

Learning arising from Audit Sub Groups, May 2016
Multi-agency audit of 8 Somerset contacts regarding unborn babies

Issue identified	ASG recommendation
Pre-birth protocol is still in draft, and not completely adhered to.	Finalise protocol, and circulate widely across agencies.
In 7 of the 8 cases, there is no evidence that the outcome of the referral was communicated to the person making the referral.	CSC to strengthen the guidelines about informing referrers of the outcome of their referral, and recording that this has been done. Agencies to be reminded that if they are not notified of the outcome of their referral they have a responsibility to check the outcome with CSC. When a concerned family member makes a referral to Somerset Direct, the outcome of their referral should be communicated to them – the amount of detail given would depend on the situation
Case involving unborn baby was closed without any communication with health agencies. CSC had been given information (by CAF/CASS, Wales) regarding putative father and this was not shared with health. It was not ascertained that health agencies were aware of this pregnancy.	Before NFAing a case, Somerset Direct should clarify the current situation with partner agencies. For unborn babies this should include the midwife, and it may also be appropriate to check with schools if there are school-age children.
Referral from Adults with Learning Disability was made with a CAF, in 8 th month of pregnancy. Somerset Direct responded that a CRIF was needed, and closed the case until a CRIF was received.	Liaise with ALD to promote use of CRIF. In this case a CAF was sent on 18/11/2015 – a CRIF was requested but a completed one was never submitted by ALD. The completed CAF focused on the parents' needs. The CAF goals are not child-focused. Liaise with ALD to promote use of pre-birth protocol, including timely referrals. Consider a specific audit focusing on cases where parents have learning disabilities.
Cases should be discussed with safeguarding lead before being referred in. The CRIF form has no space to record if the case has been discussed with managers.	Consider adding a box to the CRIF, where the name of the manager / safeguarding lead the case has been discussed with can be recorded.