Newham CYPS: Pre-Birth Assessment, Practice Guidance for SW's.

Subject	**Pre-Birth Assessment**	**Issue Date**	**September 2020**
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Target Group.	Social workers and Family Support Workers undertaking Pre-birth Work ***Please read this in conjunction with the NSCP protocols***		

ASSESSMENT GUIDANCE: For Social Workers.

Within this guidance you will find the following:

SECTION ONE - WHY DO A PRE-BIRTH ASSESSMENT?

1.Introduction:

1.0 The findings from Serious Case Reviews, now known as Child Safeguarding Practice Reviews, SPR's (WT, 2018) highlight the importance of professionals working together to maintain their focus on the needs and experiences of very young children. If parents are particularly vulnerable this can sometimes overshadow the needs of very young children, resulting in harm.

1.1 Additionally recent research from the Nuffield Family Justice Observatory covering England and Wales in 2018, 2019 has identified a growing number of children removed from their mothers and placed in care in the first week of life. These reports cite concerns regarding the quality of practice with birth families and significant regional variations in outcomes for children whose parents require additional support to parent their child safely (Bilson & Bywaters 2020).

1.2 Key to supporting children and their families is planned and purposeful assessment that focuses and effectively coordinates a multi-agency approach, leading to clear evidence informed assessment, plans and interventions to support, wherever possible children to remain in the care of their family.

1.3. Purpose of the Practice Guide

1.4 The purpose of this guide is to provide guidance on the steps to take and areas to assess when considering any case where there are potential safeguarding concerns or support needs to unborn babies or where recognised that potential risks will be present after birth. There are a number of different circumstances, in which a Social Worker, would consider the need for a pre-birth assessment. When an assessment or risk of harm to a new-born baby is required, it is important for this to be undertaken at the earliest opportunity and where possible prior to 20 weeks gestation, a strategy meeting must be held where:

- Where previous children in the family have been removed because they have suffered harm.

- Where a Person Posing Risk To Children (or someone found by an Initial Child Protection Conference or a Court to have abused) has joined a family. (Note. A PPRTC previously known as a Schedule One Offender

is someone who has been convicted of an offence against a child. It is retained on their record for life.)

- Where concerns exist regarding the parent's ability to protect.

- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities.

- Where alcohol or substance abuse is thought to be affecting the health of the expected baby, and parent's ability to respond to their child's needs and is one concern amongst others.

- Where there are concerns about domestic violence

- Where the expected parent is very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required.

- Where there a parent or a person living or visiting the home who is a person posing risk to children.

- Where a child under the age of 13 has become pregnant.

- Where the expected parent is a Child in Care or Care Leaver, active consideration to a pre-birth assessment must be given, to ensure all support needs and/or risk factors are identified. The decision not to refer for a pre-birth assessment must be recorded as a Management Decision on Case notes. **Note that this applies to both expectant mothers and fathers of the child.**

1.5 The Purpose of a Pre-Birth Assessment

1.6 The main purpose of a Pre-birth assessment is to identify:

● The needs and risks to the newborn baby;
● Parental capacity in relation to the needs and risks;
● Whether the parent(s) has appropriate capacity to recognise these and is willing and able to engage and work with professionals so that the identified risks, are addressed to safeguard the unborn baby.
● What support the parent(s) may need;
    - What support is available in the wider family and community, a genogram and ecomap would be beneficial as part of the assessment.

- Plans to ensure the needs are met and risks are addressed.

1.7 The Principles of a Pre- Birth Assessment:

1.8 A Pre-birth assessment should be undertaken on all Pre-birth referrals as early as possible, preferably before 20 weeks, and when appropriate, a strategy meeting / discussion held, where:

• if a previous child/young person has died unexpectedly in the care of the parents and the cause of death is a result of anything other than 'natural causes'

• if a previous child has been removed via Care Proceedings due to abuse or neglect or other Risk of Significant Harm or if they have a current child who is the subject of Care Proceedings or within a PLO process

• if the parents have a child living with them who is currently the subject of a Child Protection Plan

• if there is a current Sec 47 investigation on the unborn that is likely to lead to an Initial Child Protection Conference or Child In Need Plan

• if for any reason (in addition to the above) it is possible that the mother and newborn will need to be separated at birth and Children's Services will be part of the planning (not including a parent's request for adoption)

• **Should be considered** if the parents have a child under 8 who was the subject of a CPP within the previous 18 months.

1.9 Peri-Natal Mental Health.

1.10 The mental health of mothers is manifest for approximately 70% of babies who are removed from their parents care in infancy. Accessing mental health support for expectant mothers, at the earliest opportunity can result in greater awareness of support needs, more appropriate interventions and positive outcomes for mothers and their babies. Where there are concerns regarding adult mental health during pregnancy there should be effective joint working between CYPS and appropriate services.

1.11 It is recognised that the following list of risk factors can be associated with perinatal mental health:

- previous history of mental illness
- family history of mental illness
- Psychological Disturbance during pregnancy e.g. depression/anxiety

- single parent/poor couple relationship
- low levels of social support
- recent adverse or stressful life events
- socio-economic disadvantage
- teenage parenthood
- early emotional trauma/childhood abuse
- unwanted/unplanned pregnancy
- substance misuse
- domestic abuse

1.12 Contact details for the maternity safeguarding team are as follows:

Jasvir Jutle
Named Midwife for Children's Safeguarding and Acorn Team Manager
02073638516
j.jutle@nhs.net

Charlotte Fuller
Specialist Midwife For Safeguarding Children
0207 363 8516 Ex 6216
charlotte.fuller8@nhs.net

SECTION TWO - Pre Birth 'Good Practice Steps' to consider.

2.0 When carrying out assessments with families who have a baby or very young child:

- Ensure the assessment is child-focused and prioritises the needs of the child
- Make an objective, evidence based assessment of parenting capacity and capacity to change.
- If parents are already receiving support, check whether parents are engaging with the service and changing their behaviour.
- Include an assessment of the parents lived experience and background and understand the impact of this upon the baby they are caring for.
- Consider all adults who are part of the baby's life
- Assess how the baby interacts with their parents
- Have a multi-agency approach
- Consider whether safeguarding action is appropriate
- Look for and maximise opportunities for early intervention.

2.1 In a High Court judgment (Nottingham City Council v LW & Ors [2016] EWHC 11(Fam) (19 February 2016)) Keehan J set out five points of basic and fundamental good practice steps with respect to public law proceedings regarding pre-birth and newly born children and particularly where Children's Services are aware at a relatively early stage of the pregnancy. In respect of Assessment, these were:

1. A risk assessment of the parent(s) should 'commence immediately upon the social workers being made aware of the mother's pregnancy';

To conclude Practice Leads and Service Managers will need to evidence that they have made a risk assessment and reflect this in their decision making about the start of the assessment upon the confirmation of the pregnancy. There should be sufficient information in the MASH Research to inform this initial risk assessment. Where there is not sufficient information to make an initial assessment of risk or where the risk is regarded to be high, the assessment and relevant pre-birth planning processes that follow, need to begin upon notification of the pregnancy.

2.See London Child Protection Procedures 2.6.6 and 2.6.3;

On the timescales built into our current pre-birth process the single assessment should at the very latest be completed by 20 weeks gestation. There may however be other components of the assessment process that are triggered as part of any Child Protection and PLO process.

Where the local authority is considering proceedings shortly after birth, the timing of the sending of the pre-proceedings letter or letter of issue should take account of the risk of early birth and help to ensure that discussions and assessments are not rushed. Ideally the letter should be sent at or before 24 weeks." (p 19).

Any additional assessments requested as part of the PLO process must be concluded 4 weeks prior to the birth of the baby (i.e. cognitive). Practice Leads need to allow sufficient time in the planning of the assessments to have these completed prior to 36 weeks gestation.

3. The Assessment should be updated to take into account relevant events pre - and post delivery where these events could affect an initial conclusion in respect of risk and care planning of the child;

A pre-birth conference is an initial child protection conference concerning an unborn child. Such a conference has the same status and must be conducted in a comparable manner to an initial child protection conference. The conference should be held as soon as the assessment has been completed and taking into consideration the requirement in the Statutory Guidance[1] that any letter before proceedings be issued prior to 24 weeks gestation.

Assessment is a continual process and a birth plan outlining how risk is to be managed pre/post birth should be completed for the first core group following a pre-birth ICPC in preparation for the birth and shared with health and police colleagues. Chronologies must be kept up to date and accessible on file.

4. The Assessment should be disclosed upon initial completion to the parents.

- Good practice indicates that it is better to start the assessment earlier, rather than later, particularly when a high level of need is evident at the outset for e.g; previous children have been removed from the care of a parent; parent has a learning disability; has a history of giving birth early.

-Request archive files, arrange to view files in different LA and start compiling a chronology (if appropriate).

-Inform parent of the referral, seek consent for welfare checks and arrange a visit for as soon as possible following allocation. Inform professional network of SW involvement.

-Refer to Group Supervision at the earliest opportunity and prior to supervision complete Case Map regarding the level of concern and areas of focus for the pre-birth assessment. Think where your gaps in knowledge are, obtain previous case files from archives, undertake chronology as early as possible and organise an FGC at the earliest opportunity to gain knowledge of networks and potential supports/alternative carers.

2.4 Considering the voice of the child:

2.5 A good assessment take a child-centred approach and even though babies are unable to talk, they still communicate through their behaviour. Good quality observations, in the presence of their primary caregiver provides us with information key to understanding their daily lived experience. When children are unable to talk, these are indicators of their wellbeing:

- their bond with their parents/carers
- how they are dressed
- their demeanour and behaviour
- where they are positioned (for example, is the parent keeping them close by or are they being left in another room?)
- the experiences of older siblings and any comments they may make about the way the baby is being cared for.
- Consider seeking specialist advice regarding as to whether premature babies are thriving remembering that children with disabilities are more vulnerable to abuse and neglect.
- Look beyond a baby's basic care needs and consider their emotional, psychological and/or therapeutic needs

2.12 Importance of Previous History

2.13 Reder and Duncan's Beyond Blame (1999) still offers one of the best analysis as to the importance and relevance of a consideration of previous history. They propose

that parents who mistreat their children may experience “care” and/or “control” conflicts in which the parents’ own experiences of adverse parenting have left them with unresolved tensions that surface in their adult relationships and in turn can manifest in the context of the relationship with their own child.

2.14 Care conflicts: arise out of experiences of abandonment, neglect or rejection as a child, or feeling unloved by parents. They show in later life as excessive reliance on others and fear of being left by them; or, its counterpart, distancing themselves from others; intolerance of a partner’s or child’s dependency; unwillingness to prepare antenatally for an infant’s dependency needs; or declining to respond to the needs when the child is born.

2.15 Control conflicts: are based on childhood experiences of feeling helpless in the face of sexual or physical abuse or neglect, or inappropriate limit-setting. In adult life they may be enacted through: violence; low frustration tolerance; suspiciousness; threats of violence; or other attempts to assert power over others. Violence or control issues can become part of their relationship with partners, children, professionals or society in general.

2.16 Unresolved conflicts can influence the meaning that a child has for its carer. For example: the child’s birth may have coincided with a major life crisis e.g. being abandoned by a partner, or a child born of incest or into a violent relationship, following which the child can become a constant reminder of the associated feelings. The child may be blamed for problems in the parent’s life or expected to help resolve them.

2.17 Practitioners should attempt to build up a clear history from the parents of their previous experiences in order to ascertain whether there are any unresolved conflicts and also to identify the meaning any previous children had for them and *the meaning of the new born baby.*

2.18 It will be particularly important to ascertain the parent(s) views and attitudes towards any previous children who have been removed from their care, or where there have been serious concerns about parenting practices.

2.19 Is the parent able to hold the child in mind and emotionally attune to their needs?

2.20 Relevant questions would include:

- Do the parent(s) understand and give a clear explanation of the circumstances in which the 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 interventions? E.g. genuinely attempting to cooperate or characterised by tokenistic compliance?
- What are their feelings about that child now? What is going to be different?

- What has changed for each parent since the child was abused/removed?

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

2.22 It will be also be important to ascertain the parents' 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 severe domestic violence an issue in the parents' relationship?
- Is the perception of the unborn baby different/abnormal? Are there feelings of wanting 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?

2.23 In cases where a child has been removed from a parent's care because of sexual abuse there are some additional factors which should be considered.

2.24 These include:

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

2.25 The fact that the child has been removed from their care suggests that there have been significant problems in these areas and pre-birth assessment will need to focus on what has changed and the prospective parent(s) current ability to protect. Relevant questions when undertaking a pre-birth assessment when previous sexual abuse has been the issue include:

- The circumstances of the abuse: e.g. was the perpetrator in the household? Was the non-abusing parent present? The severity of the abuse?
- What relationship/contact does the mother have 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?

2.26 In circumstances where the perpetrator is the prospective mother or father, or is 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 the appropriate time-scale, then confidence in the safety of the new-born baby and subsequent child will be significantly diminished.

2.27 Circumstances where the perpetrator is convicted for posing a risk to children and is already living in a family with other children, (albeit with Social Work involvement), should not detract for the need for a pre-birth assessment.

2.28 In all assessments it is important to maintain the focus on both prospective parents, and any other adults living in the household and not to concentrate solely on the mother.

2.29 The importance of Support:

2.30 It is expected that discussions take place with the prospective Parent(s) in respect of their support network and that they are encouraged to engage in a family group conference in order to ensure there is sufficient support around the child and the network are aware of any potential risks. Research into the engagement of vulnerable parents in pre-birth planning and appointments notes the lack of trust that such parents often hold with a range of services. They often feel criticised and judged which can result in non or limited engagement which we may interpret as neglectful. It is also noted that expectant parents within the pre-birth planning process often have multiple appointments to attend and can find this overwhelming. It is therefore important to be open and honest with parents and wherever possible try to dovetail meetings for them.

2.31 Regardless of which threshold our unborn baby's meet, the Local Authority needs to consider our offer of support to the expectant parents. Assessment needs to be ongoing throughout the pregnancy and consider capacity to change.

SECTION Three – Pathways and pre-birth care planning.

3.0 The MASH will be responsible for the screening of all pre-birth referrals coming in to social care where the family is not already open to one of the Locality teams. Referrals will be accepted at or after the 6 week gestation status. If there is insufficient information to establish whether the grounds are met for undertaking an assessment the MASH will liaise with the health agencies involved to gather more information.

3.1 Based on information gathered MASH will decide one of the following outcomes:

- There are insufficient safeguarding concerns but support would be beneficial and refer to the Early Help or Families First Service.
- History and risks are such that statutory intervention is likely to be needed and thus the case transfers to the Assessment Service and the undertaking of a pre-birth assessment.
- No further action and that advice and information is given

3.2 To note if it is deemed that a pre-birth assessment is required this assessment must be completed by a social worker.

3.3 Social Work teams are to refer to MASH immediately when a pregnancy becomes known about on an open case. MASH will create the contact and forward back to Social Work Team, if the family are an open case, or if Care Proceedings have been concluded within the last year and the social work team holds a good working knowledge of the case.

3.4 If late notification of pregnancy received, case to be immediately allocated to Social Worker to begin assessment and decision made by Service Manager as to necessary acceleration of the workflow pre-birth process, dependent on level of perceived risk.

3.5 It is a Social Work judgement as to most appropriate time to initiate the assessment and as to the duration of the assessment. In all cases the expectant parent should be advised as to when the assessment will be completed.

3.6 However all Pre-birth Assessments should be concluded by 20 weeks gestation, with the exception of late bookings to midwifery, where any concerns should be referred to the MASH at the earliest point.

3.7 Planned and Purposeful Pre Birth Work:

3.8 To begin to undertake assessment, arrange regular visits and seek information from professional network to triangulate information and formulate a genogram and eco-map.

3.9 You may decide to undertake a strategy/network meeting at this stage, particularly if it is clear that there are many professionals involved.

3.10 Consider the following:

- Would a Family Group Conference be appropriate? If so, make a referral at the earliest possible point.
- If potential carers are identified via an FGC a Viability Assessment of any extended family member or connected person proposed by the parents should be considered. Advice on the conduct of such assessment should be sought from the SGO lead in Fostering Service to ensure that assessment can be used if the child does not remain in the care of the parents.
- Is the mother eligible for the Family Nurse Partnership.
- If substances are an issue refer to the Change Grow Live (CGL) Clinic and link in with Substance Misuse service.
- Is domestic abuse is an issue. Is a referral to MARAC required? Consider referral to Hestia, discuss case with advanced Practitioner for DV and make

referral to relevant perpetrator service or other appropriate service for perpetrators.

- Is the case eligible for specialist targeted health visiting support. Make a referral if they are asap.
- Are learning needs an issue. Consider whether parent needs a referral to the Adult Learning Disability Team, do they need an advocate? (Voiceability for general advocacy services or Powerhouse for women with a learning Disability).
- Are mental health needs an issue? Link in with adult mental health services. May need an advocate (MIND).

3.11 Make sure that putative father is included in the assessment. Consider all of the above in respect of putative father to the baby and ensure that this is recorded on the child's record.

Section Four: Child Protection and Care Planning pre-birth.

4.0 At 25 gestation or prior - Consider the need for a strategy discussion/meeting.

4.1 Is a s.47 enquiry necessary? If so complete relevant checks and make a decision to progress to an Initial Child Protection Conference inside of 2-3 days of the s.47 being initiated in order to satisfy 15 working day requirement. If ICPC required then present to conference **no later** than 30 weeks gestation. **Good practice is to progress to conference earlier than 30 weeks, particularly for those children's circumstances judged to be complex and requiring legal consultation.**

4.2 If the case is high risk and in your view requires legal planning, a referral will need to be made to Service Manager/HoS for consultation and agreement to progress to a Legal Planning Meeting and to scope plan post birth.

4.3 Early pregnancy notifications to be heard by the SM/HoS no later than 28 weeks gestation, late notifications of pregnancy to be progressed to SM/HoS at the earliest opportunity, if threshold is deemed to be met.

4.4 Legal Planning Meeting must be held at least 10 weeks prior to E.D.D. (30 weeks gestation). Relevant Head of Service to chair. LPM minutes will then advise on whether threshold met & if so whether there is evidence to support a care plan for separation, parent & baby or community based plan of support. If you have your evidence then LPM can happen earlier than at 30 weeks providing relevant permissions have been sought from SM/HoS.

4.5 You may decide that the case would benefit from a Child in Need plan. CiN Network Meeting to be arranged within 10 working days of the conclusion of the Single Assessment to initiate the Child in Need plan.

4.6 Following the ICPC, to be agreed at the first Core Group:

4.7 Birth Plan to be formulated (should include a police serial number). Birth plan should:

- detail risks, strengths
- Who should hospital contact when mum admitted/in labour/baby delivered
- What happens if the baby is born out of hours
- What level of contact/care (supervised or not) can the parents have
- What is the plan in relation to breastfeeding
- Identify agreed visitors/prohibited visitors.
- What are the arrangements for initial legal proceedings
- Are the parents aware of the plan and what is their attitude?
- Who will be co-ordinating contraceptive advice to Mother post birth and timescales.

4.8 Copy of birth plan should be sent to Police SIU, Safeguarding Midwives and Legal (if necessary).

4.9 Public Law Outline:

4.10 Where care proceedings are being considered at birth a Meeting Before Action, under the Public Law Outline must be convened and a Letter before Action to be formulated- Agreed by legal and signed by Service Manager.

4.11 Before 32 weeks and no later (with earlier notification) - following LPM and case being heard and agreed by SM/HoS, schedule a Meeting Before Action.

4.12 Agree at LPM and then CPP following - care plan, assessments to be undertaken within PLO and any subsequent planned proceedings, frequency of contact, assessment of family members etc. Convene the Meeting Before Action.

4.13 At the earliest opportunity start to compile your evidence, update chronology, write the Court statement, Care Plan. Understanding that there will be pressure upon hospital colleagues to discharge at the earliest point if baby and parents are fit and well, post delivery.

4.14 Complete a referral to fostering for placement and contact service (if deemed to be required as part of the pre-birth planning process). If the plan is to place with a Kinship carer, then the Viability Assessment will need to be reviewed and placement authorised under Regulation 24 by Head of Service Care Provision and Support and relevant Head of Service for the allocated social worker. Once agreed it will be referred to Fostering Service for further support and assessment and progression to Fostering Panel for approval. Should the plan be separation, a plan for contact with both parents and where relevant siblings should be agreed with appropriate referral to Contact Centre for supervision of any family time.

4.15 Should the threshold for PLO be met, planning for the initial meeting should follow normal planning time frames as per the legal protocol, resulting in the initial PLO meeting taking place in 15 working days from the legal planning meeting. PLO letters need to be explicit regarding our worries, what supports we will provide and what we are expecting the parents to do. For those cases where we are likely to issue upon birth the letter needs to be explicit about this.

4.16 Any assessments being requested need to be concluded 6 weeks before the EDD. Same applies with any assessments that we may wish to undertake post birth in that these should not be started until 6 weeks following birth

4.17 If the plan is to accommodate baby/ and parent under s.20 whilst awaiting a Court hearing the plan must be discussed prior to the birth of the baby and where possible in the Meeting Before Action. It is not considered good, fair or ethical practice to request a parent sign to agree to their child's admission into care, in the immediate period following the child's birth, due to capacity possibly being impacted

4.18 The legal planning meeting should also consider the potential risks of abduction/care and whether an EPO may be needed at birth. However, we need to be mindful that the use of EPO's requires exceptional justification and extraordinarily compelling reasons. Separation should only be contemplated if immediate separation is essential to secure the child's safety. "Imminent danger" must be actually established, through the provision of detailed and compelling evidence, with it being expected that parents will be given notice. Pre-birth planning will be essential in assessing potential risk at birth (see attached agenda - this should take place at least 2 weeks before EDD and could align with a core group meeting)

4.19 If removal of the baby following its birth is considered to the only safe option then we need to ensure that the parents:

- Have support including that of family and or advocacy services.
- Consideration must be had regarding any meetings or discussions that are had at the hospital. We need to be minded that in open wards curtains do not act as a barrier to sound.
- Planning for the removal of the baby should form part of prior discussions so that all involved are clear what will happen if the court agrees with our care plan.

This should include but is not limited to:

- How midwifery services can support life story work with pictures and any birth memorabilia.
- What the plan will be for the actual removal of the baby i.e. who will the baby be handed too, will the parents leave the hospital first, what they will want the baby to be dressed in etc.
- It needs to be acknowledged that this will be a deeply traumatising event for the parent and so any support to them should be given including any referrals to mental health services.

4.20 It is critical the at all points of decision making it is important it is clear as to who made the decision, how the decision was made and upon what information was critical to the decision making. These summaries will be used to outline the child's journey into care and out of care for those children who are subsequently return to their parents care or are placed with members of their extended family or who are adopted. The information will inform material produced for the child which will explain who they are, where they come from and in the case of children who do not return to their parents care why they did not live with them. It will also inform decisions in respect to future brothers and sisters.

Section Five: Other Useful Tools: Risk Estimation Framework

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

Factor	Elevated Risk	Lowered Risk
The Abusing Parent	• Negative childhood experiences, inc. abuse in childhood; denial of past abuse. • Violence abuse of others • Abuse and/or neglect of previous child • Parental separation from previous children • No clear explanation • No full understanding of abuse situation • No acceptance of responsibility for the abuse • Antenatal/post natal neglect • Age: very young/immature • Mental Disorders or illness • Learning Difficulties	• Positive childhood • Recognition and change in previous violent pattern • Acknowledges seriousness and responsibility without deflection of blame onto others • Full understanding and clear explanation of the circumstances in which the abuse occurred • Maturity • Willingness and demonstrated capacity and ability for change • Presence of another safe non-abusing parent

	• Non compliance • Lack of interest or concern for the child	• Compliance with professionals • Abuse of previous child accepted and addressed in treatment(past/present) • Expresses concern and interest about the effect 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 risk posed by their partner and expresses a willingness to protect • Accepts the seriousness of the risk and the consequences of failing to protect • Willingness to resolve problems and concerns
Family issues (marital partnership and the wider family	• Relationship disharmony/instability • Poor impulse control • Mental health problems • Violent or deviant network involving kin, friends and associates (including drugs, paedophile or criminal networks) • Lack of support for primary carer/unsupportive of each other • Not working together • No commitment to equality in parenting • Isolated environment	• Supportive spouse/partner • Supportive of each other • Stable or violent • Protective and supportive extended family • Optimistic outlook by family and friends • Equality in relationship • Commitment to equality in parenting

	• Ostracised by the community • No relative or friends available • Family violence (e.g. Spouse) • Frequent relationship breakdown/multiple relationships • Drug or alcohol abuse	
Expected child	• Special or expected needs • Perceived as different • Stressful gender issues	• Easy baby • Acceptance or difference
Parent-baby relationship	• Unrealistic expectations • Concerning perception of baby's needs • Inability to prioritise baby's needs above own • Foetal abuse or neglect including alcohol or drug abuse • No ante-natal care • Concealed pregnancy • Unwanted pregnancy • identified disability (non-acceptance) • Unattached to foetus • Gender issues which cause stress • Differences between parents towards unborn child • Rigid views of parenting	• Realistic expectations • Perception of unborn child normal • Appropriate preparation • Understanding or awareness of baby's needs • Unborn baby's needs prioritised • Co-operation with ante-natal care • Sought early medical care • Appropriate and 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 support network • Delinquent area	
Future Plans	• Unrealistic plans • No plans • Exhibit inappropriate parenting plans • Uncertainty of resistance to change • No recognition of changes needed in lifestyle • No recognition of a problem or a need to change • Refuse to co-operate • Disinterested and resistant • Only one parent co-operating	• Realistic plans • Exhibit appropriate parenting expectations and plans • Appropriate expectation of change • Willingness and ability to work in partnership • Willingness to resolve problems and concerns • Parents co-operating equally

Appendix A: Pre Birth Planning Meeting.

Pre-birth planning meeting agenda (to be used for babies subject to CP plans and those where proceedings will be initiated).

Attendees - is there anyone absent who needs to be involved?
How long will the baby stay in hospital?

- Midwifery
- Health visiting
- Family
- Social care
- Other services

Expected timeframe for mother and baby to remain in hospital if CP?

- How long will the baby stay in hospital?

- What needs to be planned for re discharge from hospital?

The plan should address:

- How long the baby will stay in hospital;
- Level of Supervision required.
- 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 e.g. parental substance misuse;
- The plan should include the risk of potential abduction of the baby from the hospital particularly where the plan is to remove the baby at birth;
- The plan for contact between mother, father, partner, 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
- To plan for the baby upon discharge, where alternative care has been
- agreed, e.g. discharge to extended family members; mother and baby
- foster placement; foster care and supported accommodation;
- The Social Worker may need to seek a legal order to protect and safeguard the new born baby and there will need to be a discussion with the hospital to agree the child remaining on the ward until this has been resolved in the court.
- The court order may not be immediately available; however, the social worker and the hospital must agree the best plan in the safety and
- interest of the new born baby. (A paper copy of the legal document

If care proceedings are to be issued:

- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed
- use of hospital security, police, emergency orders.
- The risk of potential abduction of the baby from the hospital (if issuing proceedings)
- Arrangements for baby's care whilst the parent(s) attend court
- Contact details and arrangements for informing parties of the child's birth

Appendix B: Pre Birth Hospital Discharge Planning Meeting:

Attendees:

Agenda:

- Reminder to all why we are having a meeting
- Update to has to how the baby and mother are - any health issues which need to be addressed
- Update on how parents have been responding to the baby/hospital staff
- Support upon discharge - agreement on who will be visiting, when and purpose.
- What support are the parents drawing upon
- Information to parent as to who to contact should concern arise
- AOB

Confirmation of plan:

What needs to happen	By Whom	By When Expected	Outcome being sought.

Date/Time and Venue of next meeting:

References:

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