



Leicester Local Safeguarding Children Board

Serious Case Review concerning CHILD A1

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February 2017
Version 0.6

Contents

1. Summary

2. Introduction

3. Terms of Reference and Methodology

4. Summary of the facts

5. Analysis of significant safeguarding events

6. Conclusion

7. Recommendations

1. Summary

1.1 The conclusion of this review is that CHILD A1 died at nine weeks old, as a result of an underlying natural cause. The Child may have been likely to die of this cause, regardless of any care that they received during their tragically short life, during which the child was either in foster care or in hospital. However, after his death, CHILD A1 was found to have a number of non-accidental rib fractures. A criminal investigation was inconclusive and no charges were brought in respect of those injuries.

1.2 This review has sought to identify what, if any, factors either inhibited or caused practitioners and their agencies to act effectively to ensure CHILD A1s safety. There are lessons to learn for agencies in overall safeguarding practice.

1.3 This review makes observations for safeguarding should similar circumstances arise in the future. The observations made are underpinned by a number of recommendations which the review author invites the Leicester LSCB and its partners to consider accordingly.

1.4 In short there were no singular failings that led to the child's death. There was however, a lack of continuity, joined up activity, and record keeping. There was also a lack of impetus and attention to detail within Children Social Care which included a lack of management oversight. CHILD A1 was not always considered as an individual. CHILD A1 was looked at as part of a wider picture becoming part of the process as opposed to being seen as a person in their own right.

1.5 Equally however there has been good practice identified.

1.6 This overview report has tried to consider what life was like for CHILD A1, and what steps can be taken to ensure that irrespective of the child's age, that the need of each individual child is of paramount importance.

1.7 The review author is grateful for the active participation of the respective agencies throughout the review process. However, would seek to ensure that the LSCB is able to promote attendance of all relevant agencies at all stages of the SCR process in future reviews. This has already been raised with the LSCB and taken forward by them.

2. Introduction to the review

2.1 Working Together (2015) states that where abuse or neglect of a child is known or suspected and the child has died, then the Local Safeguarding Children Board (LSCB) must initiate a Serious Case Review (SCR). The purpose of a SCR is to enable the professionals and organisations involved with

the child and their family to reflect on both their own practice and that of others, to identify improvements that are needed and to consolidate good practice.

2.2 Working Together also states that SCRs should be conducted in a way that:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand the underlying reasons that led individuals and organisations to act as they did;
- Tries to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

2.3 This serious case review has been conducted and undertaken by Leicester LSCB in a way that ensures these principles have been adhered to.

3. Terms of Reference, and methodology

3.1 Following extensive investigations into the death of CHILD A1, a recommendation was made to the Independent Chair of the Board that a Serious Case Review should be conducted, in relation to CHILD A1. The Chair subsequently ratified this decision and on the 20/02/2015 the case was registered with Ofsted and the National Serious Case Review Panel. The reason for the delay in the initiation of this SCR, is due to the time it took for the investigation to firmly conclude the cause of death.

3.2 Leicester LSCB set up a panel to consider the SCR into CHILD A1s circumstances. The SCR panel is independently chaired by Felicity Schofield. The lead reviewer and independent author is Russell Wate.

3.3 The Focus / key issues set for the review are:

1. To establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.
2. To identify clearly what those lessons are both within and between agencies, how and within

what timescales they will be acted on, and what is expected to change as a result.

3.4 Contributions were requested and IMR's or reports received from:

- Leicestershire Police
- University Hospitals NHS Trust
- Leicestershire Partnership Trust for Health visiting services
- Leicester City Council Children and Young Peoples Service
 - a) Safeguarding & Assurance Service
 - b) Family Placement and Support
 - c) Children in Need Service
 - d) LADO
- Leicester City Clinical Commissioning Group

4. Summary and analysis of the facts

4.0 CHILD A1 was born prematurely, at approximately 32 weeks gestation. CHILD A1 was also a concealed pregnancy and consequently his mother had received no ante-natal care. This was in fact the second concealed pregnancy by this mother who had given birth to 3 children within just 25 months. The father of CHILD A1 is known, and was engaged with by professionals along with the mother following the birth. Very little bonding to the child was noted by professionals. Following the initial fostering of CHILD A1 the father soon disengaged, and the mother similarly disengaged soon thereafter. They never cared for CHILD A1 outside of hospital.

4.1 The two other siblings of CHILD A1 were not in their parents' care at the time of the child's birth.

4.2 CHILD A1's needs were immediately identified by the hospital, midwifery and health visiting professionals as being complex. This was due to both the mother's social history and CHILD A1's individual needs being both a concealed birth and of several weeks prematurity. It is fair to comment that practitioners later estimated that CHILD A1 was born closer to 35 weeks gestation. This has been difficult to confirm in view of the mother's concealment of her pregnancy and the apparent trauma suffered by CHILD A1 at birth due to the nature of his delivery. Irrespective of the concealment, child A1 was a premature baby requiring appropriate early medical support which was provided accordingly.

4.3 The reason for the mother's concealment on this occasion is not entirely apparent however it is known that she has a history and background of drug abuse, and also as a past victim of domestic abuse.

4.4 In this case the fact that CHILD A1 was a concealed birth meant that professionals were on ‘the back foot’, and the lack of any multi-agency pre-birth assessment (clearly required in CHILD A1s case) had wide ranging implications for agencies.

4.5 Timeline of events

Post birth (whilst in hospital)

4.6 CHILD A1 was first admitted to hospital (neo-natal) immediately following the child’s birth. It is reasonable to comment that the circumstances of the birth at home were chaotic given the mother’s concealment of the pregnancy. Social Care was informed by UHL to duty and assessment on day of admission.

4.7 The birth events were followed up by a high quality of post-natal intervention. This ranged from the attendance of paramedics and midwife through to CHILD A1’s initial hospital admission and treatment. The mother is reported as being co-operative and responsive to the child following the birth although this later drifts to no involvement.

4.8 CHILD A1 was immediately identified as having potentially complex health needs and the first three weeks following on from birth was spent at Leicester Hospitals. The length of time Child A1 remained in hospital, however, appears in part to be attributed to the pace of the interim care proceedings, rather than there being a requirement for the child to remain in hospital due to their health need. As stated earlier the child’s birth was initially estimated as being at some 32 weeks gestation, although later this was adjusted by the professional’s perspective more likely to have been in the range of 33 to 35 weeks.

4.9 It is not apparent to what extent information sharing took place between agencies immediately following the birth, but the hospital did inform duty and assessment of the admission. It is noted that CHILD A1 was born on a Saturday, which may or may not have contributed to this. Records from the hospital show that in respect of the child’s initial safeguarding that an action plan was put in place by ‘hospital management’ should the mother make any attempt to remove the child. It would appear that the information had come from ‘Duty and advice’ (out of hours service) about concerns in relation to Mum’s parenting capacity. It is perhaps of some concern that although this was a clear indication of appropriate steps being taken by the hospital that other agencies should have been consulted. There should have been a Section 47 Strategy meeting, convened by Childrens Social Care (CSC) which could have guided subsequent actions.

4.10 The procedures for a new case (or in this case the birth of a sibling who was already known to CSC) were not followed. Instead, on the Monday an Independent Review Officer¹ who had been informed by 'Duty and advice' notified the sibling's social worker of the birth of CHILD A1 and she was duly allocated this case. This notification was made by e-mail contact as opposed to direct personal contact between individuals, although CSC had received notification shortly after the birth from the hospital. This delay of two days appears to be attributed to the birth being at a weekend or out of 'office hours'. The duty and advice team are a 24/7 service. By this point the circumstances concerning the birth should have in the review author's view triggered a strategy meeting. The review author is also of the opinion that by by-passing the 'front door' procedures and allocating CHILD A1 to the sibling's social worker, some essential safeguarding actions were missed, for example a strategy meeting.

4.11 Later that week the allocated social worker's notes record "*Hospital visit*" without any further information recorded. The expectation at the least was that this should have contained some analysis, risk and oversight of the case and shows that record keeping as demonstrated by this case needs to improve. It is of a concern that this was not picked up in either supervision of the social worker or management oversight.

4.12 The review notes that the allocated social worker was soon thereafter on annual leave and this further raises concern that supervision of the worker's caseload seems to have been overlooked.

4.13 It was identified that the sibling of CHILD A1, CHILD A2 was the subject of care proceedings and the IRO in consultation with the allocated social worker agreed that an Initial Child Protection Conference (ICPC) was required along with a 'Looked After Child '(LAC) review. This is despite the social worker querying the necessity to hold an ICPC in an e-mail communication with the IRO. The social worker then responded to the IRO also by e-mail confirming that an ICPC would be arranged as the IRO had identified.

4.14 Although such actions were appropriately identified by the IRO and acknowledged by the social worker no other agencies (for example the police or health visitor) were notified by any formal or informal referral for discussion. As CHILD A1 was already in a hospital setting, this process could have been relatively straight forward in both arrangement and practice and would have been achieved if the child protection procedures had been followed and a strategy meeting held. This left some key partners uninformed of the actual events surrounding the birth. The review author

¹ The responsibilities of the Independent Reviewing Officer (IRO) are laid out in Chapter 3.3.5 of the City's child care procedure manual 2010. Their responsibilities include ensuring that care plans for looked after children are based on a detailed assessment, are up to date, effective and provide a real response to each child's needs.

comments that this was needed under the circumstances. There is no record of who decided the length or type of contact that CHILD A1's mother and father could have, or what exact action would have taken place had they tried to remove the child from hospital.

4.15 No ICPC took place despite those e-mail communications and assurances between the social worker and the IRO. It is also noted that there are no formal notes of this process in any event, so 'tracking' of the key practice decision making has not been possible in the respective agency IMR.

4.16 It is not evident to the review what supervision and management oversight took place at this time of the social worker, and the review has found it difficult to assess if there were any direct safeguarding considerations for CHILD A1 as an individual at this time by CSC.

Foster carer

4.17 It was 'agreed' that there would be a Looked after Child (LAC) review and it appears that the birth mother was to be part of that process. It appears that she was informed that CHILD A1 would be placed with a foster carer, identified as Foster Carer 1. This decision appears to have been made on the basis that Foster Carer 1 was also the foster carer for CHILD A1's half sibling, Child A2 who was in the process of care proceedings.

4.18 This raises the question of was this simply the easy option? Given that as CHILD A1 had potentially significant health needs, was Foster Carer 1 suitable as the foster carer? In essence the review author comments that consideration should have been for CHILD A1 (irrespective of the lack of conference and assessments made) to be placed with a foster carer who was identified as being able to meet CHILD A1's actual and anticipated health needs. In effect it can be argued that CHILD A1 was becoming 'lost' in ongoing matters and existing arrangements as opposed to being considered in Child A1's own right. In relation to these preceding two paragraphs, the fostering placement and support service state that this analysis is too simplistic and the process is a lot more involved than this in reality and in practice. They state a placement meeting did take place. The review author accepts this point of view, however there is nothing recorded that helps the review to see what the decision making for the placement considered. This lack of recording is contrary to their procedures.

4.19 The review author also raises the question of whether this in fact added a significant burden to the foster carer that she was not asked or consulted about. Could she cope adequately under such circumstances, was she fully informed of the child's needs? Such questions could ultimately have been raised, discussed and determined within a multi-agency meeting (or at least consulted with the Midwife and HV about this proposed placement). The foster placement and support service is still

firmly of the opinion that the placement was appropriate, and they have highlighted a number of points in response to this review that would make Foster Carer 1 without doubt a suitable placement. The review author does though highlight that none of this is recorded prior to this review.

4.20 The foster carer, Foster Carer 1 was an experienced foster carer who has fostered with the local authority for a number of years and was considered by professionals within the fostering team to be an experienced and suitable person to deal with the needs of CHILD A1. The foster carer was fostering the half-sibling of CHILD A1.

Hospital discharge and period post this.

4.21 In records held by the hospital and health visitor a discharge planning meeting was held with ward staff, a social worker and hospital safeguarding team and a plan was put in place for CHILD A1's discharge arrangements (no minutes of this meeting have been found, so no idea what the plan entailed). The allocated health visitor was fully involved in this process and had met the child, mother and foster carer pre-discharge. There is however no corresponding record held by CSC of this meeting taking place, other than a line on the case notes confirming that the discharge of CHILD A1 to the foster carer was taking place. This meeting was about CHILD A1's health needs and not about the child's safeguarding needs.

4.22 CHILD A1 was initially discharged to the care of Foster Carer following the granting of an Interim Care Order (ICO). The IMR from UHL comments that this delay had effectively tied up an acute bed in the neo natal ward for a significant number of days and in circumstances where demand for spaces is very high given the regional demographics which are served by the hospital. An additional comment was made at the practitioner's workshop that CHILD A1 was a "medically fit child" to be discharged (eg the child no longer needed to be in hospital to have the child's care needs met). The review author fully acknowledges this medical perspective. It is acknowledged however that the health needs of CHILD A1 later became acute in the days and weeks following the date of this initial discharge.

4.23 CHILD A1 was discharged to the care of Foster Carer 1 in accordance with the ICO. It was observed that CHILD A1 was considered to be making progress and developing despite the child's prematurity. Foster Carer 1 had spent time at the hospital receiving advice and guidance for supporting a premature child pre-discharge and becoming familiar with CHILD A1. The birth mother attended the hospital initially on a regular basis, but for a relatively short time over the period of CHILD A1's original admission.

4.24 Although the review author has voiced concern that the foster placement may have been unsuitable at the point of discharge to the needs of CHILD A1, it was commented on by practitioners that at the time of being placed into the community the baby's needs were not exceptional. It is acknowledged that there was concern regarding the possibility of injury to the child's skull and hearing during the birth, however these were identified for ongoing intervention and assessment by hospital visits and specialist appointments, which the foster carer had been made fully aware. Although one later appointment was missed this appears to be due to an administrative error as opposed to on the part of the foster carer.

4.25 On discharge CHILD A1 was a looked after child, however due to annual leave and sickness of the social worker and IRO respectively, there was no 72 hour meeting, as required by local procedures, with the first meeting being the statutory 28 day review. This meeting eventually took place some 5 weeks after the baby's birth. Child A1 also should have had an initial LAC medical (also a statutory requirement) but the relevant health professionals, the 'designated looked after children nurse' was not advised of the child going into foster care, by the SW.

4.26 The health visitor reported that on a home visit to the foster carer, that the child was progressing and had also had a short visit from the birth mother. The following day the foster carer was visited by the fostering supervising social worker and given advice and support for her needs. No concerns were raised within either of those visits in respect of either the foster carer or CHILD A1.

4.27 A few days' later concerns were raised by the foster carer in respect of CHILD A1's apparent poor circulation and presentation as being cold. The foster carer took the child to see her GP who immediately referred CHILD A1 to hospital for possible sepsis and hypothermia. Records from the hospital indicate that the social worker was informed. CHILD A1 remained in hospital for 5 days. The foster carer regularly visited the ward and provided care to the child during this period as noted within the hospital IMR.

4.28 The foster carer is noted to have informed the social worker of CHILD A1's hospital admission by an e-mail (However the supervising SW was not informed). The review author questions such practice and how appropriate this might be when other more direct forms of communication, even text messaging, may provide the opportunity of a more direct, timely and effective dialogue. Although the review author does fully accept that it is not outside guidelines and is a line of communication that is being used. The review panel did debate this and on balance felt more care is needed in practice to not rely on only e-mail communication.

4.329 Throughout this case there has been a lack of adherence with the regulations and procedures to notify OFSTED as outlined in Notifiable Incidents under schedule 7 of the Fostering Services (England) Regulations 2011. (*'N3- Serious illness or serious accident of fostered child. Relating to repeat hospital admission /ICU'.*) Also in relation to monitoring, SCHEDULE 6 of the regulations state *'matters to be monitored by the registered person (Head of Service) 2. All accidents, injuries and illnesses of children placed with foster parents. 3. Complaints in relation to children placed with foster parents and their outcomes.'* The procedures need to be sent out to all foster carers and their supervising social workers.

4.30 The first statutory looked after children review took place, however with CHILD A1 in hospital and being cared for by the foster carer, the meeting appears to have been relatively poorly attended with [just] the social worker, health visitor and IRO present. Neither the foster carer nor their supervising social worker was in attendance. An adoption plan was agreed. It was at this meeting that the method of e-mail communication between the foster carer and social worker became known.

4.31 There is a lack of clarity between the information concerning visits made to the placement by the social worker and what was on the record. In fact no home visit specifically to see CHILD A1 in the home had been made by the date of the LAC meeting by the social worker.

4.32 CHILD A1 was discharged from hospital and on two further occasions the foster carer returned to see the GP as CHILD A1 appeared to have breathing concerns and a rash. The GP prescribed nasal drops and nappy cream as the issues did not appear to be exceptional.

4.33 Two days later CHILD A1 was admitted by ambulance to hospital following a low body temperature and reported difficulty with breathing. CHILD A1 remained in hospital, spending the first week on a ventilator in intensive care, when breathing support was reduced and CHILD A1 was again discharged to the care of the child's foster carer two weeks later.

4.34 A planned LAC visit due to be made to CHILD A1 was cancelled by the social worker on the basis that CHILD A1 was in hospital. This was a missed opportunity and the social worker should have ensured the visit took place, by seeing the child in the hospital. Although telephone contact was made to the hospital by the social worker, no visit was made and this could have helped with the coordination of continued and future planning for CHILD A1.

4.35 The social worker was notified of CHILD A1's discharge by e-mail from the foster carer, within which no details of care and after care was mentioned or discussed. In fact considering that this case had been 'live' since the child's birth the appointed social worker had made almost no visits to CHILD

A1 (not that more than two would have fitted normal procedures) and appears to have handled the case in an administrative function rather than taking what should have been a 'hands on' and direct approach.

4.36 As a follow up to the child's discharge from hospital, the health visitor made a home visit to the foster carer and a detailed assessment was made by her. CHILD A1 also had the first immunisations at the GP on the same date. CHILD A1 appears to have suffered no obvious ill-effects from the immunisations but the foster carer raised concerns about the child's general awareness and responsiveness plus a possible hernia. The health visitor noted a large area of cradle cap and also that the child's weight was increasing. The foster carer advised her that CHILD A1 had been ill following a feed, there appeared to be no immediate issues.

4.37 In a neo-natal appointment the same day the consultant identified that the child had a hernia that would require future surgery. However this was not likely to occur until there was some significant weight increase and the consultant was otherwise satisfied with the child's progress.

4.38 The next day in what was a home visit made by the appointed social worker; CHILD A1 was found to be asleep and was not disturbed by her. The social worker noted that the half sibling had a large bump to the forehead which the foster carer referenced from the half-sibling having fallen against the bottom of the stairs. This was seen by the review panel as a plausible explanation for this injury.

4.39 The foster carer reported to the social worker, again by e-mail, that CHILD A1 had another poor hearing test result and a further test would be made the following week. A planned visit by the health visitor was deferred in order for that to occur.

Death of CHILD A1 and immediate action post-death

4.40 On the day that CHILDA1 died, the foster carer took CHILD A1's half sibling to pre-school and following this was continuing to a hearing test appointment when she noticed that CHILD A1, who was secured in a car safety seat, appeared to have stopped breathing. She called for assistance and a passer-by assisted her attempts to resuscitate the child. Paramedics attended and took over but despite efforts to save the child, CHILD A1 was declared deceased on arrival at the hospital emergency department. The death was reported to the police as a sudden unexpected death of a child.

4.41 Sudden unexpected child death protocols were initiated, and the initial post mortem (PM) authorised by HM Coroner, discovered what appeared to be a history of non-accidental injury (NAI). This involved rib fractures. Paediatric pathology was immediately stopped, for a police led

investigation and for full forensic pathology to be undertaken. The result of the post mortem consequently led to a criminal investigation, due to the multiple rib fractures that CHILD A1 was found to have sustained at different time periods.

4.42 The review author has concerns that the skeletal survey for CHILD A1 did not take place in the initial stages as recommended by national guidance. This delayed the criminal investigation until the PM was carried out, and also potentially left at risk of significant harm CHILD A2.

Police investigation

4.43 The review author does not intend to rehearse the police led investigation, other than to acknowledge that the foster carer was interviewed in connection with the evidence of the historical NAI. There was also a meeting between the director of patient safety at the hospital and the police also at the early stages which agreed that UHL should not conduct any investigation until police investigations had concluded, UHL did provide details and some analysis of incidents to aid the police investigation

4.44 The foster carer denied any involvement in or knowledge of the injuries and a review of the case by the Crown Prosecution Service found that there was insufficient evidence to pass the threshold test with which to prosecute the foster carer. This review does not intend to examine whether or not the foster carer or anyone else may be culpable as the matter has been closed by the police and the HM Coroner has ruled at Inquest an open verdict.

4.45 The family when spoken to do feel that the police did a very thorough job, with no stone left unturned.

5. Further analysis of significant safeguarding events

5.1 The initial response to the birth of CHILD A1 by the paramedics was appropriate, and was then focussed to the child's medical needs as well as ensuring any initial safeguarding considerations by the UHL hospital staff. This ensured that contingencies were in place with ward staff, should any attempt be made by the mother to remove the child from hospital. Although this was well placed judgement, other agencies, in particular the police and social care, should have received referrals at this time so that safeguarding considerations falling outside of the hospitals knowledge and remit, could be appropriately addressed. The hospital had informed social care, so this would have left CSC to contact the police.

5.2 The fact that CHILD A1 was born on a Saturday should not have delayed or prevented communication within children's social care, their supervision or management. A referral was made

to 'Duty and advice' (out of hour's service). A strategy discussion should then have been held at the earliest opportunity. This did not take place and this led to an initial lack of partnership approach to the safeguarding of CHILD A1. The review author has examined the LSCB's concealment of pregnancy procedures and these are comprehensive. Although CHILD A1 had already been born just prior to being admitted to hospital, these procedures as a principle should have been implemented in this case as the child was a concealed birth and no one knew or had been able to carry out the required pre-birth assessments. Consequently, when activity commenced from the Monday it appears CHILD A1 became treated as part of the ongoing processes concerning the half sibling as opposed to a child in need of protection in their own right.

5.3 The acknowledgement of the requirement for an ICPC was correctly identified by the IRO and although initially questioned, was acknowledged by the social worker as necessary. However, no actual provision was made. This communication appears to have been by e-mail as opposed to personal discussion. Where there is a disagreement by key professionals, it is imperative that dialogue is discussion based and not left to other communication such as e-mail. This may have impacted on the fact that no ICPC took place. There were no other processes or systems in place at the time within the safeguarding unit, to ensure that the required ICPC took place. It is understood by the review author that current monitoring processes in the CSC safeguarding unit would pick this up now.

5.4 Although proceedings were appropriately identified and acknowledged, no other agencies (for example the police) were notified by any sort of referral, which should have occurred. As CHILD A1 was already in a health setting (hospital), this process should have been relatively straight forward in both arrangement and practice. The impact of this missed opportunity was that little consideration for an integrated safeguarding plan took place, therefore leaving some key partners uninformed of the actual events surrounding the birth. The key question posed should a section 47 strategy meeting have been initiated at this time? The review author comments that this was a necessity under the circumstances of the birth. Good management oversight would have meant that this case went to a Section 47, ICPC etc. The review author has been informed that there are now in place more rigorous monitoring systems within Leicester City.

5.5 In considering this concealment of the birth, the review author questions what services had the mother received arising from the previous concealment? Those reasons when explored could have reduced the risk of future concealment.² The information concerning this concealment of birth was

² This comment is supported in research conducted by Sussex University into cases of concealment of birth (2007).

not shared sufficiently, and not enough pro-active action taken in respect of Adult A who was known to have disengaged with the care proceedings for her CHILD A2.

5.6 Looking at the issues surrounding Adult A she is known to have disengaged with the legal proceedings in respect of Child A2 during what would appear to have been the latter stages of her pregnancy. The review author would suggest that her disengagement reflects the fact that had she been seen, her pregnancy may have been discovered, hence her reluctance to engage. The review author questions why there was no pro-active approach made to Adult A by a home visit which would have been entirely feasible given the circumstances.

5.7 It is noted in the IMR of the Children's Social Care that the pattern of behaviour of the mother mirrored that of her first concealed pregnancy in terms of her disengagement with services.

5.8 It appears that the social worker did not make an initial hospital visit and did not make a home visit until 3 days prior to the child's death. Although social care notes indicate "*hospital visit*" on the Monday this is not supported by any in depth record made by the social worker. Facts should have been recorded as to who was seen and spoken to and the issues arising. This quality of case recording is deemed not good practice, but should also have been picked up in supervision.

5.9 The review acknowledges that the social worker had a period of extended leave and that the IRO also had a number of days of sick leave during this same timeframe. Although accepted that CHILD A1 was deemed as safe and in foster care, this was an unfortunate set of circumstances and contingencies should apply in such circumstances. There does not appear to have been any cover in place or supervision of this case within that timeframe (it is accepted that supervision normally only takes place every 4-6 weeks, and so there may have only had an opportunity for supervision to happen once or twice during the life of CHILD A1). In essence the case received apparently little management consideration until the LAC review. These aspects of supervision and management oversight are seen by the review author as clear missed opportunities.

5.10 During the home visit made by the allocated social worker, CHILD A1 was found to be asleep and was not disturbed. This is deemed reasonable as the child was in foster care and not in a vulnerable situation. The social worker noted that the half sibling had a large bump to the forehead which the foster carer referenced from the half sibling falling against the bottom of the stairs

5.11 The post mortem identified rib fractures of a recent and earlier nature; however, there was no evidence of this or any other injury prior to this point. The post mortem also identified that one set of the injuries was likely to have occurred whilst CHILD A1 was in hospital. The review understands that the mother of CHILD A1 did not visit the child in hospital during this timeframe. The hospital did

not carry out an SI investigation as a criminal investigation was now on-going, and this was a joint decision between the hospital and the police.

Family perspective

5.12 The review author has met with both the maternal Grandmother and Aunt of CHILD A1. The child's mother was invited but declined the meeting.

5.13 The family feel that CHILD A1's mother clearly knew she was pregnant with CHILD A1, this was her third pregnancy and she had concealed the siblings pregnancy. When asked why this was, they were clear that it was because she knew the child would be taken from her.

5.14 The eldest sibling has been cared for almost since birth by the maternal grandmother. CHILD A1's sibling, who was also a concealed pregnancy until 28 weeks gestation, lived with his mother for 9 months before being taken into care. (This older sibling was removed from Foster Carer 1 following discussion between senior managers within CSC).

5.15 When CHILD A1 was born although the child's mother and father did visit for a short while, they were fully aware from the start that their child would be taken into care. Neither, the grandmother, nor the aunt visited the hospital as they also knew this was likely to happen. When asked if they were considered as kinship carers, they said they weren't but had no problems with this as they were not able to do this for the sibling so likewise were not able to do it for CHILD A1.

5.16 They didn't have any problems or concerns with the foster carer, although the foster carer had said to them about not wanting a baby to foster, when the foster carer was looking after the sibling and therefore they found it strange that CHILD A1 was placed with the foster carer. They thought the reason was maybe because CSC thought that both CHILD A1 and the sibling could have been adopted together, but they always thought this was a non-starter because they were in fact half siblings and have a different ethnicity.

5.17 They had one main concern, and this related to CHILD A1 not being the subject of a child protection plan. They could understand it whilst in foster care, but the child was in and out of hospital and they had no CCTV etc. They felt CHILD A1 needed to be on a child protection plan.

5.18 CHILD A1's grandmother would love to know how the child sustained the NAI and who did it. She felt CHILD A1 spent their whole short life fighting against illness or someone causing harming.

6. Conclusions

6.1 The chronology, IMRs, and the practitioners' workshop have developed the analysis and understanding of what occurred during CHILD A1's life. This overview report has relied on that information to help provide its findings.

6.2 As can be seen from the earlier sections within this report a number of themes for learning have developed. The overview author believes these to be:

- The lack of an assessment (recorded) of CHILD A1's placement needs.
- The lack of a section 47 Strategy Meeting, an ICPC, a 72 hour post placement meeting and an initial LAC Health assessment – all impacting on safeguarding and care planning
- Inadequate case recording within CSC;
- Lack of supervision and management oversight.

6.3 It is acknowledged that during the end of 2013 and beginning of 2014 there were work pressures for some staff in the Children In Need service which were subsequently highlighted in the Ofsted report published in March 2015. However these were not mitigating factors in this case and could not be attributed to how CHILD A1's case was managed. CHILD A1 was allocated to an experienced social worker who had an acceptable and manageable caseload. CHILD A1 had a very short life and suffered two non-accidental injuries whilst in the care of the Local Authority. The conclusion of medical experts is that the fractures were most likely to have been caused by a similar mechanism which is identified as a 'squeezing action with some force', such that is outside of a normal hugging action of adult to child. One set of those injuries appears to have occurred whilst CHILD A1 was in hospital.

6.4 It cannot be identified who was responsible for the injuries despite a thorough criminal investigation.

6.5 It is apparent that the mother's reason for concealing the pregnancy was for the child not to be taken from her at birth; this meant that she didn't experience the health involvement required for both expectant mothers and their unborn child. It is believed by the review's author, that had a more pro-active approach by agencies been made given the mother's history and the ongoing legal process for CHILD A2's adoption, identification of her concealed pregnancy may have been revealed,

which would have led to the pre-birth assessment or concealment of birth procedures being initiated.

6.6 CHILD A1's overall safeguarding was not properly considered in a joined up approach from the child's birth and procedures were not followed. The first social work visit did not take place until just a few days before CHILD A1's death. Consequently there was no coherent multi-agency safeguarding plan during the child's very short lifetime. Some missed opportunities have been identified.

6.8 There was no initial LAC health assessment because the 'designated looked after children nurse' was not informed of CHILD A1's birth. This is a statutory requirement and this review is of the view that any such initial assessment should, in the case of under 5's, be made by a paediatrician.

6.9 The review author does not believe that Foster Carer 1 was in fact the right foster carer for the child's needs. CHILD A1 required and deserved individual care and an individual placement assessment should have taken place. As previously mentioned the Foster placement and support service do not agree with the review author's view.

6.10 The management of these areas was also lacking, which really stems from the failure at the initial decision making stage and thereafter not following the practice and procedures in place, they just did not give this case a high enough priority.

Good Practice Identified

6.11 The review also identified examples of strong practice by individuals and agencies. It was noted for example that the health visitor met the birth mother, foster carer and the child while the child was still in hospital and had a clear picture of the family dynamics.

6.12 The health visitor has kept exceptionally good records of contact and was able to reference this in the review and also at the SCR practitioner's event. There was also a good system of deputation of the appointed health visitor when the primary health visitor was not available and this fact is exemplified in the chronology of the health visiting records.

6.13 There were three fostering supervision visits made to Foster Carer 1 during the period between CHILD A1's initial discharge from hospital and the child's death. This identifies a good level of supervision and support to the foster carer.

6.14 The Inquest into CHILD A1's death was held in the summer of 2014, the outcome was an open verdict.

7. Recommendations

The review author and the review panel fully acknowledge the improvement work that has already taken place within the partnership during the period since the death of CHILD A1 some 20 months ago. The review makes the following recommendations which the panel feel will continue to improve practice within Leicester City.

Recommendation 1

The LSCB should seek assurance from CSC that all children that become looked after have an assessment of their needs within 72hrs and their initial health assessments are completed within the statutory 28days.

Recommendation 2

a) The LSCB should seek assurance that the work currently on-going within the partnership to improve section 47 strategy meetings and discussions is making the necessary improvements.

b) The LSCB should seek assurance that i) in 'Concealed Pregnancy' cases an ICPC takes place that ensures focus is then made on that individual child, ii) in cases where children are removed at birth (where no pre-birth assessment had taken place) the appropriate child protection procedures are followed and iii) that assessments still take place even where there are already siblings' subject of safeguarding processes.

Recommendation 3

The LSCB should seek assurance from CSC that their current improvement plan includes case recording and adequate demonstration of consistent supervision and management oversight on cases. This needs to ensure that the improvement plan makes the necessary improvements required to prevent the issues identified in this case.

Recommendation 4:

The LSCB should seek assurance that the Fostering placement and support service are i) linking in with the LADO when complaints are made about foster carers, and ensure that the chronologies in relation to the foster carers are kept up to date. ii) They should ensure that the Fostering placement and support service is adhering to 'Notifiable Incidents under schedule 7 of the Fostering Services (England) Regulations 2011.' In addition to this foster carers and supervising social workers should be re-issued with guidance on methods of communication with each other and what instances should be referred. iii) They should consider whether Foster carer reviews should be carried out by an Independent person.

Recommendation 5:

The LSCB should seek assurance that where indicated the multi-agency child death procedures for unexpected child deaths of children under 2 years, ensure that a skeletal survey takes place at the earliest opportunity possible so the results are available to inform the post mortem.

Recommendation 6:

The LSCB should ensure that there is a clear procedure with regard to the relationship between serious incident investigations, serious case reviews and LADO investigations.