Child LF Serious Case Review Learning Brief
To be published 14 June 2017

Case Summary

Lancashire LSCB has undertaken a Serious Case Review (SCR) about a child known as Child LF who died shortly after birth following a concealed pregnancy. The review highlighted key themes which are listed below:

- Professional curiosity is crucial to understanding the family environment and dynamics. Every opportunity should be utilised to ask women about domestic abuse even if they are not in a relationship – someone other than a partner may be the perpetrator of such abuse;
- It is important for professionals to know that there are a variety of familial and sociocultural situations that enhance the risk of concealment*/ denying of pregnancy (e.g. fear of ostracism in some social groups, pressures for termination). Additional risk factors are:
  i. Women with cognitive/ learning difficulties or minimal knowledge of reproductive anatomy and physiology,
  ii. Extreme parental control, cultural/ community factors,
  iii. Complex Post Traumatic Stress Disorder (C-PTSD) which can develop from chronic or long-term exposure to emotional trauma in which a victim has little or no control and from which there is little or no hope of escape, such as in cases of: domestic emotional, physical or sexual abuse,
  iv. Psychiatric disorders, such as schizophrenia, and depression, have also been reported to contribute to denial and concealment of pregnancy,

  * For the purposes of this SCR the definition of a concealed pregnancy was based on LF's mother not seeking care and support from Health agencies on finding out she was pregnant.
- All agencies should always consider the need for a mental capacity assessment if they are concerned about a patient/ service user's comprehension or learning needs. These issues may contribute to their overall vulnerability and can inform risk assessments particularly in relation to parenting capacity;
- 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;
- Information should always be shared with GP or midwifery services if a woman presents for a termination of pregnancy post 24 weeks gestation as antenatal care will still be required (legally a termination cannot be undertaken at this stage). A referral to children's social care should also be considered;
- Records should indicate who attends **any** appointment/s with a patient/ client/ service user and full explanations of decision making/ outcomes should be clearly documented;
- This SCR highlighted a need for agencies to be mindful of inadvertent prejudice due to a parent/ carers social status (e.g. through profession or community contribution) and the effect this can have on community and/ or professional challenge, reporting of concerns and information sharing;
- It is important for 3rd sector organisations to be included in statutory safeguarding processes;
- Managers should ensure frontline practitioners understand how they can access support in the event they experience significant emotional trauma at work;
- Professionals involved in or notified of the sudden unexpected death of a child (SUDC) must implement the pan-Lancashire LSCB SUDC Protocol. In all cases.

The full SCR report will be published to the LSCB website once all other investigations are completed.