Gloucestershire Safeguarding Children Partnership

Rapid Review Practice Briefing 0125 Child J

In relation to a Rapid Review undertaken in January 2025

Learning Points:

- **Professional Curiosity**: Importance of asking detailed questions and not taking information at face value.
- **Holistic Assessment**: Need for comprehensive assessments that consider the entire family's history and current situation.
- **Multi-Agency Collaboration**: Ensuring all relevant information is shared among agencies to better understand and support families.
- **Support for Young Parents**: Providing targeted support for young parents with adverse childhood experiences to improve their parenting skills and family outcomes.

Background:

Incident Overview:

- **Child J:** a 6-month-old baby.
- **Incident**: The baby was found unresponsive with blocked airways due to vomit. Despite CPR and medical intervention, they were pronounced dead. Unexplained injuries were found.

Family Background:

- **Mother**: History of neglect, domestic abuse, and physical abuse.
- **Father**: History of physical chastisement, mental health issues, and substance abuse.

Details of review over leaf

Review:

Review Details:

- **Purpose**: To examine the practice and systems in place when dealing with unexplained injuries to non-mobile babies and parental supervision.

Key Concerns:

- **Injuries**: Multiple fractures at different healing stages, unexplained bruising, and a puncture wound.
- **Parental Supervision**: Concerns over the timeframe parents stated they left the Baby unattended.
- **Home Environment**: Issues with mould in the bedroom and cannabis smell in the housing estate.

Professional Practice:

- **Health Visits**: Missed opportunities for in-depth discussions about parental history and home environment.
- **Information Sharing**: Gaps in sharing information between agencies, particularly regarding the father's mental health and substance abuse.
- **Training Needs**: Identified need for improved training on domestic abuse, healthy relationships, and professional curiosity during home visits.

Recommendations:

- **Training**: Enhanced training for midwifery and health visiting professionals on home visits, domestic abuse, and record-keeping.
- **Working with Fathers**: Greater focus on involving fathers and understanding their needs.
- **Information Sharing**: Improved systems for sharing information between agencies to provide a holistic view of family needs.

In conclusion

The Rapid Review Report on the case of Baby J underscores the critical need for robust safeguarding practices and systems to protect vulnerable children. The tragic death of the Baby highlights significant areas for improvement, including enhanced training for professionals, better involvement of fathers, and improved information sharing among agencies. By addressing these gaps and implementing the recommendations outlined in this report, we can work towards creating a safer and more supportive environment for all children and their families. It is imperative that we learn from this case to prevent similar tragedies in the future and ensure that every child receives the care and protection they deserve.