

'LESSONS NEED TO BE LEARNED FROM THIS TRAGIC CASE'

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Murdered baby Aaron Gilbert was failed by a catalogue of errors leading up to his death, according to an official report today. Aaron died of breathing difficulties on May 6 2005 after receiving 50 external injuries while in the care of his mum's boyfriend Andrew Lloyd.

Today's report lists a series of serious mistakes that played their part in missing the threat posed by Lloyd.

It also reveals that a health visitor called to Aaron's Swansea home just hours before the 13-month-old was rushed to hospital with fatal injuries - but nobody was home.

The review by Swansea's Safeguarding Children Board revealed:

A social worker failed to take proper action when told about the risks to Aaron;

A home visit two weeks before his death never happened because of staff sickness;

Lloyd had suffered abuse as a child and attempted suicide on a number of occasions and had been diagnosed with a personality disorder, and;

His release from prison was bungled and meant police had no idea there was an arrest warrant.

The report says: "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 in place to identify vulnerable children worked effectively."

Lloyd was convicted of Aaron's murder and his mum Rebecca Lewis was convicted of familial homicide in November last year.

She was sentenced to seven years in prison and Lloyd was told he would have to serve a minimum of 24 years behind bars.

But the SSCB report shows how a series of mistakes and failings meant the risks posed by Lloyd were never spotted and allowed Aaron's case to fall through the net.

It says there were no concerns about Aaron's welfare in the first 12 months of his life. It was only when Lloyd, a subject of physical abuse and violence as a child, entered Aaron's life that he was put at risk.

The report showed that Lloyd had a long history of mental problems, having attempted suicide and having a personality disorder. He had a history of criminal activity and was sent to prison in July 2004 for GBH. When he was released from prison on probation in January 2005, his licence was not

recorded on the police national computer. The report could not find any reason for this glaring error.

It meant that when he attempted suicide again in March police were unaware a warrant had been issued for his arrest.

Lloyd and Lewis are thought to have got together some time after March 2005.

Aaron was taken to his GP with an arm injury in April, three weeks before he died. His doctor referred him to A &E but Lewis left before Aaron could be seen. Hospital staff notified Aaron's GP and the health visitor about Lewis's behaviour and a home visit was planned. But due to staff sickness, it never took place.

On April 17, Swansea Council's social services department received an anonymous call raising concerns for the baby's safety.

The social worker failed to class the call as a child protection case and instead wrote to Lewis asking her to come into the office for an interview on May 5.

She didn't attend and Aaron died the next day.

The report highlights the inadequate response of the social worker as one of a number of factors in the run-up to Aaron's death.

No agency knew Lloyd and Lewis were together. It seems that on a number of occasions a variety of agencies had the opportunity to intervene and avoid the tragic consequence, but for a variety of reasons and circumstances the risks were never spotted. Agencies held pockets of key information about Lloyd and the dangers he posed that as a whole would have raised more concerns and increased investigation, but individually did not. All the agencies have admitted that lessons need to be learned.

The report said: "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 Service, the Probation Service did not share information about 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.

"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 spokesman for Swansea Council's social service department said some recommendations were already being implemented, adding: "We will be working closely with our partners to further improve procedures in the interest of vulnerable children living in our communities."

The National Probation Service for South Wales said Aaron's death had highlighted the importance of inter-agency working to protect children.

A spokesman for South Wales Police said: "We have already taken steps to action some of the recommendations made in the report and we will continue to work with our partners to identify those

who pose a risk to society and protect those who are vulnerable."