Rapid Review Meetings

Spring 2022 Summary

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Children's Safeguarding Assurance Partnership
Blackburn with Darwen - Blackpool - Lancashire

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Background

Working Together (2018) requires safeguarding partnerships to make use of Rapid Review Meetings (RRM) to extract early learning from situations in which children have been seriously harmed or died, thereby enabling actions to be taken quickly and limiting the need for slower child safeguarding practice reviews (CSPR). CSAP has completed seven RRMs in 2022 to date, in which a number of themes have been identified. One case will proceed to a Local CSPR.

The seven reviews were of five boys and two girls aged between birth and sixteen months, three of whom sadly died. Four involved suspected non-accidental injuries, one suffocation, one opiate ingestion and one a concealed pregnancy. Common characteristics were parental mental and physical health concerns.

Maintaining a focus on the child

In four cases the parent/carer had significant physical and/or mental health concerns. Chronologies of multi-agency involvement documented significant and often successful interventions to manage these conditions. However, what was less evident was a consideration by the involved practitioners of the impact of these health conditions on the parent's ability to provide safe and effective care for their baby. All practitioners have a responsibility to safeguard children, even if their involvement and expertise is in adult facing services. What often was found lacking was simply asking about the impact of their health condition on their parenting and plans for who would look after baby if their condition deteriorated.

Similarly, in one case a focus on maternal mental health was at the expense of consideration of an older sibling and, equally, dad's ability to manage as a carer for mum and two young children.

Good practice

One baby's biological mother identified as male and good practice was seen from the social worker who ensured that he was able to access support from a local charity both during the time of the plan and as a longer-term service. Equally, it was evident that all professionals considered his identity and worked to meet his needs throughout the time under review.

Multi-agency decision making

Effective multi-agency decision making was promoted in one case by the core group of practitioners ensuring that they routinely updated each other throughout mum's pregnancy. However, in other cases opportunities for a co-ordinated multi-agency approach were missed. These would have benefitted from multi-agency meetings (often by expanding attendance at existing meetings) to allow information to be shared and acted upon, and for professional challenge to be provided to ensure robust decision making.

Children moving between areas

In wider CSAP review activity transfers of case responsibility for children moving between areas has been seen to be effective. However, two RRMs did identify learning in this respect relating to specific circumstances.

Good practice in one review of obtaining information from the Republic Ireland highlighted the importance of ensuring that histories are obtained from what may be multiple previous areas. Problems arose in one transfer due to a lack of clarity in the status of the child (whether he was a child in need or not) at the point of transfer. This could have been overcome through a multi-agency meeting involving practitioners from both areas. In another review, the transferring area failed to make the required looked after child notification. However, there was also a lack of professional curiosity about the child from agencies in our area that could have overcome this.