**Pre-Birth Assessments**

These should be read in conjunction with the Pre-Birth Procedure and Concealed Pregnancies Procedure located in the [NSCP Procedures Manual](http://northamptonshirescb.proceduresonline.com/)

**Guidance for Professionals undertaking Pre-Birth Assessments**

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1. **Introduction**

A Pre-Birth Assessment is a pro-active means of analysing the potential risk to a new born baby when there are concerns about a pregnant woman / her partner and immediate family.

The main purpose of a Pre-Birth Assessment is to identify what the risks to the new born child may be; whether the parent(s) are capable of change in order that the risks could be reduced and if so, what support they would need to make these changes.

Pre-Birth Assessments are a source of anxiety for parents who may fear that a decision could be made to remove their child at birth, but also for professionals who may feel that they are not giving parents the opportunity to show that they are able to care for their child.

The justification for statutory intervention in a family's life is to safeguard and promote the welfare of children. In cases where the child is unborn, the assessment must attempt to predict whether that child will be safe. This is especially relevant, as research studies have shown that children are most at risk of fatal or severe assaults in their first year of life – which is usually inflicted by their carers.

No single professional has a full picture of a child’s needs and circumstances and, if children and families are to receive the right help, at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action.

This guidance aims to clarify what is meant by Pre-Birth Assessments, their purpose and surrounding circumstances and should be read in conjunction with [NSCP Child Protection Procedures](http://northamptonshirescb.proceduresonline.com/index.html).

1. **Pre-Birth Assessments**

A Pre-Birth Early Help Assessment and a Pre-Birth Assessment are both assessments of the risk to the future safety of an unborn child, undertaken with a view to make informed decisions about the child and family's future.

These assessments create ethical dilemmas for the practitioners undertaking them. The bond between a parent and child is special and practitioners may be reluctant to intervene, feeling that parents must be "given a chance". Hart (2009) describes how social workers can feel ‘cruel’ when considering removal of a child at birth; however, the Children Act (1989) is clear that there are grounds for intervention if there is a *likelihood of significant harm* and that the needs of the child (in these situations, the unborn) are paramount.

Some parents will be aware of possible problems regarding their care of their child and may seek help from various agencies while others may be referred because of concerns identified by others. In the latter case, parents are unlikely to welcome the proposed assessment. In these circumstances, it is likely that the needs of the child would not be met without targeted interventions.

Early Help Assessment and Pre-Birth Assessment is required in the circumstances outlined in these procedures (Section 4). The list is not exhaustive and there are likely to be other circumstances, which may be potentially damaging to a new born baby that require Pre-Birth Assessment.

1. **The Timing of the Assessment**

Please refer to Pre-Birth Assessment and Intervention Timeline (Appendix 1).

Where it is thought that an unborn child and his/her parents would benefit from coordinated support from more than one agency (e.g. education, health, housing, police), there should be an inter-agency assessment (referred as Early Help Assessment), starting at 6 weeks of pregnancy or at the time of mother’s booking appointment with the midwife. Early Help Assessment should identify what help the child and family requires in order to prevent identified needs escalating to a point where intervention is needed via statutory assessment under the Children Act (1989). An Early Help plan should be implemented if assessed to be necessary.

The Early Help Assessment should be undertaken by a lead professional who provides support to the child and family, acts as an advocate on their behalf and co-ordinates the delivery of support services. The lead professional role could be undertaken by a Midwife, a Children’s Centre worker, a teacher, a Health Visitor and/or Special Educational Needs Co-ordinator (SENCo). Decisions about who should be the lead professional will be taken on a case-by-case basis and should be informed by the child’s needs and their family’s capacity to meet these.

Upon a referral being made to Children’s Social Care, if a decision is made that risks to the unborn baby meet the threshold for a Single Assessment to be undertaken, there will be a Social Worker allocated to the unborn child to lead the assessment. This assessment, once identified, should start by 14 weeks gestation. At this stage the midwife may also refer to the Family Nurse Partnership for under 18’s expecting their first child and who are less than 24 weeks gestation.

A [Single Assessment](http://northamptonshirescb.proceduresonline.com/p_assessment.html) must be completed within a maximum of 40 days of the referral. The timescale for the Pre-Birth Assessment may have to be reduced - depending on the timing of the referral and whether there is a risk of premature birth. The aim is always to conclude the Pre-Birth Assessment prior to delivery of baby.

If the decision is made to proceed with a Pre-Birth Assessment for the unborn baby, then the name ("Unborn" mother's surname) and the estimated due date of delivery should be entered on all electronic records. The baby's record should be linked with parents’ records. When baby is born, the Midwife should inform the Social Worker, who should update CareFirst records.

Undertaking the Pre-Birth Assessment during early pregnancy (between 12 to 22 weeks) provides parents with the opportunity to show evidence of change. If the outcome of the Pre-Birth Assessment suggests that baby would not be safe with parents, then practitioners are provided with the time and opportunity to make clear and structured plans for baby’s future and set up support for the parents where necessary.

For pregnancies that meet the criteria for CAFCASS plus (unborn babies where the mother or father have had previous children removed via public or private law proceedings) - eligible unborn babies need to be presented to Stage 1 panel by week 21/22 of the pregnancy. A comprehensively completed Single / Pre-Birth Assessment is the paperwork required; there is no need to complete a SWET. Consent from birth mother and ideally birth father needs to be sought by the Social Worker for a referral to Cafcass plus to progress by week 22-24.

The unborn baby’s father and mother’s current partner (if different) should always be established and fully included in the Pre-Birth Assessment.

If, during the completion of the Pre-Birth Assessment, it is identified that specific services are needed to support the pregnant mother (and her partner) in preparation for baby’s birth, this needs to be co-ordinated using a Multi-agency Planning Meeting (CiN Meeting). All agencies involved in the assessment must meet to coordinate a plan of intervention which is based on information arising from the Pre-Birth Assessment to date. A Hospital Discharge Planning Meeting (see Appendix 3) should be convened in order that all agencies are aware of the defined need for coordinated family support when baby is born.

If the assessment indicates that baby is likely to be at risk of suffering significant harm, then a Strategy Meeting should be held and Section 47 Enquires undertaken, with consideration given to convening a pre-birth Child Protection Conference. A pre-birth Child Protection Conference must be convened to be held at least 10 weeks prior to the expected birth - or earlier if the baby is likely to be premature (it should always occur by 28 weeks gestation).

The Pre-Birth Child Protection Conference and any subsequent reviews will proceed as with all other Conferences. A Review Child Protection Conference will be held no later than 4 weeks before the full term expected date of delivery (and may need to be earlier if there is a significant probability of early delivery) of baby’s birth or within 3 months with the approval of the responsible Social Care Team Manager. If there are other children in the family who are already subject of Child Protection Plans, the 1st Review Child Protection Conference for the unborn baby may have to be held independent of siblings’ Conference, but each subsequent Review Child Protection Conference should combine baby with his/her siblings.

The Core Group will meet prior to the birth of baby and before baby is discharged from hospital. The membership of the Core Group should include, as a minimum, parent/s, Social Worker, Midwife, Health Visitor and should be chaired by a Social Work line manager. The Core Group record should highlight the following:

* Outcome of Pre-Birth Assessment (inc. Step-Down to EH; CiN; CP; recommendation for PLO / immediate issue)
* Pre / post birth plans - including Child Protection Plan
* Hospital Discharge Planning Meeting (see appendix 3)
* Managing non co-operation
* Any plans for court proceeding and potential removal at birth, including role of Police (S.46 and EDT)

Detailed written plans need to address:

* Who should hospital contact when mother is admitted / in labour / baby delivered?
* What happens if baby is born out of hours?
* What is the plan in relation to support and advise a mum who may wish to breast feed?
* What are the arrangements for initiating legal proceedings?

What level of contact / care [supervised or not] can the parents have and who will assume responsibility for supervising care/contact?

* Are parents aware of the plan & what is their attitude?
* Possible need for further assessment (e.g. residential mother and baby unit / PAMS)
* Assessment of parental capacity
* Outline of intensive support required for mother and baby to live in the community and any other specialist assessments
* Possible Connected Persons care/shared care options (IVA etc.)
1. **Guidance on the Content of the Pre-Birth Assessment**

The three domains of the “Framework for the Assessment of Children in Need” apply to Pre-Birth Assessments. A Pre-Birth Assessment may focus much more on known aspects of parenting capacity and wider environmental factors, than child’s needs, but the child’s needs in utero and immediately after birth should be fully considered. In developing this Pre-Birth Assessment tool, reference has been made to Martin Calder’s 'Unborn Children: A Framework for Assessment and Intervention' of R. Corner's 'Pre-birth Risk Assessment: Developing a Model of Practice’?

Assessment is not an exact science and is even less so in cases when the baby has not yet been born, but a Pre-Birth Assessment can be made to be as sound as possible if it includes the following elements:

* What research tells us about risk factors?
* What practice experience tells us about how parents may respond in particular circumstances?
* The practitioners' professional knowledge of this particular family.

The Pre-Birth Risk Assessment tool (Appendix 2) provides a list of risk factors to review when considering needs of an unborn baby; whilst this identifies factors to consider, it is indicative only and may not cover all circumstances needed for an individual, comprehensive Pre-Birth Assessment – which has to be unique to that baby’s circumstances.

The content of a thorough Pre-Birth Assessment will be formed by looking at relationships between parents/carers, between parents/carers and the child (whether born or unborn), including review of previous history and how this shapes current experiences and the context within which the family is living. This is consistent with the Framework for Assessment of Children in Need and their Families.

The first vital step when planning a Pre-Birth Assessment is to review all previous history. This will entail reading the previous case files of this Local Authority and any other authority where the family have lived, including the social care history contained in the full legal bundle for any children who may have been removed from either of the parents’ care and also to ensure that searches are completed for birth parents / any new partners in the household AND any children that those partners may have parented.

It is essential to construct a multi-agency chronology of key events from the previous history, as repeated Child Safeguarding Practice Review / Serious Case Reviews illustrate failure to draw information together, to analyse it and identify patterns that would, when seen together, change the perspective of the case. Each partner agency should provide their own chronology of events, which will then contribute to the overall assessment. The knowledge gained from chronology will help direct the focus of the assessment.

* 1. **Previous History**

Practitioners must build a clear history from parents about their previous experiences in order to ascertain whether there are unresolved conflicts and also to identify the meaning of their own childhoods and any previous children had for them.

It is particularly important to ascertain the parent(s) views and attitudes towards previous children who have been removed from their care, or where there have been identified serious concerns about their parenting practices. Relevant questions include:

* Do the parent(s) understand and give a clear explanation of the circumstances in which the identified abuse occurred?
* Do they accept responsibility for their role in the abuse?
* Do they blame others?
* Do they blame the child?
* Do they acknowledge the seriousness of the abuse?
* Did they accept any treatment/counselling?
* What was their response to previous / current interventions?
* What has changed for each parent since the child was abused/removed?

This list is not exhaustive. There will be particular issues in individual cases that require the Social Workers / other practitioners to gather information about past histories and review past risk factors.

It is important to ascertain parents’ thoughts and feelings towards the current pregnancy and the new baby, including:

* 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 ante-natal 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 their care of the baby?

In cases where a previous child has been removed from a parent's care because of harm, there are additional factors which need to be considered. These include:

* The ability of the perpetrator to accept responsibility for historic abuse (this should not be seen to equate to lessening of risk for subsequent children)
* The ability of the non-abusing parent to protect any subsequent child

The fact that the child has been removed from the care of a parent(s) suggests that there have been significant problems in these areas and the Pre-Birth Assessment will need to focus on what has changed in the lives of the identified parents and any positive changes that the prospective parent(s) have made – including the current ability to protect a vulnerable new born baby.

Relevant questions when undertaking a Pre-Birth Assessment when previous sexual abuse has been identified as an issue include:

* The circumstances of the abuse: e.g. was the perpetrator in the household? Was the non-abusing parent present?
* What relationship/contact does the non-abusing parent maintain with the perpetrator?
* How did the abuse come to light? e.g. did the non-abusing parent disclose or conceal? Did the child tell? Did professionals suspect?
* Did the non-abusing parent believe the child? Did they need help and support to do this?
* What are current attitudes towards the abuse? Do the parents blame the child/see it as her/his fault?
* Has the perpetrator accepted full responsibility for the abuse? How is this demonstrated? What treatment did he/she have?
* Who else in the family/community network could help protect the new baby?
* How did the parent(s) relate to professionals? What is their current attitude?

In circumstances where the perpetrator is a prospective parent and is still living in the household, where there is no acknowledgement of responsibility, where the non-abusing parent blames the child and there is no prospect of effective intervention within appropriate time-scales, then confidence in the safety of the new born baby and subsequent child has to be poor.

Circumstances where the perpetrator has been convicted of posing a risk to children and is living in a family with other children, (following social work assessment), should not detract from the need for a Pre-Birth Assessment. It is important to maintain the focus on both prospective parents and any other adult living in the household and not to concentrate solely on the role of the mother.

* 1. **Mental Health Issues (see also NSCP Procedure** [**Children of Parents with Mental Health Problems**](http://northamptonshirescb.proceduresonline.com/p_ch_par_mental_health.html)**)**

The majority of parents who experience mental illness do not neglect or harm their children simply as a consequence of the disorder they are suffering. Children become more vulnerable to abuse and neglect when parental mental illness co-exists with other problems - such as substance misuse, domestic abuse or childhood abuse (Cleaver et al., 2007). Non-compliance with medication without medical supervision is also a cause for concern. [See NSCB Serious Case Review Child M published in July 2016](http://www.northamptonshirescb.org.uk/about-northamptonshire-safeguarding-children-board/scr/childm-serious-case-review/)

It is essential to continue the Pre-Birth Assessment based on the behaviour of the parent(s), not the diagnosis and the potential risk of that behaviour to the new born child. In addition, where there are mental health risk factors identified, on-going revaluation of risk will be essential.

* 1. **Substance Misuse (see also NSCP Procedure** [**Children of Parents who Misuse Substances**](http://northamptonshirescb.proceduresonline.com/p_ch_par_misuse_subs.html)**)**

There is little dispute that excessive parental drinking or drug misuse negatively effects the unborn child. “The foetus is most susceptible to structural damage during 4-12 weeks of gestation; drugs taken later in gestation generally affect growth or cause neonatal addiction” (Julien, 1995). Two further complicating factors in assessing the impact of maternal substance misuse on the unborn child are the combination of substances taken and the pattern of alcohol or drug misuse. For example, women who use heroin may also use tobacco, cannabis, stimulants and tranquilisers. (Cleaver et al., 2012)

Drug or alcohol misuse is not in itself a contra-indication that the parent(s) will be unable to care safely for the baby, but practitioners will need to analyse:

* The pattern of drug use and alcohol misuse
* Whether it can be managed compatibly with the demands of a new born child
* Whether the parent(s) are willing to attend for treatment
* Whether the parents(s) are willing to undertake independent testing for Substance misuse, and
* The consequences for the baby of the mother's substance misuse during pregnancy e.g. withdrawal symptoms, and for the parenting of any other children in the household.
	1. **Parents with Learning Difficulties (see also NSCP Procedure** [**Children of Parents with Learning Difficulties**](http://northamptonshirescb.proceduresonline.com/p_ch_par_learning_diff.html)**)**

It is important to understand what is meant by a learning disability and learning difficulty. This can be found in the NSCP procedure Children and Parents with Learning Difficulties. Learning disabilities and learning difficulties can affect parents in their decision making and preparation for the birth of their child. Many parents with learning disabilities / difficulties are poorly informed about contraception and the significance of changes in their menstrual pattern and, as a result, may find it hard to take realistic and informed decisions about family planning and may also fail to recognise pregnancy in its early stages (James, 2004). When women with learning disabilities / difficulties attend ante-natal care they may experience difficulty in understanding the information and advice they receive or have problems in putting it into practice. At this point it is important for all practitioners ensure appropriate access to advocacy services and easy read documents are made available.

Although a child may have inherited learning disabilities, the environment can still make a difference: children brought up in a warm and stimulating environment will have better outcomes than those who are not. Lack of stimulation that is, at times, seen in families when there is learning disability cannot be attributable solely to parents’ intellectual impairment. Parents with learning disabilities frequently experience a combination of stressors that impact on their parenting, including having a large number of children, domestic abuse, poor mental health, childhood abuse, lack of social supports and poverty (Clever and Nicholson, 2007).

* 1. **Domestic Abuse (see also NSCP Procedure** [**Domestic Violence and Abuse**](http://northamptonshirescb.proceduresonline.com/p_dom_viol_abuse.html)**)**

Where there are concerns that domestic abuse is a risk factor for an unborn baby all professionals should use [NSCP Domestic Violence and Abuse procedure](http://northamptonshirescb.proceduresonline.com/p_dom_viol_abuse.html); this contributes to assessments and analyses of risks, as well as promoting professional curiosity - which is needed in such cases. This procedure contains all of the information professionals need when assessing Domestic Violence and Abuse including details on controlling behaviour and coercive behaviour.

Domestic abuse can have a negative impact on the unborn child in three ways: through inherited traits, physical damage to the foetus and the effects of maternal stress (Cleaver et al., 2011). Domestic abuse poses a danger to the foetus. The Confidential Maternal and Child Health Enquiry in England and Wales indicates that 30% of domestic abuse began during pregnancy (Humphreys and Houghton, 2008). Women abused during pregnancy are more at risk of moderate to severe violence and homicide, including assaults such as beatings, choking, attacks with weapons and sexual assault (Humphreys, 2006).

Maternal and paternal current and/or previous histories of violence should be carefully collected from both the police and parents, this will need to be sensitively evaluated. Detail should be obtained to consider:

* The nature of violent incidents
* Their frequency and severity
* Information on what triggers violent incidents
* Information on previous history of stays in Refuges.
* Any work undertaken by either / both parents to address the behaviours (and the assessed impact of this)

* 1. **Family and Environmental Factors**

Caring for a new baby is difficult enough for any parent but it can be particularly stressful if the parent(s) are isolated and do not have an active network of positive support. It is important to identify whether parents are going to share responsibility for caring for the baby or whether it will fall to one parent disproportionately. It is important to identify support networks that the parent(s) have identified, their financial and housing position. There are clear guidelines in this matter within the Framework for Assessment of Children in Need and their Families (2000).

In order to carry out a detailed assessment of the home conditions a baby will be living in professionals should use the Graded Care Profile contained under Appendix 2 of the NSCP Neglect Toolkit. This allows for professionals to assess in detail the individual areas of parenting and identify any areas they feel parents could improve on before the birth of their child. Always ensure a Dog Assessment is completed if it is known the family have a dog/s in the property.

* 1. **Analysis**

Once information has been collated, it must be carefully analysed. In order to demonstrate sound analytical thinking the assessment needs to address five critical questions – the ‘anchor principles’ of any assessment:

* What is the assessment for?
* What is the story?
* What does the story mean?
* What needs to happen?
* How will we know we are making progress? (Taken from Brown, L. & Turney, D. (2014))

This should be a shared process and needs to include other agencies who are involved, particularly midwives and obstetricians.

If the assessment identifies that there is identified significant risk of harm to a new born baby, then key judgements will be:

* Is there evidence of the parent(s') capacities to change? (details of how to assess parental capacity to change can be found in [Appendix 1 of the NSCP Neglect Toolkit](http://www.northamptonshirescb.org.uk/assets/legacy/getasset?id=fAAyADMANAB8AHwAVAByAHUAZQB8AHwAMAB8AA2))
* Will provision of support and services be sufficient to enable the parent(s) to care safely for their baby?
* Are the parent(s) able to change in time for baby's birth?
* Do parents have appropriate support networks?

If the Pre-Birth Assessment indicates that the new born baby is likely to suffer significant harm, a Strategy Discussion needs to be held and consideration given to calling an Initial Child Protection Conference. It is also possible that early advice should be sought from Children’s Social Care’s Legal Team.

If identified risk to the unborn baby is such that removal at birth is under consideration, there should be a clear plan outlining key responsibilities and all parties must be aware of the arrangements prior to the child's birth. All members of the Core Group need to be involved in formulation of this plan. This will include clear guidelines on actions to be taken by hospital staff should the parents decide to try to remove the new born baby from the hospital.

**Appendix 1**

**Pre-Birth Assessment and Intervention Timeline**

 6-12 weeks Booking Appointment with the Community Midwifery service. Where appropriate and in accordance with Northamptonshire’s Thresholds & Pathways, Midwife / other agency to undertake Early Help Assessment and, if necessary, convene Team Around the Family meeting (TAF) in order to implement Family Action Plan.

12-14 weeks If the criteria is met, in line with Thresholds & Pathways, Multi Agency Referral Form sent to MASH. If following Multi Agency checks it is deemed appropriate, a Single Assessment begins. Assessment to be completed within 15 days (maximum).

If the unborn baby has siblings who are already open to Children’s Social Care, the allocated social worker should refer the unborn to MASH as soon as viable (approximately 12-14 weeks) and a Pre-Birth Assessment will commence.

 16 weeks Referrals to specialist health services or specialist midwifery (if available) completed if mental health issues or substance misuse are identified. If required, a referral should be made to learning disability services or an advocacy service completed. If open to Children’s Social Care, a multi-agency meeting (CiN) will take place.

For pregnancies that meet the criteria , the SA / PBA will be completed and presented to Stage 1 Panel in week 21 / 22 for cases open to CAFCASS Plus and week 21-24 for all other cases.

 22-24 weeks Review TAF meeting takes place if Early Help services are being delivered. Decision whether Early Help offer remains appropriate or whether escalation is needed.

 If referral is received after 22 weeks then a strategy meeting will be held and S47 considered, if there are concerns that the unborn child is at risk of significant harm.

Or

Pre-Birth Assessment is finalised.

If Pre-Birth Assessment has identified that baby is likely to suffer significant harm Children’s Social Care initiates a Strategy Meeting to include consideration of whether an Initial Child Protection Conference is needed (within 15 days).

 24-28 weeks ICPC to take place by 28th weeks gestation.

Children’s Social Care to ensure that child is discussed at the Legal Planning Meeting - if legal proceedings are considered to be needed (not CAFCASS Plus).

 30-36 weeks Child Protection Plan implemented, to include Hospital Birth Plan (see appendix 3).

 36-40 weeks Baby born (term)

**Appendix 2**

**Pre-Birth Risk Assessment Tool**

The model for this Pre-Birth Assessment is designed to be completed *instead of* the Single Assessment part 2, with a note on CareFirst Single Assessment part 2 that a standalone Pre-Birth Assessment is completed – refer to CareStore.

Pre-Birth Assessments are always emotionally demanding. When an unborn baby is placed on a Child Protection Plan, it is implicit that the demands placed on the baby’s parents will be greater than for other parents and the stakes are usually very high. The implications can be even more serious, in that the parent / child relationship could be significantly disrupted over a lengthy period of time, or even ended at birth; this will mean that professionals need to take great care to maintain objectivity and focus on the baby, whilst dealing sensitively with the birth parents. Objective and clearly evidenced risk assessment is critical in such assessments.

Pre-Birth Assessments are complex and time-limited pieces of work and need to involve a variety of different professionals – Midwives, GPs, Health Visitors and Nurses in maternity units all have significant parts to play, as do professionals who provide specialist services to adults – drug team workers, psychiatrists, Probation Officers etc. Effective strategy discussions, clear and rapid risk assessment, detailed protection plans and well managed Core Group / multi-agency meetings are crucially important.

As the lead professional, in a Child Protection context is the Social Worker, the assessment tool is designed with this in mind; it can, however, be used as a whole, or in part, by any other professional who wishes to do so.

|  |  |
| --- | --- |
| Worker’s Name | Date |
| Team | Manager’s Name |

|  |  |  |  |
| --- | --- | --- | --- |
| Family Name | Gender & Name (if known) | CF Reference ID | Estimated Date of Delivery |
|  |  |  |  |
|  |  |  |  |

*Insert basic Genogram: -*

*This Pre-Birth Risk Assessment should be conducted alongside the NSCB Pre-Birth Procedure and Concealed Pregnancy Procedure found in the* [*NSCB Procedures Manual*](http://northamptonshirescb.proceduresonline.com/index.html)*.*

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*UK Law does not legislate for the rights of an unborn baby. In some circumstances, agencies or individuals are able to anticipate the likelihood of Significant Harm with regard to an expected baby.*

*Although it is recognised that, in the ante-natal period, a number of professionals have responsibility to promote the welfare of the mother and unborn baby, the welfare of the unborn baby has to be considered to be paramount.*

*Identified concerns should be addressed as early as possible in order to maximise time for:*

* Full assessment, including identification and building upon positive factors
* Establishing the whereabouts of previous children
* Enabling a healthy pregnancy
* Supporting parents so that (where possible) they can provide safe care

***Part 1: Identification of Risk / Protective Factors***

Risks include current / present dangers and those any identified impending dangers to an unborn child.

**Current / Present Risk:** Immediate, significant and observable severe harm or threat of severe harm occurring at the present time.

**Impending Risk:** Danger and risk may not exist at this present moment or be an immediate area of concern, but a state of danger exists and may be predicted to be likely to occur in the future / is evidenced to have occurred in the past.

**Vulnerability:** Factors which increase the potential risk of harm to an unborn child can include: -

**Unborn Baby:**

* Unwanted / concealed pregnancy;
* Awareness of baby’s needs;
* Awareness of unborn baby’s health;
* Parental expectations of new born baby;
* Parenting plans;
* Premature birth.

**Parenting Capacity:**

* Childhood experiences: -
	+ Positive childhood;
	+ Multiple carers, including LAC/Leaving Care
* Recognition of effects of own behaviour on others;
* Drug/alcohol misuse;
* Abuse/neglect of previous child;
* Age – very young parent/immature;
* Mental disorders or illness.

**Family/Household/Environmental:**

* Domestic abuse and / or honour based violence;
* Violent or deviant network;
* Poor impulse control;
* Unsupportive of each other;
* Frequent moves or house/homelessness;
* No commitment or limited to planning or preparation to parenting;
* Perceptions;
* Ability to prioritise baby’s needs;
* Antenatal care;
* Planning;
* Special/extra needs;
* Previous child death;
* Multiple pregnancy;
* Learning difficulties;
* Physical disabilities/ill health;
* Inability to work with professionals;
* Cultural issues;
* Positive mental health;
* Child previously removed from their car / contact restricted;
* Relationship disharmony/instability;
* Multiple relationships;
* Not working together;
* Lack of community support;
* Poor engagement with professional services.

**NB – this is not a definitive list of potential triggers / risks; there will be other factors that are not included (above) which practitioners need to consider. Each Pre-Birth Assessment must be conducted on an individual basis and in a child-centred manner.**

**Directions:** Identify and indicate the presence or absence of risk based on information recorded in files, direct knowledge / observations and knowledge / observations of other professionals involved with the family. The completion of this document should be overseen by a qualified social worker.

A ‘Yes’ indicates that there is a risk or protective factor present and it can be described and observed. It is fact and not suspicion / professional opinion and can only be indicated as present when the information is credible, reasonable and believable (evidential).

A ‘No’ indicates that there is no identified risk present or observed or that the information was not deemed to be credible, reasonable or believable to indicate a risk to an unborn child.

This framework was 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** | **Present?** | **Lowered Risk** | **Present?** |
| Abusing Parent  | * Negative Childhood experiences, inc. abuse in childhood; denial of past abuse
* Violent abuse of others
* Abuse/Neglect of a previous child
* Parental separation from previous children
* No clear understanding
* No full understanding of the abuse situation
* 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 / concern for the baby
 |  | * Positive childhood
* Recognition and change in previous violent pattern
* Acknowledges seriousness & responsibility without deflection of blame onto others
* Full understanding & clear explanation of the circumstances in which the abuse occurred
* Maturity
* Willingness & demonstrated capacity & ability for change
* Presence of another safe non-abusing parent
* Compliance with professionals
* Abuse of previous child accepted / addressed in treatment (past / present)
* Expresses concern about the effects of the abuse on the child
 |  |
| Non-abusing parent | * No acceptance of responsibility for the abuse by their partner
* Blaming others or the child
 |  | * Accepts the risks posed by their partner & expresses a willingness to protect
* Accepts the seriousness of the risk & the consequences of failing to protect
* Willingness to resolves problems & concerns
 |  |
| Family issues (marital partnership & the wider family | * Relationship disharmony / instability
* Poor impulse control
* Mental health problems
* Violent or deviant network involving kin, friends & associates (including drugs, paedophile or criminal networks)
* Lack of support for the primary carer / unsupportive of each other
* Not working together
* No commitment of equality in parenting
* Isolated environment
* Ostracised by the community
* Family violence (e.g. spouse)
* Frequent relationship breakdowns / multiple relationships
* Drug or alcohol abuse
 |  | * Supportive spouse / partner
* Supportive of each other
* Stable, non-violent
* Protective & supportive extended family
* Optimistic outlook by family & friends
* Equality in relationship
* Commitment to equality in parenting
 |  |
| 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 their own
* Foetal abuse or neglect, including alcohol or drug use
* 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
* Perception of unborn child normal
* Appropriate preparation
* Understanding or awareness of baby’s needs
* Unborn baby’s needs prioritised
* Cooperation with antenatal care
* Sought early medical care
* Appropriate & regular ante-natal care
* Accepted / planned pregnancy
* Attachment to unborn foetus
* Treatment of addiction
* Acceptance of difference – gender / disability
* Parents agree about parenting
 |  |
| Social | * Poverty
* Inadequate housing
* No / limited support network
* Delinquent area
 |  |  |  |
| Future Plans | * Unrealistic future plans
* No plans
* Exhibit inappropriate parenting plans
* Uncertainty or resistance to change
* No recognition of changes needed in lifestyle
* No recognition of a problem or need to change
* Refusal to cooperate
* Disinterested & resistant
* Only one parent cooperating
 |  | * Realistic plans
* Exhibit appropriate parenting expectations & plans
* Appropriate expectation of change
* Willingness & ability to work in partnership
* Willingness to resolve problems & concerns
* Parents cooperating equally
 |  |

***Part 2: Overall Risk Assessment***

Based on your analysis of RISK and the presence (or absence) of protective capabilities identified in Part 1, please indicate whether the unborn child is safe, conditionally safe or at risk of significant harm.

* **The unborn child is safe.** There are no risks placing the unborn child in present or impending danger. Risks do not exist or have been removed; no safety planning is required.
* **The unborn child is conditionally safe**. One or more risks are placing the unborn child in present or impending danger, however, one or more protective capabilities have been identified that mitigate these risks. Some safety planning may be required, as the family, is able to support or address the risks to the unborn child.
* **The unborn child is at risk of significant harm.** One or more risks are placing the unborn child in present or impending danger and there are insufficient protective capabilities to mitigate these risks.

|  |
| --- |
| **Summary of information informing the overall Risk Assessment outcome:** |
| What are the main risks / concerns where caregiver(s) do not have identified protective capabilities required to safeguard the unborn child? (*Detail the evidence of past harm, indicators of potential future harm and any complicating family factors [housing, poverty, Mental Health concerns, social isolation, etc.])* *
*
*
*
*

What risks / concerns (if any) are unknown and / or require further exploration? *
*
*
*
*

Are there any other protective capabilities within the family unit / strengths of the caregiver(s) that mitigate the risks to the unborn child? (*Details should include any other areas of strength in the family which are not covered in the list above.)* *
*
*
*
*

What partner agencies are involved, what is their role and assessment of the risk & protective capabilities? *
*
*
 |

**Recommendation:**

What pathway should the case take through Children’s Social Care?

Does it require step-down / de-escalation to EHA?

Implementation of a Child Protection Plan?

Consideration of Legal, CAFCASS + or Looked After Children Procedures?

|  |
| --- |
| **ANSWER:** |

**PART 3 - Safety Planning:**

Where the unborn child is ‘conditionally safe’ or at ‘risk of significant harm’, please consider what may need to be put in place, alongside the identified protective capabilities of any caregiver to reduce these risks. Examples of this may include:

* Direct work / intervention by Social Worker / Family Support Worker
* Use of extended family / informal support network (please consider need for FGC)
* Signposting to community agency
* Child Protection Procedures (FGC required)
* Discharge Planning meeting following birth
* Legal intervention planned (FGC required)

|  |
| --- |
| **ANSWER:** |
| What needs to change to ensure the unborn child’s safety (*what is the ‘bottom line’ / non-negotiable) and when will progress be reviewed?*Recommendations / Safety Plan (*What actions must be implemented to provide support or immediate protection to the unborn child? Further to this, what actions are required to achieve long-term change?)* |

Worker’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth & Discharge Plan**

**To be completed by the Midwife at the Strategy Meeting**

|  |
| --- |
| **Unborn Child Estimated Due Date** |
|  |
| **Mothers Name and DOB** |
|  |
| **Mothers Address** |
|  |
| **Fathers Name and DOB** |
|  |
| **Fathers Address** |
|  |
| **Social Worker to be contacted Name and Tel Number** |
|  |
| **Team Manager Name and Tel Number** |
|  |
| **Out of Hours Contact Details** |
|  |
| **Is the baby subject to a Child Protection Plan? (delete as appropriate)** |
| Yes No |
| If yes, under which category? |

When the baby is born the parents will need the following support or observation: - please delete as appropriate and supply additional information:

|  |
| --- |
| **Little or no extra support and can be placed on the Post Natal ward**  |
| **To be observed and supported caring for the baby and should be placed on the Transitional Care Unit/Mother and baby unit**  |
| **To be separated at birth and baby placed on the Neo - Natal Unit - to include Police contact details, details of contact with mother and who will be supervising this,, family members who cannot have contact**  |
| **Staff safety issues in hospital and on return home**  |

Signed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Copies to:**

Medical Notes - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Social Worker - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Emergency Duty Team - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Midwife - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

Liaison Midwife - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date)

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