Sandwell Safeguarding Children Board

Serious Case Review

Child LS

Lead Reviewer: Stephen Ashley

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Section One – Introduction

1.1 What this review is about

This serious case review concerns a child known for the purpose of this review as LS.

Sandwell Safeguarding Children Board (SSCB) agreed this case met the criteria laid down in Working Together to Safeguard Children 2015 for a serious case review to be conducted. The serious case review was commissioned under the auspices of the previous Safeguarding Children Board and complied with Working Together 2015. Safeguarding Children Boards were abolished as a result of updates to the Children and Social Work Act in 2017 which led to changes to all local safeguarding structures. The review was completed in March 2019 however was transferred to the new multi-agency safeguarding arrangements of Sandwell Children's Safeguarding Partnership following its inception in April 2019 for ratification and publication.

All subsequent references to legislation refer to the guidance and structure that were in place at the time of initiation of this review in 2018, which was under the jurisdiction of the Safeguarding Children Board and Working Together 2015.

The brief circumstances of this case are as follows: LS was born in 2015. LS had two older siblings and one younger sibling. LS lived at home with Mother, Stepfather and siblings, with LS's Father having limited contact.

LS had no contact with agencies other than 'universal' services and some contacts with medical professionals that were not regarded as out of the ordinary. LS and the younger sibling had been seen by health visitors two months before his death and by a specialist nurse practitioner on the day the fatal injuries occurred. No concerns were raised about LS' condition or treatment.

In June 2018 LS was taken to the urgent care walk-in centre by his Mother suffering from vomiting. LS was thoroughly examined by the specialist nurse practitioner and diagnosed with a stomach upset. LS showed no signs of distress and there was no evidence of any visible injuries. LS returned home with Mother who left LS in the care of Stepfather whilst she collected LS's siblings from school. When LS's Mother returned, LS was found to be unresponsive. An ambulance was called and LS was taken to hospital where he sadly died. A post-mortem revealed that the cause of LS's death was significant injuries that were non-accidental and a police investigation was initiated. The siblings of LS were taken into the care of the local authority where they remain.

1.2 Why this review was conducted

The Independent Chair of the SSCB agreed with a recommendation of the Serious Case Review Panel that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the Local Safeguarding Children Board (LSCB) to undertake a review where –

(a) abuse or neglect of a child is known or suspected; and
(b) either –

(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of *Working Together to Safeguard Children 2015* [referred to as Working Together]. This version of Working Together was used when deciding upon the serious case review process, as it was the most current at the time decisions were taken around the review process (published in March 2015).

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of LS, whether information was fully shared by the professionals involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people.

1.3 How this review was conducted

1.3.1 The Review Panel

The lead reviewer/author was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards.

The lead reviewer is independent of Sandwell Safeguarding Children Board in accordance with *Working Together to Safeguard Children 2015* chapter 4 (10*).*

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Sandwell Safeguarding Children Board (SSCB) business unit supported the panel.

1.3.2 The Terms of Reference

This SCR has been conducted using a methodology adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals.

The review covers the period from May 2014, the point at which LS's Mother reported her pregnancy, to June 2018 when LS was taken to hospital with significant injuries. This period was selected following a Serious Case Review Panel meeting and is of a sufficient range to include all of the engagement that LS had with agencies in Sandwell (both pre and post birth). Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The review was conducted in a way which:

- recognised the complex circumstances in which professionals work together to safeguard children,
- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did,
- sought to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight,
- was transparent in the way data is collected and analysed,
- made use of relevant research and case evidence to inform the findings.

Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called *Working Together to Safeguard Children*. It contains all the processes that agencies are required to follow. Working Together has been through several iterations. This review benchmarks against the statutory guidance contained in *Working Together to Safeguard Children 2015*[1]. This is the version that professionals would be working to during the timeframe of this case.

The review worked to terms of reference agreed with the Chair of the SSCB.

The author took full cognisance of the annual reports of the national panel of independent experts on serious case reviews.

1.4 Methodology

The methodology agreed by the Sandwell Safeguarding Children Board (SSCB) review panel is based on a model consistent with the requirements of *Working Together 2015*. It ensures that:

- a proportionate approach is taken to the SCR,
- it is independently led,
- professionals who were directly involved with the case are fully engaged with the review process,
- families are invited to contribute.

As the review was being undertaken it became clear that the police investigation and any subsequent criminal proceedings would take a considerable time. The relevant information required to complete the review was completed in 2019 under the previous structure of the SSCB and the report was ratified in 2020 by the SCSP. In line with guidance, it was agreed with the National Panel for the review to be embargoed until the criminal proceedings concluded. This has now taken place and additions have been made to this report only regarding the outcome of the trial.

1.4.1 Chronologies

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked

[1] ***Working Together March 2015*** - https://www.gov.uk/government/.../working-together-to-safeguard-children--2

to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement, and the work being undertaken to address those issues, was included.

1.4.2 Learning Event

A learning event has not been conducted in this case. Contact with professionals was limited at the request of West Midlands Police. The senior investigating officer conducting the police investigation determined that a learning event may prejudice any future trial process and so would not be conducted. Given the time frame it was determined that a learning event would not assist the review in this case.

1.4.3 Family Engagement

It would be best practice to seek the views of the family involved in the case, however this was not possible due to the ongoing police investigation. Following the conclusion of the trial, birth Father has been informed of the publication of this SCR.

1.4.4 Parallel Investigations

A criminal investigation into the circumstances of LS's death was launched immediately in June 2018, with charges brought against Mother and Stepfather in March 2021 for murder and child cruelty. Both defendants entered 'not guilty' pleas and stood trial between November 2021 and April 2022 when verdicts were reached. Stepfather was found guilty of the murder of LS and three counts of child cruelty, and Mother was found guilty of causing/allowing the death of LS and three counts of child cruelty. Both were sentenced in May 2022: Stepfather received life imprisonment with a minimum term of 24 years, and Mother received 11 years imprisonment.

1.5 How this report has been structured

Following the introduction, section two provides a history of the subjects involved in this review and is the story of what happened to LS over the timeframe agreed within the terms of reference. It provides a synopsis and tries to paint a picture of the world into which LS was born, and the living circumstances during this period. Where an event or issue has proved to be significant, it is highlighted, and any pertinent questions are raised at that point. These areas of significance are analysed in greater depth in section three.

Section three analyses the significant issues exposed in section two and explains **WHAT** happened and **WHY**. From this analysis, the key themes are discussed in section four and the voice of the child in section five. Section six contains the key findings. The recommendations in section seven have been developed from these findings taking account of the work carried out by agencies since these events occurred.

This report has been written so that it can be read by the public without redaction. As a result, the names of the main subjects are not used and there are no dates that might readily identify any members of this family.

1.6 Key individuals

PERSON	RELATIONSHIP
LS	Subject of this review
F1	Mother of LS

S1	Sibling 1
S2	Sibling 2
S3	Sibling 3
M1	Father of LS
M2	Stepfather of LS, partner of F1
GM	Maternal grandmother of LS

Section Two – The Story of Child LS

2.1 Introduction

This section follows the story of LS over the review period. Those events of significance are highlighted and examined in greater depth in section three. This section begins with a pen picture of the world that LS was born into and the background of this family. It is intended to provide a degree of context around the circumstances in which LS and this family were living.

Finally, this section contains a chronological story of the events of LS's life.

2.2 What was the world like for LS?

When LS was born, together with Mother, he initially resided with maternal Grandmother. LS's Father was estranged from Mother and whilst they had some contact, Mother stated that Father had not seen LS *"for some time"* at the time of this death. LS's Father did attend the hospital at the time of LS's death.

At some point LS moved with F1 and siblings in to a first floor flat with F1's new partner. Whilst the flat was described as *"cluttered"* by professionals, the conditions did not cause concern to midwives or health visitors.

LS was always taken for appointments with health professionals and received treatment for some minor ailments such as nappy rash. In April 2018 LS was seen by a health visitor who was visiting F1 and S3 and took the opportunity to examine LS. Whilst there were some concerns around the development of LS's speech, he was described as *"a happy little boy who was very sociable. He was seen engaging with family members, was well dressed and eating a breakfast bar".*

The evidence is that LS was well cared for and was sociable and happy.

2.3 The background of LS's family

F1 gave birth to two children prior to the birth of LS in 2015. Whilst F1 refused to name LS's father, there was an initial assumption that M1 was the father of all 3 children. It is now known that this is not the case though M1 is known to be the father of LS.

F1 had no criminal convictions but was a user of cannabis. F1 stated she used cannabis on a daily basis to: *"cope with life".* F1 did not report any domestic abuse against her and had not been engaged with services except those universal services that might be expected.

M2 had convictions for drugs offences and it is believed he has a child but does not have contact with that child.

There are no reports that F1 suffered any form of domestic abuse by M1 or M2. Professionals dealing with F1 and her children were unaware of any history of M1 and M2.

F1 gave birth to her first child at 17 years old. There are no reports that S1 required any care other than the universal services that were offered. S1 developed normally and when F1 gave birth to a second child, there were no issues with development and no professionals raised concerns about either child.

In 2012 there was a referral to Children's Social Care by S1's school when F1 failed to collect S1 from school. A friend of F1 contacted the school to advise them that F1 had overslept. F1 later collected S1 from school. The school did not report any safeguarding concerns regarding the family, and this appears to have been a one-off incident. The school informed F1 they had made the referral and stated they would monitor the situation moving forward. Children's Services decided there was no requirement for further intervention and closed the case.

In summary, F1 had never had any interventions by agencies other than the universal services that might be expected. F1 had given birth to two children and had attended appointments. No professionals had raised any concerns regarding the way in which S1 and S2 were cared for. The one exception to this being a referral to Children's Social Care when F1 attended late to pick up S1 from school. At that time there was no evidence of any safeguarding concerns.

2.4 LS's Story

F1 attended her general practitioner (GP) in July 2014 and provided a positive pregnancy test. Whilst she was reporting her pregnancy relatively late, she stated that she was superstitious having had two previous miscarriages.

F1 was seen for the usual antenatal appointments and was in receipt of 'universal' services. F1 said that she had good family support but rarely saw the father of the child. Whilst F1 made regular visits to the GP with her other children, regarding usual childhood illnesses, there was nothing unusual reported by professionals throughout the pregnancy.

F1 gave birth to LS in 2015 and there were no unusual circumstances or concerns raised. F1 was discharged to GM's address.

F1 and LS were referred to the health visiting service under the category of 'universal' services.

Shortly after the birth LS and F1 were visited at GM's home by a health visitor. Usual advice was given including safer sleeping advice and information regarding immunisations. F1 reported that LS slept in her bed due to a shortage of space. F1 stated that she would only be staying at GM's home on a temporary basis. Shortly afterwards, F1 attended a baby clinic where advice was given about a nappy rash and F1 provided her new address. F1 registered with her new GP.

When LS was 3 months old F1 attended another clinic and advice was given regarding an umbilical hernia. F1 and LS attended baby clinics on a regular basis and there were no issues reported as LS progressed normally. F1 took LS to the GP on two occasions suffering from nappy rash and a cough, and he was described as: *"well, comfortable and alert".*

LS was described by the GP as: *"a lovely, plump and happy baby",* who was laughing with the GP and sibling.

When seen aged 5 months at baby clinic LS was found to be progressing normally and was at normal weight. Throughout the remainder of 2015 F1 continued to be seen regularly by health professionals. LS did have some minor childhood illnesses (coughs and nappy rash), including two GP attendances when LS was described as *"wheezy"* and having a high temperature. LS was reported by the GP to be: *"well, active, happy and smiling".* At the age of 10 months LS was admitted to hospital overnight for observations having attended both the GP and emergency department with a respiratory infection. One sibling was seeing professionals with regard to speech difficulties, and the other sibling was being seen by health professionals regarding behavioural concerns.

A health visitor undertook LS's '9-12-month development review' during a home visit in 2016. The health visitor summarised the visit in the following terms: *"mostly normal development, milestones strategies given to [F1] to increase [LS's] confidence for walking skills and reduce time in baby walker".*

LS received all immunisations in the prescribed times and progressed normally.

In 2016 following a disclosure made by S1 an Early Help referral[2] was made by school to Children's Social Care who, after discussion, considered that no further action was required and closed the case with a note that: *"School to continue to monitor then follow up with Child Protection procedures (MARF) if further disclosures made and there is a need for statutory intervention".*

In autumn 2016 LS was taken to the emergency department suffering from a minor head injury and a week later was taken to the GP suffering from sickness and diarrhoea and was seen by the nurse practitioner. Nothing significant arose from these two visits.

In 2017 during the 2-year developmental review, it was noted that LS was not reaching some expected areas of development and had some speech and language difficulties similar to the older sibling. A follow-up developmental check was agreed, and an appointment arranged for two and a half months later.

Over the next two months F1 and LS began to miss appointments and did not present for the development check follow-up appointment. No explanation was given for this. F1 brought LS for the developmental check aged two and a half and he was found to be progressing satisfactorily. The reason for missed appointments was not explored.

In summer 2017 F1 was pregnant. F1 missed a number of appointments including LS's parents' evening and a parents' lunch club. Nursery conducted a WellComm screening, an assessment on communication and language. LS's progress was reported as 'red' meaning a child not reaching the expected developmental milestone according to their age. When F1 attended nursery, she said that she did not have time to discuss the issue.

By autumn 2017 F1 had failed to attend a number of appointments at LS's nursery for lunch clubs, parents' evenings and workshops.

In early 2018 F1 gave birth. Shortly afterwards, a health visitor attended F1's home to conduct a new birth visit. F1 reported that she had the support of her Mother and Sister and that for

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3 Early Help - is an approach to working with children and families who are below the threshold of social care intervention but require a multi-agency approach that stops problems emerging and supports families to improve their situation.

reasons that she did not disclose, LS was being cared for by grandparents. There was no indication as to whether this was a short-term placement.

The health visitor was concerned at the lack of support but reported that the home was: *"acceptable, clean and warm but the furniture was worn and tired".* The health visitor also reported that: "*[F1] was very cheerful and felt well obstetrically. It was also noted that children were very polite and mother was clear with her boundaries".*

At the time of this visit S1 and S2 were present and F1 explained that the school had allowed her to keep the children at home because she would have transport problems in the bad weather conditions. This was confirmed by professionals at the school.

Significant Issue one

F1 did not seek help but there were signs she may have been struggling to cope. An Early Help intervention may have provided support to F1 and the children.

In March 2018 LS's nursery place was terminated due to funding issues. F1 was seeking alternative funding but there was no nursery provision for LS while this situation was being resolved.

Significant Issue two

Given F1's personal circumstances and the developmental issues faced by LS, there should not have been a gap in the nursery education.

It is documented in LS's record that LS was seen opportunistically by the health visitor during a routine home visit to see S3 for the ''6-8-week check" in 2018. All of the children were present. It is recorded that F1 was bonding well with S3 and states that F1 was: *"looking at [S1] lovingly".* LS was described as: *"happy and sociable, engaging with family members"*. It is recorded that LS was: *"well dressed and eating a breakfast bar".* It was recorded that LS was engaging with F1. The health visitor recorded that LS's speech was not clear, but F1 was reluctant to initiate speech and language therapy as LS could be understood by family members. F1 stated she was supported by family members including her siblings, parents and other family members. F1 was asked routine questions about domestic violence and FGM but stated that she was not affected by either. It was also reported that she had: *'"No previous mental health concerns in the past nor at this present time".*

On the day LS died F1 took LS to the urgent care walk-in centre with a history of vomiting on and off for 5 days. LS was seen by the specialist nurse practitioner. It is recorded that on examination LS was alert and aware. It is documented that: *"[LS's] temperature was 36.7 (normal), blood sugar was 4.8, chest clear, ENT clear, no rash, no headache, no abdomen pain. Abdomen described as soft with no guarding or rebound. No indication of appendicitis or acute abdominal problems. No red flag issues. [LS] recording as drinking and passing urine. Documented that [LS] was safety netted. Diagnosed viral gastroenteritis".* At the appointment F1 was advised by the specialist nurse practitioner that: "*If no improvement to attend A and E. Prescribed dioralyte sachets".*

F1 returned home with LS who was left in the care of M2 whilst she went to pick up S1 and S2 from school.

When F1 returned to her home she found LS in an unresponsive state and an ambulance was called. LS was taken to hospital but was sadly deceased.

A post-mortem revealed that LS had suffered blunt force injuries including: three broken ribs; front and rear bruising to the head; damage to the top lip and tooth; significant internal injuries to the abdomen and liver and bowel. These were non-accidental injuries and M2 was subsequently found guilty of LS's murder and F1 of causing/allowing the death.

Significant Issue three

Following the death of LS, a lengthy police investigation commenced and the focus of that investigation was the timeline from when LS was seen alive and well at the urgent care walk-in centre and the discovery that LS was seriously injured. Was there any professional intervention at that time that could have prevented the catastrophic injuries to LS?

Section Three – Analysis of Significant Issues

3.1 Introduction

This section provides further depth and analysis to the significant issues that have been identified in section two. Where appropriate it provides the basis for the key findings in section six and recommendations in section seven.

3.2 Significant Issues

3.2.1 Significant issue one

F1 did not seek help but there were signs she may have been struggling to cope. An Early Help intervention may have provided support to F1 and the children.

F1 had two children prior to the birth of LS. The contacts that agencies recorded as having had with her do not reveal anything particularly unusual. S1 and S2 did have various issues that required some intervention. S1 had issues with speech and development and S2 had some behavioural issues. However, F1 attended appointments and sought help.

Whilst F1 was caring for her children alone, she reported having support from grandparents, siblings and other family members. F1 never reported being the subject of domestic abuse even when asked during a routine health appointment. F1 regularly used cannabis but professionals were previously unaware of this information that has only come to light since the death of LS. F1 had never reported suffering from any particular health or mental health issues.

When LS was born there was nothing evident that caused any concern to health professionals. Whilst LS did have some developmental issues these were being addressed by F1 and appropriate professionals.

In 2016 an Early Help referral was made by school regarding S1 which was investigated by Children's Social Care, but the case was closed with an expectation that the school would report further concerns if they arose. This was not an unreasonable course of action: this was

the first occasion the school had registered any concerns other than the one occasion where F1 was late to collect S1 from school. These factors resulted in the case being closed.

However, by spring 2017 professionals began to see a change in the interaction they had with F1. Whereas F1 had previously kept appointments and interacted with professionals, over a period of two months F1 stopped attending important engagements. Over a 5-month period in mid-2017 F1 missed 12 appointments. These included LS's parent's evening and an opportunity to discuss LS's developmental issues.

In the summer of 2017 F1 was pregnant. At this point it seems she and the children may have benefitted from an Early Help intervention. This would have provided opportunities for agencies to engage with F1 and provide her with support. When F1 had given birth to S3 she stated that she had been allowed by the school to keep her children at home for a week because she would be unable to get them to and from school in the bad weather, having just given birth. When LS and S3 were born, health visitors expressed concern that F1 did not receive sufficient support but were reassured by F1 who stated she had sufficient help and support from friends and family.

Furthermore, in March 2018 LS was not at nursery because funding had not been made available or arranged by F1. This may have been another sign that F1 was having some difficulty in coping.

The Local Safeguarding Children Board is responsible for a threshold document that determines the level of care provided to families. There are differing levels and professionals are provided with a matrix to help them judge at what level a family may require an intervention. In this case it may have been determined that F1 and her family required a 'Universal Plus' level of service. This is defined as:

"...needing some additional support without which they would be at risk of not meeting their full potential. Their identified needs may relate to their health, educational, or social development, and are likely to be short term needs. If ignored these issues may develop into more worrying concerns for the child or young person. These children will be living in greater adversity than most other children or have a greater degree of vulnerability than most if their needs are not clear, not known or not being met and multi-agency intervention is required, a lead professional will be identified to coordinate a plan around the child."

The following are some of the risk factors that apply under the requirement for Universal Plus services that would have applied to F1 and her children:

- *Requiring support to provide consistent care e.g. safe and appropriate childcare arrangements; safe and hygienic home conditions; adequate diet.*
- *Poor engagement with universal services likely to impact on child's health or development.*
- *Parents/carers have had additional support to care for previous child/young person.*
- *Parent requires advice on parenting issues.*
- *Lack of response to concerns raised about child's welfare.*
- *Parents/Carers request advice to manage their child's behaviour.*
- *Some support from family/ friends.*
- *Large family with multiple young children.*
- *Families affected by low income/living with poverty affecting access to appropriate services to meet child's additional needs.*
- *Adequate universal resources but family may require help.*
- *The child's current rate of progress is inadequate despite receiving appropriate support and are not thought to be reaching educational potential.*
- *Slow in reaching developmental milestones.*

- *Not attending routine appointments e.g. developmental checks.*
- *Missing set appointments across health including antenatal, hospital and GP appointments.*
- *Is susceptible to minor health problems.*
- *Behavioural difficulties requiring further investigation/diagnosis."*

The threshold document states:

"*...that in these circumstances an Early Help Note should be completed to capture and record needs. If at any time the outcome indicates a need for multi-agency services, an Early Help Assessment should be completed with consent and in collaboration with family/child/young person. Complete assessment on the Early Help System to request a Team Around Family (TAF) Meeting/Forward EH1 form to MASH Early Help Desk.*

A Lead Professional will be responsible for coordination of the episode. Reviews to take place at least 3 monthly."

The point of note is that to access Early Help F1 would have had to have provided consent. The evidence is that F1 had demonstrated on a number of occasions that she preferred to keep her family issues within her own control. It is reasonable to assume that F1 would have been unlikely to have accessed Early Help, and at no stage was there evidence to take child protection to a higher level.

Conclusion: There were sufficient grounds for a health visitor and/or a teacher at S1 or S2's school or LS's nursery to have submitted an Early Help Note which they did not do. It is highly unlikely that an Early Help intervention would have affected the final outcome in this case.

3.2.2 Significant issue two

Given F1's personal circumstances and the developmental issues faced by LS there should not have been a gap in nursery education.

At the end of March 2018 LS was no longer at nursery school. It seems that F1 had not arranged funding or funding was not available. The nursery noted that LS was due to return under Nursery Education Fund (NEF) plus funding when F1 had made the necessary arrangements. This required F1 to apply for a place under the Sandwell NEF scheme.

It is unclear why the application was not made, but it resulted in LS being out of nursery. Whilst the responsibility for application was with F1 it is unfortunate that LS suffered a break in the continuity of nursery education. It should of course be noted that there is no legal requirement for a child of that age to attend nursery education.

Summary: LS had a break in nursery education and professionals should ensure that the systems in place for families are easy to follow and reminders are made to ensure parents make applications for free nursery places in the required time. The fact that LS was not in nursery did not affect the final outcome in this case.

3.2.3 Significant issue three

Following the death of LS, a lengthy police investigation commenced and the focus of that investigation was the timeline from when LS was seen alive and well at the urgent care walk-in centre and the discovery that LS was seriously injured. Was there any

professional intervention at that time that could have prevented the catastrophic injuries to LS?

The most significant factor in this case remains the timeline over which LS received catastrophic injuries. LS and F1 visited the urgent care walk-in centre on the same morning of this death. F1 stated that LS had been vomiting sporadically for the previous 5 days and was unable to keep down any food.

LS was examined by a nurse practitioner. This was reasonable and accepted practice. In fact, this had been the case on a previous occasion when F1 had taken LS to the urgent care walk-in centre with an upset stomach.

The nurse practitioner conducted all of the expected tests. There was nothing to indicate that LS could be suffering from any of the injuries later found at the post-mortem.

Police investigations included an examination of CCTV at the surgery. LS is seen to be active and showing no obvious signs of injury. LS engaged well with Mother and professionals.

Later that afternoon LS was taken to hospital and found to have catastrophic injuries including a mouth injury and severe internal injuries and broken ribs. It is inconceivable that these injuries had been inflicted before the attendance at the urgent care walk-in centre with F1. The post-mortem found that there were some older injuries but a routine examination would not have found these.

Summary: F1 took LS to the urgent care walk-in centre on the same morning of this death. LS was thoroughly examined and was not at that time suffering from the catastrophic injuries later found through the post-mortem examination.

It is perhaps worth commenting on the length of time taken to complete the police investigation. The police investigation was complex and protracted. The medical evidence was a particular issue. In particular, there were very few medical experts in the field who were able to provide the required evidence in a timely manner due to the demands they faced. One example was finding a consultant who could give an expert opinion on injuries that involve damage to a child's ribs. There is only one such person currently available nationally.

Despite the complexity and length of the investigation, the outcome was the successful conviction of the person responsible for murdering LS.

Section Five – Voice of the Child

There is evidence that the voice of the children in this case was listened to. F1 took her children to the urgent care walk-in centre regularly and these visits were taken seriously.

F1 reported that S1 had speech issues and S2 had behavioural difficulties. These were taken seriously, and appropriate referrals were made. When S1 complained of being assaulted by Father, a referral was correctly made, and the matter taken seriously.

Similarly, LS was taken for checks and when seen by a midwife during the home visit for the younger sibling when the midwife also took the opportunity to speak with LS.

Whilst there is evidence that the voice of the child was considered there is little evidence of it being recorded by professionals and this is an area for improvement.

Section Six – Key Findings

The overall finding of this review is:

Tragically, LS was murdered by Stepfather and Mother was found guilty of causing/allowing this death. Both Mother and Stepfather were also found guilty of multiple counts of child cruelty. LS received universal services from agencies. There were no missed opportunities for professionals to intervene and prevent the death of LS.

Section Seven – Recommendations

1. The LSCB should review training provided to agencies, regarding the thresholds for Early Help, and ensure that agencies are aware of their responsibilities to apply thresholds correctly.

2. Sandwell Council should be asked by the LSCB to give assurance that funded nursery provision/childcare is promoted and take up encouraged, particularly within families with children who are vulnerable.

3. Agencies should be reminded by the LSCB of the need to include the voice of the child when recording information and include this issue in section 11 and section 175 audits.