

Keeping Children Safe Together



Highlighting lessons from
Serious Case Reviews

Child A



An overview report is available to download
from the Peterborough Safeguarding Children
Board website alternatively contact

PSCB@peterborough.gov.uk

Outline

Following a normal pregnancy, Child A was born in June 2013. Her parents were Lithuanian nationals who had lived in the UK for several years.

In the following weeks Child A was seen by Health professionals during routine visits and was observed to “growing and developing well”. No concerns were noted about either her health or care.

Child A had multiple injuries. She died as a consequence of severe head injuries but other injuries that had been sustained included broken ribs, bite marks, deep cut to her liver and bruising.

Child A’s father was subsequently convicted of her murder and sentenced to life imprisonment with a minimum tariff of 22 years.

A full medical examination revealed that at the point of death, Child A had multiple injuries

On the 5th September, Child A’s mother returned to work and Child A was left in the sole care of her father whilst mother was at work.

On the evening of 5th September 2013, (aged 9 weeks) Child A was taken to A&E by her parents. She was in a state of unconsciousness and all attempts at resuscitation failed. A full medical examination revealed that at the point of the death,

The Serious Case Review concluded that “the death of Child A could not reasonably have been prevented by any agency or individual who knew her or had any information about her”. The Serious Case Review concludes that no professional, nor any family member, had any Child Protection Concerns for Child A during the period covered by the review.

Learning from the Review

- It was considered an example of good practice that the midwives provided a consistent service to the family by ensuring that a single professional conducted nearly all the interaction during the antenatal period.
- Child A’s mother was given health and maternity information however this was all in English which she found difficult to understand. Agencies must ensure that key information and literature is understood by the recipients.
- There was little information known about Child A’s father. Agencies should ensure that fathers and other significant males are engaged ([see Child T SCR leaflet](#))
- It is considered good practice that at routine health appointments, the Health Visitor personally undressed and handled Child A.
- When Child A was presented at the Accident & Emergency Department on the day of her death, the immediate procedures, emergency response, and support for the family were all appropriately completed.
- The Police response to the incident was led at the appropriate rank and expertise. The case was quickly identified by Doctors and the Police as a suspicious death and a homicide investigation was commenced promptly and professionally.

