Briefing on Serious Case Reviews

The timeliness and quality of pre-birth assessments

This short briefing pulls together and highlights research and learning from case reviews where the timeliness and quality of pre-birth assessments has been called into question.

It is based on Ofsted's report: 'Ages of concern: learning lessons from serious case reviews' which provides a thematic analysis of 482 serious case reviews that Ofsted evaluated between 1 April 2007 and 31 March 2011 and where reviews are sufficiently detailed to be useful for identifying and sharing learning points. The main focus of Ofsted's report is on reviews that concerned children in two age groups: babies less than one year old and young people aged 14 or above. In this briefing in we will highlight findings in terms of pre-birth assessment only.

Introduction
From Serious Case Reviews (SCRs), improving practice in pre-birth assessment appears to be a key area for improvement. Findings from a number Serious Case Reviews emphasise the vulnerability of infants to maltreatment and neglect, and overviews of SCRs reveal that a high percentage of babies killed are less than 3 months. Family courts statistics also demonstrate the high proportion of infants on Child Protection plans or subject to care proceedings. Many recent initiatives, including the revised Public Law Outline highlight the need for timely and decisive action from professionals to protect children. Developing an effective and evidence-based approach to pre-birth assessments is considered a critical element of this work.

When agencies are able to anticipate safeguarding risks for an unborn baby, such concerns should be addressed through a pre-birth assessment. Working Together to Safeguard Children 2013 stresses the need for Early Help intervention to prevent future harm.

Learning: Pre-birth assessments
A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, consequently, in the resulting actions. Shortcomings ranged from cases where no pre-birth assessment had been carried out, to other cases where the pre-birth assessment was delayed, over-optimistic or of poor quality.

Another message is the importance of not closing cases too quickly after the baby's birth.

No pre-birth assessment
In one serious case review, an infant girl became seriously ill while in the sole care of Father; she died aged less than four weeks and abuse was suspected to have been a factor in her death. Previous concerns about Father had led to the removal of a child from the care of Father and his then partner because of injuries that were thought to have been non-accidental. In addition, Mother had been looked after for much of her childhood and had experienced a troubled adolescence. When she became pregnant, the baby's paternal grandparents tried to alert agencies about their concerns for the unborn baby.

Learning Point 1: The main lesson for the Local Safeguarding Children Board was that the established local systems had not been followed, because of failings by individual practitioners. When practitioners became aware of the identity of the father and the extent of the mother's childhood problems, a multi-agency pre-birth assessment should have been carried out, leading to care proceedings and action to protect the baby as soon as she was born.

Timeliness of pre-birth assessments
In other instances in reviews it was evident pre-birth assessments were not started early enough. An example is a case in which a pre-birth assessment did not begin until the seventh month of the pregnancy. It should be noted that Mother was particularly vulnerable as she was a care leaver who had suffered serious abuse and neglect within her family. Agencies involved decided that the parents should undergo a pre-birth assessment but there was a long delay before this was carried out. As a result, for a period of three months during the pregnancy, the parents had no contact with children's social care. When the pre-birth assessment was undertaken, it was interrupted by the early birth of the baby. The incomplete assessment had to be continued as a parenting assessment after the birth. The serious case review was initiated after there had been non-accidental injuries to the baby when in the sole care of Mother.

Learning Point 2: Failure to undertake a timely assessment, losing time to assess and support a vulnerable woman during her first pregnancy

Quality of pre-birth assessments
In other cases reviewed, the findings were about the quality of the pre-birth assessment. In the family of one baby who died, the parents had had two previous children when teenagers. The eldest child was subject to a care order and the other one had been the subject of a child protection plan. Although the post-mortem could not establish the cause of death, co-sleeping may have been a factor and non-accidental injuries were found.

Learning Point 3: In its findings the serious case review concluded that the assessment of the unborn baby 'was wholly inadequate, relying completely on an assessment undertaken three months earlier following a referral of domestic violence in relation to the older siblings'. The Local Safeguarding Children Board found that the assessment had been badly flawed and had wrongly concluded that domestic violence was not present. This resulted in a missed opportunity to reassess the family situation and to take into account the impact of a third child in a vulnerable family.

Learning for Practitioners:
- Pre-birth assessments to be undertaken in a timely manner
- Early action to minimise the impact of any known risks to the unborn baby
- Take care not to minimise risks when reviewing child protection plans for babies.

Learning for Local Safeguarding Children Boards:
- Consider carrying out a quality assurance activity to check that pre-birth assessments are routinely being carried out (quality of assessments to be built in to QA work) whenever there may be safeguarding risks to the unborn child.

Pre-birth assessment learning from more recent SCRs

Keanu Williams (Birmingham, September 2013)
Background:
At the time of the births of the older Siblings, when Mother was the subject of a Care Order, a pre-birth assessment should have been undertaken in line with the guidance at the time. There was no evidence in the records that this had taken place. Any young mother, who was Looked After, should have been assessed and supported during a pregnancy as a matter of good practice. An unqualified Social Work Assistant and a Health Visitor were working with Mother after the births providing support but no specific parenting capacity assessment was undertaken. Such an assessment should have been undertaken to establish the children's needs and any possible risk of harm in view of the impact on Mother's parenting capacity of her background history, her experience of being 'parented' and her unsettled lifestyle. The additional stress on Mother of having premature babies, in terms of the practical care in mid-winter as well as the emotional stress of dealing with young babies, was not reflected in the Care Plan.

In this SCR the following point was noted where specific services should have functioned better to protect the children and where improvements could be made:

Service Improvement: Pre-birth assessments and care leavers
New policies and procedures have been implemented in order to ensure that the appropriate assessments and support services are provided to young mothers. The progress of these new policies and services should be audited to ensure that they have been embedded in practice.

SCR: Child D (unnamed LSCB, March 2014)

Background
Serious injuries of a 3-week-old baby girl in October 2012. Mother admitted shaking and hitting Child D and subsequently arrested. Mother had been known to a wide number of agencies since her infancy; she experienced abuse and neglect as a child and entered local authority care four months before her 17th birthday. Mother had a history of mental health problems including anxiety and depression.

Service Improvement
Arrangements between agencies for working together on concerns arising before a child is born have been clarified and improved. A pre-birth "tool kit" has been circulated to enhance the LSCB pre-birth protocol. One of the Child Protection Chairs is the nominated pre-birth lead for the children's workforce, providing advice to social workers undertaking pre-birth assessments and liaising with midwifery services. Children's Services now attend psychosocial meetings at hospitals for pre-birth referrals and weekly meetings at the children's ward.