allegations are retracted) to share multi agency intelligence and inform investigations would be recognised as good practice.
8. Frequent changes of GP (with or without children) should be recognised as a possible concern and queried with parents/ carers. Professionals/ agencies should have an overview of each new GP registration to ensure there is a continuity of care and historical knowledge of parent/ carer's childhood and family context is not lost.
9. Patterns of repeat pregnancy and loss should be seen as a possible indicator of unmet needs and trigger professional curiosity. These cases should also be discussed in supervision.