BSCB Audit Summary Findings
Pre - Birth Audit
November 2016

What did we do & why?

This Pre-Birth Audit was selected for completion as part of the BSCBs annual audit programme due to the following findings from 3 recent local Serious Case Reviews:

**Baby K**
*(published August 2015)*

An inadequate pre-birth assessment meant that a sufficiently robust plan was not in place to support the mother in this case.

Issues included a superficial history, a lack of depth regarding key safeguarding and safety issues, a lack of exploration regarding how the mother's mental health might impact on her capacity to parent and a lack of curiosity and challenge regarding the mother's assertion that she was not using alcohol.

**Baby L**
*(published October 2015)*

There was a delay in allocating the case to a social worker, which led to a delay in the undertaking of a pre-birth assessment. This was then not completed as the baby was born prematurely.

Poor recording of information relating to the father was noted in relation to some agencies and poor communication with the drug and alcohol service meant agencies were not clear about the mother’s substance misuse.

**Baby M**
*(signed off by BSCB in May 2016, but unpublished due to criminal proceedings)*

A range of assessments were undertaken by agencies, however this did not include a holistic assessment for the needs of Unborn Baby M. The pre-birth assessment was noted by the Overview Author to be totally inadequate and did not grasp the issues relating to the family. Rather than a risk assessment being undertaken, the assessment focussed on the parents’ ability to undertake basic care tasks and there was a lack of professional curiosity, for example around the mother’s assertion that she was no longer drinking alcohol.

The purpose of the audit was to look in depth at the journeys of a small number of children in order to understand:

- Which agencies are involved with the family and whether there are any gaps in service provision or response.
- Is pre-birth risk identified, understood and prioritised by agencies working with the family
- The involvement of parents in assessment and planning, and the way in which the voice and needs of the unborn child are taken into account
- The impact and effectiveness of multi-agency working including pre-birth planning and assessment
- The effectiveness of communication and information sharing - including whether there were any gaps in information sharing
- The quality of management, oversight and supervision
- The effectiveness of challenge and the resolution of any differences of opinion within or between agencies
- The impact of pre-birth planning and assessments on reducing risk and on achieving positive outcomes for the child and their family

The audit was also an opportunity to identify what worked well in the journeys of these children.

From all the cases where a pre-birth assessment had been started within the 6 month prior to the audit process, 4 cases were selected at random to review. Members of the Performance and Quality Assessment Sub Group completed an audit template for children known to their agency. The Group then met to undertake a more detailed discussion of each case. Due to the full discussion, only 3 of the 4 cases were audited.
Summary of Key Findings across the 3 Journeys

- Whatever their age, the core focus of the assessment is on the mother and not on the risks to the unborn baby.
- Fathers, whether actively involved or not, are considered and assessed less than mothers.
- Recordings are often insufficiently detailed and do not efficiently reflect the work undertaken.
- There is variability in terms of when information is shared between agencies.
- In two of the cases audited, there was no evidence of validation regarding information shared by parents with professionals either simply accepting what has been said or hoping that it was the truth.

One familiar message from this audit relates to the role that fathers play in their children’s lives, and how this is recorded in professional assessments. A secondary analysis of four large scale national surveys (Speight et al 2013) found that 87% of non-residential fathers in the UK reported having continued contact with their children, and that 49% reported having their children to stay on a regular basis. This suggests that it is not enough for professional to accept a mothers word that a father is not engaged.

In the cases audited, there was no challenge, checking or validation of information relating to the ‘absent’ fathers. This issue of insufficient recording of information in relation to fathers was also observed in the SCR relating to Baby L, where some agencies recorded the involvement of the father poorly, despite the fact that he was present and well engaged with the child.

Other findings from this audit are similar to those found through the local SCRs set out at the start of the summary (Baby K, Baby L and Baby M); delayed and poor quality pre-birth assessments which do not focus sufficiently on the risks to the unborn baby, as well as a lack of curiosity or validation of information provided by the mother to professionals.

Next Steps & Further Information

As a result of the findings from the Serious Case Reviews, the BSCB has been delivering two hour learning sessions throughout the County, focusing specifically on pre-birth and young babies. The feedback from these sessions has been extremely positive; the Serious Case Review Sub Group is now developing a information sharing strategy to disseminate the learning to a wider audience, including a briefing paper and video version of the session.

The findings from this session have also contributed directly to a pre-birth pathway / assessment review. The work being undertaken on this has included exploration of concerns around the current process. It has included liaison with Children’s Services and other partners to gain their views about how we are currently working together Pre-Birth.

The Serious Case Review Sub Group will work along side the Policy & Procedures Sub Group to deliver a pop-up event to launch the revised pathway and to further promote the learning and key messages from the audit and Pre-Birth SCRs.

Actions arising from this audit will be monitored via the Performance and Quality Assurance Sub Group and reported to the Board.

To do

Partners and relevant professionals are encouraged to:

- Share and disseminate key learning within their own agencies.
- Think about the strengths and areas for development in relation to their own practice and organisational procedures.

Further Information

- For further information on this audit or other BSCB audits contact bscb@buckscc.gov.uk
- To access the full overview reports and executive summaries for the SCRs of Baby K and Baby L, visit: BSCB I Serious Case Reviews