Wandsworth Safeguarding Children Partnership

7-Minute Briefing

Infant A

What happened

In July 2024, Infant A was brought to hospital after being found blue and unresponsive in her cot; she was 9 weeks old. She had been brought to the hospital by her mother along with extended paternal family members and her 8-year-old brother Sibling B.

Following extensive attempts to resuscitate Infant A she was sadly pronounced dead in hospital. There was no evidence of injury or harm, and her death has been treated as sudden and unexplained (SUDI -Sudden Unexplained Death of an Infant).

Wandsworth Safeguarding Children Partnership (WSCP) undertook a rapid review which brought together all of the agencies involved with the family, including those cross the borough where Infant A died and the local authority the family had previously lived in. The rapid review identified multi-agency learning and agreed that a Child Safeguarding Practice Review (CSPR) would not be required. The National Child Safeguarding Practice Review Panel agreed with this decision.

Background

Sibling B and his mother arrived in the UK in October 2022 on a migrant boat from Albania via Greece and sought asylum; they were placed in a local authority outside of London by the Home Office. Sibling B's father and some paternal family members had previously travelled to the UK seeking asylum and were already placed in this area. The family were limited in their communication as English was not their first language.

Following disclosures of coercive and controlling behaviours from Sibling B's father and paternal family Sibling B and his mother were moved to London by the Home Office. Sibling B & unborn Infant A became subject to a Child Protection Plan.

Sibling B and his mother moved to Wandsworth as part of the immigration dispersal programme several months later.

Sibling B and his mother were spending time in the area of the paternal family and with Sibling B's father and Sibling B was attending school in this area out of London. This increased when Infant A was born and it was apparent that the children's parents had reunited.

A Transfer In Child Protection Conference took place and Wandsworth commenced working with the children on Child Protection Plans. This impacted on the delivery of social work and health visiting services as the family had an address in London but were primarily living outside of London.

Good Practice

Effective communication across maternity services and external safeguarding partners during the antenatal and immediate postpartum periods.

Safeguarding referral to the Maternity Safeguarding Team and Wandsworth Children's Social Care Services was timely and appropriate.

Effective communication across local authorities to transfer the Child Protection Plan.

Multi-Agency Learning

Effective Use of Interpretation Services

Ensure families with language barriers have access to professional interpretation services, including during emergencies, to facilitate understanding of interventions and available support.

Addressing Unconscious Bias

Recognise and mitigate unconscious bias when working with asylum-seeking families to ensure equitable and empathetic service delivery.

Consider the potential influence of bias when working with non-British, asylum-seeking families

Support for Isolated Families

Understand the unique challenges faced by asylum-seeking families, particularly isolation, and ensure they are signposted to local support services promptly.

Cross-Borough Collaboration

Strengthen multi-agency relationships and maintain clear communication when working across local authorities to minimise delays in sharing information about children subject of Child Protection Plans and to ensure continuity of care.

Professional Scepticism in Child Death Cases

Apply a heightened level of professional scrutiny when the cause of death of a child under a Child Protection Plan remains unclear, ensuring all safeguarding considerations are explored.

Reducing Risks in Immigration-Driven Moves

Advocate with the Home Office to limit relocations of vulnerable families, particularly those subject to Child Protection Plans, to avoid disruptions that increase risk.

Practice Considerations

Could professionals have gained deeper insights into Infant A's experiences, considering she was born into a family affected by domestic abuse and frequently moved between homes?

How might professionals develop a better understanding of Sibling B's lived experiences, which include:

Migration between countries

Engagement with Home Office services

Witnessing domestic abuse

Relocation across multiple local authorities

Exposure to harmful behaviours

Coping with the loss of a baby sister

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