CUMBRIA LSCB

CUMBRIA LOCAL SAFEGUARDING CHILDREN BOARD

Learning from Serious Case Reviews – Child L

This short briefing summarises the findings and lessons from a Serious Case Review (SCR) into the death of Child L in Cumbria in 2011 – the SCR focusses specifically on how agencies worked together and individually from the birth of the parents' first child in October 2009, until the date of Child L's death in July 2011. Due to his short life the panel also agreed to focus on Child L's sibling as part of the review.

A Serious Case Review takes place "where abuse of a child is known or suspected; and either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child".

If you work with children and families in Cumbria, there may be additional specific actions and recommendations for your agency and your role. Please ask your manager, or contact your representative on the Cumbria Local Safeguarding Children Board, to find out more. You can read the full report at www.cumbriaLSCB.com

Child L's story

Child L was born prematurely at 31 weeks in May 2011 and was admitted to the Special Care Baby Unit Medical. Child L died at home in July 2011 only 43 days old. During his short life he had been examined several times and one examination identified a possible heart murmur. Experts concluded that he died from cardiac arrest which on balance of probabilities was secondary to some form of head injury. Child L's mother had a complex background had experienced neglect, and had been a looked after child.

THEME 1: Working with resistant families
Finding 1 In this case there was insufficient professional curiosity despite historical context.
Lesson to be learned Professionals need to establish that the family's actions agreed in the Child protection/ Family in Need or Early Help plan have been completed by the family. **Are you familiar with the LSCB Working With Uncooperative Families – Disguised Compliance Procedure?**

THEME 2: Quality Assessments
Finding 2 In the case of Child L siblings there were a number of assessments completed by professionals of variable quality which were static, did not inform planning, did not adequately consider all of the adults in the home and were not appropriately shared with the multi-agency team
Lesson to be learned Initial and ongoing assessments must be thorough, timely, gather multi-agency information, inform decision-making and take account of historic context of the family. (single agency) **Are you aware of your responsibility to use historical information when you are making an assessment of risk?**
Lesson to be learned Initial and ongoing assessments should include understanding of the whole family and regular visitors to the home, alongside observations of multi-agency professionals who are involved with the family. (Single Agency) **Do you identify and assess the significant adults who are involved in the lives of children as part of your assessment?** **Lesson to be learned** On completion of a single agency assessment professionals must consider who else needs to know this information, and whether or not there needs to be a multi-agency response (e.g. Early Help) (single agency) **The LSCB has a robust Information Sharing Protocol that sets out how and when it is appropriate to share information. Do you know when and who you can share information?**

THEME 3: Care leavers possible compromised capacity to parent
Finding 1 In the Case of Child L the known risks for care leavers and their ability to appropriately parent were not considered
Lesson to be learned Care leavers are a vulnerable group who may require more support in order to parent effectively. **As a practitioner are you aware of the risks for care leavers and how the impact of childhood trauma, abuse and neglect can affect their capacity to parent?**

Sharing learning from serious case reviews in order to improve safeguarding practice is vital. We use the recommendations from case reviews to improve safeguarding of children & young people.

If you would like to discuss this briefing or any of its contents then please speak to your line manager, your representative on the LSCB or contact the LSCB Office. 1st Floor - Lower Gaol Yard, The Courts, Carlisle, Cumbria, CA3 8NA Email LSCB@cumbria.gov.uk

The LSCB will conduct a number of workshops and a conference to raise the profile of the lessons in this and the other SCR being published