Case Mapping Exercise
6 Step Briefing
Child At

The Background

Child At was one of twins and had an older sibling. The children lived at home with their mother. The twin's father was no longer in a relationship with mother but was having regular contact.

Safeguarding Concerns

There were concerns regarding the father of the oldest sibling who has a history of drug misuse, domestic violence and gang association.

The Incident

Child At was approximately 4.5 months old when they sadly died at home having been left unattended in the bath. There is an ongoing police investigation looking at what happened that led to the child being unsupervised.

The Review

An initial review of the case led to a recommendation that no further review was required, however, it was recognised that this child had died due to neglect and a Case Mapping Exercise was agreed.

The Case Mapping Exercise was facilitated by a senior member of Northamptonshire Police and concluded with a multi-agency workshop to identify any learning.

The majority of learning tends to focus on historic events concerning the older sibling and highlighted some ongoing safeguarding concerns for the surviving children.

Findings / Themes

- Neglect – this child drowned as a result of being left unattended in the bath. **Recommendation 1.**
- Fathers – the father of the older sibling has a history of violence and drugs. The father of the twins has a history of mental health issues. ***Fathers is a theme from historic and recent Serious Case Reviews. A collective response is to promote the creation and use of genograms being taken forward by the Local Learning Review Sub Group.***
- Mother was not asked about domestic abuse by the midwife because father was present. In addition, these questions appear to be closed questions rather than using professional curiosity to explore further. **Recommendation 2**
- Police referral to the front door following an incident of mother posting a photo of her older son on Facebook sitting on a bed surrounded by a large amount of cash was signposted to Early Help. Early Help have no record of the police referral. Police did not follow up the referral.

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Findings / Themes continued

- Step down processes and decisions – the older sibling was on a Child Protection Plan for a period of nearly one year then the case was stepped down to Child In Need despite ongoing drug dealing and drug use by his father and substantial police intel. ***This is a theme from historic and two recently published Serious Case Reviews with actions in place to address and review practice.***
- There were five police referrals regarding the older sibling's father in respect of domestic abuse, county lines and drug use when the eldest sibling was a very young child. There is Intel regarding firearms and gang association.
- When mother was pregnant with the twins, there was a known history of domestic abuse, county lines and drug use yet there was no pre-birth assessment. Reflecting if this type of situation happening now, professionals round the room felt confident the case would have been considered further and if a pre-birth assessment was not deemed necessary, a referral for early help would have been submitted. ***This is a theme from previous reviews and a multi-agency Pre-Birth Team is currently being developed and due to be piloted in the county soon. The development of this pilot is being reviewed by the Local Learning Review Sub Group.***
- Voice of the child – the eldest sibling has been soiling and not coping after contact with his father in prison. Not enough consideration has taken place in terms of contact and the impact of contact. ***This is a theme from previous reviews and there is ongoing work through other review recommendations to monitor this.***
- Mother's drug use – professionals were aware as mother had admitted smoking a cannabis joint every evening. ***The misuse of drugs was a theme from a recent Serious Case Review and a tea break guide for professionals to help them recognise the signs of drug misuse is being developed to be disseminated across the partnership.***

Recommendations

ACTIONS:

1. **Older sibling's file to be reviewed in terms of impact of loss of both sibling's (one twin deceased, one removed to father's care), being pre-occupied with dying and mother's ability to parent and manage needs.**
2. **Police to review both parents to see if there is any current Intel in terms of drug dealing.**
3. **Early Help to undertake a deep dive of records to see whether any information can be located regarding the police referral from 1st May 2018.**

RECOMMENDATIONS:

1. **Review information provided to parents by midwives and health visitors to see if there is a leaflet to warn of the dangers of leaving a child unattended in the bath. If there is, midwives and health visitors to reinforce the message. If there is not, a leaflet will be developed. This action will be taken forward by CDOP (Child Death Overview Panel).**
2. **The NSCP should ask Maternity Services for both Northampton General Hospital and Kettering General Hospital to provide assurance of training and processes in place to support midwives in asking expectant mothers about domestic abuse.**

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