NHS
Morecambe Bay
Clinical Commissioning Group

AGENDA ITEM NO: 9.0.

Meeting Title/Date:	Governing Body - 18 July 2017		
Report Title:	A Summary of the Serious Case Review (SCR) for Child LC		
Paper Prepared By:	Kirsty Byrne	**Date of Paper:**	June 2017
Executive Sponsor:	Margaret Williams	**Responsible Manager:**	Jane Jones
Committees where Paper Previously Presented:	Executive Committee 11 July 2017		
Background Paper(s):	LSCB Child LC Overview Report LSCB Child LC Learning Brief		
Summary of Report:	On the 14 June, Lancashire Safeguarding Children's Board (LSCB) published the overview report and learning brief of the SCR of Child LC. This reports aims to summarise both documents for the purpose of sharing the learning from the case and advising of any associated action for the CCG.		
Recommendation(s):	The Governing Body is asked to:- • Note the contents of the paper and recommendations from the review, specifically those relevant to NHS MBCCG commissioned services. • Review the learning recommendations		
			Please Select Y/N
Identified Risks:	Impact of multiagency system wide learning		Y
Impact Assessment: (Including Health, Equality, Diversity and Human Rights)			
Strategic Objective(s) Supported by this Paper:			**Please Select (X)**
To Improve the health of our population and reduce inequalities in health			X
To reduce premature deaths from a range of long term conditions			
To develop care closer to home			
To commission safe, sustainable and high quality Hospital Health Care			
To commission safe, sustainable and high quality Mental Health Care			
To improve capacity and capability of primary care services to respond to the changing health needs of our population			X
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A summary of the Serious Case Review (SCR) of Child LC:

Child LC – Background:

Child LC was an immobile baby below the age of 12 months who died in October 2015. An ambulance was called to the home address by the father who was looking after Child LC at the time. On arrival the ambulance crew found Child LC to be unresponsive. Child LC was transported to the local hospital where cardio pulmonary resuscitation (CPR) was attempted, but after significant attempts without response Child LC was pronounced deceased.

The cause of death was initially thought to be due to overlay, (rolling onto an infant and smothering them in bed or on a chair, sofa or beanbag for example), however the Post Mortem examination revealed a number of injuries to Child LC though to be as a result of non-accidental cause. The Father has been charged with the murder of LC and Mother has been charged with causing or allowing a child to be harmed.

Child LC's Mother had contact with mental health services in her adolescence, presenting at the time with a brief history of low mood and self-harming. During his own childhood, Child LC's father was known to Children's Social Care and had spent time living with his grandmother when his relationship with his own mother and her new partner had broken down. Father had been known to the police for anti-social behaviour, theft and criminal damage. It is recorded by police that father was known to have previously self-harmed. At the time of Child LC's death it was noted that there was cannabis misuse within the home.

Involvement from Agencies:

The family were known to a number of agencies prior to the death of Child LC. Mother presented to the GP when she became pregnant and was referred to the Teenage Pregnancy Midwifery service however it was noted she did not engage well. Following a domestic abuse incident reported to the police, Children's Social Care became involved with the family and completed an assessment. Health Visiting services were also involved at this point.

From the Primary Care team there was routine contact with the family and child and contacts in line with the Healthy Child Programme. The records show some contact with mother prior to the pregnancy concerning low level mental health problems and then routinely following the birth of her child. There were no safeguarding concerns noted at these contacts.

It is apparent from this case that there are a number of presenting risk factors which include domestic abuse, previous history of offending, mental health difficulties, alcohol and cannabis use

and young inexperienced parents. Information from the review indicates that some of these risk factors were not known to agencies at the time of their involvement.

Key Learning:

Key learning from the review focussed on the need for better information sharing which includes all relevant background information to a case; a multi-agency meeting would have enabled more information to be brought together to inform joint working with the family. Professionals must also recognise the importance of engaging fathers in the work they do, to ensure a whole family approach.

In respect of the known risk factors, professionals need to be equipped with sufficient knowledge and understanding of dependent drug use to enable them to make sound judgments regarding the impact of drug use on the family. There is also scope within this case for exploring new ways of risk assessment and response to domestic abuse specific to young victims and perpetrators.

Recommendations:

The LSCB made a series of recommendations which have informed a multi-agency action plan; this will be governed and monitored by the Serious Case Review Sub Group. Single agencies will report the progress of their actions to this group for effective monitoring to take place. The recommendations include:

- All practitioners should exercise professional curiosity in relation to the role of fathers
- Professional knowledge in relation to dependent drug use should be up to date alongside an understanding of its impact on children and parenting capacity
- Multi-Agency Safeguarding Hub (MASH) should have systems in place for collating information and that this takes in to account relevant background information
- Safe Sleeping guidance should be up to date and make specific reference to the role played by fathers

Specific learning for NHS MBCCG commissioned services will focus on the need for professional curiosity, which is the skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value. This is in particular reference to working with fathers and where there are known risk factors in a family. Improving information sharing continues to be a part of other work streams of the Safeguarding Board, of which the Safeguarding Team are contributing to. Information, learning and actions will be shared with commissioned services as it emerges.

The learning will be disseminated in training and through various communications which include safeguarding leadership forums, newsletters etc. Further learning around cannabis use and also Safer Sleeping guidelines will be shared with commissioned services when this is made available by the LSCB. The Deputy Designated Nurse has spoken with the specific GP Practice Manager to share the learning and offer feedback where required.

Learning and Actions taken so far: **Appendix 1**

The Governing Body is asked to:-

- note the contents of the paper and recommendations from the review, specifically those relevant to NHS MBCCG commissioned services.
- Review the learning recommendations (appendix 1)

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