

01 – Aim of Audit:

Several recently published Serious Case Reviews (SCRs), including HS in Sandwell, involving the death/serious injury of young babies. Reference has been made to the lack of a robust Pre-Birth Assessments in reducing the risk to young babies. The audit aims to assess if Pre-Birth Assessments are being effectively used to safeguard unborn children by examining the multi-agency response to unborn children and the quality of Pre-Birth Assessments.

02 – Overview of Audit:

This audit will aim to examine the timeliness, threshold application and outcomes of the Pre-Birth Assessments, to assess if they are being used effectively to safeguarding babies and ensure there are robust plans prior to their birth.

The audit will take on three separate components:

- A deep dive audit of six cases where a Pre-Birth Assessment has been completed or the mother is currently pregnant or recently had a baby.
- An examination of all the Pre-Birth Assessments that have been conducted by Sandwell Children's Trust from 01/04/18-01/03/19.
- Evidence supplied by partner agencies of their current processes and response to unborn children.

07 - The key messages are to

know the importance of pre-birth assessments for vulnerable unborn babies, and how early identification of risk, and assessment can help and support positive change to parenting before a baby is born. (Sandwell Children's Trust, Practice Note 3, 2019)

06 – Key Notes for Practitioners:

1. Lateral checks and triangulating information

Practitioners need to be carrying out checks with partner agencies to gather information relating to the risks to the child rather than relying solely on parent's assurance that they are complying with plans and engaging with other services.

2. Conversations with colleagues from other agencies

Effective information sharing across agencies is key to successful multi-agency working. Practitioners need to be having conversations with colleagues within and outside their agencies to clearly identify and analyse risk to children and young people.

3. Showing Professional Curiosity

Explore and understand what is happening within a family rather than making assumptions or accepting things at face value.



03 – Good Practice in Deep Dive Audit:

(Social Worker) – we wanted to highlight the strength of your assessment with this family. It was very much a multi-agency document and you took time to speak to other professionals involved in the case to gain their views of the level of risk.
(Targeted Family Support Worker) – we wanted to highlight that you worked hard to build a positive relationship with this family and provide a robust plan of support involving several different agencies to ensure that the baby is protected, and the family is supported.

05 – Key Notes for Practitioners:

Referral of unborn babies Regional Policy: The West Midlands procedure is below, which states that referrals should be made 'as soon as concerns are identified' about an unborn child:
<http://westmidlands.procedures.org.uk/ykpl/statutory-child-protection-procedures/additional-guidance#s537>

Referral timeframes – Sandwell Children's Trust: "Where there are concerns about an unborn baby that meet the criteria for 'high risk/vulnerability', such cases should be referred to the Trust at the earliest opportunity. Other unborn baby referrals will be accepted at 12 weeks. Earlier social care involvement for 'high risk/vulnerability' cases will allow for earlier social care and multi-agency intervention to assess strengths and risks, offer support to parents and put a safeguarding plan in place if required."

04 – Findings from Audit:

Lack of clarity and understanding as to when to refer unborn children to Children's Social Care

Fathers were missing from around half of the assessments, so it was not known if they were a risk or protective factor.

In some cases, there was minimising of risk to the unborn child and practitioners being over-optimistic in terms of parents' capacity to protect their children from harm.