**Learning from Rapid Review for Baby Alex (assigned Pseudonym):**

**Background and introduction to review**

**Key findings:**

This summary presents the main findings from the rapid review regarding Baby Alex, who was born prematurely with a low birth weight. Due to ongoing parental drug use, Baby Alex was placed under a child protection plan at birth. An incident occurred where the mother, under the influence of illegal drugs, was found asleep on Baby Alex, leading to a cardiorespiratory arrest. Baby Alex was resuscitated, and the long-term effects on their neurological development will be continuously monitored.

## In summary the main issues found in this review were:

* The importance of thorough pre and post birth assessment, including ongoing risk assessment and safety planning after the birth
* The importance of safe sleep advice to parents, particularly where there is an increased risk due to parental drug use, and when babies are born early and have a low birth weight
* The importance of using experts within the partnership to support parents with long term drug use and consider the impact this will have on parental capacity and risk

**Themes in common with other Oxfordshire case reviews:**

* The need for a robust and detailed pre-birth assessment, supported by multi-agency partners to ensure all contingencies are considered both prior to and post birth
* Understanding of the needs and behaviours of the father
* Not making assumptions about families or other professional’s actions

**Themes in common with national reviews**

* Assessing risks and providing support for the whole family
* Recognising and responding to the vulnerabilities of babies
* Understanding the roles of fathers/male carers and other extended family members in family functioning

**Strengths in practice**

* Professionals worked hard to involve both parents in planning before the baby was born
* Agencies worked well together, there was good communication and information sharing early on
* There was a clear focus on the risks to the unborn baby, leading to timely assessments and planning during pregnancy, including the consideration of historical concerns
* There was a shared understanding of parental capacity and agencies involved made regular visits, including weekends, with support from drug and alcohol services
* Communication with both parents was clear about concerns for their unborn baby, based on their current drug use and mother’s history
* The child protection plan showed that multi-agency professionals had a good understanding of what was going on for the family and there were good examples of professional curiosity
* The involvement of drug and alcohol service support for parents

**Learning Points for practitioners**

* Where there are known risk factors there should be a dynamic risk assessment and safety plan in place that is reviewed on a regular basis by the core group. This should be agreed and communicated clearly by all parties in the core group
* If legal proceedings are delayed, consider another strategy meeting or review to identify immediate short-term actions, like increased supervision or welfare checks. There should be clear agreement of key roles and responsibilities by the core group members
* Better multi-agency understanding of parental drug use, potential risks, and how it affects parenting could improve assessments and safety plans. Advice from a specialist midwife and drug and alcohol support services should be in place
* When dealing with long-term parental drug use and lack of engagement, practitioners should openly discuss the nature of drug use, addiction patterns, and the potential for hidden compliance and deception
* The hospital was seen as a ‘safe place’ with an assumed level of supervision. This should be discussed during pre and post birth planning, jointly agreed and understood, and reviewed if risks change, e.g. there has been an active conversation about what is possible/can be arranged

**Learning points for managers/senior practitioners/IRO**

* Core group meetings should always happen, with all involved professionals from different agencies attending. These meetings should review the plan in detail to take appropriate action if things aren’t going as expected, and written updates and actions signed off by all attendees
* There should be a clear contingency plan when meetings do not happen, including supervisor oversight, a timeline for rescheduling, and clear escalation processes if meetings slip or membership is inadequate

**Key messages for the safeguarding system**

* If there is a change in worker for a child/family, it is crucial to have a thorough handover, so the new worker understands the risks and actions needed by each agency. The core group should also be notified of any change
* If a baby is likely to be born early, a pre-birth meeting should be held before the third trimester to avoid time constraints. It might also be useful to consider the timing of the Public Law Outline process
* It’s important to think about safety planning and support needs after the baby is born during the Initial Child Protection Conference (ICPC)

**Complicating Factors**

* Professionals face limitations if parents choose not to work with them or miss appointments repeatedly. There is no legal recourse or action that can be taken until after a baby is born. The partnership should remain focused on the needs of the baby to ensure their safety is paramount.

Chronologies can assist in post-birth legal processes

**If you do one thing……**

Make sure there is thorough and detailed planning involving multiple agencies to assess the needs, risks, and potential harm to an unborn baby before and after birth, especially when there are concerns about the parents or immediate family

**Did you know? The following links offer useful further information and guidance:**

* The Lullaby Trust information and guidance:
  + [Professionals - The Lullaby Trust](https://www.lullabytrust.org.uk/professionals/)
  + [How to reduce the risk of SIDS for your baby - The Lullaby Trust](https://www.lullabytrust.org.uk/safer-sleep-advice/)
  + [The Lullaby Trust: Evidence Base](https://www.lullabytrust.org.uk/wp-content/uploads/Evidence-base-2019.pdf) (factors associated with and increased risk in sudden infant death syndrome, Section 1.3.1 Co-sleeping and 1.4 Alcohol and drug use in pregnancy)
* OSCB multi-agency guidance: [**Pre-birth assessment practice guidance**](https://www.oscb.org.uk/documents/pre-birth-assessment-guidance/)

**Please share the learning from this summary in your teams, discuss in your team meetings and supervision, and make sure you are familiar with the relevant tools and guidance.**