Learning Briefing – Rapid Review RR25-4

Circumstances

A review was completed following concerns that a 2 month old child died whilst sleeping in bed with her mother who was aged 14.

Concerns had been raised in relation to cumulative risk not being appropriately considered including regarding sexual abuse perpetrated towards the baby's mother, poor home conditions, unsafe sleep and neglect.

Links to Local/National/Themed Guidance

Nottinghamshire Neglect strategy

(Nottingham and Nottinghamshire Child Neglect Strategy)

Professional curiosity professionalcuriosity.pdf (nottinghamshire.gov.uk)

The Child Safeguarding Practice Review Panel - I wanted them all to notice

Partnership Learning Points

- **Strengthen practice in accurate record-keeping, analytical reflection, and the effective use of chronologies to support robust safeguarding assessments and informed decision-making. This should include an emphasis on viewing each child and household member as individuals, with distinct needs and experiences, and ensuring this is reflected in the quality of referrals particularly when making MASH referrals.**
- Explore training and support available through the learning workforce development group for practitioners to confidently manage challenging conversations with families who may present as confrontational or hostile.
- Establish clear pathways and protocols for identifying and flagging children not in education to relevant professionals, recognising the absence of this key protective factor.
- Consideration is given as to how the FNP can improve information sharing with primary care, including consideration of their attendance at safeguarding MDTs.