People Directorate
Children's Social Care

Bracknell Forest Council

Multi-Agency Protocol and Pre-Birth Assessment Tool

Version 2
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Bracknell Forest Council
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1. Scope

1.1 This protocol 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 and fathers 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 at the earliest opportunity to ensure that timely decision making and proportionate action and intervention takes place. The protocol is in line with Bracknell Forest Council's operating model - Family Safeguarding which aspires to keep families together where it is safe to do so.

1.2 The protocol applies to all agencies involved in the local authority area but to workforces in Children's Services, Police, Health (including mental health) and relevant adult services. Safeguarding babies is everyone's responsibility.

1.3 Setting out how to respond to concerns for unborn babies, with an emphasis on clear and regular communication between professionals working with the mother, father, and their families. It provides an agreed process on working together between Health agencies, Children's Social Care and other agencies.

1.4 The protocol is supported by Bracknell Forest's online child protection procedures with additional links provided to enable further reading on specific topics such as bruising/suspicious marks on children not independently mobile and concealed pregnancy.

It is important that the guidance contained in this document is considered alongside the statutory provisions set out within Working Together 2018.

Remember where there is an urgent need to protect a child this should be reported to the police immediately by calling 999. All other concerns relating to children who may be at risk of harm should be reported to the Multi-agency Safeguarding Hub (MASH) without delay:

Telephone: 01344 352005
Email: mash@bracknell-forest.gov.uk
For further information and referral form go to:
www.bracknell-forest.gov.uk/MASH

2. Principles

2.1 We aspire to work together with partner agencies, parents, and their families to ensure all babies in Bracknell Forest are born into their families and kept safe. Where this is not possible then timely and sensitive action is taken to ensure a baby is not exposed to harm.

2.2 Together we can do more to support pregnant mothers, unborn babies' fathers and new-born babies and under ones. Everyone who works with children and families has a duty to assess need and act in a timely way.

2.3 Babies are particularly vulnerable to serious harm from abuse. Work carried out in the antenatal period can help parent/s strengthen their ability to protect their babies when they are born and minimise any potential harm. Early assessment, intervention, and support is essential. Anyone involved with parents who have adult related needs must ask themselves – 'Would this family benefit from an early help assessment or a social care assessment?'

3. Our collective duties **and areas for particular attention**

3.1 The Children Act 2004, as amended by the Children and Social Work Act 2017, strengthens this already important relationship by placing new duties on key agencies in a local area. Specifically, the police, clinical commissioning groups and the local authority are under a duty to make arrangements to work together, and with other partners locally, to safeguard and promote the welfare of all children in their area.

3.2 The National Service Framework for Children, Young People and Maternity Services (2004) recommends that Maternity Services and Children's Social Care have in place joint working arrangements to respond to concerns about the welfare of an unborn baby and his/her future, due to the impact of the parents' needs and circumstances.

3.3 All Practitioners should be alert to the key signs of abuse details of which are set out in the local procedures. Neglect is the most predominant reason children in Bracknell Forest have a child protection assessment or plan. For many children neglect is likely to be a series of concerns over a period that, taken together, demonstrate that the child is in need or at risk. Neglect also increases the likeliness of harm via accidents.

For more information about neglect provided by the NSPCC, go to:
www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/neglect/
For resources on training in identifying and dealing with child neglect.
https://www.gov.uk/government/collections/childhood-neglect-training-resourcesw
Specific guidance for health practitioners can be found at:
https://www.nice.org.uk/guidance/qs179

3.4 Unlike many safeguarding situations, the antenatal period gives a window of opportunity for practitioners and families to work together to:

- Form relationships with both parents and focus on the unborn baby
- Identify risks and vulnerabilities at the early
- Understand the impact of risk to the unborn baby when planning for their future
- Explore and agree safety planning options
- Assess the family's ability to adequately parent and protect the unborn baby and once the baby is born
- Identify family networks and offer a Family Group Conference
- Identify if any assessments or referrals are required before birth; for example, the use of an Early Help Assessment (or alternative assessments agreed with your manager) and what actions should be taken next
- Ensure effective communication, liaison and joint working with adult services that are providing on-going care, treatment, and support to a parent
- Plan on-going interventions and support required for the child and parent(s)
- Avoid delay for the child where the Public Law Outline threshold is reached
- Engage the under 1's protects and or FSM workers

Hart (2009) states that there are two fundamental questions when deciding whether a prebirth 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?

3.5 Early referrals should be encouraged to ensure that:

- This work is done sensitively
- 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.
- Babies are not born into situation where risk/needs are not well understood
- Families are able to benefit from the under 1's project

4. Information sharing

4.1 Effective sharing of information between practitioners and local organisations and agencies is essential for early identification of need, assessment, and service provision to keep children safe.

4.2 The Data Protection Act 2018 and General Data Protection Regulations (GDPR) do not prevent the sharing of information for the purposes of keeping children safe. Fears about sharing information must not be allowed to stand in the way of the need to promote the welfare and protect the safety of children.

4.3 To ensure effective safeguarding arrangements professionals must make a referral to the MASH where any of the above circumstances are prevailing using the online portal below:

[Multi-Agency Safeguarding Hub (MASH) | Bracknell Forest Council (bracknell-forest.gov.uk)]

5. Pre-Birth Referrals

5.1 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. The multi-agency safeguarding hub is the integrated front door for both safeguarding and early help referrals for children and families, information and the referral portal can be accessed here.

5.2 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.

5.3 In November 2021, BF Children's Services joined health partners in fortnightly psychosocial meetings which are attended by the MASH Manager, health visiting, GP leads, perinatal mental health and safeguarding champions within the trust. Information is shared to ensure relevant agencies are all aware of the families in their area that have an EDD within 8 weeks of the meeting, that require extra support and to gain an update from any relevant agencies as part of any on-going care planning and interventions. Any unborn open to BFCS are discussed and on what the current involvement is to ensure oversight by all relevant agencies. Any important information is shared regarding health involvement with a family that is open to us, then the MASH manager adds a case note to the family's file and emails the allocated social worker.

5.4 Mothers who are discussed and not open to BFC, where there are concerns for their MH and require BFCS involvement, the MASH Manager will advise about completing a referral.

6. Late Bookings, Concealed Pregnancy and Non-Engagement

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

6.2 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.

6.3 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

Indicators of Risk and Vulnerability
- Previous concealed pregnancy - Previous children removed from the mother's care - Fear that the baby will be taken away - History of substance misuse - Mental health difficulties - Learning disability - Domestic violence and abuse and interpersonal relationship problems - Previous childhood experiences/poor parenting/sexual abuse - Poor relationships with health professionals/not registering with a GP

7. Pre-Birth Assessments

7.1 Examples of when a pre-birth assessment would be required:

- 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/s is a Looked After child, a child under 16 (Under the age of 13 must be reported to the police)
- There are 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
- 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

Timings for pre-birth assessment and trigger points for specific steps in the journey for the assessment, the family and the baby are included in Section 9 of this Protocol.

7.2 Health Services

7.2.1 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 non-pregnant parent, father or putative father of an Unborn.

7.2.2 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/father's feeling about the pregnancy • Is the partner the father? • Having a conversation about safety at home and anything the parents may feel is a risk to their child including DV - Mother's dietary intake and any related issues - Any medicines or drugs, whether 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

7.3 Mental Health Services

7.3.1 Mental health professionals are responsible for identifying expectant service users, mothers and fathers 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

7.3.2 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.

7.3.3 All expectant parents with an unborn child/ren open to Children's Social Care Family Safeguarding Team who have a mental health issue or concern should be referred to the Family Safeguarding Mental Health workers. They will undertake an assessment, support wider referrals within CMHT and can deliver therapeutic group and 1:1 work where assessed as necessary. It is usual practice where mothers who have identified mental health conditions to work with the perinatal mental health team within CMHT.

7.4 Substance Misuse

7.4.1 Substance Misuse agencies in the community can play a key role in supporting expectant mothers and fathers 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.

7.4.2 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.

7.4.3 All expectant parents with an unborn child/ren open to Children's Social Care Family Safeguarding Teams who have a substance misuse concern should be referred to the Family Safeguarding Substance Misuse. This will involve an assessment and treatment plan. It is important that parents who expose children in utero to substance misuse are regularly drug tested whilst in treatment. Substance misuse professionals should seek advice from a Specialist Substance misuse midwife (where applicable).

7.5 Domestic Abuse and Violence

7.5.1 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 newborn 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 Bracknell providing services for an expectant mother should support her to engage with midwifery services
- Bracknell Police should ensure that when attending domestic abuse callouts, 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 abuse should carry out a DASH risk assessment. 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. All expectant parents with an unborn child open to Children's Social Care Family Safeguarding Teams where domestic abuse is a concern should be referred to the Family Safeguarding Domestic Abuse Victims/Perpetrators workers
- 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 using the online portal

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

7.6 Learning Disabilities

7.6.1 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.

7.6.2 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.

7.6.3 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 Adult 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.

7.7 Young Mothers Under 19 and Care Leavers

7.7.1 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.

7.7.2 As part of our think future new offer to care leavers, from March 2022 Bracknell Forest Council is offering all of its care leavers (under the age of 25 years), who are expecting to have a baby, a pre-birth assessment. This does not assume there will be more risk or need than for other parents but to ensure that we continue the care of corporate parents and do all we can to ensure that care leavers have the best possible start as parents and for their babies to have the best possible start in life.

7.7.3 Where there are concerns this would be a routine process as with any pregnancy but if a care leaver is closed to leaving care at the time of pregnancy they will be offered re-engagement with a PA to support them.

Factors to Consider
– Where a young parent/s do not have the support of wider family – 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. – Where the partner is not the father – If accommodation is not stable or suitable

7.8 Children Looked After or subject to a CIN or CP Plan

7.8.1 A pre-birth assessment should always be completed where the young person is a child looked after, subject to a CP plan or Child in Need. Careful consideration needs to take place between the family safeguarding teams and the CLA team to ensure that the needs of both children are met this will usually mean that the CLA worker is not the person to undertake the Pre-Birth assessment.

7.8.2 For children in receipt of a CIN and CP Plan a pre-birth assessment should always be completed usually independent of the child's social worker via the under 1's hub.

8. Timing of the Pre-Birth Assessment

8.1 Once it is agreed that a pre-birth assessment is required there is a need for this to be completed in good time before the birth and where possible with the consent of the parents to be as early as possible, preferably before 24 weeks of the pregnancy.

8.2 This work should start with meeting the parents to be and any other relevant family members (unless to do so would increase the risk to the unborn child).

At this meeting there should be discussion about the following:

- the concerns that have been identified
- the format of the assessment
- whether the mother and father will consent to information sharing (and sign the consent forms).

The assessment will include

- a chronology being constructed which will take into consideration any previous pregnancies or full-term births and any involvement from professionals this evoked.
- what worked well in the past and what hasn't.
- formal agency checks and provision of relevant information by the midwife about previous pregnancies, medical history and information from the first booking-in meeting. This information should be gathered prior to the main assessment being undertaken. The assessment should follow the format on the template (see Appendix 1).

8.3 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.

9. Pre-Birth assessment identifies risk of significant harm

9.1 Should the pre-birth assessment highlight areas of child protection concern, consideration will be given to convening a pre-birth child protection case conference. Should there be other children in the family subject to child protection registration, this will always take place.

9.2 The timescales for calling an initial child protection case conference will sometimes be less critical regarding an unborn child. Nevertheless, initial child protection case conferences should be held no later than five weeks before the baby's expected delivery date or as soon as possible before the baby is born if the referral is received too late for this to be viable.

9.3 An Unborn Baby Child Protection Conference will not normally be convened before the 24th week of pregnancy but will normally be held before 30th week of pregnancy. The first review will be held within one month of the child's birth or three months of the initial conference, whichever is sooner.

9.4 The initial conference should be called in accordance with the child protection guidelines that apply to all children if there is a likelihood of harm

.5 If the decision is that the threshold for a child protection plan is met, the first core group meeting should be before the birth of the baby and a discharge planning meeting must occur before the baby is discharged home after birth.

9.6 If the level of concern is such that it is deemed that the risk to the baby post birth cannot be managed by way of a child protection plan, a legal advice threshold planning meeting (LAM) will be convened by children social care with appropriate consideration to the urgency required. This will allow legal advice to be obtained about other steps required to secure the safety of the unborn baby following birth.

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

- General Practitioner
- Health Visitor or Named Nurse for Community Services
- The parents Midwives
- Named Midwife for Safeguarding
- 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
- Police
- Worker for under 1's project
- Any other lead professionals or services working with the parents of the Unborn and as per usual for a conference

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)

9.8 Child in Need outcome

9.8.1 If the outcome of 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 Planning meeting/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.

9.8.2 There should also be a CIN review meeting held six weeks ahead of the estimated due date to agree the post birth plan.

10. Public Law Outline

10.1 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.

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

10.3 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.

10.4 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.

11. Birth Planning Meeting

11.1 If the decision of the Legal Planning Meeting is that the unborn baby should be the subject of Care Proceedings, a Core Group meeting must take place at the hospital (Birth Planning Meeting). This is a professionals meeting which should be chaired by Social Care and invite the Safeguarding Lead Manager at the hospital.

11.2 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.

11.3 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.

11.4 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
- Arrangements for the non-pregnant parent
- 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.
- Who will ensure that the parents emotional needs are held in mind
- 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

12. Discharge from Hospital

12.1 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.

12.2 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.

12.3 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.

12.4 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.

12.5 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

12.6 Where a new-born child known to Children’s Social Care is to discharge 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.

13. Allocation and safe case transfer

13.1 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.

13.2 Where siblings of unborn child/ren are already open to other services or in care proceedings, they will continue to be allocated within those services. In cases where the court proceedings have concluded, the pre-birth assessment will be referred to the First Response Team.

13.3 In order for work to be done with the family during the pregnancy, appropriate cases should transfer to the Family Safeguarding Teams in line with the transfer policy at the Initial Child Protection Conference or Child in Need meeting. This is in order to avert the delay of intervention and further assessments of the parents taking place.

14. Under 1s Project

14.1 The under 1's project utilises seeks to provide practical and emotional training and support to expectant parents and those with young babies. The packages in place are creative but utilise group training as well as 1:1 family worker support to enable children to remain with their birth families where it is safe to do so. This project commenced in 2021 and there has already been positive feedback from parents and professionals. In addition to practical support and group training the programme seeks to involve fathers in the planning.

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.

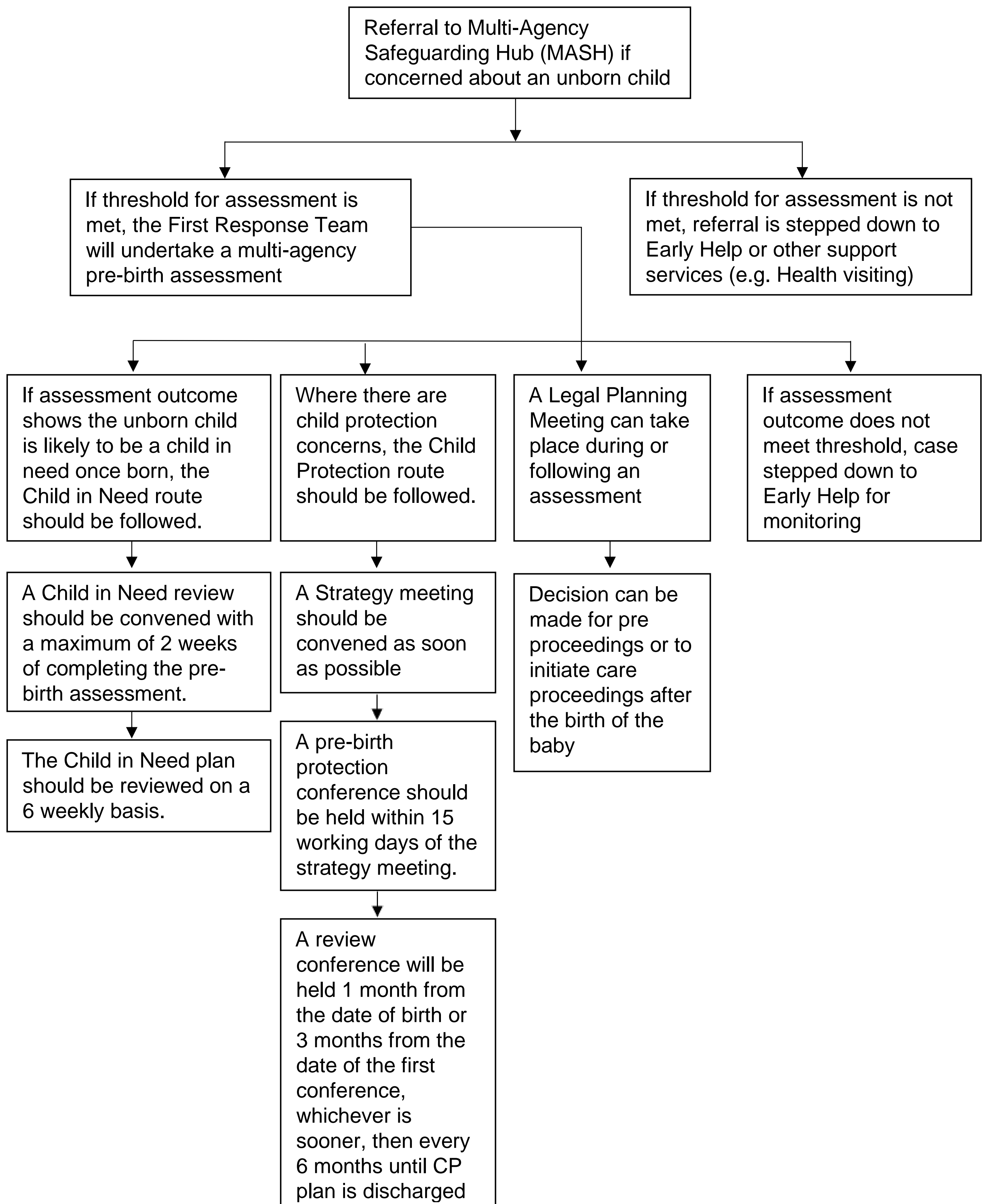
It is crucial to seek information about fathers/partners whilst conducting assessments and involve them in the process. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

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



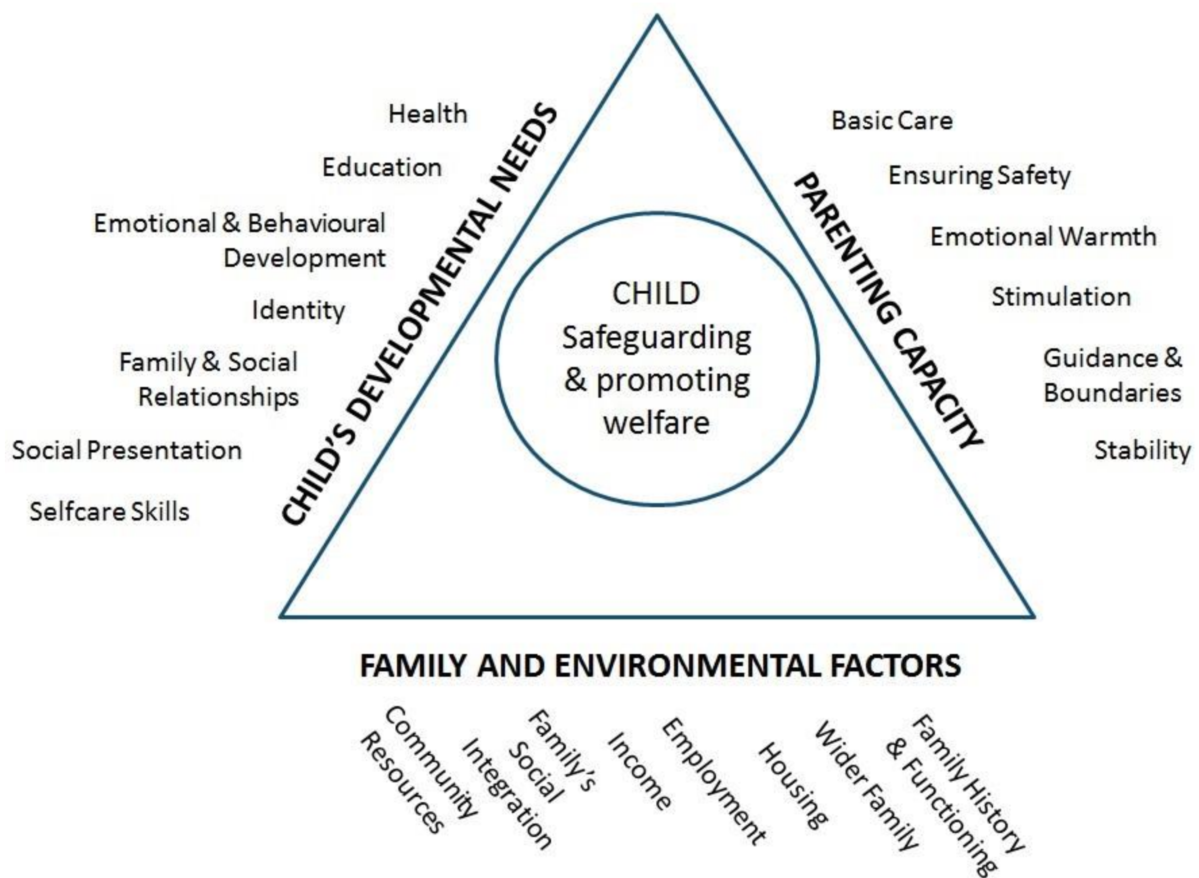
Appendix 1 – Pre-Birth Assessment Tool

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

2.11 Planning for the Future:

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

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

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 Cultural difference and diversity

- The Children Act 1989 promotes the view that all children and their parents should be considered as individuals and that family structures, culture, religion, ethnic origins and other characteristics should be respected. Local authorities should ensure they support and promote fundamental British values, of

democracy, the rule of law, individual liberty, and mutual respect and tolerance of those with different faiths and beliefs.

2.7 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
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  Current health status of other children

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/addition, 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*'.

The Abusing Parent	
Elevated Risk	**Lowered Risk**
- Negative childhood experiences, include 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 - Non-compliance - Lack of interest or concern for the child	- 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 - Compliance with professionals - Abuse of previous child accepted and addressed in treatment (past/present) - Expresses concern and interest about the effects of the abuse on the child
Non-Abusing Parent	
Elevated Risk	**Lowered Risk**
- 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)	
Elevated Risk	**Lowered Risk**
- 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 - Ostracised by the community - No relative or friends available - Family violence (e.g. Spouse)	- 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
- Frequent relationship breakdown/multiple relationships - Drug or alcohol abuse	
Expected child	
Elevated Risk	**Lowered Risk**
- Special or expected needs - Perceived as different - Stressful gender issues	- Easy baby - Acceptance of difference

Parent-baby relationships	
Elevated Risk	**Lowered Risk**
- 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 antenatal 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	
Elevated Risk	**Lowered Risk**

- Poverty - Inadequate housing - No support network - Delinquent area	
Future plans	
Elevated Risk	**Lowered Risk**
- Unrealistic 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 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