



Case Review executive summary

July 2005

Introduction

This is a summary of a local case audit conducted by ACPC in accord with paragraph 8.9 of "Working Together." It concerns the death of a six-week old infant, who was originally referred to a hospital social worker some weeks prior to her birth, but whose subsequent unexplained death was not thought to have been as a result of abuse or neglect.

Review

The purpose of the audit was to focus upon:

- How effectively agencies worked together in a family support context
- Arrangements for conducting pre-birth assessments
- Whether the child protection procedures should have been invoked and in learning any other lessons that might usefully inform professional practice.

The review panel comprised of:

Dr S Bennett-Britton – Consultant Paediatrician

F Manning – Designated Nurse

S Popadynech – Detective Superintendent

G Williams – Principal Child Care Manager

Case Summary

The child was born to co-habiting teenage parents, who had each experienced troubled childhoods. Mother had spent many years in the care of another local authority - following recurring episodes of abuse - and had experienced multiple placement moves.

The effect of the parents' earlier life experiences had significant impact upon their own emotional and behavioural development, to the point whereby each parent was found to have learning difficulties to varying degrees.

Their parenting capacity was questionable if not limited, and while proposals were made for the child to remain in their care, this was understood to be under the oversight of paternal grandmother.

Pre-birth assessment was delayed by the hospital social worker's competing priorities and in the event was not completed until after the child's birth. There followed considerable inter-agency liaison, including core group meetings in managing a service-plan whereby the child was seen to make satisfactory progress.

She was subsequently found collapsed in bed between her parents, sadly the victim of sudden and unexplained death in infancy.

Lessons Learned

1. The vulnerability of very young infants is widely reported in contemporary literature. This is the twelfth case of a child death under three months reviewed by ACPC over the past 12 years.
2. Detailed assessment revealed a range of pre-disposing factors associated with safeguarding priorities.
 - Parents' own abuse as children
 - Parents' own "looked after" history
 - Concerns about family violence
 - Emotional and behavioural difficulties
 - Teenage pregnancy
 - Concealment of pregnancy early on
3. Subsequent indicators of further domestic abuse, and then to parents' indifference to co-operating with the social worker might have otherwise led to the invoking of child protection procedures in this case.
4. Earlier assessment and an initial child protection conference might have led to more robust case-planning. The National Service Framework indeed advocates extensive support pre-birth.
5. Calling all inter-agency meetings "core groups" however can be confusing and unhelpful.
6. "Placing" vulnerable children with other family members should always be the product of informed and re-evaluated assessment.
7. Advice to parents on co-sleeping is an aspect of child welfare requiring further clarification. Risks to infants under 11 weeks has been the subject of research at the University of Glasgow. Further clarification is being sought by ACPC into other action it should be taking in consequence.
8. An inter-agency protocol governing sudden and unexplained death in infancy (SUDI) is at an advanced stage of development by both local ACPCs (incl. Stoke).

Recommendations

1. That ACPC reiterates the need to maintain a child focus in assessment and intervention.
2. The Assessment Framework remains the critical reference-point for service-planning in safeguarding the welfare of children who are in need and in agreeing thresholds of intervention.
3. That the Co. Council reviews the support to and the management of children and families social workers based in hospitals.
4. PCTs should review advice to parents within parent-held records.
5. ACPC will clarify current advice and guidance to parents on co-sleeping.
6. ACPC considers the case for publishing a safe-parenting handbook among a range of options within a forthcoming publicity strategy.
7. Health Trusts confirm processes are in place for sharing information about vulnerable children between professional disciplines.
8. ACPC will maintain training around risk assessment in reiterating the identification of pre-disposing risk factors.
9. Staffordshire Police to progress development of a local protocol governing the management of sudden and unexplained death in infancy.
10. Policy and procedures working group to review procedural advice in conducting pre-birth assessments.

***If you have any queries about this bulletin
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