CHILD SAFEGUARDING PRACTICE REVIEW

CHILD C

REVIEW REPORT

Independent Reviewer: Alex Walters

V7 completed 12.01.2026

CONTENTS

1 Introduction

1.1 Somerset Safeguarding Children Partnership (SSCP) commissioned a Local Child Safeguarding Practice Review (LCSPR) following a Rapid Review process required by Working Together to Safeguard Children 2023. This was undertaken in March 2024, following the tragic death from non-accidental injuries of a 2 week old baby to be known as Child C. The National Child Safeguarding Practice Review Panel agreed the decision for an LCSPR in May 2024.

1.2 Child C was subject to a Child Protection Plan under the category of Neglect. The Public Law Outline (pre care proceedings process) had begun, and the Local Authority were intending to initiate care proceedings to safeguard Child C while assessments of his parents' ability to care for him were undertaken.

1.3 At the time of his death Child C was still in hospital in the Special Care Baby Unit (hereafter referred to as SCBU) following his premature birth at 33 weeks. Child C's parents were arrested and charged with murder, as well as offences under Section 5 of the Domestic Violence, Crime and Victims Act 2004 – Causing or Allowing the Death of a Child. After hearing the evidence during the trial, the prosecution team had to provide a route to verdict which was that the father of Child C murdered him, whilst his mother allowed his death. The mother was subsequently acquitted of all charges, while the father was found guilty of murder and sentenced to life imprisonment, to serve a minimum of 20 years. The criminal investigation has concluded. The statutory Child Death Review process was initiated, and as part of this, an Inquest into Child C's death will take place.

1.4 This review has been undertaken in a proportionate way to ensure the key learning is identified to support improvements in multi-agency practice and policy. It is, therefore, deliberately not detailed but provides a summary of the family circumstances and key agencies' engagement with Child C and his family.

1.5 The purpose of a LCSPR, as confirmed in the current statutory guidance, Working Together to Safeguard Children 2023: Chapter 5 is clear that the focus is on learning, not holding individuals or agencies to account.

2. Process for conducting the LCSPR

2.1 The Independent Reviewer, Alex Walters, an experienced independent safeguarding consultant, oversaw the process. Reports were commissioned from six agencies (Children's Social Care, Somerset Foundation Trust (SFT), Public Health Nursing, GP, Police, and Housing), enabling reflection on practice, systemic issues, and learning.

2.2 The review has involved review of key documentation, including statutory meeting minutes, parenting observations and the SFT Internal Rapid Review learning and actions. A multi-agency panel was established to oversee this process and included representatives from Somerset Integrated Care Board, Somerset NHS Foundation Trust, Somerset Council and Avon and Somerset Constabulary. The panel met with the reviewer on multiple occasions to review emerging findings and to manage practitioner and family involvement.

2.3 A central component of the LCSPR process is to understand the perspective of front-line practitioners and the opportunities and challenges about the 'system' within which they work. Practitioners have been supported through this review by agency representatives to the panel and had the opportunity to provide their views on the final report prior to completion of the review.

2.4 The contribution of family members is also an important part of the review. Child C's parents have been informed of the review and were invited to meet with the Reviewer once the criminal proceedings had concluded. Child C's parents chose not to participate in this review process. The review has been informed by meetings with Child C's Maternal Grandmother (hereafter referred to as MGM), Paternal Grandfather (hereafter referred to as PGF) and his partner. The outcome of this process will be shared with the family, and they will be offered the opportunity to contribute to action planning in response to the review findings.

3 Background family information

3.1 Both parents are White British and began their relationship in 2021/22 while living in a hostel in Somerset. The mother, aged 20 at the time of Child C's birth, had a history of local authority care under Somerset Council due to neglect and physical abuse in childhood. After a stable foster placement ended at age 17, she became a care leaver in 2021 and continued to receive support from a Leaving Care Worker. The Father, aged 25, experienced early adversity, including a period of no contact with his mother due to risk of physical harm. He subsequently developed emotional and behavioural difficulties

leading to school exclusion. He received support from Children's Social Care under a Child in Need Plan 2009 / 2010 and specialist CAMHS involvement in Somerset.

3.2 Father is known to Wiltshire and Dorset Police and has received conditional cautions for historical domestic abuse against a previous partner and malicious communication. He was considered under Multi-Agency Risk Assessment Conference (MARAC) procedures as a perpetrator and investigated for assault, threats to kill, strangulation and an investigation into coercive and controlling behaviour. None of these progressed to charge. Following their move to Somerset, the parents had several contacts with Avon and Somerset Police as victims, witnesses and perpetrators of theft and assault but no convictions.

3.3 Redacted

3.4 From the GP records, father stated that he can experience anxiety and depression and was previously on medication. There is also evidence of a number of historical self-harm incidents. Father has ADHD and was also not in receipt of support for his mental health at the time of the incident despite offers of support from health providers.

3.5 Redacted

3.6 The Leaving Care service have provided ongoing support to Child C's mother, this support at times extended to benefit Child C's father, for example support in relation to housing or obtaining food parcels.

Section 4 – Feedback from wider family

4.1 In discussions, the extended family describe providing support to Child C's parents during times of need, for example financial support and occasional accommodation. The family sometimes found it challenging to offer support to the parents due to their behaviour and the dynamic of their relationship. Father's family have shared concerns around potential parental drug use, but they were unsure of the detail around this and disputes over money have affected relationships with Child C's father and his family in recent years. MGM described Child C's mother as very vulnerable and that she was unable to effectively challenge Child C's father as he was older and " knew best". She also described the reality of the parent's lack of permanent housing as a stress factor.

4.2 Both MGM and PGF were in contact with Children's Social Care about the parents and Child C. PGF and his partner told Children's

Social Care that they would provide as much support as possible and they put themselves forward as alternative carers if Child C could not remain in his parent's care. Both PGF and MGM felt that father should have been prevented from entering the SCBU ward although the review has recognised this view was not shared with professionals and there was no evidence that father presented a risk of physical harm to Child C.

4.3 Whilst Child C's mother has not contributed to this report so her views cannot be considered, MGM has acknowledged the benefit of the support from the leaving care worker for her daughter. MGM was also positive about the support provided by Midwifery, the social worker and the support, advice and guidance of the SCBU staff.

4.4 The review is grateful for the involvement of the extended family and the issues raised by them have been acknowledged and addressed in the Review report.

5. Key Practice Episode- July 2023- February 2024

5.1 Child C's mother completed a pregnancy booking appointment with Midwifery in September 2023. During this and subsequent appointments, she shared that she was feeling low in mood and was signposted and encouraged to contact Somerset Talking Therapies and her GP. Mother was appropriately offered an enhanced service by a Complex Care Midwife from the WREN Team (Women Requiring Extra Nurturing) due to social vulnerabilities identified. When mother demonstrated a resistance to working with Talking Therapies, a referral to the Perinatal Mental Health Services (PNMHS) was also offered, however, mother declined this support.

5.2 In addition to mental health difficulties, the mother experienced hyperemesis gravidarum during early pregnancy, requiring medication and five Emergency Department attendances. This information was shared during the Strategy Discussion held on 7/12/23. Father attended all these visits and the midwifery appointments with mother, which made it difficult to speak with mother alone regarding any worries that she may have about the relationship.

5.3 When the Leaving Care Service became aware of mother's pregnancy, they made a referral to Children's Social Care in October 2023 detailing concerns about mother's lack of accommodation, instability, ability to safely parent and concerns about coercive behaviour and financial control by father towards mother. The Leaving Care Worker had offered Crash Pad accommodation to mother in

October 2023 when father excluded her from their accommodation, although mother declined the offer and returned to father.

5.4 Children's Social Care undertook a Children and Families' assessment from October 2023. It appropriately recommended a Strategy Discussion, which was held on 7/12/23 and an Initial Child Protection Conference (ICPC) was held on 29/12/23. The Social Worker had only been able to meet with the parents on one occasion, and they had refused further contact and requested a different Social Worker. In any event the Social Worker changed due to Child C requiring longer term intervention that was co-ordinated through a Child Protection Plan. During the assessment, mother described arguments between herself and father on regular occasions, stating that she had received hateful messages from father because she goes out to meet family or friends, father was present during this discussion and acknowledged that he can get upset sometimes. Mother also raised that father had recently thrown cups at her and it is likely that mother was pregnant at this time. The assessment stated, "there is a worry that neither parent is able to recognise the risk that this could pose to unborn or their child once born, and I worry that both considered this part of a normal relationship".

5.5 A Strategy discussion was held on 7/12/23, which included the Social Worker, Police, Duty Health Visitor and Midwife. The Section 47 threshold was met and agreement for an Initial Child Protection Conference, which was held on 29/12/23. The Social Worker was unable to attend this meeting but prepared a report, their Team Manager and Leaving Care Worker attended as did the Midwife, Health Visitor and Police. The GP submitted a report, but Housing were not invited. Mother submitted an e-mail outlining her views but neither parent attended.

5.6 Unborn Child C was unanimously made subject to a Child Protection Plan for neglect, and a Core Group was identified to include the Social Worker, Health Visitor, Midwifery and parents. The actions were to undertake a parenting assessment, to allocate a Domestic Abuse worker and Mental Health worker from the Children's Social Care Family Safeguarding Team, to offer perinatal mental health support from midwifery, to continue with midwifery appointments and the Health Visitor to engage at 28 weeks, to allocate a new Social Worker from the Family Safeguarding Team and to discuss with Housing any further support they could offer. Mother was described as "independent and capable" in the ICPC minutes which may reflect the response to her engaging well with Midwifery and demonstrating responsibility for her unborn child. A Housing representative was not

invited to become a member of the Core Group to discuss any further support they could offer.

5.7 The assessment Social Worker, Leaving Care Worker and the Midwife attended the first Core Group Meeting on 10/1/24. Neither parent attended. The minutes noted that nothing on the plan had been achieved due to lack of engagement from both parents, however the Midwife reported that she had met with parents recently which was positive, and mother had an appointment with the Obstetric Consultant on the 15/1/24 and was planning on bringing MGM to this appointment. The Midwife had provided food parcels to parents, and the Leaving Care Worker had seen mother recently and also provided a food parcel. There was concern as to how parents were managing their money. The Social Worker had spoken to mother about Housing who were completing a further assessment to consider whether parents would be able to apply for housing as they were currently staying in temporary accommodation (provided by Housing). The Social Worker confirmed they had spoken with PGF who also shared worries around parent's engagement with professionals and the housing issue. The next core group meeting was due on 15/2/24.

5.8 Children's Social Care had appropriately made a decision to enter Pre Care Proceedings Public Law Outline (PLO) on 04/01/24. As part of the PLO process, a Pre-proceedings legal meeting was then held on 23/01/24 and mother attended with her solicitor. A new Social Worker had been allocated from the Family Safeguarding Team and attended with the previous Social Worker. Father had been advised to seek legal advice and invited but did not attend. Both parents had been issued with a "letter before proceedings" outlining the concerns in detail. The minutes set out the following concerns:

- The parent's relationship which was described as volatile and domestically abusive
- The impact that this could have on baby's development and safety before and after birth
- Both parents report experiencing poor mental health including anxiety and depression, but neither were currently accessing support for this
- Without support for their poor mental health this could impact on their ability to respond appropriately to unborn Child C.
- It recognised that both parents had experienced Adverse Childhood Experiences (ACEs)
- Father had a diagnosis of ADHD and there were worries about father's level of understanding into professional's concerns and

whether he may have some additional learning needs that needed further assessment and support.
- Parents being recently made homeless and staying in temporary accommodation, and the home conditions whilst living in their recent property.
- The Housing department deemed that mother had made herself intentionally homeless after leaving her own accommodation to move in with father.
- Both parents level of engagement with Children Social Care and other professionals.

5.9 The agreed actions from the PLO Meeting included a parenting assessment would be undertaken and viability assessments to be carried out if mother was unable to care for Child C once born, mother put forward MGM and PGF's names for assessment. Disclosures were to also be requested from Housing, Police, GP and Midwives. Mother stated she would like help with her mental health, this had been offered by Children's Social Care and Midwifery, but mother did not engage. Father was asked to instruct his legal representative and attend future PLO meetings. The next meeting was scheduled for 7 weeks ahead -12/3/24, 4 weeks before Child C's Estimated Date of Delivery (EDD), which was 9/4/24.

5.10 Due to mother's waters breaking and the recognition that labour was therefore imminent a multi- agency Pre-Birth Planning meeting was held on 16/02/24.The meeting minutes detailed the same concerns as had been set out in previous meetings and the multi-agency agreed plan was for parenting observations to be completed following the birth of Child C by hospital staff and shared with the allocated 'core group' of multi-agency professionals, particularly the allocated Social Worker. The details of what should be included in the observations were not agreed between agencies although there was a standard template that SFT used to record their observations. Child C was not recognised to be at risk of physical harm by his parents during his time in hospital, therefore continuous supervision was not considered.

5.11 The decision to apply for an Interim Care Order (ICO) given the overall level of risk, lack of progress with the child protection plan and poor parental engagement was not set out in the Pre-Birth Planning meeting minutes of 16/2/24 as this decision was not made until 21/2/24 by Children's Social Care and ratified by the Legal Gateway Panel on 27/2/24 retrospectively. Subsequent communication between midwifery and Children's Social Care ensured this plan was understood.

5.12 The separate social work case note of this Pre-Birth Planning meeting state the temporary accommodation was due to end on 21/2/24 and concerns regarding mother being able to remain hygienic were shared with the meeting and a request was made by social care if mother could be kept in hospital. This was not felt appropriate by the hospital, but they explained mother would be regularly monitored over the next few days. Mother had been advised by the Social Worker that she could be housed in her own right as she is a care leaver, but she said that she could not cope without father due to her own mental health and this option is not something she would consider. Mother was advised to contact MGM to see if she could stay there, which she agreed to, and to contact social care to confirm the outcome. In fact the temporary accommodation was extended for a week.

6 Key Practice episode- Child C's birth 20/2/24-5/3/24

6.1 During the time in hospital there were ongoing efforts to work with the parents, including joint visits between Child C's Social Worker and the Leaving Care Worker. The parents remained resistant to work with social work services.

6.2 Child C was born 4 days after the Pre-Birth Planning meeting; he was born at 33 weeks on 20/2/24 and placed in SCBU. He was fed through a nasogastric tube and had routine monitors. When he reached what would have been 35 weeks gestation, monitoring was reduced. Routine monitors and the feeding tube were removed on 3/3/24. As Child C was stable and developing well it was expected that he would have been discharged by the end of that week.

6.3 Hospital practitioners made daily observations of the parents during the days they visited, this included 20.2.24-26.2.24, 28.02.24-29.02.24 and 04.03.25-05.03.25. Observations up to and including 26.02.24 were sent to Children's Social Care on 27/2/24. Observations from 28.02.25 onwards were to be shared with Children's Social Care on 05.03.25. Practitioner observations were shared with the allocated Children's Social Care team via various formats; completed Parenting Observation forms, emails and telephone contact. Hospital and Children's Social Care records indicate regular communication between the services over this two week period.

6.4 It is noted from documentation that on occasions father did not follow health advice, i e "kept disturbing baby while sleeping" and "non-stop poking and stimulation" despite having been advised that Child C required undisturbed time to rest. During one visit to hospital on 22/02/24, father was given feedback from staff that he was lifting Child

C's legs too high when changing his nappy, and records indicate that he became a little defensive. On visits on 25/02/24, and 26/02/24 there was concern father was overstimulating Child C, he was observed to jiggle and poke Child C, and he was challenged by staff and advised to undertake "still cuddles" but father became angry, was reluctant to accept advice and stated "he knew how to look after a baby as he had 8 years earlier with his first child". There is no evidence to date to show that father has experience of caring for another child or has another biological child.

6.5 On 26/02/24, the Lead Nurse spoke to father about expectations of behaviour on the ward as father's approach to staff at times was considered rude and confrontational when resisting health advice. Health clinical records identify de-escalation techniques were implemented during episodes of parental conflict, but this was not reflected in the Parenting Observations. This included one/both parents leaving the ward area for periods of time and verbal reminders of inappropriateness of arguing around Child C. All of these were noted to be successful in defusing the situation at the time.

6.6 On 28/02/24, mother called 999 due to abdominal pain and bleeding. Parents advised that they were being made homeless from their temporary accommodation at 17:00 that day. Father asked ambulance crew to write a note saying that they couldn't be evicted under medical grounds, which the crew said they could not do. The temporary accommodation had already been extended due to the unexpected birth of Child C. They were evicted and then moved into the home of paternal great grandmother (hereafter referred to as PGGM) that day.

6.7 Mother told her Leaving Care Worker that she had the 'baby blues' on 29/02/24 and was encouraged to accept support for this. In addition, parents were supported to speak with a Psychological Wellbeing Practitioner who routinely attends SCBU to support parents of pre-term infants. Both parents welcomed this contact initially; however, they became increasingly resistant of support and did not engage.

6.8 Given the existing concerns, Children's Social Care sent paperwork to legal services to initiate legal proceedings on 27/2/24. This was to request that the Court grant an Interim Care Order for Child C with a proposed dual care plan for a Mother and Child Foster Placement or early permanence carer for Child C.

6.9 The parents had not stayed with Child C in the hospital overnight since his birth, despite encouragement, until the 4/3/24, the evening of the death of Child C. On 4/3/24 there had been arguing and shouting

at PGGM's house and parents were asked to leave the home by PGGM. They arrived on SCBU late afternoon and at that point they were of no fixed abode and had their belongings with them. During the evening the parents were initially described as distressed, and they requested moving to the day room with Child C in order to offer them more privacy. This request was turned down. The parents had then engaged with staff and requested bottles for Child C.

6.10 When the parents arrived on the ward, Midwifery emailed Children's Social Care to say that hospital staff would monitor father's behaviour and that he would be asked to leave if there were any concerns regarding his behaviour or safety issues towards staff. They also confirmed that parenting observations from 28/2/24 onwards would be e-mailed to the social worker the following day. Midwifery also shared concerns with Children's Social Care in this e-mail that father's aunt had raised concerns with SCBU that mother had said that father "shouts at Child C when he wees" and he had "been shouting at his PGGM's house and that she was frightened of him". Midwifery also shared that Child C would be medically ready for discharge by the end of the week- presumably 8/3/24.

6.11 Child C experienced an injury to his right arm in the days prior to his death, this was not known until after his death, the cause of this injury remains undetermined. Child C died in the early hours of 5/3/24 in hospital as a result of catastrophic injuries that his father was later convicted of causing.

7. Learning the partnership has already implemented

7.1 The learning gathered through this review process around the need for pre-birth tools to support dynamic risk assessment and ensure a more consistent understanding of "parenting observations" has already been implemented by partners. The SSCP Pre Birth guidance and Pre-Birth Planning template has been reviewed by the Partnership, with improvements in the following areas: -

- Clear statement regarding "parenting observations" to ensure shared understanding of this versus "supervision".
- Zero tolerance approach added which will be shared with all parents/relevant family members during Pre-Birth Planning meeting where possible, or when plan is shared with parents if they do not attend the meeting.

- Additional section for consideration of new "Children's Social Care Hospital Risk Assessment" which has been designed to confirm the risk for any child known to Children's Social Care in hospital.

8. Key Learning themes 1: Risk Assessment and decision making

8.1 Strengths:

- There was a timely referral, child and family assessment and ICPC. These processes supported information sharing and close oversight of progress during the pre-birth period. These processes also provided opportunities for the safe delivery of care and offers of support that were responsive to the family's needs.
- Professionals tried to engage parents in decision making processes, including through encouragement to seek legal advice and working jointly with mother's Leaving Care Worker.
- The risks that parent's lifestyle, history and relationship posed to Child C's welfare were assessed and understood. PLO processes were implemented to support parents to understand the concerns, access legal advice and put forward potential alternative carers. There was also multi-agency Pre-Birth Planning to support partners to oversee his welfare whilst in hospital.

8.2 Areas for development:

- During the two week period that Child C was in hospital there was a lack of dynamic, ongoing multi-agency risk assessment that took into account the new and ongoing factors that could have impacted the parents.
- There is limited evidence to show that the PLO process and plan was considered by the core group of professionals that were responsible for overseeing the progress of the child protection plan.
- The review process has highlighted some variability in professional understanding of family court legal processes
- There was a lack of clarity around the definition and understanding of "parenting observations" and what this entails.

- Professionals to be supported to manage the impact of abusive behaviours by parents upon their ability to safeguard children.

8.3 Recommendations:

- The partnership should review how effectively available tools, guidance and training support staff to undertake robust multi-agency Pre-Birth Planning that includes dynamic risk assessment and consideration of contingency planning.
- The partnership should find ways to support connectivity between PLO processes and multi-agency Pre-Birth Planning.

9. Learning Theme 2: Family engagement and mental health

9.1 Complicating factors

- Both parents were resistant to working with Children's Social Care, especially father who refused to attend multiple important meetings where plans for Child C were discussed. This resistance impacted attempts to undertake comprehensive multi-agency risk assessment. This resistance also complicated efforts to engage the wider family in support plans for the parents.
- Neither parent engaged with any suggested offers of mental health support, despite reporting poor mental health.
- Cognition and capacity assessment for mother were delayed due to premature birth, leaving a gap in understanding her needs and abilities.

9.2 Strengths

- Mother had a positive relationship with her Leaving Care worker and maternity services, showing that some level of engagement was possible with certain practitioners.

- Some attempts were made to work with wider family to provide background information that informed assessments and plans.

9.3 Areas for development

- There could have been improvements in communication with the family around the progress and outcome of viability assessments of the wider family members.
- There could have been better consideration of how services might have been able to work with Child C's wider family and

how any issues, such as understanding of consent, could have been overcome.

9. 4 Recommendation:

The partnership to consider how to raise awareness around how family group decision making forums can be more consistently encouraged and consider how potential barriers such as consent can be overcome.

10. Learning theme 3: Domestic abuse, coercive and controlling behaviour

10.1 Complicating factors

Given mother's life experiences it appears that she found it challenging to identify the father's behaviour that others could see was coercive and controlling. This likely limited her openness to support or understanding of how significantly this may impact Child C.

10.2 Strengths:

- The strategy discussion and subsequent Initial Child Protection Conference considered historical domestic abuse related to father when considering professional's concerns surrounding domestic abuse. Concerns about the parents' relationship were also appropriately identified.
- Domestic Abuse routine enquiry was completed with mother on multiple occasions by the maternity services, when mother was seen alone, but mother did not disclose any domestic abuse

10.2 Areas for development:

- Significant domestic abuse history not always fully highlighted or recorded by all partner agencies. The significance of past domestic abuse could have been clearer within the Child and Family Assessment and there could have been greater focus on domestic abuse within GP Safeguarding Meetings and within GP case alerts.
- Whilst mother was aware of professional concern around father's history there were missed opportunities to use the Domestic Violence Disclosure Scheme (DVDS).
- No DASH risk assessments were completed.

10.3 Recommendation

- The partnership should review how effectively training, supervision and guidance supports practitioners to utilise all available tools to support victims of domestic abuse, including risk assessment tools and use of DVDS.

11. Theme 4: Housing and Homelessness

11.1 Complicating factors

Parents consistently faced poor-quality, unsafe accommodation and stressors related to possible and actual eviction.

11.2 Strengths

The significance of parent's housing issue and the impact this could have on their capacity to provide safe care for Child C was considered. There was also support from the Leaving Care Service to encourage mother to access temporary accommodation for herself.

11.3 Areas for development

- Limited multi-agency practitioner understanding of housing duties when families are deemed "intentionally homeless."
- Housing officers were not consistently involved in statutory safeguarding meetings.

11.4 Recommendation:

The partnership to consider how they can ensure practitioners understand the role of housing departments and consistently involve Housing in safeguarding children, particularly where housing is a significant issue.

12. Learning theme 5: Information sharing

12.1 Complicating factor

Father provided limited information to partners around his past experience of caring for another child that contributed to professional difficulties with accessing full information about this child.

12.2 Areas for development

- Key background information not consistently requested from or shared with all agencies for both parents. The Child and Family assessment did not include information from housing or GP for both parents, the booking form was not sent to father's GP. Information requested from other Local Authorities were not responded to in a timely way.
- Parenting observations after Child C's birth were not detailed or consistently passed to Children's Social Care in a prompt timeframe.

12.3 Recommendation

The partnership to build on recent work around information sharing. This includes ensuring that key information is routinely shared and responded to with appropriate professional curiosity to inform assessments. This includes family background information held by each agency, parenting observations or incident reports when a child is in hospital.

13 Conclusion

13.1 The safeguarding concerns in relation to Child C were recognised and responded to quickly with some effective multi-agency practice. Due to Child C's premature birth this work was co-ordinated within a shortened 4 month period. Professionals followed due process effectively within the pre-birth period, making efforts to work with parents and co-ordinating planning within a number of multi-agency meetings. There was a great deal of environmental stressors for the parents as well as ongoing concerns around domestic abuse and a relatively unstable support network.

13.2 Despite the known concerns it could not be foreseen that Child C would be murdered by his father in a hospital environment. Practitioners made efforts to try to engage and support Child C's parents and improve his safety. There has been system learning identified from this review which the partnership will take forward, further learning may also emerge from other statutory review processes that remain ongoing.

Alex Walters

12/01/2026