7-Minute Briefing – Multi-Agency Case File Audit on Pre-Birth Planning

Links updated April 2025

01 Purpose of this Briefing

A deep-dive multi-agency case file audit, focusing on Pre-Birth Planning, was carried out by the Leicester and Leicestershire & Rutland Safeguarding Children Partnerships (LLR SCPs) between May and September 2023. This briefing shares the good practice and learning identified.

02 Background to Audit

This theme was agreed to support the Safeguarding Babies business priority and in light of learning from local Rapid Reviews. It considered whether services complied with, and applied, the LLR SCP procedures including thresholds, partner identification and service response to the unborn/born child via pre-birth planning.

03 Audit Scope

The group of babies was identified for review based on cases where the expectant parent/s had previous children removed from their care. A total of 12 cases were reviewed – 5 from Leicester City, 5 from Leicestershire and 2 from Rutland.

04 What worked well

There was evidence of a clear history of risks identified in 9 out of 12 cases; timely actions through the process in 8 out of 12 cases; and good multi-agency engagement in 8 out of 12 cases.

6 out of 12 cases demonstrated creative work by the Social Worker and tenacity over time working with the parents. There was evidence of safeguarding referrals by Midwives linked to Signs of Safety to help generate maternity safeguarding plans; 7 out of 12 cases were discussed at monthly GP Multi-Disciplinary Team meetings, with risks to the unborn demonstrated clearly in 11 of 12 cases; there was good liaison across Health services by Leicestershire Partnership NHS Trust in 6 of 12 cases. The National Probation Service (NPS) and Domestic Abuse agencies participated in the audit.

05 Learning Points

- When working with parent/s who have a learning disability or learning difficulty and/or mental health needs, there should be an assessment of learning needs at an early stage of the referral to ensure understanding of information, including any diagnosis, and to assess parenting capacity. Services should adapt their work to increase understanding for these parents to enable them to demonstrate change.
- Culture, ethnicity, race, and diversity were not reflected in all assessments and records. There needs to be a better understanding and reflection of cultural and diversity needs.
- Cross agency presence at conferences and key meetings needs to be strengthened. GPs need to be given sufficient time to contribute to conferences. It is important to recognise that no single health practitioner represents all of health.
- There needs to be improved sharing of information across Health agencies, including around fathers and male carers/partners and the detail of the family networks.
- Practitioners need to consider services to parents after their baby is removed, as they may need advice on contraception and practical support, and demonstrate a trauma-informed approach.

06 Reviewing Practice

- Have you considered and recorded the voice and lived experience of the un/born child and any siblings?
- Have you engaged with fathers/partners/ carers/families/support networks and recorded this?
- Have you kept comprehensive chronologies and genograms to understand family networks and relationships? Have local resources been used to support assessments, e.g. Neglect Toolkit?
- Have you reflected on culture, race, ethnicity, acting in a culturally competent way?
- Have you sought management oversight and supervision regarding complex cases?
- Have you given key messages around ICON/ Safer Sleeping, including to fathers/partners?

07 Resources to support practice

- Pre-Birth and Post Birth Planning procedure and flowchart (under Safeguarding Practice Guidance)
- Training video on Pre-Birth procedure
- Children of Parents with Learning Disabilities procedure
- Children of Parents with Mental Health Problems procedure