Child LL 'Lily' Serious Case Review Learning Brief
Publication Date: 6th August 2019

Case summary

Lancashire Safeguarding Children Board commissioned a Serious Case Review (SCR) regarding a child to be known as 'Lily' (LL) who died in 2017 aged 20 months.

Lily was born in 2015 when both her parents were children themselves aged 16 years old and they moved into a flat together with Lily. The couple separated in late 2016 and Mother became involved in a relationship with a new partner who she and Lily lived with at the flat for a short time before Lily died. For at least one month prior to Lily's death, a male friend of mother's Partner was also staying at the flat. Sadly, in March 2017, Lily died after being put to sleep in an unsafe setting which contributed to her death. Following a criminal trial mother and her partner were convicted and imprisoned for causing or allowing the death of a child. The full SCR report is available on the LSCB website.

Learning Themes

Supporting older children – Children are children until aged 18 in law; the Children Act 1989 (section 105(1)) defines a child as any person under the age of 18 (section 105(1)). The Review identified Lily's parents had support from wider family members which saw as protective factors; however, with any new incident (even low risk), the impact on *all* children should be holistically re-considered.

> *"What should not be ignored is the vulnerability which age itself can present due to a lack of life experience, maturity and resilience to evolving circumstances."*

Coordinating support for young parents – All professionals when working with young parents must not lose sight of the vulnerabilities and pressure which can exist for the individuals involved. Opportunities to coordinate formal support, encourage engagement and to act on new information, must be taken to ensure wherever possible contact continues with young inexperienced families. As a result, how young parents are coping and any evolving risks will be more likely to be identified.

Safer Sleep Processes – there are challenges faced by some families regarding toddlers not settling to sleep and getting out of bed – this was the catalyst for Lily to be placed to sleep in the unsafe setting which contributed to her death. It is important professionals discuss safer sleep and bedroom safety with families of toddlers as well as babies, this should include seeing where the child sleeps and accurately recording the discussion and environment.

Overlooked individuals – This term has been used to include all people not just 'hidden males'.
There is a need for all professionals, particularly frontline staff for whom safeguarding is only a part of their core role, to be aware of wider safeguarding issues, and to take any appropriate action relevant for your agency. This is particularly important where there are risks from unknown/ new adults living with families and how this can change the dynamics of a household including any risks or vulnerability this may introduce.

Responses to Domestic Abuse Victims aged under 18 years – There is national and international evidence that abuse and violence in young people's relationships represents a substantial problem with 1 in 5 teenagers having been physically abused by their partner. Due to systems and processes at the time (2016) the opportunity to assess the lived experience and risks to Lily and her Mother and for professionals to re-engage within the family was missed. It is important professionals recognise when children are perpetrators and victims of domestic abuse and may require protection.

Effective information sharing after vulnerabilities have been identified – Information sharing and being professionally inquisitive is paramount to enable robust and dynamic risk assessments to be completed. Furthermore, it can support frontline professionals to be safe e.g. Do you know who is in the house and whether it will be safe for you to undertake a home visit? Information should always be shared with partner agencies when there are safeguarding concerns.

Homelessness of 16/17 year olds – Mother's partner and partner's friend where both homeless at some point throughout the timeframe of the review. It highlights additional pressures and vulnerability faced by some older children and young adults. There are several documents relating to homelessness on the Board procedures page of the website to support agencies in working with homeless young people. Furthermore, the Local Authority procedures relating to homeless 16-17 year olds are now assessed as 'child in need'.

Awareness of private fostering arrangements – A private fostering arrangement is made privately (without the involvement of the local authority) for the care of a child under the age of 16 (under 18, if disabled) by someone other than a parent or close relative of the child, or a person who has parental responsibility for the child, with the intention that it should last for 28 days or more. It is vital that all professionals, particularly operational staff having contact with families, can identify a private fostering situation and make a referral to CSC to enable the circumstances to be assessed.