7 Minute Briefing: Rapid Review A2

Date: August 2023

1. Background

This review relates to a 3-week-old baby who suffered significant injuries whilst at home. A referral was made by South East Coast Ambulance Service after they had received a 999 call. The baby presented as purple, limp and floppy when was found in bed at the family home.

Both parents were known previously to Children's Social Care. Mum and her sibling had been on Child Protection Plans themselves as young children, under the category of Neglect. Both parents experienced Domestic Abuse and Domestic violence at home whilst growing up.

2. The child's story

"Although I had a normal birth, I wasn't very well at first. I felt cold and didn't want to eat so I was put in a heated cot to help me warm up.

My mum and I were also given medicine (antibiotics) to help us fight off infection (Group B Strep) and then after 2 days my Mum took me home.

I still had some problems feeding though and had to go back into hospital for a check up after choking whilst at home.

We had regular reviews with health visitors and midwives who were all supporting me and my mum and they seemed happy with how I was progressing. Then I suddenly fell ill again"

3. Learning Point 1

The **Quality of Referrals** and the way in which referrals were made in this case, led to the child's needs not being picked up and responded to in a timely and appropriate manner.
Referrals had been sent via email to other agencies and there was no record of them arriving or being seen as referrals.

The way in which referrals are made need to follow accepted and published protocols and receipt should be checked to ensure that the referral is being acted upon.

It has been recommended that a portal be used to ensure that referrals are logged and responded to in a consistent and traceable way.

4. Good Practice

Although assessed as requiring a Universal Service level, good practice was identified that the same Health Visitor was able to be involved with the baby and family during this short period of time. This ongoing support from the same Health Visitor provided the family with consistency in support and a deeper knowledge base on the family, for reviewing and assessing information when shared by other professionals.

5. Learning Point 2

Weaknesses **in information sharing** left gaps in knowledge between agencies e.g. Father's medical condition which would have influenced his ability to care for the baby. There was no record of a diagnosis at the time the panel met, but information has since identified that there was a diagnosis in 2021. Father also self-disclosed that he had been diagnosed with ADHD and ASD, but there is no record of this information being shared.

The panel explored why there had been no sharing of the minutes from the MARAC meeting, but it was noted that minutes are not generally produced after a MARAC it is just the agreed actions that are shared.

6. Conclusions

Whilst this case meets the criteria for carrying out an LCSPR, SSCP have recently completed an LCSPR on a very similar case.

The panel agreed therefore that an LCSPR was unlikely to provide the SSCP with any additional learning. Instead of commissioning another LCSPR therefore the panel agreed to conduct a thematic review, which will consider the learning from this case together with the learning arising from other recent and similar cases in Surrey.

The review will also consider the findings within any relevant national reviews such as: The Myth of Invisible Men: Safeguarding children under 1 from non-accidental injury caused by male carers (September 2021) and The CSPRP's National Review of Non-Accidental Injury in under 1s (Sept 2021).

7. Next Steps for sharing the learning

This 7-minute briefing will be shared widely with all relevant agencies and published on the SSCP website.

There is a review of the C-SPA "front door" service being undertaken by Children's Services at present and we will be sharing the learning of this review with the project lead (Asst Director of C-SPA) so that issues around mechanisms and systems for making referrals can be addressed.

A working group will be set up to take a thematic approach to the learning from this review and other similar reviews in order to explore the following questions "what is currently happening to improve the particular gaps identified by these reviews and improve practice?" and "What more do we need to do?".