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Background

Baby MD's mother experienced Adverse Childhood Experiences (ACE). She had a history of alcohol misuse & mental health difficulties.

Mother had 4 children prior to commencing a relationship with father. They were in the care of grandmother or birth father following private law proceedings.

Baby MD's father had alcohol misuse issues & convictions for violent offences. Domestic abuse (DA) in the parental relationship was a key risk factor.

Mother moved across LA boundaries twice. The first move to GMLA 2 was during her 5th pregnancy. The second move to Salford was during her pregnancy with Baby MD.

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Safeguarding Concern and Incident

The first CSC case transfer was ineffective as key information about the historical risk factors wasn't fully shared resulting in 'start again syndrome'. The second case transfer to Salford was robust.

Practitioners were assured by mother the parental relationship had ended prior to her move to Salford. Father was a 'hidden male' after this move- attempts to assess the risks he posed were unsuccessful. In reality, the relationship had continued.

Baby MD died, aged 5 weeks, after being placed to sleep in parents' bed. Parents had consumed a significant amount of alcohol and there had been a DA incident prior to Baby MD's death.

3

Findings

Trauma informed practice can support service users in forming effective working relationships with practitioners, increasing their resilience and in making the changes required to achieve a positive outcome.

Case transfers should ensure all relevant information including that related to significant historical risk factors and parental ACEs is shared. There is a need to explore more effective safe sleep interventions for vulnerable families.

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Findings Cont..

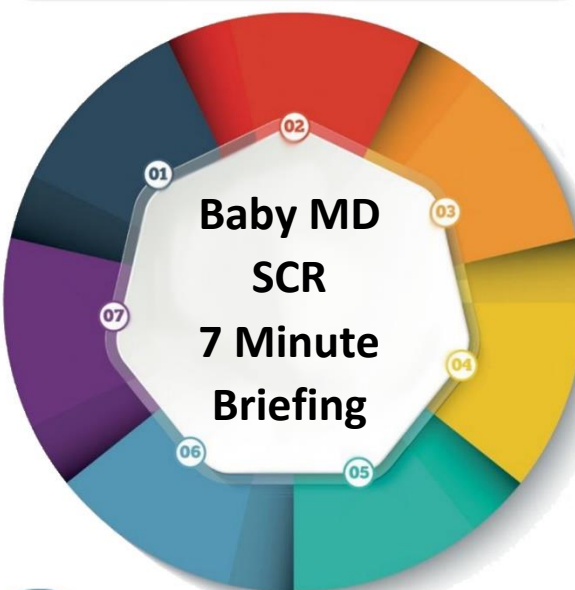
A good understanding of the relationship history is vital. A DA victim may say it has ended for many reasons e.g. coercion. Working agreement requirements for the victim to prevent contact with children are inappropriate. Probation, as a key adult service in DA cases, may hold vital information about perpetrator risk and compliance.

Fully understanding why children are not in parent's care supports robust assessment of parenting capacity & capacity to change.

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Implementing Change

- Reflect on the findings and discuss the implications for your service/practice.
- Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations



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Recommendation 2

2. The North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance should be reviewed and updated in light of the learning from this review. SSCP to:

-endorse the recommendation and request the GM Policy & Procedures Group considers this and determines the actions required to meet it &

:- be assured the procedure and guidance have been reviewed and updated.

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Recommendation 1 & 3

1. SSCP to consider sharing the trauma informed practice learning with the GM Standards Board for that Board to consider implementing actions aimed at supporting the development of trauma informed approaches to practice across GM.

3. SSCP to be assured multi-agency partners have considered the relevant learning points and developed implementation plans to support safeguarding practice for complex families with multiple risk factors.

Additional Information

Please download and read the full [SCR Final Report](#)

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