Central Bedfordshire Guidance in relation to Pre-Birth Planning and Assessments

This guidance is for managers and practitioners involved in work with families prior to the birth of a child where there are indications of identified needs/risk.

The guidance is intended to inform a sustained approach to assessment in which parents are engaged and supported throughout the ante-natal period. Identifying the needs of and potential risks to the unborn child at the earliest possible stage reduces the likelihood of last minute activity around the time of birth and enables help to be provided at the earliest possible stage.

This guidance should be read in conjunction with Central Bedfordshire Council Child Protection Procedures, the information sharing guidance and the joint protocols on multi-agency working, all of which are available on the Central Bedfordshire Safeguarding Children Board website http://www.bedfordshirelscb.org.uk/lscb-website/home-page

1. Purpose

Where it has been identified that a women and her family are in need of support and or where there are safeguarding concerns the main purpose of a Pre-Birth assessment is to identify:

- What the needs of and risks to the new born child may be
- Whether the parent/s are capable of recognising these and working with professionals so that the needs can be met and the risks reduced
- What support the parents may need
- What plans need to be put in place to ensure the needs of the expected child are met and risks addressed

Hart (2000) states that there are two fundamental questions when deciding whether a pre-birth assessment is required:

- Will the new born baby be safe in the care of these parents/carers?
- Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

Where there is reason for doubt about the above a pre-birth assessment is required.

2. Principles

Pre-birth assessments should be multi-agency;

Early referrals (accepted from 12 weeks, ideally no later than the 15th week) are essential in order to ensure the following:

- Sufficient time is allowed in order to undertake a detailed assessment including the preparation of a detailed chronology
- There is sufficient time for effective planning
- Parents have time to contribute to any assessment and to increase the likelihood of a positive outcome to the assessment
- Support services can be provided in a timely fashion

- To facilitate an immediate Multi-Agency response at the earliest and most appropriate opportunity

3. Pre-Birth Assessment and Interventions

The majority of women access their GP within 6-8 weeks of pregnancy leading to a booking appointment with Midwifery Services between 6 and 12 weeks of pregnancy, where routine antenatal assessment and screening processes are commenced. Antenatal care begins as soon as the pregnancy has been confirmed.

The Community Midwives, GPs and Obstetricians are in a key position to identify women and their families who are in need of early support or when there are child protection concerns.

Other practitioners working in Children's or Adult Services may also be in contact with pregnant women or their partners. They should actively consider any support needs; whether any additional services are identified and could be provided through an Early Help Assessment, or if there is any child protection issues that warrant a referral to Children's Social Care.

All practitioners should refer to their agency records to establish whether information held in relation to a previous pregnancy or family history may have an impact on the current pregnancy.

It is vital that there is good communication with the pregnant women, the birth father and, if different, her current partner. Consideration must be given to the communication needs of the pregnant woman and her family, and communication aids, interpreters, sign language should be used as appropriate.

Considering the role of the birth father from the beginning

Local Serious Case Reviews have identified that professional attention has often almost entirely focussed on the mother, with assessment of the father being through the mother's views or not obtained at all. Practice has indicated insufficient direct involvement of the father, or insufficient attention being paid to establishing his views and interest in the children, particularly when not living in the same household. This guidance therefore, deliberately aimed at also raising the profile of the father.

Within the early stages, in the context of assessing needs of the baby it is important to gather full information about the father of the unborn. Even if not living with the mother, the father and his family may be an important source of support and care once the child is born. In addition, there may be previous issues of concern in regard to the father which remain a threat or concern to both mother and baby.

Involving fathers in a positive way is important in ensuring a comprehensive assessment can be carried out and any possible risks fully considered.

When the mother is living with a partner who is not the father of the unborn, the implications of their involvement must also be taken into account. The partner must be included in the assessment, in the same way as the birth father.

Parents with a Learning Disability

It is important to assess the needs and provide support for learning disabled parents as early as possible.

Parents with learning needs may need additional support to enhance and develop their knowledge and understanding, their experiences and skills of being able to meet the needs of their child. Such support is particularly important if they also experience additional stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty or a history of growing up in care.

The ability of parents with learning needs or a disability, to provide a reasonable standard of care to their children will depend on their own individual abilities, support network and circumstances

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The GP and/or midwife should make a referral to Adult Learning Disability Team (ALDT) for a Care Act assessment to assess the pregnant woman's needs, her capacity for self care and her ability to provide adequate care for the baby. This assessment should consider strengths and the nature of any support available from family and partner.

If any professional or agency has **any** concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby, a referral should be made to Children's Social Care. The pre birth protocol should be applied and followed in conjunction with adult services. It is crucial that the involvement and support of the adult services is put into place as early as possible.

Where evidence of a learning disability is present in one or both parents, the paramount consideration of all the agencies will be the welfare and protection of the child/ren

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Parents with learning difficulties are likely to require long term support to be able to meet their child's needs. Where this cannot be provided within the family or community, the parent may then require this support from professionals.

Parents with Mental Health difficulties

There are significant reasons as to why the mental health of the pregnant mother and those around are them are important to the well being of the unborn baby and should be considered very seriously.

We know that:

- Exposure to maternal stress in utero can affect a child’s ability to cope in stressful circumstances in later life. (Shonkoff et al, 2012)
- The importance of ultrasound examinations should not be underestimated in relation to the formation of bonds between the parents and an unborn child.

- After giving birth, severe mental illness may progress more quickly and be more serious than at other times.

It is therefore crucial that professionals who are working with pregnant women are aware of the mental health history and if required ensure that the appropriate Adult Mental Health Services are involved. If they are not involved then the relevant referrals must be made as soon as practically possible.

Parents with Substance and Alcohol Misuse

Drug and alcohol misuse before and during pregnancy can be major risk factors for miscarriage, maternal and infant death and health inequalities.

The potential for harm from the use or abuse of substances such as drugs, tobacco and alcohol is particularly acute during pregnancy and can have a severe and damaging impact on pregnancy and the health of the baby. Substance misuse can significantly harm a foetus, yet pregnancy can act as an equally strong incentive to make a positive change in behaviour and lifestyle. It is important that this is both recognised and supported by early years and health practitioners who work with pregnant women. There is good evidence that early interventions can improve outcomes. (Maternal and Early Years, NHS Health Scotland).

Fear that their child or other children, maybe removed can increase the risk for these women to be reluctant in contacting or engaging with antenatal services and thus increase the possibility of further harm being caused to the unborn baby or even lead to a concealed pregnancy.

Local services for adults with drug and / or alcohol misuse is Path 2 Recovery. It is important that all professionals work together to support the parents of the unborn baby where they are using or misusing drugs and alcohol.

Path 2 Recovery will routinely ask their male and female service users if there is a possibility if they are or likely to be, expectant parents. They also offer on site pregnancy tests and will add the service user to their pregnant clients team meeting agenda. Referrals to the hub will made if and when the pregnancy reaches 12 weeks.

4. Early Help and Support

Where it has been identified that the parent/s may need additional support to meet the needs of their unborn child, a referral should be made for an Early Help Assessment as the means to clearly identify needs/strengths and the support required. this can be undertaken by professionals in contact with parents e.g midwife, health visitor or through a member of the Early Help Service

Families who may need early support and help include:

- Parent/s who are asking for help
- Young parents under 18 or with limited support from family/friends, including care leavers
- Families who dynamics result in a level of instability
- Parent/s struggling to maintain standards of hygiene /repair with the family home
- Families in poverty or where food, warmth and other basics may not always be available
- Families where the advent of a new baby may exacerbate existing difficulties
- Families with housing issues which places them at risk of homelessness or are currently homeless
- Parent/s with mental health issues or drug and/or alcohol issues or with learning disabilities, where it is considered that this may impact on parenting
- A parent has self harmed during pregnancy
- Parents who may not be able to care for their baby adequately because of a physical disability
- Parent has a mild learning difficulty
- Where there is domestic abuse within the household
- Late presentation/booking

In all cases where there has been late presentation of pregnancy urgent consideration should be given to timely follow up and appropriate information sharing.

A review meeting should take place at 20 weeks pregnancy to review the progress of the action plan. There should be an explicit discussion about whether the Early Help Assessment remains the most appropriate way to meet the unborn baby's needs. Given the relatively short timescales of a pregnancy, any decisions regarding the effectiveness and impact of the Early Help needs to be tightly managed. If the services involved with the family believe that they cannot meet the needs of the pregnant women and her family or additional services are required but unknown, a referral to the Access and Referral hub (Children's Social Care) should be considered.

5. Initial Contact Stage

The Access and Referral hub will be responsible for screening all pre-birth referrals. This will be undertaken within 24 hours of receipt of the referral. If there is insufficient information to establish whether the grounds are met for undertaking the Pre-Birth assessment, the Referral and Advice Officers, - **query_mash** may liaise with the referring agency/ midwifery/GP and other relevant agencies, including Adult Services and the Mental Health Team if they are involved with the mother or her partner.

(Refer to the following link for further clarity regarding the issue of sharing information.

https://www.gov.uk/government/publications/protecting-vulnerable-children-and-families-information-sharing

If it is considered that there are insufficient grounds for a Pre Birth assessment to be undertaken, the hub will identify the most appropriate professional to undertake an Early Help assessment to ensure that multi-agency support is in place.

It is important that the expected date of delivery (EDD) is ascertained from the referrer at the point of referral and recorded on Mosaic. If this is not established at the point of

referral this will be a priority task for the allocated social worker or Early Help Lead professional.

All teenage parents and their unborn child must progress to separate Contacts on Mosaic so that there is the collation of information and an analysis of the current situation and necessary action in relation to each of them.

It is also expected that the father- to- be is entered on Mosaic, as a "Relationship" if over 18, a strategy meeting should be considered. If under 18 a separate contact is to be created in his own right so we can determine if there are any significant issues in the relationship and if not, that he is then considered regarding any support needs he may have.

The details of the father of the child and the current partner of the mother if this is different, must also be obtained and recorded on Mosaic.

If there are any difficulties in establishing relevant health information, locating health visitors etc. there must be consultation with the lead safeguarding nurse at this stage.

6. Assessment Stage

Pre-birth Assessments should be considered on all pre-birth referrals where any of the following factors are present:

- There has been a previous unexplained death of a child whilst in the care of either parent
- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children
- A sibling is the subject of or has been a **Child Protection Plan**
- The parent is or was, a **Looked After** child and where concerns have been identified
- A sibling has previously been **Looked After** voluntarily or via a Court Order
- Domestic abuse is known to have occurred or domestic abuse has occurred/been discussed during pregnancy and there other children in the home.
- The degree of parental substance misuse is likely to have a significant impact on the baby's safety or development
- The degree of parental mental illness/impairment is likely to have a significant impact on the baby's safety or development
- There are concerns about parental maturity and ability to self care and look after a child eg an unsupported young mother
- The degree of parental learning disability is likely to have a significant impact on the baby's safety
- Both parents have mild or moderate learning difficulties
- There are concerns about a parent's capacity to adequately care for their baby because of the parent's physical disability
- A child aged under 14 and found to be pregnant – strategy meeting to be convened as soon as possible
- Female genital mutilation victims
- A child aged under 16 and found to be pregnant where there are concerns identified that cannot be met through Early Help

- Where there may be concerns that the young person is at risk of child sexual exploitation.
- If there is a history or concerns regarding honour based violence or forced marriage.
- If the pregnant mother has No Recourse to Public Funds.
- Any other concern exists that the baby may be likely to suffer **Significant Harm** including a parent previously suspected of fabricated or inducing illness in a child

This list is not definitive and further discussion should take place with the appropriate Manager if required.

Best practise suggests that there should be at least one joint visit made with the health visitor and/ or midwife during the course of the assessment and other joint visits with the health specialist and relevant agencies as appropriate during the assessment.

Once the decision has been made for the Pre-Birth assessment to be undertaken, a Pre-Birth Multi Agency Meeting should be held within 20 working days. It is imperative that this meeting is held as early as possible to ensure that all risk factors and protective factors are considered as part of the Pre Birth Assessment.
The meeting should be attended by both the allocated social worker and their Manager or Senior Practitioner who would chair the meeting. The community midwife or safeguarding midwife should always attend. Parents should also be invited to this meeting so they can participate in the sharing of information.

If there are siblings already open to children services and receiving the ongoing support from a social worker – this pre birth meeting can be incorporated within a CIN or Core Group meeting as long as the agenda of that meeting is clearly set out at the beginning of the meeting.

Agenda for discussion at this meeting should include:

- Introduction of the presenting concerns by the chair of the meeting
- Clarification of both parent's details and any siblings, including dates of birth, ethnicity and religion
- EDD of the baby
- Ante-natal care and obstetric history
- Social care history, including parent's own childhoods
- Current family structure, extended family and proposed support
- The parental relationship, (including any DV history considering nature, frequency and severity of violent incidents, and triggers to violence)
- Family functioning: (lifestyle, roles and responsibilities and how they envisage adapting to the arrival of a new born baby)
- Issues that may affect the baby : Risks and needs in relation to either parent's ability to understand a baby's needs. Any mental health issues for either/both parents. Risk of premature birth, likely to stay in hospital following delivery, risk of disability, indicators that parent-child relationship may not produce a secure attachment
- What assessments and by whom, are required to ensure risk and need are identified comprehensively
- Are there any factors that may trigger a premature birth; such as a mother under 19, drug use, domestic abuse or previous premature birth.

The midwife attending the meeting should be sent the agenda in advance of the meeting so that they are able to prepare and attend the meeting with the relevant obstetric history relating to any previous pregnancies and that of this pregnancy that is required.

If the meeting is following a late referral and birth is likely within the next month the meeting should be convened as soon as possible, where the following questions should also be considered:

- Practical arrangements for mother and baby
- Who will inform the social worker of the birth
- Plans for out of hours/emergency birth
- Discharge plans and a support package
- Contact arrangements with parents and other family members
- Parental attitudes to the plan
- Management of parental non co-operation
- Arrangements for legal planning/proceedings/removal
- Health and safety issues

The Pre-Birth Assessment should be completed within 45 days of the referral.

If following the assessment the needs identified are low risk, a Child in Need meeting should be held to form an inter-agency Child in Need Plan. Usual Child in Need procedures and meetings should continue.
A good plan should ensure that everyone is clear about what should happen when the baby is born. The pre-birth assessment conclusions must be reviewed once the baby has been born and the actual observation of parenting can be started.

7. Child Protection Concerns

7.1 Strategy Meetings

It is important that the potential risks to the unborn child are flagged up as early as possible to inform effective planning and so that information can be gathered at an early stage including relevant Police checks.

If it is evident that there are reasonable grounds to believe that the unborn child may be likely to suffer Significant Harm, a multi agency **Strategy Meeting** should be convened. A strategy meeting will be held towards the end (day 40-45) of the Child and Family Assessment to determine whether child protection procedures are needed.

There are exceptions to this:

- If a pregnancy hits xx weeks and there are concerns regarding significant harm then a strategy meeting should not wait until the end of the assessment and should be held immediately, an example of this may be a serious domestic incident.
- In the event of exceptional circumstances, i.e high risk of premature labour or high risk flight risk, or where there has been an attempt by the mother to conceal the pregnancy (see 7.2).

Social workers and managers should refer to the Central Bedfordshire Council Child Protection Procedures in relation to the purpose and agenda for Strategy Meetings.

These Strategy Meetings can be held in a variety of settings including the hospital/GP practices and should facilitate the attendance of all relevant professionals.

In cases where previous children have been removed by a Local Authority and continue to be Looked After, the allocated social worker from the Looked After Children Service must be invited to the Strategy Meeting in order to provide relevant background information and history.

In cases where previous children have been removed a legal planning meeting should be considered and an application to the resource panel should be requested in light of this.

In cases where **Care Proceedings** had been conducted in Central Bedfordshire, the Assessment worker should ensure that details of the proceedings including any assessments that have informed the court are known. It will be the responsibility of the allocated worker undertaking the assessment to request any historical files / court bundles etc …relating to the family that would be deemed necessary as part of the forthcoming pre birth assessment.

The Strategy Meeting should consider the circulation of country-wide alerts including hospitals if it is thought if the baby may be born outside of the area.

Social workers need to request that Conference and Review Service send out these alerts on their behalf.

Where there are concerns that the mother may present at a local hospital other than the one she is booked into, social worker to ensure that copies of the strategy meeting should also be sent to the named Midwife at those identified hospitals ie Luton and Dunstable, Bedford, Lister, Stoke Mandeville and Milton Keynes Hospitals.

Any plan arising from a strategy should consider the following:

- Timescales for completion of an assessment
- Securing the engagement of the Multi Agency network
- Contingency planning
- The need for an Initial Child Protection Conference
- Whether the Public Law Outline process should be considered – see Initiating Care Proceedings Procedure – Section 9.

7.2 Late Bookings and Concealed Pregnancy

For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 13 weeks of pregnancy.

There are many reasons why women may not engage with ante-natal services or conceal their pregnancy, some of, or a combination of which will result in heightened risk to the child.

Some of the indicators of risk and vulnerability are as follows:

- Previous concealed pregnancy
- Previous children removed from the mother's care
- Fear that the baby will be taken away
- History of substance misuse

- Mental health difficulties
- Learning disability
- Domestic abuse
- Previous childhood experiences/poor parenting/sexual abuse
- Poor relationships with health professionals/ not registering with a GP
- Cultural dilemmas

NB This list is not exhaustive.

In cases where there are issues of late booking and concealed pregnancy, it is extremely important that careful consideration is given to the reason for concealment, assessing the potential risks to the child and convening a Strategy Meeting (refer to 7.1) as a matter of urgency with further consideration given to the attendance of a legal representative at this Strategy Meeting.

Possible implications:

- Concealment of a pregnancy can lead to a fatal outcome (for both mother and/or child), regardless of the mother's intention;
- Concealment may indicate uncertainty towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity;
- Lack of antenatal care can mean that any potential risks to mother and child may not be detected. It may also lead to inappropriate advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy;
- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected;
- Underlying medical conditions and obstetric problems will not be revealed;
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery;
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth;
- Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently;
- There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community;
- Risks to the unborn baby from prescribed medications.

There may be risks to both mother and child if the mother has concealed the pregnancy due to fear of disclosing the paternity of the child, for example where the child has been conceived as the result of Sexual Abuse, or where the father is not the woman's partner.

7.3 **Parental Non-Engagement**

There are many reasons why expectant mothers may fail to engage with the assessment, some of which relate to the factors outlined above. It is extremely important that parental non-engagement does not become the reason for delaying the assessment and the making of multi-agency contingency plans for the birth of the baby.

Consideration to be given for a Strategy Meeting to be convened in the event of:

- More than two failed social work visits
- Disengagement from ante-natal process to include Midwifery and maternity care
- Disengagement with other involved agencies to include P2R / Mental Health support

***Professional judgement to apply in context of what the current situation presents at that time.

7.4 **Pre-birth Child Protection Conferences**

If it is decided that a pre-birth Child Protection Conference should be held it should take place as early as assessed as required, as is practical and never later than 8 weeks before the due date of delivery, so as to allow as much time as possible for planning support to the baby and family. Where there is a known likelihood of a premature birth, the Conference should be held earlier. Eg factors which may indicate possible premature labour include young mothers (19 and under); substance misuse; domestic violence; maternal use of some prescribed medication.

7.5 **Child Protection Plan**

If a decision is made that the baby needs to be the subject of a **Child Protection Plan**, the plan must be outlined to commence prior to the birth of the baby.

The **Core Group** must be identified and should meet prior to the birth and prior to the baby's discharge home after a hospital birth to make detailed plans at both stages. Following the completion of the pre birth assessment normal child protection / core group meetings apply.

7.6 **Pre-birth Review Child Protection Conferences**

The first review Conference should take place within one month of the child's birth**.**

8. **Public Law Outline**

In some cases the concerns relating to the unborn child will result in a Legal Planning Meeting. In all cases this meeting should consider all of the risk factors and strengths. Where it has been agreed at the Legal Planning Meeting that work should be undertaken under the Public Law Outline (PLO) framework, there should be as little delay as possible in sending out letters before Proceedings and holding PLO meetings. This is in order to avoid such approaches to the pregnant woman in the late stages of pregnancy and to work with the family to explore all options in order to preferably avoid initiating Care Proceedings. In all cases a referral should be made for a Family Meeting. The PLO process is also an opportunity to commission specialist assessments. These requests should be presented to the Central Bedfordshire Resource Panel in the first instance for consideration and review and no later than 24 weeks gestation.

8.1 CAFCASS Plus

As part of a new joint initiative Children's Services is taking part with Children and Family Court Advisory and Support Service (CAFCASS) to try out a new way of working with parents before any Court proceedings are issued in respect of children. It is hoped that this new way of working might avoid Court proceedings having to be issued, and, it is hoped that it will reduce the length of time it takes for cases to be dealt with by the Courts if the cases are issued.

The Social Worker and Team Manager will present any such case at the Resource Panel as soon as possible after the social care Pre Birth Assessment has been completed. This must be no later than a gestation period of 24 weeks.

The request to Resource Panel is for a Legal Planning Meeting to be held and for an in principle decision that the unborn baby's case should be included in the CAFCASS Plus scheme .

Following the LPM a referral is to be made to CAFCASS, ideally between weeks 20-28 gestation. If the referral is made after 28 weeks gestation, the referral will be will accepted at the discretion of CAFCASS. After 32 weeks gestation CAFCASS will not accept the referral and the scheme cannot be utilised. A parents consent is required for the Family Advisor to become involved.

A Family Court Advisor should be allocated within 2 days of the referral.

At the first PLO meeting a Family Court Advisor from CAFCASS will also attend the meeting so that they can advise on what they also consider as being in the best interests of the unborn baby. The CAFCASS officer may visit the family and/or the Social Worker before the meeting so that they know more about the situation.

There should be no more than one review prior to the birth of the child. Any review meeting should include the Family Court Advisor.

Eight working days after the pre-proceedings meeting, the Family Court Advisor will provide a CAFCASS Plus report setting out an initial analysis and recommendations as to the way forward. This report will be forwarded to Children's Services and the parents.

In the event that proceedings are commenced then the same Family Court Advisor who has been involved in the pre proceedings to be allocated wherever possible and so becomes the allocated Children's Guardian. (Also refer to CAFCASS plus guidance for more detailed information).

9. Initiating Care Proceedings

Any request to initiate care proceedings is a decision to be presented and made through Resource Panel. Once agreed, the professional network should be kept fully appraised of the Local Authority plan. Where an Initial Child Protection Conference has been held this will be through the core group.

The purpose of the proceeding core group meeting will be to make a detailed plan for the baby's protection and welfare around the time of birth so that all members of the hospital team are aware of the plans. The lead midwife will ensure that the midwives are fully appraised of the plan for the baby at birth.

The agenda for this meeting should also address the following:

- How long the baby will stay in hospital (a minimum of 7 days is usually recommended to monitor for withdrawal symptoms for babies born to substance using mothers)
- How long the hospital will keep the mother on the ward once medically fit
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the eg parental substance misuse and /or mental health; domestic abuse. Consideration should be given to the use of hospital security, informing the Police and other safety planning measures
- The risk of potential abduction of the baby from the hospital particularly where it is planned to remove the baby at birth
- The plan for contact between mother, father, extended family and the baby whilst in hospital. Consideration to be given to the supervision of contact – for example whether contact supervisors need to be employed. Hospital staff cannot be responsible for supervising contact
- Consideration of any risks to the baby in relation to breastfeeding eg HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding
- The plan for the baby upon discharge that will be under the auspices of care proceedings, eg discharge to parent/extended family members; mother and baby foster placement; foster care, supported accommodation
- A visiting matrix on discharge
- Where there are concerns about an unborn of a pregnant woman who intends to have a home birth, the Ambulance Service Lead should be invited to the Pre-Birth Planning Meeting. The safeguarding team in the hospital should place a marker on the address
- How to manage a request for a home birth when there are concerns or the unborn child is subject to a child protection plan
- Contingency plans should also be in place in the event of a sudden change in circumstances
- Hospital staff should be given clear instructions regarding any birth that is likely to occur over a weekend or Bank Holiday
- The Emergency Duty Team should also be notified of the birth and plans for the baby and the plans entered onto Mosiac
- A copy of the plan should be given to all participants and the parents GP .

10. Birth and Discharge of a New born Baby

The hospital midwives need to inform the allocated social worker, or the Emergency Duty Team at weekends and Bank Holidays of the birth of the baby and there should be close

communication between all agencies around the time of labour and birth. Maternity staff must keep contemporaneous notes to include visitors/basic care/maternal interaction/parenting style/ any unusual activity such as leaving the ward for extended periods.

During the out of hours periods, the social worker should ensure what role there is (isnt) for the Emergency Duty Team and whether they will need fully appraising of any potential decision making that maybe required or if maternity staff are simply notifying them of a birth. Equally, the lead midwife should also ensure the midwifery /maternity staff are aware of any concerns / plans for the baby upon birth so that if they are contacting the Emergency Duty Team they are fully aware of why they are making this contact.

In cases where legal action is proposed or where the unborn child has been the subject of a Child Protection Plan, the allocated **Social Worker** should visit the hospital on the next working day following the birth. The Social Worker should meet with the maternity staff prior to meeting with the mother and baby to gather information and consider whether there are any changes needed to the discharge and protection plan. The Social Worker should keep in daily contact with the ward staff and visit the baby and the parents on the ward on alternate days to meet with the parents.

Whether the baby is subject to a Child In Need plan or a Child Protection plan, a Discharge Planning Meeting should be held to draw up a detailed plan prior to the baby's discharge home. If this is not possible, the CIN or Core Group should meet within 7 days of the baby's birth.

If a decision has been made to initiate care proceedings in respect of the baby, the Allocated Social Worker or Hospital Social Worker must keep the hospital up-dated about the timing of any application to the courts. The lead midwife should be informed immediately of the outcome of any application and placement for the baby. A copy of any orders obtained should be forwarded immediately to the hospital.

11. Pregnancy of Young People in Care

When it is established that a young person in care or a supported care leaver is pregnant, the referrer must ring for a consultation with the Access and Referral hub. A decision can then be reached about the assessment process between both the referring team and the Assessment Team.

It should not be an automatic decision to complete a pre-birth assessment in relation to the pregnancies of all care leavers unless the thresholds are met as outlined above. Alternatively a referral for an Early Help Assessment should be considered.

If an assessment is required, the Corporate Parenting service should provide a full written history and chronology of the young person either at the point of referral or at the Strategy Meeting. The assessment should consider the Care Plan for the young person and any additional resources needed to support the young person throughout the pregnancy. The Independent Reviewing Officer should be kept up to date with the assessment process and should the needs of the (unborn) baby require changes to the care plan for the young person, a Looked After Child review should be convened at the earliest possible time.

If a young person is looked after by another Local Authority and living in Central Bedfordshire then the allocated social worker from that Local Authority should be invited to the Strategy Meeting.

If the young person's placement is out of county the Corporate Parenting Service must refer the unborn baby to the relevant Assessment Team within that area. Where a child is a mother/expectant mother and is accommodated or subject to leaving care arrangements (potentially up to 25 years), and is placed by the originating authority in another borough, the authority in which the mother is living is responsible for the baby. However, in practice this is an area where there can sometimes be disputes regarding case responsibility. It is therefore important that case responsibility is negotiated at an early stage by managers

12. Allocation and Case Transfer

The Access and Referral Practise Manager will be responsible for the initial screening of all pre-birth cases referred to Children Social Care. A decision about allocation will be made within 24 hours of receipt of the referral. If it is agreed for a pre birth assessment to be carried out the case will be passed to the relevant Assessment Team for allocation.

Cases where siblings of unborn children are already open to other Services or in Care Proceedings, these unborn children will continue to be allocated within those Services – with the exception of the Leaving and After Care Team. The pre birth planning meeting and pre birth assessment in respect of the unborn baby should apply as referred to above.
In cases where the court proceedings have concluded in the last 6 months, consultation should take place with the Head of Corporate Parenting Service, as to whether the assessment should be completed by the Assessment Team or the Corporate Parenting Team.

Where long term social work planning support is required, the pre birth assessment will be completed by the Assessment Team and transferred to the relevant team as per the transfer protocol.

If a family have been closed to a Family Support Team and there is notification of a new pregnancy and meets the threshold for social care intervention – the pre birth assessment will be completed by the Family Support Team as per transfer protocol.

For families where the unborn child is not the subject of a Child Protection Plan then the Pre-Birth Assessment, with parental agreement, should be shared with the Lead Midwife who will disseminate the relevant professionals.

13. General Guidelines for Conducting Pre-Birth Assessments

The importance of conducting pre-birth assessments has been highlighted by numerous research studies and **Serious Case Reviews** which have shown that children are most at risk of fatal and severe assaults in the first year of life, usually inflicted by their carers.

Pre-Birth Assessment is a sensitive and complex area of work. Parents may feel anxious about their child being removed from them at birth. Referring professionals may be reluctant to refer vulnerable adults and be anxious about the prospective parents losing trust in them.

It is important to undertake the assessment during early pregnancy (following the 12 week scan) so that the parents are given the opportunity to show that they can change. If the outcome of the assessment suggests that the baby would not be safe with the parents then there is an opportunity to make clear and structured plans for the baby's future together with support for the parents.

Where the concerns have not met the threshold for a Pre-Birth Assessment a referral for an Early Help Assessment should be considered by the relevant Health professional in order to ensure appropriate early help is in place.

It is important that social workers do not conduct assessments in isolation. Working closely with relevant professionals such as midwives and health visitors is essential. Liaising with relevant substance misuse, mental health and learning disability professionals is also crucial. The mental health safeguarding lead will also offer advice on cases with a mental health component and become involved in liaison with mental health professionals.

The importance of compiling a full chronology and family history is particularly important in assessing the risks and likely outcome for the child. Where there have been previous children in the family removed, the previous Court documents such as copies of Final Court Judgements and assessment reports should be accessed at an early stage. If there have been Social Workers involved from the Looked After Children service, they should be consulted and invited to relevant meetings.

Workers should try to compile a clear history from the parents about their own previous experiences in order to find out whether they have any unresolved conflicts, for example that may impact on their parenting of the child. It is important to find out their feelings towards the new born baby and the meaning that the child may have for them. For example, the pregnancy may have coincided with a major crisis in the parent's life, which will affect their feelings towards the child.

It is also important to find out the parents' views about any previous children who have been removed from their care and whether they have demonstrated sufficient insight and capacity to change in this respect.

It is crucial to seek information about fathers/partners whilst conducting assessments and involve them in the process. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

Working with extended family members is also crucial to the assessment process and achieving positive outcomes for unborn children. Consideration should always be given to convening a **Family Meeting** in any cases where there is a possibility that the mother may be unable to meet the needs of the unborn child.

Family Meetings can enable the families to be brought together to make alternative plans for the care of the child thus avoiding the need for Care Proceedings in some cases. Parallel assessment of alternative family carers can prevent delays in Care Planning for the child.

A pre- birth assessment tool is attached to this guidance to help social workers consider the key questions to address when undertaking assessments. It is important to provide an analysis of the likely impact of parental issues on the unborn child rather than just providing a description. For example, the likely impact of parental substance misuse on both the unborn and the new born child needs to be spelled out explicitly.

Appendix 1 Pre-Birth Assessment Tool

MULTI- AGENCY GUIDANCE FOR PLANNING & COMPLETING PRE-BIRTH ASSESSMENTS

When undertaking a Pre-Birth assessment, social work practitioners will complete a Child and Family Assessment. To ensure that the assessment specifically identifies and addresses those areas which are relevant to expectant mothers where there are vulnerabilities and concerns, the following checklist can be used to enhance and supplement the assessment.

ASSESSMENT CHECKLIST

1.0	**FAMILY STRUCTURE**	
	Names Addresses Ages Extended family members and others offering potential support should be included	
2.0	**MEDICAL AND OBSTETRIC HISTORY**	

	INFORMATION REQUIRED FROM MIDWIFE / HEALTH PROFESSIONAL AS PART OF A PRE-BIRTH RISK ASSESSMENT *This section should be completed by an appropriate Health Professional. (See annex B for general guidance)* Factors to consider as part of the Assessment and the likelihood of these having significant adverse impact on the child: • Details of the medical and obstetric history and relevance in terms of parenting • Partner support? • Family structure and support available (or potentially available or not available)? • Whether pregnancy planned or unplanned? • Feelings of mother about being pregnant? • Feelings of partner / putative father about the pregnancy? • Dietary intake - and related issues? • Medicines or drugs - whether or not prescribed - taken before or during pregnancy? • Alcohol consumption? • Smoking? • Previous obstetric history? • Current health status of other children? • Miscarriages and terminations? • Chronic or acute medical conditions or surgical history? • Psychiatric history – especially depression and self-harming?	
3.0	**ASSESSMENT of PARENTS AND POTENTIAL RISKS TO CHILD**	
	This section will usually be completed by the Social Worker who will need to draw on help from a range of other professionals regarding some aspects of the assessment. Particular care should be taken when assessing risks to babies whose parents are themselves a young person. Attention should be given to: • evaluating the quality and quantity of support that will be available within the family (and extended family) • evaluating the quality and quantity of support that will be available within the family (and extended family) • the needs of the parent(s) and how these will be met) • the context and circumstances in which the baby was conceived, and the wishes and feelings of the child who is to be a parent	
FACTORS TO CONSIDER WHEN UNDERTAKING AN ASSESSMENT		
3.1	**Relationships**	
	• History of relationships of adults? • Current status? • Positives and negatives? • Violence? • Who will be main carer for the baby? • What are the expectations of the parents re each other re parenting?	

	Is there anything regarding "relationships" that seems likely to have a significant and negative impact on the child? If so, what?	
3.2	**Abilities**	
	• Physical? • Emotional? (including self control) • Intellectual? • Knowledge and understanding re children and child care? • Knowledge and understanding of concerns / this assessment? Is there anything regarding "abilities" that seems likely to have a significant negative impact on the child? If so, what?	
3.3	**Social history**	
	• Experience of being parented? • Experiences as a child? And as an adolescent? • Education?	
3.4	**Behaviour**	
	• Violence to partner? • Violence to others? • Violence to any child? • Drug misuse? • Alcohol misuse? • Criminal convictions Chaotic (or inappropriate) life style? Is there anything regarding "behaviour" that seems likely to have a significant negative impact on the child? If so, what? If drugs or alcohol are a significant issue, more detailed assessment should be sought from professionals with relevant expertise.	
3.5	**Circumstances**	
	• Unemployment / employment? • Debt? • Inadequate housing / homelessness? • Criminality? • Court Orders? Social isolation? Is there anything regarding "circumstances" that seems likely to have a significant negative impact on the child? If so, what?	
3.6	**Home conditions**	
	• Chaotic? • Health risks / insanitary / dangerous? Over-crowded? Is there anything regarding "home conditions" that seems likely to have a significant negative impact on the child? If so, what?	
3.7	**Mental Health**	

	• Mental illness? • Personality disorder? • Any other emotional/behavioural issues? Is there anything regarding "mental health" that seems likely to have a significant negative impact on the child? If so, what? If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.	
3.8	**Learning Disability**	
	Is there anything regarding "learning disability" that seems likely to have a significant negative impact on the child? If so, what? If learning disability is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.	
3.9	**Communication**	
	• English not spoken or understood? • Deafness? • Blindness? • Speech impairment? Is there anything regarding "communication" that seems likely to have a significant negative impact on the child? If so, what? If communication is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.	
3.10	**Support**	
	• From extended family? • From friends? • From professionals? From other sources? Is there anything regarding "support" that seems likely to have a significant negative impact on the child? If so, what? Is support likely to be available over a meaningful time-scale? Is it likely to enable change? Will it effectively address any immediate concerns?	
3.11	**History of being responsible for children**	
	• Convictions re offences against children? • Children subject to CP plan? • CP concerns - and previous assessments? • Court findings? • Care proceedings? Children removed? Is there anything regarding "history of being responsible for children" that seems likely to have a significant negative impact on the child? If so, what? If so also consider the following: • Category and level of abuse • Ages and genders of children • What happened?	

	• Why did it happen? • Is responsibility appropriately accepted? • What do previous risk assessments say? Take a fresh look at these - including assessments re non-abusing parents. • What is the parent's understanding of the impact of their behaviour on the child? • What is different about now?	
3.12	**History of abuse as a child**	
	• Convictions - especially of members of extended family? • Subject to a CP plan? • CP concerns • Court findings? Previous assessments? Is there anything regarding "history of abuse" that seems likely to have a significant negative impact on the child? If so, what?	
3.13	**Attitude to professional involvement**	
	• Previously - in any context? • Currently - regarding this assessment? • Currently - regarding any other professionals? Is there anything re "attitudes to professional involvement" that seems likely to have a significant negative impact on the child? If so, what?	
3.14	**Attitudes and beliefs re convictions or findings (or suspicions or allegations)**	
	• Understood and accepted? • Issues addressed? Responsibility accepted? Is there anything regarding "attitudes and beliefs" that seems likely to have a significant negative impact on the child? If so, what? It may be appropriate to consult with the Police or other professionals with appropriate expertise.	
3.15	**Attitudes to child**	
	• In general? Re specific issues? Is there anything regarding "attitudes to child" that seems likely to have a significant negative impact on the child? If so, what?	
3.16	**Dependency on partner**	
	• Choice between partner and child? • Role of child in parent's relationship? Level and appropriateness of dependency? Is there anything regarding "dependency on partner" that seems likely to have a significant negative impact on the child? If so, what?	
3.17	**Ability to identify and appropriately respond to risks**?	
	Is there anything regarding this that seems likely to have a significant	

	negative impact on the child? If so, what?	
3.18	**Ability to understand and meet needs of baby**	
	Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what? It may be appropriate to consult with Health professionals re this section.	
3.19	**Ability to understand and meet needs throughout childhood**	
	Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what? It will usually be appropriate to consult with relevant Health professionals re this section.	
3.20	**Ability and willingness to address issues identified in this assessment**	
	• Violent behaviour? • Drug misuse? • Alcohol misuse? • Mental health problems? • Reluctance to work with professionals? • Poor skills or lack of knowledge? • Criminality? • Poor family relationships • Issues from childhood? • Poor personal Care? Chaotic lifestyle? Is there anything regarding "ability and willingness to address issues" that seems likely to have a significant negative impact on the child? If so, what? It will usually be appropriate to consult with other professionals re this section.	
3.21	**Any other issues that have potential to adversely affect or benefit the child**	
	E.g. one or more parent aged under 16? Context and circumstances of conception?	
3.22	**Planning for the future**	
	Realistic and appropriate?	
4.0	**SUMMARY RISK ASSESSMENT AND CONCLUSIONS**	
	The assessment analysis should address the following issues. The guidance in **Annex A** should inform the assessment and analysis of need/risk. 1. **Concerns identified** 2. **Strengths or mitigating factors identified**. 3. **Is there a risk of significant harm for this baby?** It is crucial to clarify the nature of any risk - of what? From whom? In what circumstances? etc - and to be clear how effective any strength or mitigating factors are likely to be in reality 4. **Will this risk arise:** a) before the baby is born?	

	b) at or immediately following the birth? c) whilst still a baby (up to 1 year old)? d) as a toddler? or pre-school? or as an older child? If there is a risk that the child's needs may not be appropriately met ... 5. **What changes should ideally be made to optimise well-being of child?** If there is a risk of significant harm to the child ... 6. **What changes must be made to ensure safety and an acceptable level of care for child?** 7. **How motivated are the parent's to make changes**? 8. **How capable are the parent's to make changes? And what is the potential for success?**	

Annex A
Framework for Practice: Risk Estimation

Framework taken from an adaptation by Martin Calder in 'Unborn Children: A Framework for Assessment and Intervention' of R. Corner's 'Pre-birth Risk Assessment: Developing a Model of Practice'.

Factor	Elevated Risk	Lowered Risk
The abusing parent	• Negative childhood experiences, inc abuse in childhood; denial of past abuse • Violent abuse of others • Abuse and/or neglect of previous child • Parental separation from previous children • No clear explanation • No full understanding of abuse situation	• Positive childhood • Recognition and change in previous violent pattern • Acknowledges seriousness and responsibility without deflection of blame onto others • Full understanding and clear explanation of the circumstances in

	• No acceptance of responsibility for the abuse • Antenatal/postnatal neglect • Age: very young/ immature • Mental disorders or illness • Learning difficulties • Non-compliance • Lack of interest or concern for child	which the abuse occurred • Maturity • Willingness and demonstrated capacity and ability for change • Presence of another safe non-abusing parent • Compliance with professionals • Abuse of previous child accepted and addressed in treatment (past/present) • Express concern and interest about the effects of the abuse on the child
Non abusing parent	• No acceptance of responsibly for the abuse by their partner • Blaming others or the child	• Accepts the risk posed by their partner and expresses a willingness to protect • Accepts the seriousness of the risk and the consequences of failing to protect • Willingness to resolve problems and concerns
Family issues (marital partnership and the wider family)	• Relationship disharmony/instability • Poor impulse control • Mental health problems • Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks) • Lack of support for primary carer/ Unsupportive of each other • Not working together • No commitment to equality in parenting • Isolated environment	• Supportive spouse/ partner • Supportive of each other • Stable • Protective and supportive extended family • Optimistic outlook by family and friends • Equality in relationship • Commitment to equality in parenting

	• Ostracised by the community • No relative or friends available • Family violence (eg Spouse) • Frequent relationship breakdown/multiple relationships • Drug or alcohol abuse	
Expected child	• Special or expected needs • Perceived as different • Stressful gender issues	• Easy baby • Acceptance of difference
Parent- baby relationships	• Unrealistic expectations • Concerning perception of baby's needs • Inability to prioritise baby's needs above own • Foetal abuse or neglect, including alcohol or drug abuse • No ante natal care • Concealed pregnancy • Unwanted pregnancy identified disability (non acceptance) • Unattached to foetus • Gender issues which cause stress • Differences between parents towards unborn child • Rigid views of parenting	• Realistic expectations • Perceptions of unborn child normal • Appropriate preparation • Understanding or awareness of baby's needs • Unborn baby's needs prioritised • Co-operation with antenatal care • Sought early medical care • Appropriate and regular ante natal care • Accepted /planned pregnancy • Attachment to unborn • Treatment of addiction • Acceptance of difference – gender/disability • Parents agree about parenting
Social	• Poverty • Inadequate housing • No support network • Delinquent area	
Future plans	• Unrealistic plans • No plans • Exhibit inappropriate parenting plans • Uncertainty of	• Realistic plans • Exhibit appropriate parenting expectations and plans

	changes needed in lifestyle • No recognition of a problem or a need to change • Refuse to co-operate • Disinterested and resistant • Only one parent co-operating	• Appropriate expectation of change • Willingness and ability to work in partnership • Willingness to resolve problems and concerns • Parents co-operating equally

Annex B

General Guidance regarding ante natal care

Antenatal care begins as soon as the pregnancy has been confirmed and midwives continue care in the postnatal period for at least 10 days following birth. A booking interview with the community midwife takes place ideally between 8-12 weeks gestation. This is usually in the woman's home or at the GP's surgery. It is at this interview that the midwife is able to assist women in their choices for childbirth and ensure they are informed of all the options available to them.

Women are given choices in early pregnancy of lead professional and place of birth: Midwife-led care (MLC) means the midwife is the lead professional. All antenatal care would be conducted in the community and is often shared with the General Practitioner (GP). Women would have the choice of giving birth in the hospital under MLC or at home with midwives in attendance.

GP led care is less frequently offered and again all antenatal care is conducted in the community and is shared between GP and community midwife. The place of birth is rarely at home with the GP in attendance so most GP births occur in a low-risk hospital environment.

Consultant led care is offered to women who have recognised health risk factors or who choose to see the consultant team. These pregnancies require additional surveillance both pre-birth and in labour. Care is shared between the community midwife, GP and a hospital consultant team consisting of midwives and doctors specialising in care of high risk pregnancy. Delivery of the baby will take place in the hospital. The booking interview is a time of collection of information and an opportunity for the midwife and mother to plan her care in pregnancy. It is an ideal time for the midwife to assess health and social needs of families and to consider packages of care and support suitable for individual needs.

Antenatal appointments are arranged to suit the individual clinical needs of the mothers and the initial choices may change if complications of pregnancy arise. A collaborative approach between all health professionals is encouraged with direct midwife referral to obstetrician being available at all times. In the case of home births all postnatal care is provided in the home by the community midwife. For births in hospital - with either the midwife, GP or obstetrician as the lead professional - initial postnatal care is provided by midwives and support staff on the maternity wards. Hospital stays are getting shorter with many women going home within a few hours of birth but generally 12-48 hours are the more normal lengths of stay. On transfer home care is undertaken by the community midwife for at least 10 days following the birth. Care can be extended to up to 28 days if a particular clinical or social need is identified. Liaison between the Health Visitor attached to the GP's surgery and community midwife usually takes place during the antenatal period with some Health Visitors making contact with the mother in pregnancy. Following the birth of the baby most Health Visitors arrange a primary visit at 10 days postnatal, which coincides well with the handover of care from the midwives.