Learning themes from Serious Case Reviews and Audits

- **Awareness of Unborn Baby Protocol:** Learning from three local rapid reviews found a need to increase the awareness of the unborn baby protocol. There was insufficient evidence that professionals used the protocol and there was little evidence that it was having a positive impact. To access the unborn baby protocol click here.

- **Information sharing:** A lack of information sharing between professionals and also the method used to share information, for example, email not being the best way to share important information as there is a risk it can be overlooked. There is a practice briefing Effective information sharing and consent - Swindon Safeguarding Partnership

- **Brief Unresolved Events:** Also referred to as BRUE's not recognised as a successful resuscitation attempt by practitioners and lack of understanding of what a BRUE is. This was identified in both a Child Safeguarding Practice Review (CSPR) and audit. For more information click here.

- **The need to consider and involve fathers**: A common theme across CSPRs and audits, men are often hidden from view or little is known about them. Also a lack of consideration for fathers outside of the family home. Much of the important messages around things such as safe sleeping tend to be focussed on the mother and the expectation that she then disseminates this knowledge to anyone else caring for the baby.

- **Professional curiosity:** A theme throughout CSPRs and audits, professionals not being professionally curious and accepting what they are told by families. There is a practice briefing Resource pack - Professional Curiosity - Swindon Safeguarding Partnership

- **The impact of COVID across agencies:** Strategy discussion audit found the Impact of COVID on families was not considered for example, impact of isolation on families etc.

- **Impact of maternal mental health on unborn and new born babies:** CSPR findings that there was lots of focus on the impact of mental health of the mother but not how mental health impacts upon the baby. Also mentioned about parental mental health when babies are born prematurely and also when they are on Special Care Baby Unit (SCBU) and the impact predominately being on mother's mental health. Decisions made on mental health services based on maternal reports with no consideration for the impact on the baby.

- **Communication:** Appropriate information sharing routes, for example emails not being the most appropriate way to share important information as it can be missed (noted in CSPR).

- **Assessment and analysis of risk:** Pre-birth assessments should be shared widely with the professionals involved in the families. There is a need for improved awareness of the impact of particular issues in pregnancy such as substance misuse, learning disability. Analysing the risks posed to the unborn and new born baby was identified in CSPR's and audit. Inadequate partnership working to jointly and accurately assess risk.

- **Documentation:** Importance of documentation noted in CSPR. There was important information that is reported to have not been documented.

- **Recording the Voice of the Child** not being included in documentation was a theme identified in audits. There is a practice brief **Capturing the voice of the child in records - Swindon Safeguarding Partnership**