SERIOUS CASE REVIEW

EXECUTIVE SUMMARY IN RESPECT OF AARON GILBERT

1. Introduction

1.1 A Serious Case Review has been conducted in accordance with guidelines published in "Working Together to Safeguard and Promote the Welfare of Children: a guide to inter-agency working" published by the National Assembly for Wales (2000).

1.2 It is a requirement of the guidance that a Local Safeguarding Children's Board (LSCB) undertake a Case Review whenever a child dies and abuse or neglect are known or suspected to be a factor in the death.

1.3 In this matter Swansea SCB, having established a Serious Case Review Panel following the death of Aaron Gilbert, took the decision to conduct a review.

1.4 The purpose of the case review is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children.
- To identify what these lessons are, how they will be acted upon and what is expected to change as a result.
- To improve interagency working and better safeguarding for children.

This executive summary brings together the analysis of the key findings from the various individual agency management reports.

2. Reasons for the Case Review

2.1 This review relates to the events leading to the death of Aaron Gilbert. He died at the age of 13 months as a result of the actions of Andrew Lloyd and his mother, Rebecca Lewis.

2.2 At the time of his death Aaron Gilbert was not subject to any legal or child protection procedures. His mother had sole parental responsibility for him.

2.3 On the evening 5th May 2005, following a call to emergency services, Aaron was taken to a hospital Accident and Emergency department.

2.4 Aaron was subsequently transferred to a specialist unit where his condition was seen to worsen. Aaron underwent a formal brain stem test. No evidence of brain stem activity was noted. He died at 11 minutes past 11 on 6th May 2005.

2.5 In November 2006 Rebecca Lewis was found guilty of Familial Homicide. Her partner Andrew Lloyd was convicted of Aaron's murder.

3. Serious Case Review Process

3.1 Swansea SCB Serious Case Review Panel identified the following key agencies as contributors to this review.

- City & County of Swansea, Social Services, Child & Family Division

- National Probation Service for South Wales
- National Public Health Service for Wales (on behalf of Swansea LHB)
- South Wales Police

4. Summary

4.1 The professional involvement in relation to the death of Aaron Gilbert at the hand of his carers falls into two distinct areas.

4.2 Firstly the involvement with Aaron Gilbert and his mother. This was largely with the Health services and was characterised by frequent and consistent contact with the General Practitioner and Health Visitor. There was a brief contact with Social Services just prior to Aaron Gilbert's death.

4.3 Secondly the involvement with Andrew Lloyd. This surrounds the work of the Adult Psychiatric Service, the Probation Service and the Police and Andrew Lloyd's place in the public protection system.

4.4 The following commentary will focus on how the risk which Andrew Lloyd posed in the wider community came together with the vulnerability of Aaron Gilbert without the knowledge of the professional network.

4.5 As with many other cases there are large parts of the circumstances which led to the death of Aaron Gilbert which could not have been known or predicted. It is important to acknowledge that many of the safeguards put in place to identify vulnerable children worked effectively.

4.6 However there are areas of the work of all of the agencies indicated above which had an impact on the outcome of this case.

5. Case Commentary

5.1 All accounts agree that Andrew Lloyd was a very troubled young man. As a child he was the subject of physical abuse, neglect and observed domestic violence between his mother and her partner. He was the subject of a Care Order to Swansea Social Services from the age of 11. Although he returned to live with his mother one year later he remained the subject of a Care Order until the age of 18 in 2001.

5.2 Andrew Lloyd's contact with the Police as a result of offending behaviour began in 1998 and continued regularly through to his arrest for murder in 2005. This offending involved two convictions for violence including a conviction for assault causing grievous bodily harm in 2004. He also had two convictions for threatening behaviour. There were also numerous other convictions for non violent offences. None of his convictions involved domestic violence or violence against a child.

5.3 Lloyd first came to the notice of Adult Mental Health services in January 2004 when he was referred after taking an overdose. A further suicide attempt followed in March 2004. Both of these seemed to be linked to relationship issues. At this time he was diagnosed with a personality disorder. His problem with alcohol and drug abuse was also noted as a significant issue in his behaviour.

5.4 During a previous relationship and in response to the concerns in relation to the safety of another child, Adult Psychiatric Services twice contacted the child's prime carer who expressed the view that Andrew Lloyd was no threat to the child. Although the Adult Psychiatric professionals involved quite appropriately identified risks to a child from an adult service user and took this forward by holding discussions with the child's mother, it is not clear how they assessed the safety of the child having identified the possible risks. They did not make a referral to Social Services.

5.5 The subsequent appointments offered to Andrew Lloyd by psychiatric services were missed as a result of his imprisonment for GBH in July 2004.

5.6 Andrew Lloyd was released on licence in January 2005. A Probation Service risk assessment report, which should have been but was not updated prior to release, classified him as presenting a middle range of risk.

5.7 The Prison and the National Identity Service did not place information of that licence on the Police national computer. It is not clear where the fault for this lies.

5.8 Andrew Lloyd was on licence to the Probation Service from 14th January 2005 until the end of March 2005. Probation's contact with Andrew Lloyd was limited to a single meeting on the day of his release. He missed three subsequent appointments and efforts to ensure his compliance with his licence proved to be unsuccessful.

5.9 In February 2005 a Court warrant was issued for Andrew Lloyd for breach of licence. Due to the fact the licence was never placed on the Police national computer, that warrant was also absent from the data base.

5.10 On 7th March 2005 Andrew Lloyd was admitted to psychiatric hospital as the result of a further attempt at suicide. He walked off the ward on 11th March. The suicide attempt followed an incident on 6th March of domestic violence perpetrated on his former partner by Andrew Lloyd. He broke into the home of his former partner and child when they were asleep. They escaped to relatives.

5.11 This attempted suicide was Andrew Lloyd's last contact with the police before his arrest for murder. Despite Lloyd being on licence and a warrant being issued for his arrest in relation to breach of that licence Lloyd was not arrested. Officers were unaware of these details as they were not on the Police national computer.

5.12 Following a routine assessment by police officers in line with South Wales Police policies, the police took a decision not to hold a Domestic Violence Multi-Agency Assessment Conference which would have brought together Police, Probation, Psychiatric Services and Social Services.

5.13 This incident is the last time before the murder that agencies with significant information about Andrew Lloyd might have become aware of each others work and come together to address the risks which Andrew Lloyd posed to the wider community. The Domestic Violence Multi-agency Risk Assessment Conference potentially would have allowed for the production of an action plan which may have reduced the risk of future offending by Lloyd with particular reference to domestic violence.

5.14 The date at which Andrew Lloyd and Rebecca Lewis started their relationship and on which Andrew Lloyd first started taking a parenting role in respect of Aaron Gilbert is unknown. However it is possible to identify the period between 12th March 2005 and 15th April 2005 as the period within which their relationship must have started.

5.15 During this period between the establishment of the relationship and the end of Aaron's life, some four to seven weeks, professionals from various agencies had seven contacts regarding Aaron. At no time were they aware that Andrew Lloyd, Rebecca Lewis and Aaron Gilbert were living together as a family unit.

5.16 Aaron Gilbert was a child who for the first 12 months of his life lived in an environment which raised no concerns for his welfare. Rebecca Lewis and Aaron Gilbert's contact with the health service from Aaron's birth was consistent and unconcerning. Rebecca appeared to be meeting all of Aaron's needs and sought health advice and assistance when appropriate. Assessments of Aaron in his first year identified him as meeting all of his developmental milestones.

5.17 In the three weeks before Aaron's death, his mother took him to the GP with an injury to his left arm for which he was referred to a local hospital A&E department. Aaron was taken to the hospital by his mum but she then took him home before he was seen. This action caused the A&E department to be concerned and contact the GP.

5.18 Throughout this review the piece of information which all professional agencies lacked which might have lead to the consideration of the safety of Aaron Gilbert was the presence of Andrew Lloyd in a parenting capacity in relation to him. The earliest opportunity to identify this piece of information was the planned home visit subsequent to Rebecca Lewis's failure to remain at Accident & Emergency with Aaron when he had an injured arm.

5.19 On the 15th April 2005 the A&E department informed both the GP and health visitor that Aaron had attended the department but that Rebecca Lewis had left before being seen. A home visit was to have taken place in the week of 18th April 2005 to follow up this issue but staff sickness prevented the call being made. Had that visit occurred, then the health visitor may have become aware of Andrew Lloyd's presence in the family. It is clearly not possible to suggest that such a visit would have prevented Aaron's death, however it is possible that it would have been more likely that the professional network would have been in possession of information which was relevant to ensuring the safety of Aaron and as such provides a lesson for future practice.

5.20 Also on the 15th April 2005 Aaron was seen during a swimming activity at a Sure Start Dads' parenting group with Andrew Lloyd's sister's partner. Aaron's unexpected attendance at this group with an unrelated carer was questioned by staff. No concerns were raised about the possible abuse of Aaron. He had no bruises or marks.

5.21 Ten days after this Aaron was again seen by the GP. His mother had attended surgery concerned about a rash on him. He was examined and no concerns about his physical state or mother's attitude were raised by the GP.

5.22 On 27th April 2005, the Social Services Access and Information (A&I) team received an anonymous phone call from a female caller who hung up in the middle of the call. Although the referral was brief, jumbled and judgemental and the referrer was uncooperative, within this call an allegation was made that Aaron Gilbert was one year old, that he had bruises, and that he was being cared for by a mother and her partner who possibly had problematic drug use. The source of the alleged bruising was not identified and an address was given.

5.23 The call was passed by the A&I worker to a social worker as an allegation of physical abuse and neglect. Despite the information seeming to indicate that this referral required a child protection response, the social worker did not initiate an immediate child protection investigation.

5.24 The social worker did not seek advice or pass the decision on to a manager or senior practitioner colleague for review even though those opportunities were available.

5.25 The referral was received on the day after the established Team Leader of the A&I team left their post and 3 days before the new Team Leader effectively took up the position. These managers routinely scrutinised the work of their staff at the end of the working day. At the time of the call no effective fail safe system was in place which automatically reviewed the social work decision making process. In hindsight if such a system had been in place, the decision of the social worker could have been questioned on the day, the error of judgement could have been identified and the case relabelled as a child protection case.

5.26 While the social worker did not execute a child protection response, she did recognise that the family may require services and took action in the form of writing to Rebecca Lewis inviting her into the office to ask about the allegations. This visit aimed to produce an open and cooperative dialogue with Rebecca Lewis which may have then resulted in a child protection investigation being instigated.

5.27 A letter was sent out on 29th April offering the first available office appointment, one week later on 5th May. The address which the referrer had provided was incorrect and so the letter was sent to the wrong address and presumably was never received.

5.28 On 4th May a second anonymous referral was received by the same A&I Assistant from the same anonymous caller asking to know what action Social

Services was taking following her earlier call. No new information was provided and the social worker, after being made aware of the call, decided not to change the original plan, which was to interview Rebecca Lewis in the office on the following day.

5.29 On 5th May, Rebecca Lewis did not attend the office for the interview having not received the invitation letter because the caller gave an incorrect address. An opportunistic visit by the health visitor to the address where Rebecca Lewis was living was also made that day. No one was at home and a card was left.

5.30 At five o'clock Aaron was admitted to hospital suffering from head injuries from which he did not recover.

6. Conclusion

6.1 The Serious Case Review concludes that all the agencies involved with Andrew Lloyd, Rebecca Lewis and Aaron Gilbert and the individuals involved in Aaron's life have lessons to learn from this case.

6.2 Action needs to be taken to ensure that safeguards which exist to protect children, and those which aim to identify and act on risks posed to the community by individuals, work effectively. For example within their child protection polices, all agencies need to ask the question: "How would this policy work if a mistake was made by an individual or if an individual was absent for an unplanned period of time?"

6.3 There were opportunities for the services working with Andrew Lloyd to exchange information and make an assessment of the risks he posed to the public. The agencies held a variety of information which, if it had been put together would undoubtedly have raised additional concerns and possibly further investigation and action.

6.4 However Andrew Lloyd's licence was not placed on the Police national computer, concerns about his mental health and personality disorder were not shared outside of Adult Mental Health services, his history of domestic violence was not shared with the Probation Service, the Probation Service did not share information about Andrew Lloyd with Social Services, the Police or Adult Mental Health. As a result Andrew Lloyd was not identified as a significant risk to the public and to his partner and children.

6.5 NHS health services had extensive contact both with Aaron Gilbert, his mother and Andrew Lloyd. They might well be considered the agency that held the most information on all of the actors in this case. The work of the Health Service in this case was largely very positive. However despite recognising a need to follow up the abandoned visit to A&E with Aaron regarding his injured arm and planning to do so two weeks before Aaron's death, no visit was undertaken due to staff sickness. Such a visit would have provided a means of monitoring Aaron's welfare at a time when it is now known he was very vulnerable.

6.6 With regard to Social Services it would appear that a clear referral of a young child possibly suffering physical abuse and neglect was met with an inadequate response, a letter being sent out to the subject of the referral, offering an appointment.

6.7 Three areas of social services involvement which are explored in the review are the interaction between Social Services and the general public, the judgement of a specific individual social worker who was responsible for making the initial decision, and the effectiveness of the system established by the Social Services department to oversee the social work decision making process.

6.8 The role that the public can play in cases such as this must not be forgotten and it is important to make the community aware of their place within the child protection system. Police reports following Aaron's death reveal that on at least two occasions prior to his admission to hospital, injuries were spotted by relatives but went unreported. When a report was made, it lacked vital information such as Andrew Lloyd's involvement and a correct address for the child.

6.9 Services such as Social Services and the Police not only need the community to pick up the phone where they see the need to protect a child but also make sure their action is effective by ensuring services get vital and correct information.

Summary of recommendations

7.1 A comprehensive review of the A&I function should be undertaken by Swansea Social Services to focus on the systems and personnel involved in the making of critical child protection decisions.

7.2 A review of SSCB Policy and practice for engaging the community as partners in the child protection process should be undertaken.

7.3 Information sharing protocols and procedures within the SSCB should be reviewed to ensure that they are fit for purpose.

7.4 The procedures for calling a Domestic Violence Multi-Agency Risk Assessment Conference should be reviewed.

7.5 The failings of the process for placing details on the Police national computer should be raised with those organisations responsible, with a recommendation that the present process be audited and reviewed.

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