Cases classed as "perpetrator not assigned"

2015 - Blackpool - Child BV

Death of a 1-month-old infant in Winter 2014. Ambulance service found Child BV unresponsive in 2-year-old sibling's bedroom, lying between the bed and wall.

Background: both parents had consumed large quantities of alcohol the previous day and could not remember how or why BV was not asleep in usual place. Family were known to universal services only. Father attended Accident and Emergency and visited GP prior to BV's birth and disclosed that he was a regular heavy drinker.

2015 - Nottinghamshire - Child H

Death of a 4-month-old girl in December 2012. Child H died of unknown causes but had a number of injuries which were thought to be non-accidental.

Background: the family was known to a number of agencies due to the serious domestic abuse the mother had experienced with her previous partner, who was the father of Child H and her sibling. Mother had a history of mental health problems, abusive relationships and alcohol misuse.

March 2015 – Bromley – Child E

Death of a 12-week-old boy in March 2014 as the result of Sudden Unexpected Death in Infancy (SUDI).

Background: Child E was Looked After at the time of the incident and had been placed, with his twin brother and two older siblings, in the care of his maternal aunt. Both parents had been arrested for burglary offences and were remanded in prison at the time of the incident. Family are from an Irish Traveller background and had lived in a number of different Local Authorities. History of: parental offending; parental drug and alcohol misuse; and maternal mental health problems.

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. There had been no previous concerns about the mother's care of her children and they were not known to children's social care.

January 2015 - Leeds – Child Y

Death of a 14-week-old girl in March 2012. Post-mortem examination jointly conducted by two pathologists resulted in the recording of two different probable causes of death: Sudden Infant Death Syndrome and unascertainable.

Background: Child Y lived with mother, father and five older siblings in a three bedroom property at the time of the incident. Family had been known to children's services since 2003 and children were subject to Child in Need and Child Protection plans at different times before and after Child Y's death. Professionals' concerns primarily related to home conditions, children's personal hygiene and school attendance.

January 2015 – Liverpool - Mary
Death of a 6-month-old girl in July 2013, cause of death unascertained. Post-mortem recorded that Mary was a well-nourished child and found no past or current injuries; a number of risk factors for sudden infant death syndrome were identified, including prematurity and parental smoking.
Background: History of family violence; parental substance misuse; and professional concerns about school attendance levels and the health of Mary's two older siblings who were significantly overweight.

November 2014 - Sunderland – Baby A and Child C
Death of a 1-week-old in April 2013. Coroner's Inquest concluded no explanation for cause of death.
Background: Baby A was admitted to hospital following a cardiac arrest and later died, following the withdrawal of life support. Mother had a history of abusive relationships and had received support for a long-standing heroin addiction for a number of years. Mother was well known to children's social care. Baby A was the subject of a Child Protection Plan at the time of the incident and had been discharged from hospital, post-birth, into the care of maternal grandparents. Mother's eldest child and Child C were also living with maternal grandparents at this time and mother's second eldest child was living with their father. Child C was subject to Child in Need or Child Protection Plans for most of their life prior to the incident.

August 2014 - Manchester – Child C1
Death of a 2-year-old boy by choking. Child C1 had been left alone with his older sibling when he swallowed and choked on a small item. He later died in hospital.
Background: following his death some unexplained bruising was identified and Child C1's sibling was made subject to an interim care order. No charges were made against either parent.

June 2014 - Coventry - Child A
Death of an 18-day-old baby in March 2012.
Background: Child A died while in bed with mother and her partner who had both consumed alcohol the previous evening; Child A's death was considered accidental.

June 2014 - South Gloucestershire – Child C
Death of a 17-week-old baby girl in November 2012; death was recorded as due to unascertained causes.
Background: Mother reportedly experienced sexual, physical and emotional abuse as a child. Mother was 15-years-old when she became pregnant with Child C's older brother and still a teenager when Child C was born. Mother's partner was known to police and children's social care in a neighbouring authority. Significant maternal history of domestic abuse, inconsistent parenting, anxiety and low self-esteem.

April 2014 – Bury - Child H
Death of an 8-year-old boy in April 2013, as the result of an asthma attack.
Background: Child H and his siblings were the subjects of a child protection plan under the category of emotional abuse at the time of the incident. Child H was diagnosed with moderate/severe asthma and experienced problems with his eyesight, nosebleeds and enuresis.

January 2014 - Hereford – HH
Death of a 17-year-old boy in May 2013, as a result of diabetic ketoacidosis.
Background: HH and his family were known to children's services and HH became a looked after child three months before his death.
Issues identified include: parental neglect of HH's health needs not adequately acknowledged by professionals; HH's disguised compliance in relation to the management of his diabetes; and lack of awareness of the need for HH to test his blood sugar regularly among non-health professionals.

2013 - Barnsley – Child K
Death of an 11-month-old boy in September 2011, as the result of a head injury. Medical opinion was that non accidental injury was a likely cause of death.
Father said the injury took place when Child K was knocked over by the family dog. Medical opinion was that the injuries were not consistent with this explanation and that non accidental injury was a likely cause of death. At the time the case review report was written no charges had been brought.
Background: Child K lived with mother and father at the time of the incident; father was Child K's primary carer. Father was known to children's social care in relation to his older child with another partner. Paternal history of: neglectful parenting; anger management; Attention Deficit Hyperactivity Disorder (ADHD); depression; domestic abuse perpetration; substance misuse; a serious health condition; criminal activity and imprisonment.
Key issues: failure to properly consider the significance of earlier injuries and weight loss; father's sense of isolation as the main carer of Child K, particularly as he found it difficult being the only man in baby and toddler groups; and lack of consistency in the health visitors work with the family.

July 2013 - Lancashire - Baby H
Death of a 4-month-old baby boy from a serious head injury in November 2010.
Background: Baby H died three days after presenting to hospital in cardiac arrest. Issues include: significance of mother's young age on parenting capacity not recognised by agencies; lack of agency engagement with and knowledge of mother's partner; and lack of professional scepticism. *Placed in this category only because perpetrator, if any, not clear.*

September 2013 - Bolton - Child 1
Death of a baby as a result of a traumatic head injury.
Background: Mother had limited leave to remain in the UK following her marriage to father. Father had some learning difficulties, which was not known to mother before the marriage. Prior to Child 1s birth mother, father and Child 2 lived with father's extended family. After moving to their own accommodation mother and father reported that paternal grandfather was physically abusive and controlling. Mother had previously disclosed domestic abuse and unhappiness with father to her GP. (*Could not determine the perpetrator*).

May 2013 - Bournemouth and Poole - Baby J
Death of a 5-month-old baby boy on 19 September 2012, of natural causes.
Background: Baby J's mother was found to have consumed significant amounts of alcohol and to be co-sleeping on the sofa with Baby J at the time of his death. The family were known to children's services and there was a history of domestic abuse, maternal risk-taking and criminal behaviour in adolescence.

May 2013 - Buckinghamshire - Baby C
Death of a baby boy in October 2011, from a head injury thought to have been caused by shaking.
Background: Post mortem revealed additional fractures, which occurred approximately two weeks before Baby C's death. Parents were questioned by police at the time of Baby C's death and a criminal investigation and care proceedings in relation to Baby C's siblings were underway at the time review was published. History of maternal depression and panic attacks; maternal cardiac condition; family homelessness and house moves; and claims of racial harassment from neighbours. *Placed here despite almost certainly being a death due to abuse because the perpetrator unclear at time of report - criminal investigations were then still progressing.*

February 2013 – Isle of Wight – Child D
Serious injury of a 12-week-old baby girl in December 2008.
Background: Child D was presented to hospital by her mother, following the identification of unexplained bruising by her GP. Child D was found to have 16 separate fractures thought to have been up to 4 weeks old. No individual has been convicted of causing the injuries, though medical evidence has shown them to be non-accidental. *Placed here despite almost certainly being a death due to abuse because the perpetrator unclear at time of report.*

January 2013 - Rhondda Cynon Taf - 1 / 2011
Death of an infant under 3-months-old from a serious head injury.
Background: Family was known only to universal services until the time of the incident. (*Classed here due to no further information available*)

2012 - Flintshire - Sion D
Review into the death of Sion D, a 7 year old boy with disabilities and developmental delay. Sion died of an infection that had affected his breathing but review carried out because of concerns about indicators of neglect, unexplained injuries and faecal smearing before his death. Sion's parents struggled to cope with his disabilities and were resistant to professional assessment and intervention. Sion was home schooled. The review finds that professionals were not sufficiently challenging to the parents during their contact with the family. *Placed here due to lack of other details on-line.*

2012 Child A: Islington Safeguarding Children Board (2012)

Revised executive summary of a review into the death of a 4-month-old baby boy in the summer of 2009. Mother and father were arrested in 2009 but later cleared of any criminal offences in 2011. Rrevised executive summary reflects the finding that Child A suffered from rickets, suggesting the possibility of organic, non-inflicted causation of Child A's injuries.

2012 Child H: executive summary.

Pembrokeshire Safeguarding Children Board

Review into the circumstances surrounding the death of a seven week old baby, Child H, born to young parents (both under 20 years old). Child H died as a result of an unexplained infant death. Abuse and neglect were not a contributory factor but a review was undertaken because Child H was subject to a child protection investigation at the time of death.

2012 - Westminster - Child EG

Review into agency involvement after the "accidental death" of EG, aged nearly one. Mother died a few days later from natural causes (a sudden fatal cerebral illness). Likely that mother became too ill to provide for EG leading to dehydration and a lack of food. *Had the mother lived this would probably be a case of culpability of neglect. However, in view of the evidence that the mother was extremely ill culpability may be waived.*

2012 - Leicester and Rutland - Child H

Child H (not specified whether a boy or girl) aged just over 9 weeks died at home. It is believed that Child H's father fell asleep in a chair suffocating Child H. Both parents had a history of drug use and mental health problems, had a chaotic lifestyle and were known to a number of agencies. An older child was being taken care of by a relative as part of an ongoing child protection plan.

2011 Caerphilly Child K.

Abstract Examines the case of a 5 month old boy who died on 11 December 2009 from a suspected non-accidental head injury. The father of Child K had had previous contact with the Police and the Probation Service in another Local Authority Area and had a report of domestic abuse from a previous relationship. However, checks were made and there were no reported concerns in relating to the current relationship. Good contact with health professionals was maintained throughout Child K's life. The review concludes that there was no evidence that Child K's death was predictable or preventable, and identified no lessons to be learned. *Placed here because perpetrator unknown.*

2011 Cardiff Child C

Abstract Review into the sudden death of an infant from co-sleeping in April 2009. Issues include: the importance of recognising risk factors associated with co-sleeping with young babies; domestic abuse; school attendance; disguised compliance and disengagement. Recommendations include: child protection conferences must formally consider risk factors surrounding sudden infant deaths; information from GPs must be available to child protection conferences either through attendance of GP or through submission of medical reports; where disguised compliance may be an issue, the child's view must be sought in all assessments; and a review of housing policy to ensure it meets the needs of tenants in domestic abuse situations. *No further details on-line to permit any culpability to be determined.*

2011 - Southwark - Jack

Abstract 'Jack' died aged 11 weeks in March 2008, probably as a result of sudden infant death syndrome. He was subject to a child protection plan following a pre-birth child protection conference. Although not connected to his death, a post mortem revealed healing fractures to an ankle and several ribs. Mother had a history of childhood sexual abuse, self harm, depression, alcohol misuse and occasional aggression. Father was in his late teens and had a family history of domestic violence, parental substance misuse, and offending behaviour. Mother was referred to services for her mental health and alcohol misuse and the inter-agency protocol for parents with mental health problems was followed. Father referred to adolescent psychiatric services for an assessment of his moods, self-reported aggression and a forensic risk assessment. Finds that although there were gaps in the assessment, the essential elements of the possible harm of abuse and neglect were understood and there was no evidence that Jack's death was caused by the care he was receiving. Notes that father was closely supervised.

2011 - Medway - services provided for Beth and her family

Abstract Death of a 7-month-old baby girl in December 2011, of natural causes. Identifies a number of features of the care that Beth was receiving at the time of her death that heightened the risks to her, including: sleeping position, smoking in the home, and bed and bedding unsuitable for an infant. Family was well known to children's services and Beth's older siblings had all been subject to child protection plans.

2011 - Leicestershire and Rutland - : Child F.

Abstract Child F died within a month of birth. The post mortem revealed the baby had a skull fracture but the cause of death has not yet been established. There is a continuing criminal investigation. *The detailed report was not on-line so placed here due to lack of in formation on perpetrator.*

2011 - Durham - Child T

Abstract Review into a 4 month year old baby boy who died of a traumatic brain injury in 2008. Child T was born 11 weeks early with a congenital condition which required a significant level of medical treatment. His mother was in England visiting the child's father, and had intended to return to Eastern Europe for the birth. 11 weeks after returning home Child T was taken to hospital, where he was pronounced dead. Post-mortem examinations were inconclusive, but they did identify a growth on the rib, found to be the result of a fracture. A lack of communication between the police, health services and safeguarding services about the nature of Child T's death resulted in the parents' second child being removed from their care on the day he was born, with no prior planning or assessment. *Placed here due to uncertainty about what happened, and who the perpetrator might have been.*

2011 - Kirklees - Child who died aged 2 years 11 months.

Abstract Executive summary of a review into the death of a 2-year-11 month-old child on 17th November 2010, during surgery undertaken following the child having swallowed caustic liquid plant food. A post mortem concluded that the child's death was a result of complications arising from internal chemical burns associated with ingesting potassium hydroxide. The child was born extremely prematurely and was profoundly deaf. Issues identified include: non-attendance; mother's unwillingness or inability to ensure the child wore hearing aids; lack of social stimulation and interaction for the child

2010 - Lancashire - Child F

Abstract Review into the death of a young person in December 2008 who was suffering from an inherent congenital condition which was treatable but not curable. Young person expected to live to adulthood, review undertaken to consider professional intervention with family and child and circumstances which led to death. Child and one of step-siblings placed on child protection register following allegation about family life by other step-sibling, which was later withdrawn. Concerns over quality of care of child at home. Child's father not keen to engage. Recommendations include: attendance at case conferences and core groups to be monitored; ongoing audits of safeguarding arrangements in schools; and a review of risk assessment policies and procedures. This executive summary was reviewed in 2010, following an Ofsted evaluation, which commented that an internal review of this case would have been more appropriate.

2010 - Stoke on Trent - child BSK410.

Abstract Review into the death of an infant following a life threatening event in early 2010. Infant was found not breathing whilst co-sleeping with father on sofa and died in the summer of 2010. History of domestic abuse and alcohol abuse in family. Infant, born to young parents, was on child protection plan and in the care of an extended family member, who was experiencing a number of social, emotional and environmental stressors. Recommendations include: creation of a multi-agency service to assess the needs of children and families; an audit tool for pre-birth assessments; the involvement of fathers in parenting assessments; and a campaign to raise awareness of the risks of co-sleeping.

2010 - Cardiff - Child A

Abstract Review into the death of a 3 year old boy in 2007 from injuries sustained after being knocked down outside the family home. Child and 5 siblings had been on a child protection plan because of concerns over child neglect. No adequate assessment of the children's needs or the parenting capacity of the mother. Recommendations include: evaluation of training and practice guidance on neglect; review of training to lead professionals involved in assessing children in need; and the referral of cases where children who have been subject of child protection plans are placed again under a child protection plan within 12 months.

2010 - Blackpool - Child I

Abstract Death of a 3-month-old baby boy on 6th February 2010, from unknown causes. Post-mortem revealed healing rib fractures thought to be non-accidental. Child I's death was found to be unpreventable. Identifies issues relating to sibling experiences of being looked after and being subject to a child protection plan and parents co-sleeping with Child I at the time of his death. Lists seven themes for improvement, including: assessments; quality assurance, management and supervision; balance between supporting adults within vulnerable families and safeguarding children; and strategic management of multi-agency and commissioned services. Makes various single agency and multiagency recommendations for: children's services, family services, Barnardo's, early years, police, health and education services. *Classed as "unknown events or perpetrator" - report not on-line.*

2010 - Coventry - Child CD.

Abstract Review into the death of Child CD in May 2009 aged 15 months. He was found by his father apparently lifeless in his cot. Charges of neglect against both parents dropped. Cause of death was a natural disease but post mortem found two rib fractures and the presence of illicit drugs in CD's body. CD's contact with agencies was restricted to health services. In February 2009 he was taken to hospital by his mother after becoming drowsy and 'floppy'. Hospital considered ingestion of drugs but did not undertake toxicology tests. Diagnosed with an eye infection although an injury to lip also noted. In early May he attended A&E with an elbow injury which was consistent with an accidental injury.

2010 - Dudley - Child D

Abstract Review into the circumstances surrounding the death of Child D at 8 weeks old. D died from a trauma to the brain although the exact cause of death is unknown. Non-accidental head injury was suspected but charges against the father were dropped after he admitted shaking D after he found him not breathing. Parents reported that D had experienced spontaneous bruises on his body before his death. Tests after death ruled out a serious blood disorder. Parents claimed they told health professionals about the bruises but no record of this kept by agencies. There were no previous concerns about Child D. Father had seen his GP shortly after D's birth for anxiety, anger and stress-related issues but he was not considered a risk of harm to others. Review finds that agencies could not have anticipated or prevented D's death. Highlights the importance of balancing support to parents where a child has died unexpectedly with prompt investigations when suspicions of non-accidental injury are raised. Makes brief recommendations for health services, children's social care, police and the LSCB.

2010 - Flintshire - Child C

Abstract Review into the death of a 1 year old girl, Child C, who drowned in the bath. Family had experienced domestic violence, and the police had attended the house on numerous occasions. Mother had depression and abused alcohol and the review finds that Child C and her siblings should have been considered 'children in need' prior to this event. Recommendations include improved protocols for dealing with domestic violence cases. *Insufficient information to establish culpability (report not on-line).*

2010 - Kent - Claire

Abstract Death of a 10 week old baby in April 2009, who was found lifeless in her cot and later confirmed dead, despite efforts to resuscitate her at hospital. Family known to children's services and other local agencies but, despite various 'children in need' referrals and external reports of physical and sexual abuse, neither Claire nor her two siblings had ever been subject to a child protection plan. Claire and her siblings had all experienced faltering growth yet had not been referred to the community paediatrician to consider if the concern was due to organic or non-organic issues. Considers issues of assessment; interagency working and information sharing; accurate and timely record keeping; and, the implications that police verdict of a non-suspicious death has on the Serious Case Review process. *Another of the many cases in which chronic neglect and/or parenting incompetence appears likely to be the root cause of the death but that this has not been formally established nor is there sufficient information to identify culpability (report not on-line).*

2010 - Merthyr Tydfil - Child A.

Abstract Review into the health-related death of Child A aged several months. There was agency involvement with the family due to domestic violence, parental substance abuse, child neglect, poor compliance with health services, injuries considered non-accidental and Child A being born prematurely. Highlights weak practice in: noticing patterns of concern, pre-birth assessment, challenging parents, engaging with father and referrals procedures. Stresses inadequate care should have been viewed as a child protection issue. Recommendations include using a graded care profile. *Insufficient information to establish culpability - report not on-line.*

2010 - Knowsley - Child E.

Abstract Child E was just over five weeks old when he died in hospital in 2009. He had been sharing his parents' bed when they woke to find him lifeless with blood across his face. Father admitted to smoking two cannabis cigarettes before coming to bed and his wife reported to emergency services that her partner had "rolled on top of him". Final pathology report found the cause of death "unascertainable" although acknowledged that "overlay" was likely given the parents' statements. The history of the family, especially extended family, raised a number of concerns which did not necessarily relate directly to outcomes for Child E, but highlighted issues of early identification, shared information and tracking relevant histories of vulnerable children. Review was satisfied that prior to his death, Child E had received good care from his parents as did his older sibling.

2010 - Croydon - Baby H

Abstract Review into the death of a 4 week old baby girl in Hounslow in February 2010 whilst sleeping in a bed with her mother and father. The family had moved from Croydon a few days earlier. There were consistent concerns about neglect. Both Child H and her older brother were subjects of child protection plans. The mother was an adolescent and both parents were evasive and difficult to engage. Recommendations include: auditing the implementation of the protocol on adolescent parents; improving the attendance at and the management of child protection conferences; training on involving and engaging with fathers. Also raises the issue of recording ethnicity and religion but not using this information in service provision.

2010 - Reading - Twins A & B: twin A died aged 4 months

Abstract Summary of a review into the death of a 4-month-old baby boy, Twin A, in 2009. Coroner's Inquest had not reached a verdict regarding cause of death at the point the review was published. Twins A and B were put on child in need plans post-birth but the family did not comply with and there was no follow-up. Mother was 15-years-old when she became pregnant; father was 4 1/2-years older. Both parents experienced abuse or neglect as children and were well known to health and social care. Issues identified include: insufficient focus on parents' histories and the impact that their childhoods may have on their parenting capacity; and insufficient exploration of the nature of parents' relationship, given the discrepancy in ages and that mother became pregnant under the age of consent. Makes recommendations, including: Local Safeguarding Children Boards (LSCBs) should establish clear understandings about the transfer of cases between LSCBs; and where there are concerns over the parenting capacity of a child under 16-years-old, the parent should also be assessed as a child in need.

2010 - Herefordshire - Baby HA.

Abstract Review into Baby HA who died aged 6 weeks. Baby HA had been born prematurely and despite poor weight gain otherwise progressed well. The mother and two other adults in Baby HA's life were all known to abuse substances. Baby HA's older sibling had been on the child protection register prior to Baby HA's birth and there was very poor school attendance in the family. Cause of death is unascertained although earlier skull fracture and signs of overlay and asphyxiation found. Review finds that services missed many opportunities to intervene with this vulnerable family, and includes extensive recommendations for interventions with drug using parents.

2010 - Rochdale - Child T.

Abstract Review into agency involvement with Child T (age unspecified) who was the subject of safeguarding concerns when he was found dead in his cot by mother's husband. Cause of death unascertained but numerous injuries to T's head, face and body, suggesting non-accidental injury. Nursery first noted bruises to Child T and made a referral to children's social care. Medical investigations were inconclusive and T was returned to mother's care while awaiting child protection case conference. Child T had previously been seen by A&E doctors for a leg injury (allegedly caused by trapping it in cot bars). Review notes issues of concern including: the failure of the investigating doctor to refer T for a second opinion when faced with an uncertain diagnosis of non-accidental injury; poor risk assessment and information sharing; and the lack of challenge when making inquiries. Also highlights concerns around the placement of T's half sibling with grandparents while investigations continued.

2010 - Nottingham - Child D.

Abstract Review into the death of a baby, aged a few weeks, in Spring 2008 from brain injuries. Very little information is given in the summary, but the lessons include that agencies did not fully understand how a combination of substance misuse, alcohol abuse, domestic violence and mental health can be damaging to families and that agencies focused on the adult rather than the child.

2010 - Slough - Baby C.

Abstract Review following the death of a 9 month old baby boy who choked on a sausage in May 2008. Baby C's parents were of Eastern European origin and lived in multiple-occupancy housing. Baby C's parents and friends had been drinking when he choked on pieces of sausage. Recommendations are around seeing immigrant families as vulnerable groups and assessing and meeting their needs. (*Who the Hell gives a 9 month old baby a sausage?*)

2010 - Leeds - Child R

Abstract Review into the death of a 13 year old girl, with multiple disabilities, from complications following Chicken Pox. Teenage mother managed care of her child and received support from various social services departments. On occasions, mother displayed challenging behaviour. Self referral from mother in 2004 but assessments did not indicate need for child protection procedures despite concerns over Child R's weight and diet.

2010 - St.Helens - case review: R

Abstract Review following the death of baby girl (age unspecified) who died after sustaining a subdural haemorrhage. Her mother's partner, was present when R became unwell. R had been born prematurely and had been failing to gain weight, an issue which was not addressed adequately during clinic visits. No safeguarding concerns had been noted. Agencies did not know about the mother's partner. Recommendations include that all staff need to be alert to the concept of a 'hidden male' involved with clients / patients. *Despite the hinting of this Abstract that the partner might have been responsible, no actual evidence for this is offered. Being present when the injuries were sustained does not preclude the presence of the mother also. Hence classed as "unknown perpetrator".*

2010 - Torbay - case review: C11

Abstract Review into the death of C11 who died aged 6 days whilst co-sleeping with their mother. The family had multi-agency support relating to issues including alcohol abuse, domestic violence, physical abuse, sexually harmful behaviour, neglect, non-attendance of school, ADHD, parental illiteracy, criminal and anti-social behaviour and homelessness. Review finds that no agency had a complete picture of the challenges faced by the family which resulted in a failure to provide the level of support required. *Yet another case of an incapable mother, the death of whose child can hardly be considered as unrelated to her unsuitability as a mother. These cases are problematic as regards assigning culpability - classed her as "accidental" though this hardly really addresses the issue.*

2010 - North Yorkshire - Child D

Abstract Review into the sudden death of a 12 year old boy with disabilities and complex health needs following ingestion of mother's medication. No child protection concerns prior to death. History of child ingesting objects and medication. The child also suffered a minor injury following a fall from a bedroom window. Criminal investigations concluded insufficient evidence to charge either parent with child's death. Themes include: impact of parental mental ill-health on parenting; assessment of child's poor sleep pattern and impact on whole family; and professionals' focus on child's disability and not on safety issues.

2009 - Waltham Forest - Child Z.

Abstract Review into the death of a two and a half year old disabled girl in May 2009. Mother had left child in bath alone and returned to find child not breathing. Child required a high level of care due to a presumed genetic condition resulting in global developmental delay. History of maternal depression and post-natal depression. Significant level of involvement with health, welfare and voluntary agencies. Additional stress factors of bereavement and father's loss of employment. *It is difficult to determine culpability in cases of child deaths by drowning when left unsupervised in a bath. Generally I assign culpability if the child is an infant, especially if there is a history of poor parenting. But this case is more debatable and so I have classed as 'accidental'.*

2009 - Cornwall and the Isles of Scilly - Death of a Female Child

Abstract Review into the death of an 8 year old girl on 2 December 2005 from renal failure due to dehydration. Child had history of gross dental decay and had been admitted to hospital in November 2005 refusing to eat, drink and communicate, after having a loose tooth. Child referred to child psychologist and clinical psychologist, no clear written plan was made on discharge. School concerns over health but reassured by parents. Recommendations include: training for frontline housing staff on child protection issues; police enquiries into intra-familial sexual abuse should consider risks to all children in extended family; and review of hospital discharge procedures for paediatric cases to ensure involvement of parents and other professionals. *Placed here due to lack of clarity regarding culpability.*

2009 - Lewisham - Child C

Abstract Review into the death of a newborn baby, Child C. Mother was subsequently found not guilty of criminal charges arising from the death. She had concealed this and previous pregnancies. Recommendations include the development of procedures and practice guidance on concealed pregnancy for child protection services and for NHS trusts to review arrangements for communication, liaison and joint working between midwives, health visitors and general practitioners.

2009 - Havering - Child B

Abstract Review into Child B who died in 2008, aged six weeks. Child B died after sleeping on the sofa with his mother, Ms C. Ms C was an isolated individual who had drunk alcohol and may have been using drugs on the night Child B died. The formal cause of death is expected to be recorded as Sudden Unexplained Death in Infancy (SUDI). It is not established whether the death of Child B is related to 'co-sleeping' with his mother. Review finds that Ms C had a history of depression and had a difficult pregnancy, following the death of her mother. Recommendations include improved interagency working with relation to concerns about maternal vulnerability. *Yet another case for which it is difficult to be definitive about culpability. In the absence of a history, this case is classed as 'accidental' - though most people would consider the mother to have been to blame.*

2009 - Herefordshire - Child HB

Abstract Review into the death of HB who died aged 7 years, following routine surgery. Neglect was suspected in causing her death. HB was born with a chromosomal abnormality which caused developmental delay, hearing and visual impairment and learning disabilities. HB's mother was resistant to help offered to the family to support HB and many health appointments were missed. Following routine surgery, HB experienced health problems, but communication problems between professionals prevented any intervention until she collapsed. Review recommends training to deal with non or disguised compliance, and improved assessments of children. *Despite the implication of neglect this is classed as 'accidental' here due to the complexity arising from the child's condition.*

2009 - Kent - Bethany.

Abstract Review into Bethany who died in a house fire aged 15 months. Bethany and her siblings had been left on their own whilst their mother went out to look for her partner. The partner was a sex offender with a history of fire setting. The children sustained injuries prior to this event, but professionals did not properly evaluate the risk the children were exposed to. There was no evidence the fire was deliberately started. Recommendations include interviewing children at risk away from their carers. *This is obviously suspicious but who was culpable. If the partner committed arson, was this with the mother's knowledge and consent? Don't know.*

2009 - Kent - Billy.

Abstract Review into Billy, who died after an accident in the home. Billy was subject to a child protection plan for neglect at the time. Review finds that domestic violence also existed in the home, and that the assessment of Billy and the impact of the neglect was not satisfactory. There were significant delays in sharing information between agencies. Recommendations include improved training and practice for professionals working with neglected children. *Not enough information to determine culpability (report not on-line).*

2009 - Kirklees - death of a Child, Aged 4 Weeks

Abstract In July 2008 a child aged four weeks died from asphyxiation after sleeping on her father's chest. There were no signs of physical abuse or neglect. The child was subject to a child protection plan. Both parents had a history of drug use and two older half-siblings had been placed with extended family. Considers the tendency to focus one feature drug misuse rather than the complexities of chaotic substance misuse; communication between professionals from different disciplines; provision of advice about co-sleeping; and optimistic attitude to parenting capacity.

2009 - Cheshire East - Child X006.

Abstract Review into the death a baby boy aged 3-months-old (X) from choking on vomit/fluids in the airways. The coroner recorded accidental death. On the morning X died, a health visitor observed him being 'prop fed' and advised that he should be fed sitting upright. Directly before being found not breathing, X had been left alone with his 2 year old brother. There were concerns of domestic violence. X's brother had previously been the subject of a child protection plan. Recommendations include pre-birth assessments on a child whose sibling is subject to a child protection plan and plans assessing all areas of risk.

2009 - Northumberland - Andrew.

Abstract Highlights learning from a case review into the death, by unexplained causes, of a baby boy. The baby was found to have two old fractures that did not contribute to his death, and were also unexplained. The family was known to children's services due to concerns that the mother could not cope with a baby without support. Three initial assessments of the family were carried out, in the first two instances the case was subsequently closed. The baby died shortly after the third assessment. Lessons learned include: in cases where families are involved with a number of agencies, consultations should take place with all the relevant teams before the decision is made to close a case, and case histories should be fully analysed when a worker takes over a new case.

2009 - Nottinghamshire - Sarah

Abstract Sarah was a white British child who died aged 4 months in late 2007. The cause of death was not known, but circumstances before and surrounding her death and in particular the discovery during a later examination that she had suffered fractures raised questions about the circumstances of her death. Both parents were drug users. Sarah's death was subsequently recorded as a Sudden Infant Death (SIDS) and the injuries were assessed as not related to the cause of death.

2009 - Doncaster - Child V.

Abstract Review into Child V who died of natural causes which were linked to the complex congenital condition they were born with. Child V died whilst staying with a registered foster carer who provided respite care for his parents. The review finds that prior to his death, the respite care provided for Child V may have been losing sight of his best interests, but overall good care was provided and his death was not preventable. Recommendations include improved record keeping for respite care placements.

2009 - Hertfordshire - Baby D.

Abstract Review of agency involvement with Baby D and family, following the child's death at 7 months. Sudden infant death recorded, possibly as a result of baby getting trapped in cot bars due to an ill-fitting cot mattress. Issues around domestic violence, maternal depression and mental health problems, a previous allegation of sexual abuse against a child within the family, and substance misuse. Recommendations include: the local safeguarding children board (LSCB) should ensure good quality assessments (initial, core, and CAF) are carried out in a timely manner and that fathers/male carers are included; the LSCB should consider developing a protocol in relation to professionals having greater vigilance around safety in the home, particularly where there are high risk factors; and multi-agency training should be considered for professionals dealing with adult mental health, domestic violence and substance misuse focusing on how these issues can impact on parenting.

2009 - Bradford - Child D.

Abstract Review into the death of Child D, a twelve year old severely autistic boy who died as a result of smoke inhalation caused by a fire in his home. Child D was challenging to care for, and his sister has been identified as a young carer. Despite the involvement of numerous agencies, the lack of parenting capacity demonstrated by the family was not acted upon. The review is critical of the use of unqualified staff and inappropriate supervision for professionals. Recommendations include improved supervision procedures and information sharing procedures.

2009 - St.Helens - Child C

Abstract Review following the death of an 8-week-old boy who died after choking whilst in the care of her father. Older injuries were found. No previous concerns had been raised. The summary does not give any recommendations. *A single instance of negligence does not constitute neglect. The phrase "whilst in the care of her father" is loaded - inviting blame. But if the child had been "in the care of her mother" this would not have been deemed to constitute evidence of guilt.*

2009 - St.Helens - Baby A aged 8 months.

Abstract Review following the death of a 8 month old boy, who died of natural causes. His mother was young, had been in care and was known to be volatile. She was unwilling or unable to fully cooperate with support offered. She moved frequently and was exposed to domestic violence and at the time of baby A's death, the family had returned to accommodation previously deemed as unsuitable. The family received "child in need" support, but despite concerns, no child protection procedures were properly followed. Findings include that some agencies providing services/support for the family appeared to defer to the social worker's overly optimistic view of the mother's capabilities. Recommendations are around improving basic safeguarding procedures. *As with so many cases, it is clear that the mother /parents have a degree of culpability and it is always a delicate judgment as to whether such cases are classed as 'accidents' (as here) or not.*

2009 - Waltham Forest - Child JK

Abstract Serious case review into the circumstances surrounding the death of JK, aged 3 months, died 24 September 2007. JK was found to have multiple physical injuries of varying ages. The review found that, from the evidence collated by the health services, there were opportunities for improved information gathering, record keeping and communication that may have led to a different assessment of need, and the provision of additional services.

2009 - Wigan - Child B.

Abstract Review into Child B who died aged six as a result of an accident. Child B was subject to a child protection plan before her death. Her parents were separated and she lived with her mother and her mother's partners. Child B experienced domestic violence involving the majority of significant adults in her life, and her carers seriously abused alcohol. The review identifies that the support provided to Child B was disjointed and the assessments of her needs was not properly undertaken. However, Child B's death was not caused by failures in the child protection system. Recommendations include better support for children living with domestic violence and alcohol abuse. *I have little choice about classifying this as 'accidental' because that is the claim of the Abstract. However, fatal accidents are far more common in these chaotic households of alcoholics - and so are not as accidental as they are claimed to be.*

2009 - Hartlepool - Child 1.

Abstract Review into the death of a two and half year old child in 2006. Post-mortem found cause of death likely to be result of a non-accidental serious head injury. Criminal proceedings did not establish who was responsible for child's death.