

Executive Summary Of Serious Case Review

LR

November 2007
Updated June 2008

INTRODUCTION

- 1.1 Serious Case Reviews are conducted whenever a child dies and abuse or neglect are known or suspected to be a factor in the death.
- 1.2 The purpose of a serious case reviews is to establish whether there are lessons to be learned from the case about how local professionals and agencies worked together; to clearly identify these lessons and how they will be acted upon; and to improve inter-agency working to optimise safeguarding children.
- 1.3 On 13th November 2006, LR, aged ten weeks, (dob 03.09.2006), was taken to hospital, with suspicious injuries, which were indicative of non-accidental injuries, from which she subsequently died. On 14th April 2008 her father was convicted of manslaughter. At the time of writing he has not yet been sentenced. Her mother was charged under sec 5 of the Domestic Violence, Crime and Victims act 2004 (failure to protect). She was found not guilty on 14th April 2008.
- 1.4 Each key agency undertook an internal management review, conducted by a senior manager or child protection advisor. Leicestershire and Rutland Local Safeguarding Board (LSCB) Serious Case Review Subcommittee made a detailed examination of the occasions when contact with agencies occurred in case there were lessons to be learned.
- 1.5 Leicestershire and Rutland LSCB Serious Case Review Subcommittee then completed an Overview Report, bringing together and analysing the findings of individual agencies.
- 1.6 This report summarises the Overview report
- 1.7 Prior to her death, there had been no occasion when concerns had been raised about LR's care.

CONCLUSIONS

- 1.8 There is nothing recorded to suggest that practitioners should have been concerned about the parenting capacity of either parent. It had been noted that SK, the mother, was estranged from her family who did not approve of her relationship with the child's father.

- 1.9 LR was reported to be a healthy baby from birth. Weekly home contacts from health visitor until LR was six weeks old had raised no concerns about her care. There appears to be no indication of any concerns about the care of LR prior to the incident on 12th November 2007. There was nothing to indicate that information should have been passed between agencies about LR or her parents.

RECOMMENDATIONS

There are no recommendations arising from this case.