Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

CONCISE CHILD PRACTICE REVIEW

CHILD O

1 BACKGROUND

The CTMSB commissioned a Concise Child Practice Review (CPR) in relation to Child O, a three-month old baby, who died suddenly and unexpectedly, without an identifiable, or established cause of death. The purpose of the CPR was to identify any multi-agency learning to inform future practice. An independent person was identified to chair a multi-agency Review Panel and two independent reviewers were identified to write the report. Access the report here

2 CONTEXT

The parents were aged 24 and 19 when O was born. The mother has another child who resides with them, the father has a child who lives with its mother. Both parents had involvement with Social Services and Police during their childhood and adolescence. In the year preceding O's death, Police responded to a number of domestic incidences. Reports were also received alleging physical abuse towards the children but the threshold for a Section 47 investigation was not met. Parents engaged with the early intervention service and some progress was noted.

3 GOOD PRACTICE IDENTIFIED

- Good verbal handover between Health Visitor and Social Worker. CP referrals were submitted at each point that Health raised concerns
- Midwifery & Health Visiting reiterated advice regarding safe sleeping to both parents
- Professionals worked to engage with parents
- Effective information sharing between the Emergency Duty Team, Police and British Transport Police in dealing with an incident
- Parents spoke positively about the support they received following O's death

4 PARENTS' PERSPECTIVE

The parents were spoken to as part of the Review. Father shared that their child was born at home, he stated that this was scary, and he felt his partner was not listened to and should have remained at the hospital. The child's mother said that she felt a bit depressed after her baby was born, stating she would struggle to get up, feed and comfort her baby. This was the reason why her partner took on the lead role. The child's mother felt there was not much support given when she became a parent for the second time and that she felt everyone thought she would know what to do.

5 LEARNING THEMES

- Understanding the relevance and importance of chronologies to provide family history and identify previous vulnerabilities.
- The need to explore missed opportunities for important intervention by agencies
- The relevance of good communication and handover of care/information between professionals/agencies
- Routine Enquiry and the opportunity to explore any concerns
- The impact of COVID
- Referrals were viewed in isolation so did not meet the threshold for Child Protection

6 IMPROVING SYSTEMS & PRACTICE

- Midwifery & Health Visiting to develop a consistent process for sharing relevant information about families
- Agencies to review/update guidance in relation to Police Public Protection Notices
- Midwifery & Health Visiting to complete Routine Enquiry audit
- Chronologies should be present in all cases
- Local authority to review screening processes to ensure that safeguarding concerns are recognised and responded to appropriately.

7 IMPROVING SYSTEMS & PRACTICE

- Practitioners should be alert to patterns of coercive or controlling behaviour, as well as incidents of abuse.
- Professionals should remain professionally curious when working with individuals and families.
- Agencies should assist professionals to recognise when an individual(s) are resisting engagement with services and how this can manifest itself.
- Police to ensure that information relating to anti-social behaviour is submitted to relevant agencies without unreasonable delay.