

Why did the CSCP undertake this audit?

This audit was requested by Vicky Ford, Under Secretary of State for Children and Families, who asked Local Authorities to review the current circumstances of children who had recently stepped down from Child Protection Plans and families who had had a new baby in the previous 6 months where there had been previous concerns, to provide assurance around the decision making process for vulnerable babies. To provide greater assurance, we extended the review to include children currently subject to a Child Protection Plan. This follows the findings of a recent National Child Safeguarding Practice Review Panel report called 'Out of Routine' where they found there had been a shift to Sudden Unexpected Death in Infancy (SUDI) occurring predominantly in families from deprived social and economic backgrounds; risk factors for child abuse and neglect overlap with those for SUDI and situational risks and out-of-routine circumstances act together to further increase the risk of SUDI.

What's working well?



- Practitioners are trained and well-equipped to identify risks and vulnerabilities.
- There was evidence of good multi-agency working between professionals.
- Management oversight and case direction was clear, concise and decision making was timely
- The Early Help Partnership and Health Visiting Service discovered some good evidence of relationship-based practice and building trust with families
- The quality of chronologies continues to improve in most agencies.



One Minute Guide

Learning from the CSCP Vulnerable Infant Audit

July 2021

What are we worried about?



- Information sharing between key partner agencies were inconsistent and further exploration was required to understand if there are any barriers to sharing information
- 'Think Family/Whole Family' approach is an area for development.
- The audit identified some missed opportunities to engage with families at the earliest opportunity.
- There was some variable practice noted in relation to professional curiosity.
- The Covid-19 pandemic has had an impact on the way practitioners are able to view and assess children and their families in their homes.
- It was evident there is no risk-based, multi-agency tiered approach to safer sleep advice

What needed to happen?



- Improve communication pathways between GP, Midwifery, Health Visiting Service and Children's Services
- Develop Think Family/Whole Family model across all agencies
- Exploration of family networks and Family Group Conference at the earliest opportunity
- Practitioners need to gain a better understanding of risks and vulnerabilities for a family in order to obtain an insight into the child's lived experience.
- More effective use of chronologies and family history
- Practitioners need to develop skills to encourage families to engage in the Early Help Partnership when they have been stepped down from statutory intervention.
- Agencies to continue to review their position and service delivery in line with any restrictions related to Covid-19
- CSCP to develop a new, multi-agency tiered approach to safer sleep advice and undertake safer sleep awareness raising for parents, carers and communities

What have we done?

- Agencies have provided the the CSCP with assurance that they are promoting the Think Family/Whole Family Model across their agencies.
- CSCP have shared the audit findings with the Named Safeguarding Professionals in GP surgeries in relation to their role in recording information within Primary Care. A dip sample of 10 cases will also be undertaken.
- CSCP has produced a One Minute Guide to raise awareness and promote best practice across partner agencies regarding the need to identify support and safety networks with families at the earliest point in their involvement and the benefits of early participation in the Family Group Conference Service
- Regional guidance on professional curiosity and the effective use of family history and chronology and how this is key to inform current assessment and decision making with children and families has been produced.
- CSCP has produced a One Minute Guide to help practitioners encourage families to engage in Early Help
- Partners agencies have continued to provide the CSCP with a bi-monthly COVID-19 Position Statement identifying any risks in the safeguarding system for escalation to the CSCP Executives.
- CSCP and Warwickshire Safeguarding have produced Safer Sleep Practice Guidance for practitioners and lots of different resources to share with families which are available on the CSCP website. The guidance and resources were launched at a virtual Safer Sleep Learning Event held on 12th July 2021 attended by approx. 180 practitioners. The webinar included learning from national and local reviews, information from the Lullaby Trust on how to have opportunistic conversations and highlighted practical resources to use with families.

Further Information

- [National Child Safeguarding Practice Review Panel Report – 'Out of Routine'](#)
- [Coventry Safeguarding Children Partnership's Safer Sleep Guidance](#)