

# Multi-Agency Pre-birth Protocol & Pre-birth Assessment Tool



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## 1. Scope

This guidance provides a framework for multi-agency working so that a clear system is in place to respond to concerns for the welfare of an unborn child and/or where there may be concerns following their birth. It sets out the role of agencies in referring expectant mothers to the most appropriate service for support, contributing to assessment and implementing any agreed plan of action to support families and safeguard and promote the welfare of the child to ensure that timely decision-making and proportionate action and intervention takes place.

This guidance applies to all agencies in Merton but in particular to Children's Services staff, police, health (including mental health) and relevant adult services.

This guidance should be read in conjunction with the London Child Protection Procedures, which offer detailed guidance in relation to this area of work.

Full details of the LCPP are at:

[www.londoncnp.co.uk/chapters/referral\\_assess.html?zoom\\_highlight=pre---birth#prebirth](http://www.londoncnp.co.uk/chapters/referral_assess.html?zoom_highlight=pre---birth#prebirth)

## 2. Principles

**2.1** Pre-birth assessments should be undertaken within a multi-agency approach and driven by partnership working to ensure meaningful engagement of families. It is essential that professionals involve fathers, same-sex partners and other adults living in the household in the process of assessment to explore their potential role in caring for the child and also whether they may pose a risk to the child on birth.

Hart (2009) states that there are two fundamental questions when deciding whether a pre-birth assessment is required:

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

**2.2** Early referrals should be encouraged to ensure that:

- There is sufficient time to undertake a detailed assessment and make adequate plans for the baby's protection;
- Parents have time to contribute their ideas and solutions to any assessment to increase the likelihood of a positive outcome for the baby;
- Parents are not approached in the latter stages of pregnancy which is an already stressful time and;
- Services are provided in a timely way to facilitate optimum outcomes.

## 3. Purpose

**3.1** A pre-birth assessment is an assessment of the risk to the future safety of the unborn child with a view to making informed decisions about the child and family's future. The main purpose is to allow social workers and the professional network to identify:

- What the needs of and risks to the newborn child may be;

- Whether the parent's are capable of recognising these and working with professionals so that needs can be met and risks reduced;
- What support parents may need to help strengthen parenting capacity;
- Plans for the child's care and decisions or interventions to address risk and keep the child safe in the present and long-term.

**3.2** A pre-birth assessment would be required in the following circumstances:

- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children;
- A sibling or child in the household is the subject of a child protection plan;
- A sibling or child has previously been removed from the household either temporarily or by court order;
- The parent is a Looked After child
- There are significant domestic abuse issues;
- The degree of parental substance misuse is likely to impact significantly on the baby's safety or development;
- The degree of parental mental illness/impairment is likely to impact significantly on the baby's safety or development;
- The degree of parental learning disability is likely to have a significant impact on the baby's safety;
- There are concerns about a parent's capacity to adequately care for their baby because of the parent's physical disability;
- There are significant concerns about parental ability to self-care and/or to care for the child;
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a child;
- A child under the age of 13 is found to be pregnant;
- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent;
- There are maternal risk factors e.g. denial of pregnancy, failed appointments, non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.

Professionals **Must** make a referral to the MASH where any of the above circumstances are prevailing

## **4. Multi-Agency Recognition of Risks for Unborn Children**

Agencies in the community can play a key role in the identification of risk and provision of support through advice or referral for vulnerable expectant parents and their unborn child.

### **4.1 Health Services**

Health professionals, particularly midwives and GPs, are most likely to be in contact with expectant mothers, putative fathers, and therefore critical to recognising risk factors and making appropriate referrals to Children's Social Care. They have responsibility for addressing the mother's health needs and sharing relevant information with the network

about factors that may affect parenting capacity. This also includes any concerns they may have about the putative father of an Unborn.

When assessing risk, midwives should gather relevant information about the mother during the booking appointment and consider whether any aspects of any of the following risk factors may have significant impact on the Unborn child, and if so how.

#### **Risk Factors to Consider**

- Family structure and support available
- Whether the pregnancy is planned or unplanned
- The mother's feeling about being pregnant
- The partner/putative father's feeling about the pregnancy
- Mother's dietary intake and any related issues
- Any medicines or drugs, whether or not prescribed, taken before or during pregnancy
- Alcohol consumption and smoking
- Previous obstetric history
- Current health status of other children
- Any miscarriages or terminations
- Any chronic or acute medical conditions of surgical history
- The mother's psychiatric history, especially depression and self-harming
- Whether the mother has been subjected to FGM and if any medical intervention is required to enable the mother to safely proceed with the delivery of her baby.

#### **4.2 Mental Health Services**

Mental health professionals are responsible for identifying expectant service users and sharing relevant information with midwives, GPs and social workers on how the service user's mental health diagnosis may affect parenting capacity or how treatment may affect development of the foetus. Professionals should be aware of the following, which may raise risks to unborn and new-born children:

- Where the nature or degree of risk in relation to a parental mental health causes concern for the unborn or others
- Parents who incorporate their (unborn) child into delusional thinking;
- Parents who are not complying with medication or treatment;
- Where the (unborn) child is viewed with hostility or;
- Where there is dual diagnosis (mental ill health together with substance misuse).
- Where there is a risk of self harm or suicide

Identifying the needs of the child, when their parent, carer or expectant mother is experiencing mental health problems

- How does their mental health is impacting on the safety or welfare of any children in their care, or who have significant contact with him/her
- Whether they have access to the relevant support services
- Whether the child/young person is a young carer.

The birth of any new child changes relationships and brings new pressures to any parent or family. Agencies need to be sensitive and responsive to the changing needs of parents or carers with mental health problems.

*For further guidance on the impact of mental health Professionals should refer to the Multiagency protocol to meet the needs of children and unborn children whose parent or cares have mental health problems*

### 4.3 Substance Misuse

Substance Misuse agencies in the community can play a key role in supporting expectant mothers such as identifying drug/alcohol use in pregnancy at an early stage, referring on to appropriate help and support and providing needed advice and intervention. Substance misuse professionals are responsible for sharing relevant information with midwives, GPs and social workers on how the expectant mother's substance misuse and accompanying treatment may affect parenting capacity or development of the foetus.

Professionals should take into account:

- Patterns of substance misuse;
- Whether it can be managed in conjunction with caring for a newborn child;
- Whether parents are willing to attend treatment;
- Any dual diagnosis (substance misuse together with mental health problems);
- Consequences for the unborn baby of continued misuse of substances or withdrawal during pregnancy.

Substance misuse professionals may wish to seek advice from a Specialist Substance misuse midwife (where applicable) or the MASH Team.

### 4.4 Domestic Abuse and Violence

Domestic abuse can pose a serious threat of physical harm to an unborn child and on birth; exposure to domestic abuse can have a negative effect on the baby's emotional and cognitive development. Pregnancy is known to increase the risk of domestic abuse, or lead to the escalation of existing violence. The stress of caring for a new born baby, particularly if the child is demanding or difficult can also trigger domestic abuse and violence within the home.

- Midwives are required to offer domestic abuse screening for women. It is an expectation that midwives are able to see all expectant mothers alone so that they are able to raise the issue of domestic abuse safely and to allow disclosure
- Domestic abuse services in Merton providing services for an expectant mother should support her to engage with midwifery services.
- Merton Police should ensure that when attending domestic abuse call-outs, they are aware of the presence of expectant mothers in the household, and share this information with the MASH Team, and Victim Support

Professionals who are working with expectant mothers experiencing domestic violence should carry out a CAADA-DASH risk assessment to decide on whether to make a referral. Where there are concerns about domestic abuse and violence, the mother can be referred to Victim Support and linked with an Independent Domestic Violence Adviser (IDVA) for advice and support. A referral to the Multi Agency Risk Assessment Conference (MARAC) should also be considered where Domestic Abuse is a concern. Significant concerns about the effect of domestic abuse on the unborn child **MUST** be referred to the MASH.

### Factors To Consider

- The nature of domestic abuse and violent incidents
- The frequency of the domestic abuse and severity
- The triggers for abuse and violent incidents
- The extent to which the victim recognises the risk of the abuse and violence on the (unborn) child
- Any incidents of hostility or aggression towards professionals by the perpetrator
- The effect of the abuse or violence on the pregnancy

#### 4.5 Learning Disabilities

Parents with a high level of and/or significant learning disabilities can face many difficulties and will need a high level of support from the professional network. It is important that learning disabilities are identified as soon as possible in the pregnancy in order to ensure an advocate is in place to support parents during the pregnancy and after birth.

Merton Learning Disability staffs that become aware that a service user is pregnant should encourage the expectant mother to engage with midwifery services and should contact the named midwife and GP to share information about the service user.

Midwives who believe that an expectant mother may have a learning disability or learning need that may impact on capacity to parent, should check health records and contact Disability services within Adult Social Care, to check if they are known to the service and make contact with the key worker. If the expectant mother is not known to the Learning Disability Service, but it is thought they could be eligible for a service, the midwife should make a referral to the Learning Disability Service for an assessment.

Where there are significant concerns about parenting capacity, a referral must be made to the MASH, An early pre-birth assessment should take place with the Learning Disability key worker liaising with the Children's Social worker in order to assess the expectant mother's parenting capacity and to plan what support will be needed once the baby is born. The expectant mother's advocate should be involved in this assessment.

#### 4.6 Young Mothers Under 19

Some young mothers may have difficulties in meeting their child's needs due to their own vulnerabilities. Young mothers under the age of 19 should only be referred for a pre-birth assessment if the professional believes them to be vulnerable.

See attached link for further information

[https://www2.merton.gov.uk/48\\_13\\_teen\\_pregnancy\\_pathwaya3\\_withcrop.pdf](https://www2.merton.gov.uk/48_13_teen_pregnancy_pathwaya3_withcrop.pdf)

Where a young mother is already known to Children's Social Care as a child in need, the Team Manager will decide whether or not to carry out a pre-birth assessment (**See section on Looked After Children in 5**) A pre-birth assessment should always be completed where the young mother is looked after by Merton. Consideration will also be

given to completing a pre-birth assessment where the expectant mother is a Merton care leaver and there are concerns about the parenting capacity.

Pregnancy and birth are also likely to have an effect on a young person's education and training opportunities and this will need to be taken into account within the pre-birth assessment.

Midwives, GPs and health visitors can refer pregnant young mothers under 19 or women under 24 (with added vulnerabilities) to the Merton Family Nurse Partnership for support up to 28 weeks gestation.

#### **Factors to Consider**

- Where a young mother lives in an unstable family home that is unlikely to be able to offer support
- May have become pregnant as a result of child sexual exploitation
- Is under the age of 13 (these cases **must** be referred to the police and to the MASH as it is an offence to have sex with a child under the age of 13)
- Is concealing the pregnancy from her family and/or is concerned about their parent's reaction to the pregnancy
- Has specific issues that make her more vulnerable, for example mental health difficulties/Learning Difficulties.

## **5 Looked After Children**

**5.1** A pre-birth assessment should always be completed where the young person is a looked after child by Merton. However, 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.

If the Section 47 threshold is met and a Strategy Meeting convened, a manager from the Safeguarding & Child Protection or 14+ LAC & Permanency Service (depending on where LAC is allocated) should be included. The service where the LAC is allocated should provide a full written history and chronology of the young person either at the Strategy Meeting, or within 14 days following it. The meeting should consider the Care Plan for the young person and any additional resources needed to support the young person throughout the pregnancy. **N.B.** If a young person is looked after by another Local Authority and living in Merton, 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 borough, the service where the case is allocated must refer case of the unborn to the relevant Local Authority, and also inform the Health Services in the area where the young person is placed. The London Child Protection Procedures clearly state that '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. The Quality Assurance Service can also be consulted in terms of agreeing Child Protection Conference arrangements in such cases.

## **6. Pre-Birth Referral**

**6.1** Where any agency or individual considers that a prospective parent may need support services to care for their baby, or that the baby may be at risk of significant harm, they must refer to the Multi-Agency Safeguarding Hub (MASH) as soon as concerns are identified. Referrals that are not child protection can be referred to the Early Years Service using the Early Years Referral form, via the link

**[www2.merton.gov.uk/early\\_years\\_referral\\_form\\_march\\_2017.docx](http://www2.merton.gov.uk/early_years_referral_form_march_2017.docx)**

Please also send details to the CLCH Merton Health Visiting Service. Women will be offered antenatal contact with the Health Visiting Service. The Health Visiting Service can be contacted at: [clcht.hcpadminmerton@nhs.net](mailto:clcht.hcpadminmerton@nhs.net)

**6.2** A referral made to the MASH will be screened within 24 hours to assess whether it meets the threshold for a pre-birth assessment. Referrals not meeting the threshold for assessment will be stepped-down appropriately to the Early Years, Health Visiting or any other identified community based Services for support and intervention.

Further guidance on pre-birth referrals and assessments is provided in the London Child Protection Procedures.

[London Child Protection Procedures, Core Procedures, Part A, section 2.6.](http://www.londoncp.co.uk/chapters/referral_assess.html)  
[http://www.londoncp.co.uk/chapters/referral\\_assess.html](http://www.londoncp.co.uk/chapters/referral_assess.html)

### **Lifestyle and behaviour risk factors**

- High levels of substance misuse
- Chronic and disabling mental health problems
- Significant levels of domestic abuse and family violence
- Homelessness and chaotic lifestyles
- Parental learning difficulties
- A parent has a previous history of neglect or abuse
- One parent is thought to be a risk to children
- A concealed pregnancy or failure to engage with ante-natal services
- The mother has undergone female genital mutilation and is expecting a female child.

**See Section 3.2 above for other indicators**

### **Other Vulnerabilities Factors**

- Chaotic lifestyle and frequent moves
- poor housing or homelessness
- A care leaver from another borough
- A concealed pregnancy or non-engagement with ante-natal services (see section 8)

-pregnancy occurring following rape  
-Where the mother has experienced FGM.

Following referral, there should always be consideration as to whether a strategy meeting is required and whether threshold for a Section 47 enquiry should be initiated.

## 7. Early Help Responses

There are a range of Early Help Series available that can support with both practical support and financial advice including housing. Please visit the information, advice and guidance pages of the Family Service Directory ([www.merton.gov.uk/fsd](http://www.merton.gov.uk/fsd)) for further information, using the search facility with key words ie maternity, pregnancy, housing etc. .

The Early Years service has a single referral form (see section 6.1 above) and the range of services available can be found on the children's centres services timetable, here:

[www2.merton.gov.uk/childrenscentres](http://www2.merton.gov.uk/childrenscentres)

The referral form is also available to download on this page.

## 8. Pre-Birth Assessment

**8.1** A pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, preferably before 24weeks of the pregnancy. This should focus on:

- Strengths and concerns about both parents and extended family members;
- Family history of both parents, fathers of any previous children and the extended family;
- Previous proceedings and any previous expert reports/assessments including parenting assessments;
- Concerns around parental mental health, substance misuse or learning disabilities including previous involvement with these services;
- Parents' attitude to the new baby and preparedness for its birth;
- Building a good relationship with the family, particularly the expectant mother, through a strengths-based approach to gain understanding of family systems and dynamics;
- Support requirements for the expectant mother and partner and how these will be met and;
- Engagement from the wider family, potentially through Family Group Conferencing, and identification of help needed to safely parent the child.

**8.2** The pre-birth assessment must be completed within 35 working days of the referral. All agencies working with the expectant mother and family are expected to contribute information to assess immediate and future risk and parenting capacity.

**8.3** It is crucial to involve the midwives and Health Visitors in pre-birth assessment. There should be at least one joint visit made with the relevant Health visitor/midwife during the course of the assessment, and other joint visits with relevant agencies as appropriate.

**8.4** Professionals who are working with vulnerable expectant mothers and Social Workers who are completing pre-birth assessments should refer to the Pre-birth Assessment Tool in Appendix 2 of this protocol, and use this as a guide to inform their risk and pre-birth assessment.

## **9. Child in Need Route**

**9.1** If the pre-birth Single assessment indicates that the unborn child is likely to be a Child in Need (CIN) once born, the assessing social worker will convene a CIN Review within a maximum of 2 weeks of completing the pre-birth assessment. The meeting should be attended by all professionals working with the family to draw up a plan for the child, which will be reviewed on a 6-weekly basis.

## **10. Child Protection Route**

### **Strategy Meetings**

**10.1** If it is evident at the point of referral or during the course of the completion of a pre-birth Single assessment that there are reasonable grounds to believe that the unborn child may be likely to suffer significant harm, a multi-agency Strategy Meeting must be held within 72 hours. This is particularly urgent where the referral has been received after 24 weeks gestation, or where there has been an attempt by the mother to conceal the pregnancy (**See Section 11 on Late Booking, Concealed Pregnancy and Non-engagement**).

The Strategy meeting will:

- Decide whether the threshold has been met for a child protection enquiry and what action should be taken;
- Decide what needs to be covered in the pre-birth assessment;
- Identify involvement and roles of agencies and professionals;
- Decide on how parents will be informed of concerns;
- Agree any actions from adult services in relation to parents;
- Consider the circulation of London-wide Hospital alerts where there is a risk of a mother absconding. Copies of such alerts to be sent to the Safeguarding midwife at the Hospital the mother is registered, and also to the Quality Assurance Unit for nationwide circulation.
- Agree any actions from the midwife and/or obstetrician immediately after the birth (these should be incorporated into the birth plan and all staff notified of concerns) and;
- Decide on the circumstances at birth under which Children's Social Care will seek an Emergency Protection Order from the court.

**10.2** These meetings must be held at the hospital in which the expectant mother has been booked in line with the London Child Protection Procedures. All strategy meetings or discussions must involve health partners including GPs to obtain their views on the threshold for s47 as well as any relevant information to inform the risk assessment. If adult substance misuse or mental health services or domestic abuse services have knowledge or information, they must also be invited. In cases where previous children have been removed

by a local authority and continue to be Looked After, the allocated LAC social worker must be invited to the Strategy Meeting to provide relevant background information and history.

Strategy Meetings should not be delayed purely in order to trigger a Child Protection Conference at a later stage.

### 10.3 Pre-birth Child Protection Case Conference

If the child protection enquiry establishes that the unborn child has suffered and continues or is likely to suffer significant harm, a pre-birth child protection conference will be convened by the social worker to be held within 15 working days of the strategy meeting.

Pre-birth conferences have the same status as an initial child protection conference and needs to be held as soon as possible after the pre-birth Single assessment has been completed, and **at least 10 weeks before the expected 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 or there is a very high level of concern, the conference should be held earlier. It is worth noting that drug using pregnant women are more likely to give birth prematurely, therefore early conferencing in such cases is vital.

### 10.4 A pre-birth conference will always be held where:

- A pre-birth assessment shows that the unborn child is suffering or likely to suffer significant harm;
- A previous child of the parent has died or has been removed from their care as a result of significant harm;
- A child is born into a family where children in the household are already subject to a child protection plan and;
- An adult or child who poses a risk to children lives in the household or is a regular visitor.
- The impact of parental risk factors such as mental ill-health, learning or physical disabilities, Substance misuse and domestic violence, raises concerns that the unborn child may be at risk of significant harm.
- There are concerns regarding a young vulnerable mother and her ability to care for herself and/or care for her baby.

### 10.5 The following agencies should always be invited to the child protection conference

- General Practitioner
- Health Visitor or Named Nurse for Community Services
- Ante-Natal Clinic Midwives
- Community Midwives
- Named Midwife for Safeguarding
- Community Child Health
- Family Nurse Partnership (parents under 24)
- School Nurse where there are school-age siblings
- Police Child Abuse Investigation Team
- Any other lead professionals or services working with the parents of the Unborn

An invitation to the following agencies should be considered:

- Neo-Natal Special Care (for babies whose parents are substance users or where a baby is likely to need additional neo-natal care)
- Delivery Unit at the hospital where the expectant mother is booked
- Drug and Alcohol Services
- Adult Mental Health Services
- Adult Social Services
- Probation
- Domestic Abuse Services

**10.6** If the unborn child needs to be the subject of a child protection plan, the main cause for concern must determine the category of registration and it must be outlined to commence prior to the birth of the baby. A review conference should be held one month from the date of birth or 3 months from the date of the first conference, whichever is sooner, then every 6 months until the child protection plan is discharged, when the child then becomes CIN.

**10.7** In the event of an expectant mother going missing during a s47 investigation or when a pre-birth child protection plan has been drawn up, the allocated social worker should discuss making a missing persons report. If the expectant mother is under 18, a missing persons report must be undertaken. In these circumstances an alert to other local authorities and hospitals must be made.

## **11. Late Bookings, Concealed Pregnancy and Non-Engagement**

**11.1** For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 24 weeks of pregnancy.

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

<b>Indicators of Risk and Vulnerability</b>
<ul style="list-style-type: none"><li>- Previous concealed pregnancy</li><li>- Previous children removed from the mother's care</li><li>- Fear that the baby will be taken away</li><li>- History of substance misuse</li><li>- Mental health difficulties</li><li>- Learning disability</li><li>- Domestic violence and abuse and interpersonal relationship problems</li><li>- Previous childhood experiences/poor parenting/sexual abuse</li><li>- Poor relationships with health professionals/not registering with a GP</li></ul>



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

For further guidance, professionals may refer to the relevant section in the London Child Protection Procedures on **“Managing Work with Families Where There Are Obstacles and Resistance”**

## **12. Public Law Outline**

**12.1** In cases where it has been agreed at Legal Planning Meeting that work should be undertaken under the Public Law Outline framework, there should be as little delay as possible in sending out Notice of intent Letters, and holding Pre-Proceedings meetings in order to avoid approaches to the expectant mother in the late stages of pregnancy, and to work with the family to explore all options in order to avoid initiating Care Proceedings.

**12.2** In cases where there is recommendation to initiate Care Proceedings at birth, cases should be booked into the weekly Legal Planning Meetings at the earliest possible date prior to the birth. The pre-birth Single assessment, full chronology and genogram must be available at the Legal Planning Meeting and there should have been a referral for a Family Group Conference.

In the case of late referrals meeting the threshold for legal planning, the Head of Service can be requested to convene an emergency Legal Planning Meeting rather than waiting until the weekly Legal Planning Meeting. (Note: LPM's are held in the Safeguarding & Child Protection Service on Wednesday mornings and in First Response on Thursday mornings).

**12.3** In cases where Children's Social Care has a high level of concern about the safety and welfare of a new-born child if removed from the hospital by their parents, an application may be made to the court for an Emergency Protection Order to direct that the child is not to be removed from the hospital.

## **13. Birth Planning Meeting**

**13.1** If the decision of the Legal Planning Meeting is that the unborn baby should be the subject of Care Proceedings, a Birth Planning Meeting must take place at the hospital. This is a professionals meeting which should be chaired by a Hospital Safeguarding Lead for Maternity Services. If the Safeguarding Lead Manager is unable to chair this meeting the line manager for the allocated social worker must undertake this task.

This meeting must take place at the most 7 working days after the legal planning decision. The decisions of this meeting should be recorded on the patient's records by the lead midwife who will ensure that the midwives are fully apprised of the plan for the child.

The purpose of the meeting is 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.

**13.2** The agenda for this meeting should address the following:

- How long the baby will stay in hospital (taking into consideration monitoring period for withdrawal symptoms for babies born to substance using mothers);
- How long the hospital will keep the mother on the ward;
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the baby e.g. parental substance misuse; mental Health; domestic violence and abuse. Consideration should be given to the use of hospital security; informing the Police etc.
- 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;
- Consideration of any risks to the baby in relation to breastfeeding e.g. 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, e.g. discharge to parent/extended family members; mother and baby foster placement; foster care, supported accommodation;
- 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 Birth Planning Meeting;
- 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 Children's Emergency Duty Service should also be notified of the birth and plans for the baby.

## **14. Discharge from Hospital**

**14.1** The hospital midwives need to inform the allocated social worker of the birth of the baby and there should be close communication between all agencies around the time of labour and birth.

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 allocated 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 record a brief note of their visit on the child's medical notes, which should include the time, key points of the discussion, agreements and social work contact details.

The Lead 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.

**14.2** If the baby is the subject of a Child Protection Plan, a Core Group Discharge Meeting should be held to draw up a detailed plan prior to the baby's discharge home if this is not possible; the 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 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

Where a new-born child known to Children's Social Care is to be discharged from hospital, the allocated social worker will convene a discharge from hospital meeting to ensure that it is safe for the child to leave the hospital and that plans are in place to support the family.

## **15. Allocation and Case Transfer**

**15.1** The MASH will be responsible for the initial screening of all pre-birth cases, and thereafter a decision about allocation will be made within 24 hours of receipt of the referral.

15.2 Cases where siblings of unborn children are already open to other services or in care proceedings, will continue to be allocated within those services with the exception of the Permanency Service. In cases where the court proceedings have concluded, the pre-birth assessment will be referred to the First Response Team.

In order for work to be done with the family during the pregnancy, appropriate cases should transfer to the Safeguarding Children & Child Protection Services as soon as the Single Assessment has been completed. This is in order to avert the delay of intervention and further assessments of the parents taking place. **N.B** The transfer process should not necessarily be delayed until an Initial Child Protection Conference can be convened.

### **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 **Adults at Risk** and be anxious about the prospective parents losing trust in them.

It is important to undertake the assessment during early pregnancy 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.

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 liaison mental health worker 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 long term 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.

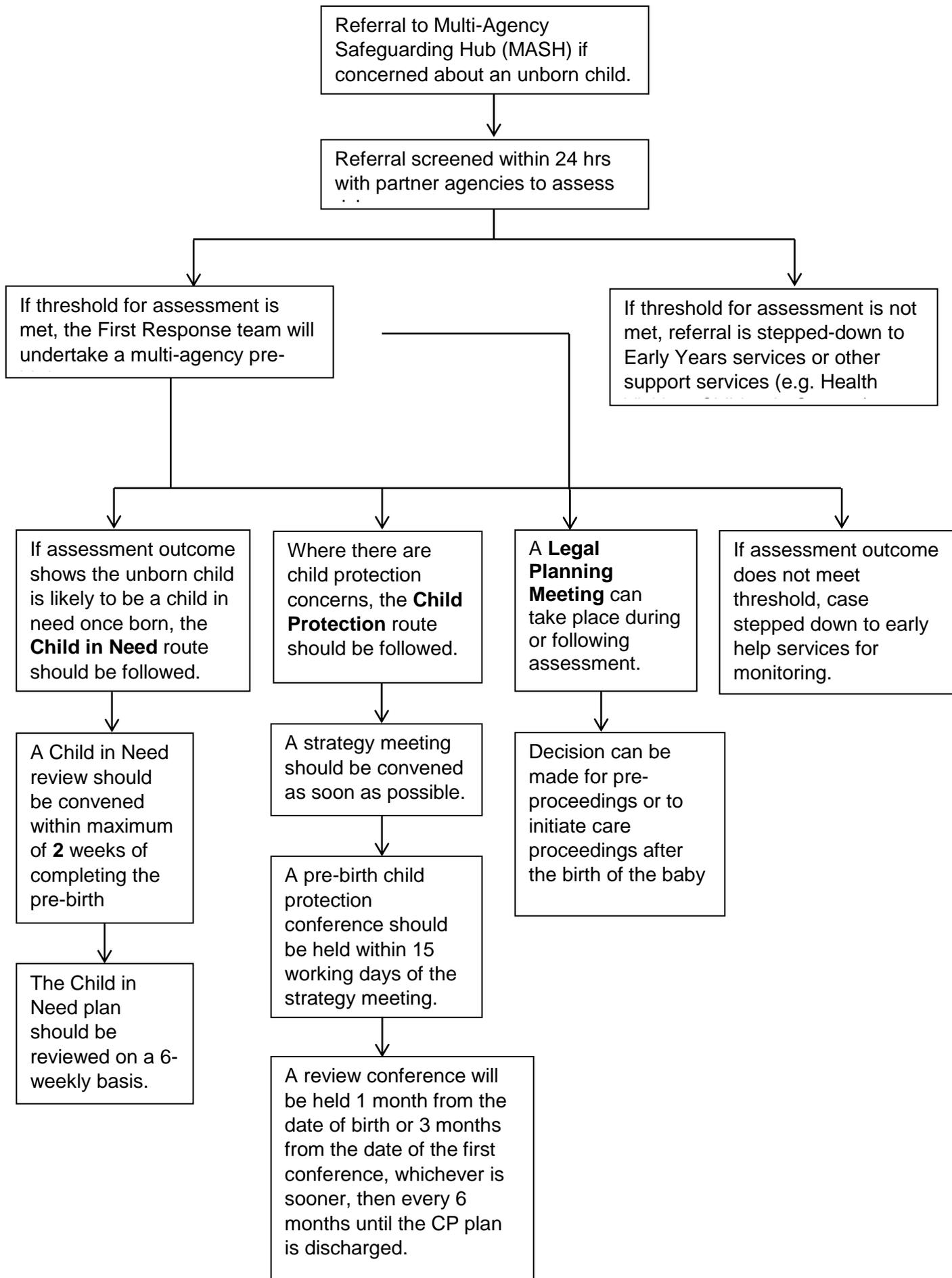
It is crucial to seek information about fathers/partners whilst conducting assessments and involve them in the process. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

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

Family Group Conferences 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 Referral Flowchart



## **Appendix 2 – 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 Adults at Risk and be anxious about the prospective parents losing trust in them.

It is important to undertake the assessment during early pregnancy 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.

Social Workers undertaking the assessments should ensure access to appropriate resources, liaison with key professionals and also request to undertake joint assessment visits with key professionals where appropriate. 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 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 long term 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 newborn 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 families is also crucial to the assessment process and achieving positive outcomes for unborn children. Consideration should always be given to convening Family Group Conferences in any cases where there is a possibility that the mother may be unable to meet the needs of the unborn child.

Family Group Conferences 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 in **Appendix 3** of 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 newborn child needs to be spelled out explicitly.

## **Appendix 3 – Pre-Birth Assessment Tool**

### **Introduction**

This assessment tool is designed to help professionals to carefully consider a range of themes and to identify the issues that will potentially have a significant negative impact on the child. It has been adapted from the work of Martin C Calder as described in “Unborn Children: A Framework for Assessment and Intervention”.

Social worker analysis must substantiate why the assessment is being undertaken and provide a clear picture of the individual unborn child’s needs. The assessment should state clearly what work needs to be done to support the family to make the necessary changes within the Signs of Safety (SoS) framework, e.g. what are you worried about, what is working well and what needs to happen.

This list is not exhaustive and there may be particular issues for individual cases that require social workers and other practitioners to gather and review information around additional concerns.

### **1. Family Structure / Background**

*Is there anything regarding family structure / background that seem likely to have a significant negative impact on the child? If so, what?*

**1.1** Names, addresses, ages and relationships with extended family members. If possible, this should include a genogram.

### **2. Parenting Capacity**

*Is there anything regarding parenting capacity that seems likely to have a significant negative impact on the child? If so, what?*

**2.1 Health:** General physical health of prospective parents including existing health conditions, relevant family health history and ability to recognise own health care needs.

**2.2 Relationships / Social History:**

- Experiences of being parented (positive/negative memories, main carer, parental relationships)
- Experiences as a child/adolescent (violence, abuse, neglect, care/control issues)
- Current relationship status with father of unborn child

- Who will be the main carer for the baby?
- What expectations do the parents have of each other with regard to parenting?

### **2.3 Abilities:**

- Physical
- Emotional (including self-control)
- Intellectual
- Knowledge and understanding about children and child care
- Knowledge and understanding of concerns and the reason for assessment

### **2.4 Behaviour:**

- Violence to partner, others or to any child
- Drug or alcohol misuse
- Criminal convictions
- Chaotic (or inappropriate) lifestyle

### **2.5 Communication:**

- English not spoken or understood
- Presence of learning difficulty
- Deafness / blindness / speech impairment

### **2.6 Circumstances:**

- Education
- Unemployment/employment
- Finances including benefits or debts
- Inadequate housing / homelessness
- Criminality / court orders
- Social isolation

### **2.7 Home conditions:**

- Chaotic (including frequency of people coming and going)
- Children regularly left in the care of friends/acquaintances
- Health risks / insanitary / dangerous
- Over-crowded

### **2.8 Dependency on partner:**

- Choice between partner and child
- Role of child in parent's relationship
- Level and appropriateness of dependency

### **2.9 Support:**

- From extended family or friends
- From professionals
- From other sources
- Nature of support available including detail around timescale, ability to enable change and effectiveness in addressing immediate concerns

### **2.10 Care of Previous Children: (including children of both parents/carers)**

- Child-minding or involvement in caring for younger siblings
- Childcare course / school curriculum childcare content
- Present care arrangements where previous children have been removed
- Events during intervening period since previous removal of children

- Current health status of other children

#### **2.11 Planning for the Future:**

- Preparation for parenthood, e.g. environment, equipment or birth plan
- Realistic / appropriate or unrealistic / inappropriate expectations

### **3. Pregnancy Background**

*Is there anything regarding pregnancy background that seems likely to have a negative impact on the child? If so, what?*

#### **3.1 Parents' Feelings:**

- Is the pregnancy wanted or not?
- Is the pregnancy planned or unplanned?
- Is this child the result of sexual assault?
- Is domestic abuse an issue in the parents' relationship?
- Is the perception of the unborn baby different/abnormal? Are they trying to replace any previous children?
- Have they sought appropriate antenatal care?
- Are they aware of the unborn baby's needs and able to prioritise them?
- Do they have realistic plans in relation to the birth and care of the baby?

#### **3.2 Family Perceptions:**

- Perceptions of significant others about pregnancy and how these have been handled or responded to
- Expectations of adult family members and how these have been handled or responded to
- Cultural narrative around early pregnancy (teenage motherhood)
- Parents' understanding of their own cultural/family narrative around childbirth

#### **3.3 Obstetric and Medical Information:**

- Obstetric history including previous pregnancies, outcomes or complications
- Booking history including date of booking, concealed pregnancy/reason for concealment, expected date of delivery and hospital/home care
- Attendance and engagement with ante natal care / midwifery / Health Visiting services
- Medicines or drugs – whether prescribed or not – taken before or during pregnancy
- Dietary intake and any related issues
- Alcohol consumption / smoking
- Chronic or acute medical conditions or surgical history
- Psychiatric history – especially depression and self-harming

*This information should be provided by midwifery or an appropriate health professional.*

### **4. Previous or Current Professional Involvement**

*Is there anything regarding previous or current professional involvement that seems likely to have a negative impact on the child? If so, what?*

#### **4.1 History of Responsibility for Children:**

- Convictions for offences against children
- CP concerns and previous assessments
- CP Registration / subject to a CP plan
- Court findings
- Care proceedings and/or children removed

**It is important to ascertain the parent(s) views and attitudes towards any previous children removed from their care, or where there have been serious concerns around safeguarding or parenting practice. Relevant questions may include:**

- Do the parent(s) understand and acknowledge the seriousness of the abuse?
- Do the parent(s) give a clear explanation and accept responsibility for their role in the abuse?
- Do they blame others or the child?
- What was their response to previous interventions and did they accept any treatment/counselling?
- What is different now for each parent since the child was abused and/or removed?

**Relevant questions in cases where previous sexual abuse has been the issue include:**

- What were the circumstances of the abuse e.g. was the perpetrator in the household?
- Was the non-abusing parent present?
- What relationship/contact does the mother have with the perpetrator?
- How did the abuse come to light, e.g. disclosure by non-abusing parent, child or professional suspicion?
- Did the non-abusing parent believe the child and did they need help / support for this?
- What are the current attitudes towards the abuse and do the parents blame the child?
- Has the perpetrator demonstrated acceptance of responsibility and what treatment did they undertake?
- How did the parent(s) relate to professionals? What is their current attitude?
- Who else in the family / community network could help protect the new baby?

**Additional factors to consider in cases where a child has been removed from a parent's care because of sexual abuse include:**

- What is the ability of the perpetrator to accept responsibility for the abuse (this should not be seen as lessening the risk for additional children)?
- What is the ability of the non-abusing parent to protect?

## **5. Specific Issues of Concern**

*Is there anything regarding specific issues of concern that seems likely to have a negative impact on the child? If so, what?*

### **5.1 Mental Health:**

- Clarification and description of illness, e.g. depression, schizophrenia, personality disorder, psychosis
- Non-compliance with medication without medical supervision
- Potential risks with regard to parenting capacity, including increased risk of abuse by psychotic parents when incorporated into delusional thinking
- Additional concerns from parents' mental health difficulties
- Evidence of difficulties in forming emotional attachments with previous children

- Co-morbidity (with drug / alcohol abuse, domestic abuse, learning difficulties)

*This information should be provided by the adult mental health team or appropriate professional.*

#### **5.2 Domestic Violence:**

- Nature of any violent/abuse incidents and frequency / severity
- Triggers for violent incidents
- Known to local DV services?

#### **5.3 Drugs / Alcohol:**

- Acknowledgement and details of the substance / alcohol abuse including extent of involvement in local drug culture
- Duration and pattern of usage/addiction, e.g. experimental, recreational, chaotic, dependent
- Health implications and risks
- Engagement with Drug and Alcohol services and nature of any detox
- Presenting behaviour, e.g. passive, aggressive, resistant to support
- Aspects of drug use posing a risk to children, e.g. conflict with or between dealers, exposure to criminal activity
- Presence of a drug-free parent, supportive partner or relative

*This information should be provided by adult drug and alcohol services or an appropriate professional.*

#### **5.4 Learning Disability:**

- Consideration of the parent's intellectual functioning and subsequent ability to learn to respond to the needs of their child
- Psychological factors impacting on parenting ability, e.g. loss, mental illness, emotional issues resulting from trauma
- Some mothers with learning difficulties may not recognise they are pregnant – this should be considered if there are suspicions of concealing or having concealed a pregnancy
- Living skills assessment may be required – any joint planning and assessment should take place from the beginning

*This information should be provided by the adult learning difficulties team or appropriate professional.*

## Appendix 4 - Framework for Risk Estimation

This has been 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'*.

<b>The Abusing Parent</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Negative childhood experiences, include abuse in childhood, denial of past abuse</li> <li>- Violence abuse of others</li> <li>- Abuse and/or neglect of previous child</li> <li>- Parental separation from previous children</li> <li>- No clear explanation</li> <li>- No full understanding of abuse situation</li> <li>- No acceptance of responsibility for the abuse</li> <li>- Antenatal/post natal neglect</li> <li>- Age: very young/immature</li> <li>- Mental disorders or illness</li> <li>- Learning difficulties</li> <li>- Non-compliance</li> <li>- Lack of interest or concern for the child</li> </ul>	<ul style="list-style-type: none"> <li>- Positive childhood</li> <li>- Recognition and change in previous violent pattern</li> <li>- Acknowledges seriousness and responsibility without deflection of blame onto others</li> <li>- Full understanding and clear explanation of the circumstances in which the abuse occurred</li> <li>- Maturity</li> <li>- Willingness and demonstrated capacity and ability for change</li> <li>- Presence of another safe non-abusing parent</li> <li>- Compliance with professionals</li> <li>- Abuse of previous child accepted and addressed in treatment (past/present)</li> <li>- Expresses concern and interest about the effects of the abuse on the child</li> </ul>
<b>Non-Abusing Parent</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- No acceptance of responsibility for the abuse by their partner</li> <li>- Blaming others or the child</li> </ul>	<ul style="list-style-type: none"> <li>- Accepts the risk posed by their partner and expresses a willingness to protect</li> <li>- Accepts the seriousness of the risk and the consequences of failing to protect</li> <li>- Willingness to resolve problems and concerns</li> </ul>
<b>Family issues (marital partnership and the wider family)</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Relationship disharmony/instability</li> <li>- Poor impulse control</li> <li>- Mental health problems</li> <li>- Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks)</li> <li>- Lack of support for primary carer /unsupportive of each other</li> <li>- Not working together</li> <li>- No commitment to equality in parenting</li> <li>- Isolated environment</li> <li>- Ostracised by the community</li> <li>- No relative or friends available</li> <li>- Family violence (e.g. Spouse)</li> </ul>	<ul style="list-style-type: none"> <li>- Supportive spouse/partner</li> <li>- Supportive of each other</li> <li>- Stable, or violent</li> <li>- Protective and supportive extended family</li> <li>- Optimistic outlook by family and friends</li> <li>- Equality in relationship</li> <li>- Commitment to equality in parenting</li> </ul>

<ul style="list-style-type: none"> <li>- Frequent relationship breakdown/multiple relationships</li> <li>- Drug or alcohol abuse</li> </ul>	
<b>Expected child</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Special or expected needs</li> <li>- Perceived as different</li> <li>- Stressful gender issues</li> </ul>	<ul style="list-style-type: none"> <li>- Easy baby</li> <li>- Acceptance of difference</li> </ul>

<b>Parent-baby relationships</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Unrealistic expectations</li> <li>- Concerning perception of baby's needs</li> <li>- Inability to prioritise baby's needs above own</li> <li>- Foetal abuse or neglect, including alcohol or drug abuse</li> <li>- No ante-natal care</li> <li>- Concealed pregnancy</li> <li>- Unwanted pregnancy identified disability (non-acceptance)</li> <li>- Unattached to foetus</li> <li>- Gender issues which cause stress</li> <li>- Differences between parents towards unborn child</li> <li>- Rigid views of parenting</li> </ul>	<ul style="list-style-type: none"> <li>- Realistic expectations</li> <li>- Perception of unborn child normal</li> <li>- Appropriate preparation</li> <li>- Understanding or awareness of baby's needs</li> <li>- Unborn baby's needs prioritised</li> <li>- Co-operation with antenatal care</li> <li>- Sought early medical care</li> <li>- Appropriate and regular ante-natal care</li> <li>- Accepted/planned pregnancy</li> <li>- Attachment to unborn foetus</li> <li>- Treatment of addiction</li> <li>- Acceptance of difference-gender/disability</li> <li>- Parents agree about parenting</li> </ul>
<b>Social</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Poverty</li> <li>- Inadequate housing</li> <li>- No support network</li> <li>- Delinquent area</li> </ul>	
<b>Future plans</b>	
<b>Elevated Risk</b>	<b>Lowered Risk</b>
<ul style="list-style-type: none"> <li>- Unrealistic plans</li> <li>- No plans</li> <li>- Exhibit inappropriate parenting plans</li> <li>- Uncertainty or resistance to change</li> <li>- No recognition of changes needed in lifestyle</li> <li>- No recognition of a problem or a need to change</li> <li>- Refuse to co-operate</li> <li>- Disinterested and resistant</li> <li>- Only one parent co-operating</li> </ul>	<ul style="list-style-type: none"> <li>- Realistic plans</li> <li>- Exhibit appropriate parenting expectations and plans</li> <li>- Appropriate expectation of change</li> <li>- Willingness and ability to work in partnership</li> <li>- Willingness to resolve problems and concerns</li> <li>- Parents co-operating equally</li> </ul>

## **Appendix – Useful Contacts**

### **Children’s Social Care**

MASH

020 8545 422 or 020 8545 4227  
Email: [mash@merton.gov.uk](mailto:mash@merton.gov.uk)

Children Emergency Duty Team  
Early Years Service  
Child Protection co-ordinator

020 8770 5000

### **Midwifery Services**

St Georges Hospital

Philippa Camps – Named Midwife for  
Safeguarding  
Tel:  
email: [philippa.camps@stgeorges.nhs.uk](mailto:philippa.camps@stgeorges.nhs.uk)

St Helier Hospital

Carolyn Payne: Named Midwife for  
Safeguarding  
Tel: (07717320144/ 07812249023)  
email: [carolyn.payne@nhs.net](mailto:carolyn.payne@nhs.net)

Kingston Hospital:

### **Health Visiting**

[clcht.hcadminmerton@nhs.net](mailto:clcht.hcadminmerton@nhs.net)  
Tel: 0330 053 9264  
Monday – Friday 9-5pm

**Merton Family Nurse Partnership:**

**020 8102 5362**  
[clcht.fnpmerton@nhs.net](mailto:clcht.fnpmerton@nhs.net)

### **Mental Health Services**

**Contact Centre**

**020 3513 9063**

**Email: [merton@addaction.org.uk](mailto:merton@addaction.org.uk)**

**Substance Misuse Services**

Westminster Drug Project (WDP)  
7-8 Langdale Parade  
Merton  
CR4 2YS  
[Elizabeth.Campbell@wdp.org.uk](mailto:Elizabeth.Campbell@wdp.org.uk)

Elizabeth Campbell – Operations  
Manager  
Tel: M: 07918 738 906  
Email:

**Domestic Abuse & Violence Services**

Victim Support  
IDVA  
MARAC

**Adults Learning Disabilities Team**