Serious Case Reviews: Record of cases from which the statistics were derived. Only cases involving the mother are recorded here.

revised 2/2/17

Mother as lone perpetrator: Lone-living mother

April 2015 - Lancashire – Child N

Death of a 4-year-old boy and his mother in May 2014 as the result of a house fire in Liverpool. Parents had separated acrimoniously some 4 years earlier. Due to concerns about his safety and on-going contact disputes, Child N's care was subject to a number of court proceedings. The court's decision in the second case resulted in the father, who lived in Lancashire, being granted a residence order and the mother a contact order. During the fourth and final set of proceedings, whilst Child N was on a contact visit, the mother made allegations of child sexual abuse which resulted in Child N staying with her in Liverpool. Police evidence indicated that mother had purchased petrol in a container which had been used to start the fire. The Coroner's report[3] states *"... it is found that the fire was started deliberately ... with the intention of causing death or being reckless"*. The Coroner's verdict was that Child N had been unlawfully killed and mother had taken her own life after deliberately starting the fire. Hence, the mother killed Child N whilst the child was on a contact visit with her.

April 2015 – Croydon – Josh

Death of a 3-year-old boy in March 2013. Mother carried Josh into the path of an oncoming train, killing them both.

April 2015 – Fife and Edinburgh Child Protection Committees – Child MK

Death of a male child in January 2014. MK was reported missing by his mother on 16th January; his body was found on 17th January following a police search. Mother pleaded guilty to culpable homicide and was sentenced to 11-years imprisonment.

June 2015 – Cambridgeshire – Child K

Death of a 2-year-old boy in January 2014. Primary cause of death was bacterial pneumonia infection with secondary causes of dehydration, failure to thrive, norovirus and cerebral palsy. Background: following his death, mother received a police caution for cruelty against Child K contrary to Section 1 of the Children and Young Person's Act 1933. Child K and his sibling had been subject to a child protection plan for neglect for a month prior to the incident.

2015 - Sunderland – Baby Penny

Death of a baby girl as a result of drowning in May 2014. Mother found Baby Penny under water in the bath after she left her unattended to answer the door. Mother had experienced significant mental health problems during a previous pregnancy, following which her children were subject to child protection plans until it was established that her ex-partner would take over sole responsibility for their care. She had repeated mental health issues before and after the birth of Penny.

November 2015 - Harrow – Baby F

Death of an 11-month-old boy of Irish-traveller descent from a brain injury after being found submerged in water whilst unsupervised in a bath. Baby F and 2 half-siblings were subject to child protection plans under neglect. Mother given a 6-year custodial sentence after pleading guilty to manslaughter.

August 2015 – Anonymous – Child F

Death of a 5-month-old baby in September 2014. Child F was found unresponsive by mother after mother and baby had fallen asleep on a sofa when staying overnight at mother's friend's home. Ambulance crew noticed the smell of alcohol on mother and called police. Mother was arrested on suspicion of neglect, having thought to have unintentionally rolled on top of her baby. Mother reported that her ex-partner had accused her of not looking after the children properly. The health visitor recorded that child F was 'well cared for and thriving'. Criminal investigation concluded with no charges being preferred.

July 2015 – Anonymous – Subject Child

Death of a 6-7-week-old-girl in May 2012. Subject child was found by mother with her face pressed up against the back of the settee at home where she had earlier fallen asleep. Mother had just woken from sleep after having drunk alcohol earlier in the day. Background: mother was arrested in 2011 for being drunk in charge of a child, leading to half-brother being placed in foster care.

April 2015 - Lincolnshire – Baby W

Death of a baby boy during the hours following his birth in September 2013. Mother was 16-years-old at the time of the incident; she had concealed or denied her pregnancy and given birth, unassisted in her bedroom at home. Post mortem revealed that Baby W died from a tissue blocking his airway; mother pleaded guilty to infanticide and was sentenced to a 2-year Youth Rehabilitation Order (YRO).

March 2015 - Coventry – Child T

Death of a 3-week-old girl in June 2013; coroner classified cause of death as 'unascertained'. Background: Following Child T's death, a home visit found that the family were living in dirty and unhygienic conditions. When the family home was visited immediately following Child T's death, it was found to be squalid with dirty nappies, rubbish and food all over the floor. It was very hot and there were flies everywhere. In the police officer's opinion it was not fit for human habitation. The police investigation concluded that whilst a case for criminal neglect had been established, it was not in the public interest to prosecute.

March 2015 - Kirklees – Subject child

Death of a 1-year-9-month-old child in February 2012 as the result of severe brain damage. Police were unable to establish how the subject child sustained the fatal head injuries however medical evidence indicated that they were inflicted non-accidentally**.** Background: Maternal history of depression and concerns raised by father and paternal grandparents relating to an unexplained burn to subject child's hand and a bruise.

January 2015 – Liverpool - Maisie

Death of a female infant as a result of Sudden Infant Death Syndrome (SIDS). Background: Family were known to children's services in a neighbouring local authority where one of Maisie's siblings, Sibling 4, had been subject to a Child Protection plan. Two other of Maisie's siblings had died - apparently of natural causes, though one had been the subject of a Serious Case Review.

August 2014 – Oxfordshire – Child N

Death of a 1-year-old girl in May 2013 whilst in the care of her mother, recorded as unexplained death but treated as suspicious. Parents grew up in Africa. Child N had been the subject of contested proceedings for residence and contact in the family court between her mother and the father. Child N is believed to have been in her mother's care during the last days of her life and her mother is known to have left the UK in the hours following the child's death. A Residence Order had been granted in favour of the father due to fear of the mother leaving the country with Child N. The day after the order was granted the mother left the country and Child N was found dead in her flat. As yet there has been no inquest. The initial post mortem examination of Child N was unable to ascertain the cause of her death; however it noted that Child N did not have the commonly observed symptoms of unexplained sudden infant death. The death of Child N is therefore being treated as suspicious and is the subject of a continuing criminal investigation. There is no evidence or reason to suspect that Child N was ever caused any harm by her father.

November 2014 - Torbay – C42

Death of 2 siblings and their mother. Child A and his mother died on the 12 July 2013 following a fall. The body of Child B was found later that same day at their home address. Background: the inquest into the deaths found that the mother took her own life and that Child A was unlawfully killed. An open verdict was recorded in respect of Child B. Children were living with their mother following a short period in foster care whilst their father was charged with the assault of their mother. (*Author's note: one wonders whether the right person had been removed from the presence of the children*).

November 2014 – Tower Hamlets - Jamilla

Death of a 4-month-old girl, suspected to be caused by malnutrition. Mother was charged with causing or allowing the death of a child and the neglect of Jamilla and her two older siblings; she pleaded guilty to manslaughter and cruelty.

October 2014 – Isle of Wight - Baby Z

Death of a 2-day-old baby. Cause of death was unascertained but evidence suggests that safe sleeping and temperature control advice had not been followed. Post mortem examination revealed small doses of non-prescribed drugs in Baby Z's blood, likely to have transferred via the placenta or breast milk. Maternal history of: substance misuse.

April 2014 – Devon – CN08

Death of a 2½-year-old boy. Mother admitted to killing the child; she was convicted of manslaughter and received a hospital order. Mother had been detained under the Mental Health Act for a period in 2011. A history of domestic abuse reported against the father had led to a Restraining Order against the father being in place at the time of the incident. [*Author's note: One wonders whether the danger of the mother to her children was considered by the authorities at all*].

March 2014 – Windsor and Maidenhead – EY and OY

Death of an 11-month-old boy (EY) as the result of a serious head injury. Post mortem revealed older fractures and bruising. Mother was arrested under suspicion of causing EY's death. The children lived with their mother in Windsor and Maidenhead. Their father lived at a separate address.

January 2014 - Suffolk - The Anderson Family

Death of three children and their mother. Children were aged 3-years, 2-years and 13-months at the time of their deaths and mother was 7 months pregnant. Evidence suggests mother killed the children prior to committing suicide. All three children were subject to child protection plans under the category of neglect.

2013 - Portsmouth – Child D

Death of a 3-week-old girl in December 2011, as the result of Sudden Unexpected Death in Infancy. There had been substantial involvement from various agencies prior to Child D's death. 2 siblings had suffered significant injuries as infants and as a result they were subject to formal child protection arrangements and were living in kinship care. Child D was subject to a child protection plan from birth and was living within the extended family following an interim supervision order at the time of her death. On the night that she died she had been left sleeping in circumstances which were not safe. Her death did not result in any criminal prosecution. There was a history of substantial contact with her family which included the investigation of very serious, inflicted injuries to some of her half-siblings at an early age.

November 2013 - Bradford - Hamzah Khan

Death of a 4-year-old boy in December 2009, as a result of chronic neglect. Hamzah's body was discovered by police during a search of the family home. (The child had been dead for two years and this fact had been covered up). Mother was convicted of manslaughter and child cruelty in October 2013. Maternal history of chronic alcohol dependency; depression; social isolation; domestic abuse; and reluctance to engage with services, including registering children for health and education services. Father was made the subject of a non- molestation order in 2008 following an arrest for assault against mother.

November 2013 - Surrey - Child J and Child K

Death of Child J, aged 3-years and sibling, Child K, aged 2-years. Mother was convicted of murder. Child J and K were known only to universal services until 4 months before their deaths. Mother left father and moved to Surrey from East Sussex at which point Father reported concerns for the welfare of the children to police. **Key issues:** allegations of domestic violence made by mother and accepted "at face value"; and concerns from Partner 1 and teacher of emotional abuse by Mother towards older children. **Learning:** the potential impact of gender and class bias; the need to verify allegations of domestic violence in order to inform action.

July 2013 - Lancashire - Baby E

Death of a 4-month-old baby boy from a serious head injury in December 2011. Both parents had been looked after as children, had experienced childhood abuse and were chronic substance users. Both adults were charged with child neglect and the mother was also charged with gross negligent manslaughter.

October 2013 - Birmingham - Keanu Williams
Death of a 2-year-old boy in January 2011 from multiple injuries, later determined to be the result of separate incidents with several major injuries being sustained over a period of days. Mother was convicted of Keanu's murder and of 'cruelty to a child' in respect of one his older half siblings; she was sentenced to 18 years imprisonment. Mother's partner was convicted of 'cruelty to a child' and received a 9 month suspended sentence. Mother spent periods of time in foster care subject to care orders throughout her own childhood. Keanu's older siblings were subjects of residence orders to maternal grandfather.

February 2013 – Manchester – Child U
Death of a 4 year old girl in September 2011 who was subject to a child protection plan. Mother pleaded guilty to manslaughter on the grounds of diminished responsibility and was detained in a secure mental health facility. History of inappropriate sexual behaviour by mother towards her daughter and parental mental health issues.

2012 - Bury - Child D (Case Arlene 11)

Death of a 4-year-old girl from multiple stab wounds. Suicide notes indicated that Child D was killed by her mother who then attempted to kill herself. Mother had recently been dismissed from her job and was due to attend court in relation to offences in contravention of the Data Protection Act. Following her dismissal, mother maintained the pretence that she was employed to family, friends and Child D's nursery. Identifies additional stress factors that likely contributed to mother's actions, including her failure to gain employment because of unsatisfactory references and the breakup of her relationship.

2012 - Warwickshire - Death of a Child

Death of a 6-year-old girl in the summer of 2011. It is believed G.A was killed by her mother who then took her own life. The post-mortems recorded the causes of death as follows: Mother: hanging; Child: "interference with the normal mechanisms of respiration". Father lived with mother and G.A for most of her life, interrupted by periods of parental separation; the most recent period of separation began several weeks before the incident. Mother's recreational drug use resulted in an episode of drug induced psychosis and compulsory detention under Section 2 of the Mental Health Act 1983 when she was 17-years-old.

2012 - Leicester - Baby L

Summary of review into the death of Baby L (aged 7 months) in 2011 after being smothered by her mother who then attempted suicide. Mother pleaded guilty to infanticide and was ordered to undergo secure psychiatric treatment for severe post-natal depression. Review finds that Baby L's death could not be predicted but there were missed opportunities. Family not known to agencies until marriage breakdown (when Baby L was about 3 months old) which resulted in several incidents of domestic violence and police involvement.

2012 - Newham - Death of Michael

Death of a 12-year-old boy in May 2011 as a result of organ failure brought on by bronchial pneumonia. Although the death was judged to be from natural causes a number of concerns prompted the serious case review. History of children's services involvement since Michael's birth and Michael and his brother were both subject to child protection plans at the time of his death. Legal action had previously been taken against Michael's mother in response to frequent absence from school. Children's services undertook repeat investigations into allegations of neglect and Michael's school nurse raised various health concerns, including rapid weight gain and enuresis. Issues of mother being uncooperative with health and children's services professionals and non-attendance at health and mental health appointments.

2012 - Renfrewshire - Death of Declan Hainey

Report for the Community and Family Care Policy Board at Renfrewshire Council about the significant case review into the death of Baby X (aged nearly 2 years old). His mother was sentenced to life imprisonment for his murder. Actual cause of death unknown as mother concealed his death for up to 6 months. Mother had a history of heroin and alcohol abuse. Known issues of homelessness, missed antenatal appointments and non-attendance at drug rehabilitation support meetings. Drug Worker raised concerns about Baby X to Health Visitor but after a series of failed attempts at contact, no further action taken. Mother was articulate and provided plausible reasons for missed appointments. In total, there were 19 occasions of failed attempts to see Baby X. Finds that professionals focused on mother's drug problems rather than child protection issues and the needs of Baby X.

2012 - Leeds - Child Q

Child Q died aged 32 months old after being taken to an Accident and Emergency department. Q had ingested a lethal amount of drug prescribed to mother. Q and 8 year old half-sibling were both subject to child protection plans. Review looks at agency involvement from mother's arrival in the UK as an asylum seeker in 2001 to Q's death in December 2008. The family were supported by asylum seeker services and were in contact with a wide range of health services as well as being known to children and young people's social care. Concerns over mother's alcohol misuse and mental health (isolated and reported anxiety/low mood). Also numerous incidents (41) of domestic violence attended by Police. Number of occasions when Q or older sibling had unexplained injuries and older sibling, who displayed challenging behaviour, disclosed physical abuse to nursery and school staff. Mother was difficult to work with, manipulated agencies and in some cases intimidated staff. Review discusses the potential links of older sibling's behaviour to abuse and neglect; responses of school to disclosure of abuse; challenges by agencies of Q's mother; supervision and accountability; the impact of maternal mental health problems on children; and agency focus on parents rather than children.

2011 - Gwynedd & Anglesey - Child G and Child H

Abstract Review into the death of a 5 year old boy (Child G) and his 2 year old half-brother (Child H) in December 2010. Both children were suffocated by their pregnant mother who committed suicide. Family had contact with several agencies because of concerns over the impact of custody and contact disputes. Mother was involved in 2 separate sets of proceedings, one involving her three older children and the other in relation to Child H.

2011 - Bury - Case G10 Baby A

Abstract Redacted review into agency involvement with Baby A's family following his/her death in 2010. Baby A's body was found by a member of the public. Cause of death unascertained but established that Baby A was alive at birth. Mother (Ms Z) traced by police 3 weeks after A's body found. Mother had concealed pregnancy and the birth had taken place at the family home without others being aware. Ms Z was arrested on suspicion of murder but no decision had been made by the CPS at the time of the review. Ms Z was in contact with Police (not clear why from review) and they knew about the pregnancy which she said she intended to terminate. Ms Z attended an NHS walk-in clinic twice on unrelated matters but no concerns were raised or identified about the pregnancy. She also contacted NHS Direct using an alias to ask about terminations. *Placed in this category because fairly clear case of infanticide.*

2011 - Torbay - Child 24

Abstract Executive summary of a review into a girl, aged 2 years 8 months, who died in hospital after being admitted to the Emergency Department with cardiac arrest. The mother was 18 years of age at the time of child 24's birth; the second child with a partner from whom she separated shortly after. The child had been admitted to hospital a number of times in the first six months of her life following apnoeic episodes. There were a number of incidents of domestic abuse throughout the child's life. There were also ongoing concerns relating to child neglect, and both Child 24 and her sibling failed to gain weight as expected. Findings include: a failure by services to make a comprehensive assessment of the children's situation, a lack of understanding of the features of neglect, a failure to put each individual referral in its historical context, and a failure to keep the father informed of the well-being of his children.

2011 - Havering - Child D

Abstract Full overview report of review into the death of a 6 month old infant found between the wardrobe and other furniture at the family home. Emergency services had been called by father after he was contacted by neighbours concerned by mother's behaviour. Mother was under influence of alcohol. Cause of death unascertainable but mother was convicted of one count of neglect and sentenced to 2 years in prison, later reduced to 16 months. Mother had history of mental health issues and alcohol dependency. Involvement of a number of agencies. Concerns had been raised by father and police called to an incident at family home in May 2010. Issues include: lack of focus on mother's alcohol abuse and impact on parenting capacity; and lack of thoroughness in assessments

2011 - Kirklees - child aged 2 years 7 months.

Abstract Review into the death of a child, aged 2 years and 7 months, at the family home on 19 February 2010. Pathologist findings suggest cause of death due to smothering. Mother was detained under the Mental Health Act 1983. Mother had received mental health services since 2000 for psychosis and possible schizophrenia. History of alcohol and cannabis misuse. Condition stable until the beginning of 2010 when there were concerns about her deteriorating mental health. Pre-birth assessment did not include detailed history of mother's mental health.

2011 - Monmouthshire - Child A

Keywords Single mothers, Review into the death of an 11 month old infant girl from multiple stab wounds in November 2010. Mother, 23, was ordered to be detained in hospital indefinitely in July 2011. Findings of review include: although mother had experienced difficulties as an adolescent and young adult and been diagnosed with periodical symptoms of depression there was no evidence this affected her parenting capacity; nor were there any predictive factors suggesting child was at risk of harm from her mother. Appendix 2 of the review provides a brief indicative research view on filicide.

2011 - Durham - Child Q

Abstract Executive summary of a review into the death of a 2-year-old boy in early August 2010 as a result of strangulation. Mother presented herself at a police station with Child Q who was found to be unresponsive and to have ligature marks on his neck. Child Q was immediately taken to hospital where he died. Mother was arrested on suspicion of murder and subsequently detained under the Mental Health Act and admitted to a psychiatric hospital. Mother and father's divorce was acrimonious but mother was described as devoted and caring, and Child Q as thriving. During the weekend of Child Q's death, mother had various contacts with police and emergency services, from which she discharged herself. She was described as having "acute psychosis" in a letter from the A&E doctor to her GP. Recommendations include: awareness raising of the importance of fathers across universal and specialist services.

2010 - Bexley - Child A.

Abstract Review into the death of a 21 month old boy in December 2008 following head and internal injuries. Child A's mother was found guilty of his murder. Findings include that there were no causes for concern before December 2008, but child protection procedures following an admission to hospital earlier that month were not fully followed. Recommendations include that a consultant paediatrician reviews the documentation prior to discharge of all children if there are safeguarding concerns.

2010 - Birmingham - Case reference - BSCB/2009-10/2.

Abstract Summary of a review into agency involvement with regard to the death of a pre-school child in February 2010 (cause could not be ascertained). Mother was found guilty of unlawful killing and detained indefinitely in a mental health institution. Mother was an asylum seeker from Somalia who entered the UK in March 2009. Relatives reported concerns about her mental health and the child's safety but mother convinced agencies she was being abused by relatives and the stories were false. Issues discussed include: mother's mental health and how it affected her parenting capacity; mother and child's isolation; mother's ethnicity and culture and how this could have affected her presentation and others interpretation of the situation, including the use of interpreters; the effect of the mother's immigration status on her parenting capacity; housing; referral pathways open to the police; and the GP's role. Concludes that a proper mental health assessment would have led to better support and a better understanding of the risks to the child but there was no indication that the mother would physically harm her child.

2010 - Barking and Dagenham - Baby M

Abstract Review into the sudden unexpected death of a 6 week old girl in October 2009. Coroner returned verdict of accidental death possibly as result of overlying. History of multi-agency involvement with mother's family during her childhood due to neglect, physical abuse and incidents of sexual abuse. Lack of change within family despite this involvement over a 30 year period. Learning difficulties and disability a feature of the family. *Despite the coroner's verdict, I have classed this as a 'killing' due to the following extracts from the full report*: Several family members (including Baby M's mother) were assessed as having learning difficulties, and one of Baby M's mother's siblings is learning disabled. Their parents were also thought to possibly have some learning difficulties. Baby M's mother and her siblings' hygiene and presentation tended to socially isolate them. Professionals reportedly considered them to be 'smelly'; it is likely that this would have been expressed much more forcefully by their peers. The health visitor did note the home to be in a dangerous state, but was reassured by the maternal grandfather that he was in the process of undertaking repairs. The ambulance crew and police officers, who attended the family home on the day of Baby M's death, clearly identified concerns for children living in such household conditions. Probation offender managers were involved following the conviction of D's parents for failing to secure D's regular school attendance (D is child M's sibling). The offender managers did recognise the risks to the unborn baby (i.e., child M) arising from the poor 'conditions of the property' and planned to make a referral to Safeguarding & Rights. Through an oversight, this did not occur. Neither child had any contact with their fathers. *This example illustrates how difficult it is to establish culpability in such cases of chronic neglect and incompetent parenting.*

2010 - Cambridgeshire - Child C and Child E

Abstract Rewritten report of the 2007 review into the deaths of Child C and E. The children died of stab wounds inflicted by their mother. The review identifies a history of physical and emotional abuse towards the children, but finds that there were no indicators which may have prevented the murders. Recommendations include a focus on the impact of parental behaviour rather than just the causes and a recognition of the impact of emotional abuse.

2010 - Nottinghamshire - Baby AN09

Abstract Review following the death of an infant (age unspecified) who died whilst sleeping in the same bed as his mother, her partner and his sibling. Cause of death was sudden unexpected death in infancy. *Despite this official categorisation, this has been classed here as a killing by neglect due to the following extracts from the full report*: AN09 and his sibling were subject to child protection plans at the time of his death under the category of neglect. The independent chair of NSCB decided that an SCR should be convened as neglect was suspected to be a factor in the death. Many agencies were involved before and after AN09 was born, providing services and undertaking assessments. When mother became pregnant with AN09, health agencies noted a number of concerns relating to her, the main one being her misuse of alcohol. The putative father of the children denied paternity and played no part in their upbringing. Mother had two partners during the review period. However, she is no longer in a relationship with either of them. Following AN09's premature birth, concerns grew around the standard of care of him and his sibling. These concerns led social care to conduct a section 47 child protection enquiry. This in turn led to the convening of a child protection conference, at which the children were made subject of child protection plans under the category of neglect. Advice was provided to mother and her partners about the risks associated with co-sleeping. AN09 died whilst co-sleeping with his mother, his sibling and his mother's partner.

2010 - Halton - Child C aged 2 years and 7 months.

Abstract Review into the death of a boy as result of blunt force trauma to his head in November 2007. The mother had expressed the need for help managing her child's behaviour, and feelings of self-harm. She received medication and specialist services, but found it hard to engage with some services. Child C had been admitted to hospital on a previous occasion with unexplained injuries, and had been subject to child protection procedures. *Report not on-line but classed as killing by the mother since no father or male partner mentioned but 'manslaughter' appears in the list of Keywords*.

2010 - Surrey - Child I

Abstract Death of an infant girl in late 2009 while in the care of her 18-year-old mother. Mother pleaded guilty to an offence under the Children and Young Person's Act 1933 and was awaiting sentence at the time the case review was published. An initial child protection conference had been scheduled at the time of Child I's death. Child I's mother had involvement with a number of agencies back to 2006. Mother had a background of: substance misuse, including a series of overdoses; teenage pregnancy; domestic abuse; running away; mental health problems; issues with housing and a lack of engagement with services. Lessons identified include: mother's lack of cooperation with agencies and fabrication of information led to the risk to her child being underestimated.

2010 - Manchester - Child T.

Abstract Review into the events leading to the death of 13 month old Child T in Manchester. Child T died strapped into his buggy in front of a gas fire. He had been dead for a number of days when discovered. Cause of death could not be ascertained so it is not possible to determine whether it could have been predicted or prevented. However, concludes that whatever the cause of death, Child T's situation was not helped by mother's state of inebriation and consequent incapacity to attend to his needs in the days and hours before his death. Despite failed multi-agency attempts to work with the mother, and repeated referrals from relatives, Child T remained in her care. Child T's mother experienced abuse as a child and seriously abused alcohol. Police arrested mother when Child T was 3 weeks old as mother was intoxicated while caring for him. Child T was returned to his mother's care and arrangements were made for support to be offered via a 'Child in Need' (CiN) plan. Community Alcohol Team assessed the risk of harm of mother's drinking to herself and Child T was low. Child T remained the subject of a CiN plan for 7.5 months. During this time he lost weight, missed a number of health appointments, and his immunisation programme was delayed. There were repeated expressions of concern about mother's drinking and she withdrew from counselling she was receiving. Despite the lack of progress, mother was assessed as being able to offer a 'good enough' standard of care to Child T without additional support and he ceased to be the subject of a CiN plan in June 2009. A number of calls were made to children's social care by friends and relatives regarding mother's alcohol abuse and allegations of Child T being left unattended and being neglected. The review identifies similarities to other child deaths in Manchester; including a failure to assess the impact alcohol has on parenting capacity, and failing to focus on the child. *This is yet another of the very common cases where the child's death is obviously due to chronic neglect and yet such cases will generally not appear on the homicide record since it unlikely that such mothers would be charged. (I don't know whether this mother was charged, but it is unlikely - "not in the public interest"?).*

2010 - Newport - Child 'AB'

Abstract Review into the death of Child 1, aged 4 years, as a results of suffocation by their mother. The family had moved house frequently, including relocating from London to Newport, and the parents of Child 1 had a violent relationship before separating. Review identifies that the mother suffered a significant decline in parenting capacity and mental health which was not assessed by professionals. This became severe paranoid schizophrenia, which resulted in her causing the death of Child 1. Recommendations include better integration of adult mental health services in child protection proceedings.

2010 - NHS North-West - death of Child A

Abstract The executive summary of a serious case review and a paper focusing on the NHS involvement in the death of Child A, aged 5 years, stabbed to death by her mother. Mother suffered paranoid schizophrenia. Concludes that death could not have been predicted. Recommendations include better communication between mental health and children's services and police training in mental health issues.

2010 - Rotherham - Child T.

Abstract Review into the death of an 11 day old girl. The post mortem gave cause of death as sudden unexpected death in infancy. Co-sleeping identified as recognised risk for sudden infant death. Mother not charged due to insufficient evidence. History of alcohol abuse and domestic violence. Child T was put on child protection plan at birth for physical abuse, her siblings were already on child protection plans for emotional abuse. Recommendations include: a multi-agency review of training around constructive challenge and "respectful uncertainty" and dissemination of a revised procedure on safeguarding children of drug and alcohol misusing parents. *No longer available online. Placed in this category because the Abstract implies the mother was a known risk and that criminal proceedings were considered if not taken up due to lack of evidence.*

2010 - Torbay - case review: C18

Abstract Review into the death of a 10 day old infant from asphyxiation in April 2010. Mother was made the subject of a Section 37 Hospital Order under the Mental Health Act for infanticide. Mother had history of mental ill health and was reluctant for information about her condition to be shared. Review highlighted that the unborn child was not the centre of focus for practitioners, who were also influenced by the socioeconomic status of the family. Extended family had concerns about mother's deteriorating condition during latter stages of pregnancy.

2010 - Sefton - Child 1.

Abstract Review into the death of Child 1, who died aged 13 days from a cardiac arrest resulting from a bacterial infection. Finds that abuse played no part in the death of Child 1. The review was undertaken due to identified failings by professionals working with the family. Domestic violence, alcohol abuse and serious school attendance issues are identified. Also notes that professionals focused on the difficulties of the mother, rather than considering the impact on the child. *Despite the Abstract concluding that abuse played no part in this baby's death, I have classed the mother as culpable due to the following extracts from the full report*: Ms A had four children. Child 4 died in 1998 from meningitis and myocarditis (inflammation of the heart) and Child 1 died in 2009 from a bacterial infection. There are two surviving children, Child 3 and Child 2. Ms A worked at a local firm in a clerical capacity and throughout the review period she reported to the Police being the victim of domestic violence from four successive male partners. There is also evidence to say that for much of the period she drank to excess and probably became dependent; although she claimed not to have a problem with alcohol. On one occasion she was arrested and charged with being drunk in charge of a child. On several other occasions Ms A disclosed to her GPs the extent of her drinking and sought help from one of them. *The Abstract identifies the shortcomings of professionals in this case - but these shortcomings are a failure to recognise the threat posed to the children by their mother. Hence my categorisation of the mother as culpable.*

2010 - Southend-on-Sea - Baby Robert.

Abstract Review into the circumstances surrounding the death of Baby Robert at 34 days old. His mother was homeless and living with a relative at the time. It was reported that his mother had consumed large amounts of alcohol the night of his death and Baby Robert was found lying with her when found dead. Mother had a family history of domestic abuse, alcohol misuse and mental health issues, and spent time in foster care as a child. She misused alcohol, had self harmed by drug overdose, was the victim of domestic abuse and experienced multiple miscarriages until Baby Robert. During her pregnancy, mother became homeless and was placed in a hostel. Review finds that local child protection referral procedures to children's services were not followed by agencies and maternity services did not refer mother for a joint assessment. Staff shortages and an increase in referrals after the Baby Peter case, meant that there was a lack of management oversight and direction of staff in the child protection service; recording of information was sometimes inadequate especially within the hostel; and agencies did not access historical records. Agencies including primary care services, the probation service and health visitors "failed to recognise the safeguarding needs of Baby Robert"

2009 - Anglesey - Child F

Abstract Review into the death of Child F, an 8 week old infant who died after sleeping in a bed with her mother and 8 year old half-brother. The family moved to the area 4 weeks before during which time there were four reports of domestic violence. Police passed three child protection referrals to social services. Background checks were done, the case was dealt with as a child in need and an assessment was carried out the day before Child F died. *I presume the domestic violence referred to here is violence perpetrated by the mother against the children since no male is mentioned (as would undoubtedly be the case if a man were the culprit). Hence I class this as the mother being the perpetrator despite it apparently being a case of 'death by overlaying' in view of the history. (Full report not available on-line).*

2009 - Lancashire - Child S.

Abstract Review into the sudden and unexpected death of an infant whilst co-sleeping with mother. Review also looked at the involvement of services with child's mother in 12 months prior to birth. Mother was a looked after child in a long-term foster placement up until 17, but left due to her abusive behaviour. Mother led a chaotic and vulnerable lifestyle with periods of homelessness, alcohol misuse and frequent house moves. Recommendations include: a multi-agency assessment of need for young people who have left care, become pregnant and had a termination of pregnancy; the development and use of a multi-agency evidence based risk assessment tool for cases which have identified drug, alcohol and mental health problems during pregnancy; and pre-birth assessments which identify risk factors must consider the impact of maternal behaviours once child born.

2009 - Wirral - Subject A: 4 years.

Abstract Review following the death of a 4 year old girl, also known as CF, whose mother drowned her in the bath in April 2009. The mother was known to adult mental health services. There had been concerns over domestic violence and there were ongoing problems in finding suitable accommodation. The mother did not always keep appointments with the agencies and A's attendance at nursery was intermittent. There were concerns about neglect and bruising. Findings include that the agencies did not understand the extent of the mother's mental illness and when support packages were not working, more appropriate interventions were not sought.

2009 - Essex - Child Agnes

Abstract Review into the protection of Agnes and highlights the significant risks that she was exposed to, without being removed from her mothers care. Agnes' older siblings had all been taken into care, but Agnes remained with her mother, Ms T. Agnes was subjected to emotional, physical and sexual abuse and neglect. The report identifies over 200 different incidents which should have prompted child protection inquiries. Ms T was threatening and violent to social care staff, and she was not challenged appropriately on the failure to care for Agnes. Ms T had been abused as a child and had mental health problems. The review identifies comprehensive failures to act to protect Agnes, and an allowance by professionals to allow Ms T to dictate proceedings. Recommendations include training for social workers dealing with uncooperative or hostile parents.

2009 - Coventry - executive summary 5.

Abstract Review into agency involvement with the family of a 23 month old child who died as a result of an electrical fire while left at home unsupervised. Previous concerns about injuries and incidents of children left unsupervised. Child protection conference held. Father in prison for drugs related offence at the time of the incident. Lessons learned include: the need to comply with recommendations made at child protection conferences; the importance of support and clear guidance to less experienced staff; the importance of speaking directly with children and making direct offers of support; and the need for effective communication within and across agencies. *There seems a tacit acknowledgement that the mother was culpable for leaving the child unattended.*

2009 - Enfield - ST

Abstract Review into the death of a 16 year old girl at her family home in November 2006. Cause of death could not be established because the body was not discovered until March 2007. Mother pleaded guilty to preventing the lawful burial of daughter and neglect of son. Children were home educated but no professional concerns about family or circumstances. Extended family had concerns about welfare of family and mother's behaviour but did not make referral to social care services. Recommendations include: Government guidance on child protection arrangements in relation to children in elective home education; and a review of the current arrangements for assisting families who have chosen home education, to include increasing the frequency of contact and direct child contact.

2009 - Newport - Child A and Child B.

Abstract Review into the death of a one year old child from an undiagnosed congenital condition and the neglect of the two year old sibling. Mother had disability which meant she had difficulty understanding others' thoughts, feelings and needs. This condition, in addition to alcohol abuse and mental health problems, led to involvement by a number of agencies. Mother's disability a possible barrier to engaging with services. Assessments did not sufficiently address whether mother had motivation and capacity to sustain acceptable standard of care. Recommendations include: a model of neglect to be used across all agencies; and interagency training on the impact of lifelong disabilities on a parent's capacity to provide adequate care.

2009 - Flintshire - Sarah

Abstract Review into the death of Sarah who was drowned by her mother at the age of four years and five months on 26 November 2007. History of maternal depression since the age of 17, relapse in January 2007 and concerns over drinking. Sarah diagnosed with mild cerebral palsy in January 2006. Review concludes that Sarah's death could not have been predicted and that agencies provided appropriate care. Recommendations include: fuller involvement of mental health services with carers; assessments of families with a parent with mental illness should include parenting capacity and support; and care pathways in midwifery services to ensure expectant mothers with mental illness receive holistic assessments and a multi-agency plan. *Not clear if single mother - assumed so due to no men being mentioned.*

2009 - Birmingham - Death of Case No. 10. added 2/2/17

Keywords Abusive mothers, Bangladeshi people, Child deaths, Children in violent families, England, Family violence, Homicide, Immigrant families, Interpreters, Language, Mothers, Official inquiries, Pregnancy, Self harm, Suicide

Abstract Review into case no. 10, which involves a Bangladeshi family in Birmingham. The family home was violent and volatile. The mother self-harmed twice, once when she was pregnant, but a lack of interpreter and reliance on her husband meant that the risks were not properly assessed by professionals. The mother and two children were found deceased in their home. The children were unlawfully killed. Recommendations include acknowledging that women from BME communities can be perpetrators as well as victims of domestic violence.

Mother as lone perpetrator: mother living with father or partner

November 2015 - Kingston – Family A
Death of a 4-year-old girl and two 3-year-old twin boys who were smothered by their birth mother on 22 April 2014. The mother was given a hospital order in November 2014 after admitting manslaughter by diminished responsibility.

March 2015 – Nottingham City – Child G
Death by drowning of a 10-month-old baby girl in May 2012. Mother stated she briefly left her infant unsupervised in the bath and pleaded guilty to involuntary manslaughter.

February 2015 – Nottingham – Child H
Death of a 7-month-old girl in September 2013; inquest concluded with a finding of unlawful killing. Mother pleaded guilty to infanticide and was made the subject of a hospital treatment order under the Mental Health Act 1983.

October 2014 – Hull – Child T
Death of a 2-year-7-month-old boy in January 2013 as the result of drowning in the bath whilst left unattended. Post-mortem examination revealed hot water burns to Child T's body, caused after his death. Mother was convicted of manslaughter and received a 3 year custodial sentence.

January 2014 - Hull - Child L
Death of a 5-week-6-day-old baby girl in October 2012 as the result of a severe skull fracture. Mother admitted to a charge of infanticide due to post natal depression and received a community order with a supervision requirement for three years.

May 2014 - Southampton - Child I and Child M
Deaths of a 2-year-old boy, Child M, and his 4-year-old half-brother, Child I, 3 months later. An open verdict was recorded for both deaths but subsequent care proceedings found that both boys had experienced neglect. Mother was arrested on suspicion of murder but charges were later dropped. Child I and Child M were subject to child protection plans at the time of Child M's death. Mother expressed worries about coping to agencies on a number of occasions and admitted not feeding and hitting Child I.

January 2013 – Cardiff – Yaseen Ali
Death of a 7 year old Asian Muslim boy in July 2010 as a result of complications from blunt force trauma as inflicted by his mother. History of domestic violence but no recent reports of violence or contact with specialist services.

2012 - Surrey - Child Q

Death of a 1-year-old baby boy on 16th September 2011. Child Q was found face down in bathwater at home on 12th September 2011 and died in hospital four days later. Child Q and his brother had been left unsupervised in the bath for an extended period of time. Mother was arrested and convicted of manslaughter and neglect. Maternal history of: mental health and behavioural problems from age 8, involvement with children's services as a child and aggressive and anti-social behaviour including drug and alcohol misuse.

2012 - Coventry - Child W

Death of a baby, a few months old, in July 2011. Child W was found dead by his/her mother, after the child had been brought to bed by the mother's partner and placed between the couple as they slept. *The long account which follows is included to explain why culpability has been assigned to the mother in this case...*

The mother had suffered an earlier episode of domestic abuse in Birmingham prior to moving to Coventry to escape it. This domestic abuse case was allocated to inexperienced officers and administrative mistakes were made in both the Birmingham and the Coventry Police areas and as a result the case was dealt with inappropriately. This had the effect of concealing the mother's inability to prioritise the needs of the children over her own, potentially exposing them to future risk. The mother was housed in a domestic violence refuge after the Birmingham incident. Six months after becoming resident at the DVA supported accommodation the mother met a new partner. Staff became aware of this new relationship. The mother notified staff that she was five weeks pregnant with Child W by which time the relationship had ended. While resident in the DVA supported accommodation the staff there were concerned about the mother's ability to prioritise her children's needs and tried to persuade her to stay resident there allowing the time for her to develop life and parenting skills.

The Case notes refer later to an anonymous referral from a neighbour which led to the Children's Social Care Service intervening and escalating the case to Child in Need status.

A month after Child W‟s birth the police and Children‟s Social Care Services were called to the family home. Both of the parents had consumed large amounts of alcohol and they had had a violent argument in which the mother had sustained an injury. They were both judged to be incapable of looking after the children at that time.

After Child W was born, suitable advice was given, both verbally and in writing to the mother by both hospital and health support staff in respect of the safe care of the newborn child which included safe sleeping arrangements. Subsequent to Child W‟s death Child W‟s mother confided in a member of the Review Team that she had remembered being given advice about safe sleeping and not taking Child W to bed and had understood the advice. However, she acknowledged that she and her partner had ignored the advice on a number of occasions.

Following this incident a Children's Social Care Services strategy meeting was held to consider the case going forward to a child protection case conference.

One week after the strategy meeting, the mother and her partner had been consuming alcohol and Child W was taken into bed with them by the partner. The mother awoke in the morning to discover that Child W was lying in between them and was not breathing. An ambulance was immediately called but the child was subsequently pronounced dead. It is the view of the Review Team that while the potential for some form of harm to Child W may have been predictable, the death was not preventable.

2012 - Waltham Forest - Child B

Full overview report of review into agency involvement with Child B's family. Child B was found dead in her cot aged 8 weeks. The initial cause of death ascribed by the pathologist was 'dehydration due to gastroenteritis' and included observations that '…at 8 weeks of age, baby measures 57cm in length (50th centile) and weighed 3,810gms (2nd centile) indicating she was underweight for her height. The presence of dirt beneath finger nails and in skin creases as well as the nappy rash might be taken as evidence of sub-optimal care'. The couples' first child (sister 1) was born in 2007; a second (sister 2) in 2009. Concerns about neglect of both daughters and mother's mental health led to several episodes of involvement by Children's Social Care. Mother had been a 'child in need' and had a history of mental health issues. *Police deliberations regarding whether neglect was a contributory cause were either incomplete or unavailable at the time of the report but this case has been taken as 'death due to neglect' in view of the evidence above.*

2011 - London Borough of Waltham Forest - Child W

Summary of review into agency involvement with Child W who died aged 10 months from pneumonia after being force fed. Mother was convicted of 'allowing or causing the death' of W. Father was acquitted.

2011 - London Borough of Barking and Dagenham - Child T and Child R

Abstract Review into the death of a 12 year old boy who was forced to drink bleach by his mother in February 2010. Mother admitted manslaughter and was remanded for inpatient psychiatric assessment. Child had severe learning difficulties and possibly a disorder on the autistic spectrum.

2011 - Wandsworth - Sarah

Abstract Review into circumstances surrounding the death of "Sarah" and her mother in a house fire (probably caused by an unattended candle as flat was without electricity). Mother was intoxicated and had recently taken opiates. She had a history of drug and alcohol misuse and was attending a drug treatment programme. There had been a previous chip pan fire at the flat after mother fell asleep. Fire service made 3 unsuccessful attempts to carry out a fire safety check. Shortly after incident, ambulance was called out to mother after reported overdose (she had taken methadone on top of alcohol). Sarah's two older siblings lived with their maternal grandparents after being subject to child protection plans because of mother's addiction. Sarah's father had drug problems and a history of criminal offending. Some concerns raised about possible neglect of Sarah (including dental neglect) and she did not attend pre-school care despite health visitor referrals. Notes that although Sarah appeared to be developing normally, the pattern of neglect emerging (which was similar to that experienced by the older children) was not identified.

2011 - Bradford - Death of HD, a child (male) aged 2 years

Abstract HD, aged 2 years, died on 16 July 2006 as a result of having ingested drugs. HD's mother pleaded guilty to manslaughter. Two children had previously been removed from the care of HD's mother after concerns about physical injuries. Bradford Safeguarding Children Board's serious case review concludes HD and his mother received significant support from different agencies and professionals could not be expected to recognise HD was ingesting methadone.

2010 - Manchester - Child H and Child I.

Abstract Review into the death of two brothers, Child H aged 2 years and Child I aged nearly 4 months who were stabbed to death by their mother in November 2008. The mother was suffering from an acute psychotic episode. Issues highlighted include whether the mother's history of child protection, looked after child status and mental health needs were taken into account when assessing her parenting capacity, and the role of the father.

2010 - North Tyneside - child F.

Abstract Review into the death of an 11 month old infant boy who died from a morphine derivative overdose in January 2010. His mother was sentenced to an indefinite Hospital Order for manslaughter. Mother had history of depression and suicidal ideation. An earlier suicide attempt had been attributed to racist abuse at work. Concerns raised by child's father about mother's mental health.

2009 - Cambridgeshire - Child A.

Abstract Serious case review relating to a baby, aged a few days, who died from unascertained causes. The mother had a previous conviction against an older sibling and another baby had died about a year previously. Safeguarding concerns were raised but assessment led to the case being closed. Findings include that professionals failed to engage the father in their work with the family, even though he was very involved in the day to day care of the children. *Yet another cases which probably would not have entered the homicide statistics though the mother appears highly likely to be culpable.*

2009 - Luton - services provided to A and his brother

Abstract Review into the death of a 3 month old boy from a non-accidental head injury in November 2007. A's mother was convicted of manslaughter. The family is of South Asian origin and the mother spoke poor English. There was no evidence of previous abuse.

2009 - Blackburn with Darwen - Baby M.

Abstract Review into the death of 5 month old Baby M. Baby M was the second child to a young mother who struggled with the difficulties of bringing up her children. Both children were on the child protection register for neglect and there were concerns about domestic violence and alcohol consumption in the house. Baby M died from pneumonia, which the review rules that the carers could not have known about at the time. The mother had earlier decided that Baby M's older sibling should live with a member of the extended family for a short period until she felt able to care for it. This child spent several months with this relative, returning to the mother's care following a failed application by the relative for a residence order. (*Although the report does not state this, the fact that the relative applied for a residence order might suggest a lack of confidence by the relative in the mother's parenting ability*). During the separation, the mother had maintained some contact with her child, but had at times expressed some uncertainty about whether or not she wanted to have the child back to live with her. But this child did return home with a package of services for mother and child, including Early Years family support, a nursery place, support from a worker from Children's Social Care and health visiting services. The mother's boyfriend (baby M's father) subsequently moved in with her. The mother had a normal pregnancy with Baby M, but there were further concerns about her care of the sibling, her inappropriate levels of drinking and suspected domestic violence (the report does not state who was suspected of violence). A decision was made to convene a Child Protection Conference. There was a delay in this being arranged and it took place in January 2008. Both children were made subject to a child protection plan on the grounds of neglect. Baby M died towards the end of January 2008.

2009 - Buckinghamshire - Child A aged 2 years 1 month.

Abstract Summary of a serious case review into the actions of agencies involved with Child A and his family. A was born drug-dependent as a result of his mother's heroin addiction. Child A later died as a result of ingesting a fatal amount of methadone. A rigorous police investigation followed but was inconclusive as to how he had ingested the methadone. His mother and extended family had been known to the statutory agencies since her own childhood. At the time of Child A's birth, mother had attempted unsuccessfully to de-toxify several times. A was placed on the Buckinghamshire Child Protection Register and care proceedings initiated. Subject to a statutory supervision order to the probation service, mother was placed at a drug rehabilitation unit and Social Care agreed to fund A's place with his mother. There is good evidence that mother remained drug free from April 2006. In December 2006, the Family Proceedings Court made A the subject of a one year supervision order and the family were supported in parenting A. Child A's parents relationship deteriorated and mother moved back to her family home with A. Report suggests that conflicting requirements of the different processes (eg Looked After Child, Family Court requirements of a case in Proceedings, Criminal Court expectations) each with their own set of targets driven by Central Government, made it too difficult for professionals to work together with the child as a focus. Concludes it was not possible to identify any one significant event or action by any agency, which if done differently, would have prevented A's death. *That's all very well but I take the view that addiction does not exonerate the mother from culpability*.

2009 - Barnet - Child D aged 4 months

Abstract Review into the death of a 4 month old boy (Child D) who died from Sudden Infant Death Syndrome (SIDS). He was placed on the child protection register before his birth under the category of neglect, as the mother had had a previous child taken into care (failure to protect from domestic violence). Health care staff had warned of the risks of co-sleeping and smoking. Recommendations include supporting young people to help them develop positive partner relationships parenting skills for the future.

2009 - Redbridge - Child L

Abstract Death of a baby boy of streptococcal septicaemia in December 2008. Child L was taken to hospital after mother found him on the floor. Rigor mortis had set in and child had not been observed or checked for some 12-15 hours prior to discovery. Following a police investigation, it was decided that there was insufficient evidence to charge the mother in connection with Child L's death. Cause of death was initially recorded as 'unascertained', but was subsequently found to be streptococcal septicaemia. Mother was visually impaired and had a history of substance misuse. Family had a history of non-attendance for appointments relating to Child L's health. Issues identified include: lack of professional curiosity about child care arrangements and family relationships, lack of effective handover between midwives and health visitors, failure by health care staff to properly monitor and respond to Child L's faltering growth and a lack of awareness amongst professionals of issues relating to visual impairment and parenting.

2009 - St.Helens - Child D

Abstract Review following the death of a 4 week old boy who died whilst sleeping with his mother. Findings include domestic violence and the father had expressed concern about the welfare of the children and the mother's capacity to care for them, partly due to her drinking and depression. *Not made clear who were the perpetrator and victim of the DV. Keywords do not flag 'violent men'.*

2009 - Hammersmith and Fulham - Baby J.

Abstract Report into the death of 8 month old Baby J, who died from non-accidental head injuries as a result of being shaken by their mother. Review identifies that although there were no prior concerns of child protection in the family, the mother had identified herself as struggling to care for her three children. Also identifies a lack cultural understanding by professionals of their Bangladeshi background, arranged marriage, family support and honour/izzat.

Mother plus father perpetrators

2015 – Tri-Borough (Hammersmith and Fulham, Kensington and Chelsea, Westminster) - Sofia

Death of a 1-year-old girl from asphyxiation due to choking on food. Autopsy findings found Sophia was significantly underweight and there were signs of historic untreated injuries. Parents may be charged with neglect.

September 2015 - Solihull – Child S

Death of a 22-month-old boy. Child S was taken to hospital after his mother found him lifeless. A post mortem examination established that he had suffered severe abdominal injuries. Mother and father were both convicted of causing or allowing the death of a child in December 2014.

May 2015 - Blackpool – Child BT

Death of a young child. Initial post mortem proved inconclusive; second post mortem concluded that cause of death was inhalation of stomach contents with the underlying cause being poisoning by Methadone. Mother pleaded guilty to manslaughter; father went to trial and was found guilty of manslaughter and child cruelty.

April 2015 - Lambeth – Child I

Death by drowning of a 20-month-old boy. Child I and his two older siblings were subject to child protection plans under the category of neglect at the time of the incident. Parents both had learning difficulties and at times reacted with anger and hostility to professional interventions. Child I was found face down in the bath; mother reported she had left Child I in the bath, informing father she had done so, before leaving the house.

January 2015 - Surrey – Child X

Serious, non-accidental injury of a 4½-week-old child. Child X was admitted to hospital with injuries including: up to 8 rib fractures, retinal haemorrhages, traumatic subdural haematoma, and leg and foot fractures. Mother and father were convicted in relation to the injuries.

February 2014 – Bexley – Baby F

Death of a 5-month-old baby boy in June 2012 as the result of florid rickets caused by severe vitamin D deficiency. Following Baby F's death, parents reported that he had been unwell for three days; both pleaded guilty to manslaughter.

February 2014 – Northamptonshire – Child I – Kieran Lloyd

Death of an 8-week-old baby boy in March 2012 from a significant head injury. **Background:** Both parents were arrested on suspicion of murder.

January 2014 - Derby - ED12

Death of six sibling children in May 2012, as the result of a fire at their home where they lived with their father and mother A. Father and mother A and another adult were convicted of the manslaughter of all six children. Father lived simultaneously with his wife (mother A) and their six children and another partner (mother B) and their five children until February 2012. Family had appeared on television and had, at times, a high profile in the media. History of paternal conviction for attempted murder and wounding with intent in 1978; domestic abuse in mother A's previous relationship; and father and mother A's suicide attempts within 2-weeks of each other in February 2012.

December 2013 - Derbyshire - BDS12
Death of a 2-year-old boy in March 2013 from cardiac arrest. BDS swallowed his mother's methadone, which was in a child's beaker. Posthumous toxicology reports found traces of Class A drugs and alcohol in BDS' system, thought to have been directly ingested. Mother and father were convicted of manslaughter and received custodial sentences. Mother was also convicted of cruelty against a child under 16. Mother was a long-term substance misuser; she was on a methadone programme at the time of the incident and also using Class A drugs.

December 2013 - Oxfordshire - Child Y
Death of a 22-month-old baby boy from a serious head injury. Mother and father were arrested; father later pleaded guilty to child neglect and received a 15-month custodial sentence. Maternal history of: troubled upbringing; behavioural issues at school; alcohol and drug misuse; depression; housing and debt problems; and one known suicide attempt. (Not clear what happened to the charge against the mother who is reported to have "moved to the Republic of Ireland").

December 2013 – Wolverhampton – Daniel Jones
Death of a 23-month-old boy in May 2012, as a result of ingesting heroin. Post mortem revealed evidence of regular exposure to heroin. Father was convicted of manslaughter and mother was convicted of causing or allowing the death of a child. Maternal history of drug and alcohol misuse and offending; she had one older child who did not live with the family. Paternal history of prolific offending and drug misuse. Both parents were known to addiction services, had separate key workers, were involved in a methadone programme and were known to have used heroin during Daniel's life. Family was well known to children's services.

October 2013 – Croydon – Child X
Death of a 20-day-old baby in September 2012. Child X died three days after suffering brain trauma whilst co-sleeping with twin sibling and both parents. Child X's older sibling, Child W, was removed from the family home in 2011 due to neglect. An application for removal and Interim Care Orders in relation to the unborn twins was made; this was contested in court and rejected on the grounds that the twins were not at "imminent risk". Maternal history of: depression; sexual abuse; bullying by step-siblings; and physical and emotional neglect by mother.

October 2013 - Southampton - Child G
Death of a 3-month-old baby boy (Child G) and injury of his twin brother (Child H). History of maternal depression and incidents of maternal and paternal self-harm. Father had been convicted of child cruelty against one of his children from a previous relationship and served a 12 month prison sentence when living in a different local authority and before meeting mother. Following the death of Child G, Child H was placed in the care of the local authority and mother and father were arrested.

September 2013 - Bury – Baby E
Death of an 11-week-old girl in December 2012. Mother found Baby E dead after falling asleep on the sofa with her; both parents had been drinking at home prior to the death. Parents' 2 oldest children had been subjects of child protection plans under the category of emotional abuse, and later for child sexual abuse, before being taken in to care. The younger children were on plans under the category of emotional abuse and neglect. Parental history of: moving house, alcohol misuse, domestic abuse and lack of engagement with professionals.

July 2013 - Northamptonshire - Maisie Harrison
Death of a 4-week-old baby girl on 4th May 2012, found in her parents' bed with blood around her nose and mouth. Cause of death is unknown but co-sleeping is thought to be a contributory factor. Maisie was subject to a child protection plan under the category of neglect. Maternal history of alcohol abuse; learning difficulties; sexual relationships with older men; homelessness; and domestic abuse. Father had a previous conviction for grievous bodily harm to a child, after causing serious internal injuries to his 6- year-old step son.

May 2013 - Knowsley - Child J
Death of a baby boy in 2010. Child J was found dead after falling asleep on his parent's chest in a warm room where both parents had been drinking and had smoked cannabis. Maternal history of domestic abuse and extensive history of parental substance misuse. Child J's older half siblings were in the care of mother's family members and Child J's younger half siblings were subject to child protection plans.

January 2013 – Worcestershire – FW
Death of a baby from cardiac arrest. FW was found not breathing by the parents who called an ambulance. FW had been co sleeping with the parents, who had both consumed alcohol and cannabis, prior to the ambulance being called. A criminal investigation was conducted but a cause of death could not be ascertained. Family was known to a wide range of agencies and there was a history of maternal mental ill health and suicidal thoughts and parental alcohol and drug misuse. FW was born into an overcrowded and somewhat chaotic and cluttered household with parents, particularly the mother, who regularly drank alcohol to excess and there were indications that cannabis use by the parents also took place. FW's mother has a history of alcohol abuse, suicidal thoughts and overdosing on medication. There is evidence that FW's eldest sibling often took on a caring role of the younger siblings and to some extent of the mother, being very protective of her. The eldest sibling raised concerns about the mother's drinking on a number of occasions to health professionals, reported domestic disputes between the parents and called for ambulances when the mother overdosed on drugs and alcohol. There were reports of the children being left alone in the house and also playing outside unsupervised.

2012 - Bristol - Child K

Death of a 2 year old on 21 August 2011 who was subject to a child protection plan. Methadone had been ingested over a period of time. Mother and father, both with a history of addiction and taking prescribed methadone, were convicted of manslaughter (father) and child cruelty/ causing or allowing the death of a child (mother). Mother continued injecting drugs during her pregnancies and K's younger sibling suffered neonatal abstinence syndrome. Issues around missed appointments (antenatal and drugs) and a lack of cooperation and dishonesty from parents. K suffered four injuries as a young child.

2011 - Blackburn with Darwen - Child H

Abstract Review into the death of a 6 month old infant from bronchopneumonia in 2009. A post mortem examination revealed 18 non-accidental injuries caused over a period of about 12 weeks before the death. Both parents were convicted of child cruelty and sentenced to five years each. Mother was a looked after child from her early teens, following physical assaults by family over her lifestyle and behaviour, and had three children whilst a teenager. Opposition from extended family to marriage of child's parents who were from different Asian communities.

2011 - Bristol - Child M

Abstract Review into the death of a 2 year old boy who was found in a pond at his maternal grandmother's home in June 2010. His parents and maternal grandmother were convicted of manslaughter and child cruelty. History of alcohol abuse and domestic violence in mother's family. Initial assessment completed on mother a year before child M born, whilst she was still at school. Concerns raised about mother's mental health and school attendance. During child's life, concerns were raised about child's appearance, unhygienic home conditions and safety issues

2011 - East Sussex - deaths of DC & BC

Abstract Review into the deaths of two brothers aged 7 and 5 who died in a fire at their home in 2008. Issues include: the children had an obsession with fire but this was not known to agencies; family violence; and parental drug and alcohol misuse. From 2007 school staff identified DC and subsequently BC as troubled children whose challenging behaviour appeared to be linked to inconsistent parenting and alleged domestic abuse perpetrated by their father. Attempts were made to help the children cope better in school, with support provided from a voluntary agency. School made a referral to children's social care in early 2008, which decided to work with the family in a supportive way rather than through a formal child protection plan. DC was also referred by the school to a play therapist. Recommendations include: LSCB to identify assessment procedures that should be amended to include fire safety; LSCB to ensure agencies are aware of the impact of domestic violence on children's development and behaviour; and LSCB to highlight the impact of alcohol misuse on parenting capacity in its Child Protection training. Inquest delivered a verdict of misadventure and stated that the school, Social Services, and all other agencies could not have done anything else for the children. *I have classed this as mother and father both responsible for the deaths as a consequence of neglect. One can hardly blame 5 and 7 year olds for being careless with fire - they should have been stopped by proper parental care.*

2010 - Cambridgeshire - Baby F

Abstract Review into the death of a 6 week old baby girl in June 2009 for which both parents were charged. F and her 3 year old sister were subject to child protection plans. Both parents had a history of mental health problems. There were concerns over extreme religious beliefs leading to isolation and refusal of support services. Recommendations include sharing the triggers for deterioration of mental health with all agencies, child protection plans covering when a parent is well and not well and training on working with families with fundamental religious beliefs. This review was revised in September 2010.

2010 - Derbyshire - Learning summary ADS10.

Abstract Death of two children (approx 6 and 3 years old) and serious injury to third infant in May 2010. Children living with both parents at the time of incident despite father having a Residence Order. Living arrangements were kept secret from agencies. Parents had a volatile relationship characterised by domestic disputes, intermittent alcohol abuse and financial difficulties. Mother had previously experienced some mental health issues including a suicide attempt. Highlights several missed opportunities for family assessment although finds no evidence that the children were ever physically harmed before the incident. Also notes a general concern about the potential impact of mobile phones and social media on parent-child interaction and child development. *This case clearly involves killing but who was responsible is not clear. The full report is not on-line. In view of the father having a Residence Order, and in view of the mother's history, it seems likely that the mother was the killer. This suspicion is reinforced by the absence of any mention of criminal charges. However, since this is not definitely established it has been categorised here as mother and father being joint perpetrators*.

2010 - Bridgend - Child K

Abstract Review into the death of a two year old boy following the ingestion of methadone in 2008. Both parents were sentenced to 12 months imprisonment for familial homicide. Parents had history of substance misuse and offending behaviour. Attachment difficulties between mother and child's brother. Insufficient action taken by agencies to hazards in home. Over optimistic approach by professionals to the family and the parents controlled professional intervention through obstruction and disguised compliance.

2009 - Birmingham - Case No. 11.

Abstract Review into Case No. 11 in Birmingham, in which a pre-school aged child died following the ingestion of Methadone, belonging to their parents in Birmingham. Both parents were drug users, and the father was well known to agencies due to violent and criminal behaviour. The parent's relationship was also abusive. The parents appeared to comply with professionals for limited periods before their standards of care deteriorated.

2009 - Birmingham - Case No. 12.

Abstract Review following the death of a baby (age unspecified). The cause of death could not be ascertained. Both parents were convicted of child cruelty. A baby from the father's previous relationship died in similar circumstances. Findings include failure to act on risk factors of: domestic violence, drug and alcohol abuse, missed medical appointments, dirty and neglectful living conditions and previous knowledge about the family.

2009 - Lancashire - Child D.

Abstract Review into death of a 7 week old girl who died whilst co-sleeping with the mother, who had been drinking heavily. Recommendations include procedures for domestic violence cases where a child is in the household, one health professional coordinating the care for all family members living in the same household and agencies providing mental health services to adults checking if there are any children living in the same household.

2009 - Doncaster - Child B and Child C

Abstract Serious case review following the death of Child B as a result of a number of serious non-accidental injuries including a spinal haemorrhage due to a fractured lumbar vertebrae. The child who was 16 months old was also thin and poorly nourished. B's father was found guilty of murder and B's mother pleaded guilty to causing/allowing the death of a child or vulnerable person. There had been some prior contact with South Yorkshire Police as a result of domestic violence and Child C, the brother of Child B, and his mother had had previous involvement with several statutory social welfare and health agencies.

2009 - Cambridgeshire - Baby A

Abstract Review into the death of Baby A who died aged 7 weeks as a result of multiple non-accidental injuries. Her father was convicted of murder, and her mother for allowing the death of a child. The review identifies that the parents were subject to multiple stress factors, including domestic violence but that agencies did not share the information that they had which could have built up a clearer picture about the family situation.

2009 - Isle of Wight - Child 1.

Abstract Review into Child 1, who died aged 30 days following a premature birth. The death was recorded as sudden unexpected death in infancy. Child 1 was subject to a pre-birth registration for a child protection plan for neglect, along with three older siblings. The parents were methadone dependent and review identifies that the initial assessment by social workers seemed to normalise the very poor living standards, which led to a continuing acceptance of poor environmental conditions. Parents also chose to home educate some children in unsafe conditions. Identifies that disguised compliance led to some professionals believing that the parents were engaging with services. Recommendations include better interagency working with unborn children subject to a child protection plan.

2009 - Kent - Caroline.

Abstract Review following the death of a girl, aged several weeks, who was found dead in her parents' bed. Both parents had been drinking and there were concerns around neglect, alcohol abuse and domestic violence. Findings include that neglect cases should involve an in-depth assessment to understand the pattern of concerns. Recommendations include considering a public health campaign around "overlaying".

2009 - Leeds - Child N

Abstract Review into the death of a 4 month old girl in March 2008 from shaken baby syndrome. Father, 16, was convicted of manslaughter and mother, 18, convicted of causing or allowing the death of a child. Father had emotional and behavioural difficulties, had been looked after as a young child and had some contact with CAHMS. School unaware father's girlfriend was pregnant and no risk assessment of unborn child. Recommendations include: review of services for teenage fathers; procedures and protocols in place for the referral of all cases to the Teenage Pregnancy Service; and the appropriate engagement of fathers in ante natal, birth and post natal services.

2009 - Birmingham - death of Case No. 9.

Abstract Review of the chronic neglect suffered by a Bangladeshi family of eight children resulting in one child being admitted to hospital for malnutrition in June 2008. All the children were taken into care, the father was convicted of child neglect and the mother was deemed mentally unfit to plea. Learning points include robust thresholds for neglect (not influenced by race, culture, standards of customs), procedures for children left home alone, seeing children in large families as individuals, impact of learning difficulties on parenting and using interpreters.

2009 - Tameside - Child J

Abstract Findings from a review of the involvement of agencies with Child J (aged 6 months) and his family prior to his death from bronchial pneumonia. Child J was not subject to a child protection plan but this parents were convicted of child cruelty and received prison sentences. There were concerns over neglect and evidence of non-accidental injuries; Child J had previously been admitted to hospital for failure to thrive.

2009 - Hartlepool - Baby 1.

Abstract Review into Baby 1 who died at 1 month old. Baby 1's parents abused alcohol, and the father had been convicted of violent alcohol related behaviour. Baby 1 and an older sibling were subject to child protection plans which were discontinued two weeks before the death of Baby 1. Baby 1 was found lifeless beside the mother where they had been sleeping. Baby 1 may have drunk alcohol prior to death, and circumstances indicate death may have been due to asphyxia caused by over-laying. However the death is regarded as "unascertained". Review finds that professionals failed to identify extent to which alcohol abuse and violence were risk factors to

parenting capability and recommends training in this area. *Mother & father assumed equally culpable.*

Mother plus partner perpetrators

January 2015 - Oldham – Child D
Death of a 7-week-old English/Polish child as the result of a severe head injury and multiple other injuries. Mother, mother's boyfriend and another adult male were arrested on suspicion of murder. All adults were sentenced for Perverting the Cause of Justice; sentencing Judge commented that at least one of the adults must have been responsible for the injuries.

January 2014 - Bolton - Child J
Death of a child as a result of a cardiac arrest, having received multiple injuries. **Background:** Mother's partner, Adult Q, was convicted of Child J's murder and sentenced to life imprisonment. Mother was found guilty of causing or allowing the death of a child.

October 2014 – Bedford – Child A1301
Death of a 19-month-old child in April 2013, as the result of a non-accidental head injury. Child A's mother and her partner were arrested but it was not possible to establish who caused the injury. Child A's parents separated almost immediately after Child A's birth and mother entered into a new relationship. Parents separation was acrimonious; allegations were made against father and against mother. Key issues: preconception of father as controlling leading to his concerns over mother's parenting being minimised; insufficient challenge to information provided by mother, which was later found to be untrue; and drink-driving allegations made against mother not being shared with the police agency responsible for assessing potential harm to children. [*Author's note: this is a rare case in which the Review acknowledges that evidence that the mother might be a danger to her child was available but ignored*].

October 2013 - York - Baby A
Death of a 20-week-old baby from a brain injury thought to be non-accidental. Mother and her then partner were arrested on suspicion of murder and causing or allowing the death of a child. Baby A was known to children's services and a pre- birth core assessment was commenced when Mother was 12 weeks pregnant.

September 2013 - Coventry - Daniel Pelka
Death of 4 year old boy on 3 March 2012 as the result of an acute subdural haematoma. Daniel's mother and step father were convicted of murder in August 2013 and sentenced to 30 years' imprisonment. For a period of at least six months prior to his death, Daniel had been starved, assaulted, neglected and abused. History of incidents of serious domestic abuse and violence, chaotic lifestyle with multiple house moves and alcohol misuse by mother and various partners.

May 2013 – Gateshead – Baby A
Death of a 10-week-old baby boy as the result of a severe blow to the head. Further examination revealed older injuries to Baby A. Mother's partner, Mr C, was found guilty of murder and mother was found guilty of causing or allowing the death of a child. Maternal grandmother was 16-years-old when mother was born and mother was 18-years-old when Baby A was born. Mother separated from Baby A's father before Baby A's birth and reported that the relationship had been abusive.

2011 - Peterborough - Child: born 2006: died 2011:

Abstract Review into a case in which a 5 year old boy died (early 2011) after an incident at home. Mother and partner claimed incident was an accident but post mortem revealed injuries probably caused by blunt trauma to the abdomen and head. Mother and partner arrested as part of murder enquiries. Mother's partner had a conviction for domestic violence offences against former partner and was subject to a treatment court order. Known to have been violent towards child's mother. Concerns about injuries to child including a fractured leg and injuries to genitals. Children's Social Care failed to undertake agreed Core Assessments after hospital attendances despite concerns of non-accidental injury. *Classed here as both mother & partner culpable since both arrested - though this is in doubt.*

2010 - Haringey - Child A (*this is the infamous "Baby P" case*)

Abstract First overview report of the review into the death of 17 month old Baby Peter (also known as Baby P or Child A) at the family home on 3 August 2007. Child was found to have multiple injuries including a fractured spine and 8 fractured ribs. Mother, partner and partner's brother were charged with murder and causing or allowing the death of a child. History of domestic abuse in maternal family and maternal depression. Health professionals, police and social services had been involved with child on a number of occasions due to bruising and physical injuries, including 8 times in last 3 weeks of child's life. Issues highlighted include: lack of involvement of father and invisibility of mother's partner; inability to identify and prosecute perpetrator of child's injuries; perception that injuries caused by insufficient supervision and child's own behaviour; and reliance on family friend concerning welfare of the child and his siblings. Recommendations include: multi-agency review of joint protocols and practice for referrals, strategy discussions, core group meetings and child protection conferences; development of detailed guidance on the use of family friends as temporary carers for children; and active oversight and monitoring of medical treatment to children on child protection plans.

2010 - Birmingham - Child: BSCB 2009-10/3.

Abstract Review into the death of a two year old child in February 2010. Cause of death was untreated burns resulting in septicaemia. Mother and partner were convicted of manslaughter and imprisoned for 6 years and four and half years respectively. Mother was from Latvia and had history of mental health problems. Partner was from Sikh community and had been mother's landlord. Concerns raised about lack of care and attention of child compared to sibling who was spoilt. Bruising had previously been noted on child but explanations accepted by health visitors.

2010 - Birmingham - Case Number 14

Abstract Full overview report of the review into the death of a 7 year old girl who died of bronchial pneumonia and septicaemia with focal bacterial meningitis in May 2008. At the time of death, the child was malnourished with severe wasting due to significant starvation over several months. Also bruising to the body. The surviving 5 siblings also showed varying degrees of malnourishment and bruising. Mother and her partner were convicted of manslaughter. Review identified the change in mother's behaviour under the influence of her partner, as an important feature. Legal evidence suggested that the mother's partner's belief that evil spirits inhabited the child, led to severe physical chastisements, beatings and humiliating punishments for all of the children, including the withdrawal of food. Two attempts were made by members of the public to share their concerns, one telephone call and the second by a referral in person at a Children's Social Care office, but this information was not acted upon. School staff also raised concerns.

2010 - Gloucestershire - Executive summary 0109.

Abstract Review into the death of a 14 month old girl, Jamie, from ingesting methadone in 2009. Both child and her older sibling had ingested methadone on an infrequent basis over a period of time. Mother and new partner convicted for three counts of child cruelty. History of domestic violence, substance abuse, offending and maternal depression. Mother moved children between two counties. Referrals made to Children's Services did not lead to home visits nor assessments. Professional focus on needs of adults and not on impact of adults behaviour on children.

2009 - Birmingham - death of a child: BCSB 2008-9/5

Abstract Review into the death of a baby from serious injuries to the head. Parents were both adolescent care-leavers with childhood experiences of physical and sexual abuse. Their relationship was violent, and they separated after their child's birth. The mother's new partner and her brother (who had also been abused himself, and had previously been arrested following allegations of offences against a child) moved in with the mother following the separation. The mother was abusing alcohol and drugs, and the father made two referrals expressing concerns about her parenting capacity, and about his child being left alone with the uncle.

2009 - Kirklees - death of a child aged two years and five months

Keywords Child deaths, Child neglect, England, Interagency cooperation, Intervention [social work], Official inquiries, Physical abuse, Pre-school children

Abstract Review into the death of a two year old girl who was discovered in the bath underwater by her mother. Post mortem discovered multiple injuries to the child including fractures, but found no evidence of drowning. Review identifies that concerned had been raised about the welfare of the child, but these were not recorded or acted upon appropriately by staff. Emphasises the need to focus all intervention of the welfare of the child. Mother and her and her partner, both aged 21, were imprisoned for manslaughter and murder respectively.

2009 - Newham - Child A

Abstract Review of the circumstances leading to the death of a 2 month old. He died 8 May 2006 following numerous physical injuries. His mother and her boyfriend were charged with assault and neglect. His mother was homeless with mild learning difficulties and a had a history of substance misuse and domestic violence. No background checks were carried out on the mother's new boyfriend.

2009 - Northamptonshire - Child E

Abstract Revised review into a boy, known as Child E, who died in suspicious circumstances in March 2007. The child lived with his mother, her new partner, his sister and two stepbrothers. The family had been known to children's services since September 2004, and had been on the child protection register since June 2006. Many of the professionals involved were overly focussed on the parents' needs, and all found the family hard to work with. Recommendations include: a holistic approach to midwifery including the use of a risk assessment form, and a policy for assessment and intervention in cases of neglect. *Report not on-line so lack of detail - assumed to be homicide by neglect with both mother & partner culpable (but this could be wrong).*