Barking & Dagenham Safeguarding Children Board

NHS North East London and the City

Executive Summary
Child L

Child L was admitted to Hospital on 25th August 2012 having suffered a number of injuries and neglect whilst in the care of her mother and her mother's partner.

The injuries sustained were consistent with both long term neglect and child cruelty, and Child L's mother and Mothers partner were both convicted of Grievous Bodily Harm after a hearing at Snaresbrook Crown Court. In March this year, each received prison sentences of 15 years.

On 21st September 2012 a Serious Case Review panel was convened by the Barking and Dagenham Safeguarding Children Board (BDSCB) Chair to consider the case of Child L and determine whether the criteria were met for a serious case review or individual agency management reviews.

After careful consideration, the decision taken was that with the information available and known to us, the criteria laid out within Working Together 2010 for a full Serious Case Review was not met. However, it was agreed by the SCR panel that there was sufficient information known about possible health involvement in this case to request that an Individual Management Review (IMR) be carried out by our health partners.

The IMR was led by NHS North East London and the City through the Designated Nurse Safeguarding Children.

This report outlines the findings of this Review and the involvement of health agencies within the case.

It is important to note from the outset that this report has concluded that within this case, there were no indicators that could have suggested the events that took place could have been predicted or prevented by any agency.

Early history known indicated that Mother had initially engaged with Health Service both prior and post Child L's birth. She had attended antenatal appointments and was accessing primary heath for concerns around baby's digestion and constipation.

At a point soon after, Child L was taken out of the UK for a considerable period of time and it appears that it was on their return to the UK, with mother having entered into a new relationship, that Child L begun to suffer harm.

Mother and her new partner successfully evaded the attention of statutory agencies having made a number of moves across Local Authorities and avoided the child being seen outside of the home. They took deliberate and measured steps to ensure that agencies were unable to keep good records on their movements and took wilful and intentional actions to prevent Child L from receiving health treatment or accessing health services

The report looked closely into whether there were any lessons that could be identified for Health in working with evasive families.

The outcome of this was that whilst it was recognised and acknowledged that there were some processes that could be better strengthened, there was nothing identified within this case during the period when the child was being seen or accessing services, that would have raised any level of concern.

Processes in place across the agencies to deal with children who are presented to them were robust and without a child being made known to them there was little any agency could do.

Mother and child were seen pre and post birth and reports were very positive. Their exit and entry into the UK would not have been routinely monitored and their success in deliberately evading statutory agencies through multiple address changes meant that there was little or no chance for any agency to fully assess the need of this child. Mother did not have any known history with health or other agencies that would have raised any concern and even less was known about her partner.

The child was presented at GP surgeries for routine health services such as immunisations and on a few occasions routine ailments which did not raise any areas for concern, despite this the family managed to orchestrate a continued and prolonged absence from any agency and were able to subject a child to such a level of harm, that had the police not attended that day and seen the child, it is highly likely the level of harm would have resulted in her death.

It is not known why this child was subjected to the harm that she was. However, the report has not identified any aspects of involvement or known information that could have predicted or prevented the events that took place. However, in conducting the Review, the author has recognised that there is a need to strengthen the transfer processes when families move in and out of local authorities and health boundaries.

Whilst this would not have prevented the actions that took place in this case, it was felt that stronger processes may result in children accessing services sooner once they move, as well help to identify any patterns in patient behaviour that may give rise to concern.

An action plan was developed and is being maintained and monitored by the LSCB.

It is also important to note that the combined partnership working between statutory agencies, once this case was presented, has successfully enabled Child L to make a full recovery and ensure that she was able to be placed quickly into a new and permanent safe home.