Report into death of one year old is published by Oxfordshire Safeguarding Children Board (OSCB)

Today OSCB publishes the report of a serious case review following the death of Child N aged one, in circumstances that have so far not been explained.

The report concludes that the death was neither preventable nor predictable.

Maggie Blyth, Independent chair of the Oxfordshire Safeguarding Children Board, said:

“OSCB expresses its sympathy for the family and everyone involved in this tragedy. This was a sad case of a young child who died in unexplained circumstances.”

“The serious case review paints a picture of a mother involved in a custody process that clearly had an impact on her wellbeing. However up until her death, Child N had apparently been well cared for and was thriving.”

“The review finds that the death of Child N was neither predictable not preventable, though there are lessons for the agencies to learn so they can improve their approach to safeguarding in the future.”

“For instance sharing of information between agencies could be improved particularly in cases involving allegations of domestic violence. I am hopeful that the new multi-agency safeguarding hub being set up in Oxfordshire will help address this issue.”

“There are lessons to be learnt for agencies when working with families from all ethnic origins.”

“I am sure the agencies involved with Child N and the family will want to accept the recommendations made in the report, and I will be asking them to report back on their progress in doing so.”

Child N was found dead in the family home in Oxfordshire in May 2013, and it was later established that the mother had left the country. The mother and father separated before Child N was born, and had been involved in a custody process related to mother’s wish to return to her country of origin with the child. Mother made allegations of domestic abuse against the father, though these allegations were never substantiated.

The report states that the serious case review “proceeded on the basis that it is likely that Child N’s mother was implicated in some way in the child’s death. There is no evidence to suggest that the father had any involvement and at the time of writing there is no evidence to implicate anyone else.”

There is a continuing criminal investigation.

Child N and the family had contact with a number of agencies including social services, health services, housing, the police and the family court system.

The review found some minor areas of concern in agencies practice, but none that suggested the death of Child N was predictable or preventable. These include:

- A referral involving bruising to Child N when she was 10 months old should have been investigated
- Reports of alleged domestic abuse should have been followed up with the father
- Professionals should have sought more information about the background of Child N's parents
- Information sharing between professionals could have been better.

The report concluded that none of these issues contributed to the death of Child N. In the summary of findings and recommendations, the report says:

"Agencies with safeguarding responsibilities could neither have predicted Child N's death nor taken action to prevent it. However the review has identified a number of areas in which services could be improved. Whilst there is no reason to believe that the minor weaknesses identified had any impact on the outcome for Child N they should be addressed as they highlight potential areas of vulnerability in services which might impact negatively on other children and their families."

The serious case review identified some areas of learning that need to be taken forward and these include:

- Review the way that expectations of parents in 'change of residence' cases are handled
- All agencies account of cultural differences when dealing with children and families from all ethnic backgrounds
- Greater involvement of fathers during the pre-natal period, particularly with the health service
- Ensuring the new 'multi-agency safeguarding hub' (MASH) has improves information sharing about allegations of domestic violence

The following agencies had involvement with Child N and her family during her life:

- Children and Family Court Advisory and Support Service (Cafcass)
  Media Contact: Collette Jacobs 07867908215

- NHS England Thames Valley / Oxfordshire Clinical Commissioning Group in relation to GP services

  Media contact for NHS England:
  Graham Groves 0113 824 9846 or email graham.groves@nhs.net

  Media contact for Oxfordshire Clinical Commissioning Group:
  Sarah Rayner-Osbon 01865 334640 or email cscsu.media-team@nhs.net

- Oxford University Hospitals NHS Trust which provided antenatal services
  Media Contact: Susan Brown or Melanie Proudfoot, 01865 231471 or media.office@ouh.nhs.uk

- Oxford Health NHS Foundation Trust - in relation to health visiting and a service providing community based psychological therapies

Media Contact: Oxford Health Communication Team, 01865 782195

- Oxfordshire County Council
  - Children's Social Care
  - Early Intervention Service
  - Legal Services

  Media Contact: Paul.Smith2@Oxfordshire.gov.uk 01865 810256

- Northamptonshire County Council - Children, Families and Education Directorate – which had dealings with the family when the mother and Child N lived briefly in Northants.
  Media Contact: Eva Duffy, 01604 367658

- Thames Valley Police
  Media Contact: Michelle Campbell, 01865 846484

About the serious case review

When a child dies from abuse or neglect, Oxfordshire Safeguarding Children Board will decide whether to conduct a serious case review to identify how local professionals and organisations can improve the way they work together.

Serious case reviews are also carried out if a child is seriously harmed and there are concerns about how organisations or professionals worked together to protect the child.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/281368/Working_together_to_safeguard_children.pdf