

## **Statement from Jenny Myers, Independent Chair Leicester Safeguarding Children Board**

Today the Leicester Safeguarding Children Board (LSCB) is publishing a serious case review concerning a child who we shall refer to as Child A1.

Serious case reviews are carried out if a child has died or been injured and neglect or abuse is suspected. They look at the role played by any professionals involved with a child or their family, to see if there are lessons to be learned that could improve ways of working.

Child A1 was nine weeks old when he died in 2014. He never lived with his birth parents and was either in hospital or in foster care throughout his short life. After his death he was found to have rib fractures that were considered non-accidental.

A coroner's inquest was conducted after a criminal investigation. This found that no cause of death could be identified. The fractured ribs were not the cause of death or a contributory factor. An open verdict was recorded.

Child A1 was a concealed pregnancy, born prematurely. His mother received no ante-natal care. His concealed birth meant that professionals were on the back foot and the lack of any multi-agency pre-birth assessment had wide ranging implications for agencies.

The Leicester Safeguarding Children Board takes every death of a child seriously and is committed to learning from such deaths and holding partners to account to take appropriate action to ensure that there are real and sustained practice improvements, where these have been identified.

The review found there were no singular failings that led to Child A1's death. There was however, a lack of continuity, joined-up activity and record keeping. Child A1 was not always considered as an individual, but was looked at as part of a wider picture where he effectively became the process as opposed to a person in his own right.

The agencies that took part in the review were Leicestershire Police; University Hospitals NHS Trust; Leicestershire Partnership Trust for Health Visiting Services; Leicester City Council Children and Young People's Service; Leicester City Clinical Commissioning Group.

Recommendations around six key areas were made to the LSCB following the review and these have all been acted upon.

**More.**

They include asking the LSCB to seek assurances from children's social care that all children who go into care have an assessment of their needs within 72 hours; that in all cases where children are removed at birth that the appropriate child protection procedures are in place; and that the improvement plan for children's social care includes case recording and adequate demonstration of consistent supervision and management oversight on cases.

The board was also asked to seek assurance that the fostering service is linking in with the local authority's child protection service; following regulations around notification of incidents; and re-issuing guidance on methods of communication between foster carers and social workers.

The LSCB is satisfied that all of the agencies that took part in the review have reviewed their ways of working where relevant and taken the actions identified.

The SCR Improvement plan will be monitored by the Serious Case Review Incident Group (SIRG) and evidence will be sought from agency partners to demonstrate impact and improvement.

The serious case review report and recommendations are available on the LSCB website at <http://www.lcitylscb.org/>

***Ends***

*For further details contact Leicester City Council's press office  
on 0116 454 4151*