CYSUR 2 2020

Concise Child Practice Review

1 Background

This review concerned the tragic death of a 12 week old infant. On the night of their death, the parents, who were both adolescent care leavers, had some friends to stay. Both parents fell asleep on the sofa, after the baby had been settled in their Moses basket downstairs. The baby's mother woke in the night and went upstairs; when father awoke in the morning, he found the infant cold and lifeless facing inwards in the corner of the sofa. Emergency services were called and resuscitation was attempted, however, sadly, 'Recognition of Life Extinct' was recorded by the first responders and the infant's death was later certified at the hospital.

2 Police Investigation

The father was arrested at hospital on suspicion of causing the death. Toxicology tests found the father to be positive for various class A drugs, however, it could not be established whether he was under the influence of such substances on the night of the infant's death. The pathologist concluded that the case involved a sudden unexplained infant death. The police enquiry concluded with no further action to be taken.

Cosleeping was highlighted, however, it could not be determined if this contributed to the infant's death. Safe sleeping advice had been provided to the mother on at least four occasions prior to the death.

3 Adverse Childhood Experiences and Parental Needs

The review reflected on the numerous Adverse Childhood Experiences (ACEs) both parents had experienced, including domestic violence, parental substance misuse, neglect and child sexual exploitation. It was identified via the review that the compound impact of these factors placed the parents at a higher level of need and risk in terms of caring for their infant, which should have been taken into account in assessments and when working with and supporting the family.

4 Identified Concerns

The review identified three missed opportunities to submit a Multi-Agency Referral Form (MARF) in respect of the family. One of these was in relation to suspected drug dealing, with the other two relating to domestic abuse. The third incident related to a significant instance of domestic abuse, whereby furniture was smashed at the home with the baby, who was 6 weeks old at the time, present. There is clear learning in this review that these incidents presented an opportunity to report concerns, which may have led to greater intervention to safeguard the child.

5 Identified Good Practice

- The Health Visitor undertook the routine enquiry into domestic abuse with the mother on three occasions.
- The Personal Advisor built a positive relationship with the infant's father, which was the first time that he felt he could trust a support worker.
- The Leaving Care service provided an IRO and Wellbeing Worker for the parents, over and above their statutory duty.
- Good management oversight of the initial pre-birth assessment.
- A Pre-Birth Pathway has been implemented regionally since the events at the centre of this review.
- Housing supported the family well in respect of rent arrears.

6 Practice and Organisational Learning

- The LA to ensure thorough understanding of safeguarding responsibilities is embedded in day-to-day practice.
- Agencies to ensure information is readily available to young people in respect of the support available to them before and after they become parents.
- Further policy and practice guidance to be developed in relation to support provided to young parents in and leaving care.
- Local review to take place in respect of recording, screening and responding to MARFs.
- All agencies to ensure information sharing policies are up to date.

7 Practice and Organisational Learning

- Audit of Pre-Birth Pathway to ensure robust regional implementation.
- Dyfed Powys Police to review intelligence sharing processes where criminality falls below the threshold for a statutory discussion.
- CYSUR to ensure an effective multi-agency response to risks associated with unsafe sleep.
- Joined-up approach to be achieved in respect of housing support to care leavers.
- Health to review management of Domestic Incident Notifications.
- All agencies to review their internal transfer policies and procedures to ensure timely, fully informed handovers take place in operational practice.

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