7 Minute Practice Briefing: Rapid Review

Background

A rapid review took place in Dorset in January 2023 in respect of the sudden unexpected death of a baby. It was agreed by the Dorset rapid review panel, and then ratified by the National Child Safeguarding Practice Review Panel, that a Local Child Safeguarding Practice Review was not required since the baby's death was not directly linked to abuse or neglect. There were key learning points, however for professionals and agencies working across the Pan-Dorset Safeguarding Partnership which the rapid review process identified.

This practice briefing aims to support professionals working with children and families across all statutory and voluntary agencies with the key learning from this rapid review, as well as identifying what has already and is being done by the Pan-Dorset Safeguarding Children Partnership to address this learning.

Learning Point 1: Professionals did not appear to have a full understanding of parental alcohol use, including in pregnancy, and the potential impact on children & young people (including unborn/newborn babies).

1. The rapid review noted that parents of the baby had issues with alcohol. The Midwifery team were aware of this during mum's pregnancy with baby, however full alcohol screening was not completed for mum due to an error with the electronic note system.
2. A referral to ChaD was not made by Midwifery following mum's disclosure of alcohol use during her pregnancy.
3. Health visiting to review how they work with parents when parents disclose alcohol use, including whether they have effective tools and approach to explore this and having courageous conversations with parents about their alcohol use.

What is being done by the PDSCP to address this?

1. In relation to point 1, the anomaly within the electronic maternity system will be discussed during the mandatory Safeguarding updates for 2023.
2. In relation to point 2, the Midwifery team will ensure their staff are aware and refreshed in safeguarding training to ensure referrals are made to ChaD in the future.
3. In relation to point 3, screening tools for alcohol use have been shared (to match midwifery) and signposting to Gov.uk online training in use of screening tools. Further work will be completed to ensure practitioners feel confident in having the courageous conversations with parents.

Learning point 2: Professionals did not have a full understanding of the role of the partner/father of the baby.

1. Health visiting and midwifery to review how they gain information about fathers/partners and how this is used to inform their assessment.

What is being done by the PDSCP to address this?

1. In relation to point 1, Practitioners have been prompted to consider a genogram when completing the S1 risk assessment template and family composition including fathers/partners is routinely discussed at contacts and details added to S1 record. Relationships are recorded in groups and relationships.

Learning point 3: There was missed opportunities to bring information together across agencies to have a full understanding of what was happening for the family.

1. Children's Advice and Duty Service (ChaD)* to consider the learning from this review in terms of information sharing between agencies and bringing information together to identify a full picture of concerns.
2. ChaD to review their responses to requests from information from CAFCASS to ensure outstanding safeguarding requirements are being addressed via dip sampling and offer some training and support around professional curiosity.
3. Police to review their response to referrals where a child has been reported as being left without any suitable adult supervision to them to ensure the learning is embedded.

What is being done by the PDSCP to address this?

1. In relation to point 1, staff sessions are being held as a reminder to professionals about this.

Learning point 4: Professionals did not always view the current circumstances in light of the historical information, and as such did not respond appropriately. They did not have a full understanding of the lived experience of the family.

1. Professionals are to be reminded that when working with families where there is a history of concerns to view and be mindful of any new information in the context of these concerns.

Learning point 5: Professionals to ensure effective record-keeping in terms of the advice they have provided parents e.g., co-sleeping.

1. Health visiting to assure themselves that they are accurately recording advice given to parents particularly around co-sleeping.

What is being done by the PDSCP to address this?

1. In relation to point 1, Health visiting are looking at updating their recording template on S1 around safe sleep advice to be more comprehensive.

Learning point 6: Professionals did not fully explore or understand why grandparents appeared to be the primary caregivers for the children.

1. Schools to review how they explore living and caring arrangements with parents/carers, where there may be a different primary caregiver such as grandparents, and the impact for the children and young people.

Learning point 7: There was an over-reliance on the court managing the concerns and as such agencies did not explore in depth the concerns/history of the family.

1. ChaD to review their responses to requests from information from CAFCASS** to ensure outstanding safeguarding requirements are being addressed via dip sampling and offer some training and support around professional curiosity.

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Agreed by the Dorset CSPR sub-group on: 08.03.2023
* Reporting Concerns and Continuum of Need - Pan-Dorset Safeguarding Children Partnership (pdscp.co.uk)
** Home - Cafcass - Children and Family Court Advisory and Support Service