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**CHILDREN AND YOUNG PEOPLE SERVICES**

**Multi-agency working with the families of unborn children**

This document sets out guidance and locally agreed procedures for practitioners working with pregnant women and their families in Early Help, Health agencies and Calderdale Children and Young People’s Services.

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**1. Introduction**

The National Maternity Review: Better Births 2016 recognised the need for an individual approach to every woman, pregnancy, baby and family. Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise the potential for harm through early assessment, intervention and support (Brandon et al. 2016).

The success of pre-birth work lies in the quality of multi-agency involvement and partnership working and meaningful engagement and involvement with families. The family GP, midwife and health visitor all have critical roles in relation to vulnerable expectant mothers, alongside other statutory agencies and organisations working with family members.

In the vast majority of pregnancies, there will be no safeguarding concerns. However, in some cases it will be clear that a co-ordinated response is required by agencies to ensure that the appropriate support is in place during the pregnancy to best support and protect the baby before and following birth. It may also be necessary to consider the need for particular arrangements to be in place during and immediately following the baby’s birth.

These procedures are intended to ensure that every unborn baby in need of support and protection is safeguarded through multi-agency assessment, planning and decision making as early in the pregnancy as possible.

**2. Early Identification and Assessment**

**Where professionals become aware that a woman is pregnant, at whatever stage of the pregnancy, and they have concerns for the mother or unborn baby’s welfare, or that of siblings, they should NOT assume that Midwifery or other health services are aware of the pregnancy or the concerns held.**

Professionals should consider whether the new-born baby will be safe and if there is a realistic prospect of the parents/carers being able to provide adequate care throughout childhood. Where there is doubt, a pre-birth assessment may be required. Each professional should follow their agency’s child protection procedures and discuss concerns with their safeguarding lead/named/designated professional for safeguarding.

There is an expectation that all agencies working with pregnant women and expectant fathers are aware of the risk indicators for harm to an unborn child/new-born baby. Advice from maternity services and/or Children and Young People Services should be sought if any professional working with an expectant parent is unsure as to how an identified or suspected area of need or risk might impact upon an unborn or a very young baby i.e. substance or alcohol misuse, mental health needs and/or prescribed medication, learning disabilities/difficulties, domestic abuse.

In the early stages of the pregnancy, the Midwife must assess the strengths, risks and needs of the family and where there are concerns for the welfare of the unborn baby consider completing a referral for an Early Intervention Single Assessment (EISA) in relation to the unborn child to ensure that services and the Team Around the Child (TAC) are in place. In cases where more serious safeguarding concerns exist a referral to Children and Young People Services (CYPS) should be made.

An EISA can support the development of a TAC Plan, led by an Early Help services when additional help is required and there are no safeguarding risks present. The TAC approach can swiftly mobilise support for pregnant women and expectant fathers to mitigate against future harm and optimise outcomes.

**3. 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](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/serious_case_review.html)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.

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:

* a risk assessment of the parent(s) should ‘commence immediately upon the social workers being made aware of the mother’s pregnancy’;
* any assessment should be completed at least 4 weeks before the mother’s expected delivery date;
* 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;
* the assessment should be disclosed upon initial completion to the parents and, if instructed, to their solicitor to give them the opportunity to challenge the Care Plan and risk assessment.

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

It is important that workers undertaking the assessment have a clear understanding of the **background history**. One of the early tasks should be to complete a chronology detailing the history.  Information can be gathered from a variety of sources including; children's and adult social care files and electronic records, including those of other local authorities, interagency discussions e.g. Police, Health, Education.  In addition it may be useful to meet with previous social workers.

Where English is not the first language or there are literacy issues, this should be taken into account at the planning stage. Workers should ensure that written information is provided in a format that can be understood e.g. obtaining a foreign language translation, using an advocate or an interpreter. Time needs to be set aside to make sure that written information is understood.

An interpreter may be required for the assessment sessions themselves.

Workers need to be aware of any risks to their own safety during the assessment and these may need to be addressed in supervision.

Where the decision has been made to undertake a comprehensive pre-birth assessment it is good practice to draw up a working agreement between Children and Young People Services and the parents. The agreement should outline the reason for the assessment, its purpose and aims, and how the assessment will be carried out:

* Dates, times, venues of sessions and who will attend each session;
* Areas to be covered in the assessment;
* How the assessment will be shared and who with;
* Expectations of those participating in the assessment.

Parents should be seen individually and as a couple, and extended family members may need to be contacted. Assessment sessions will normally take place at the family home and local area office. One of the sessions in the family home should assess the home environment and preparations made for the baby's arrival. The main focus of the meeting to share the working agreement is to clarify expectations, identify tasks and clarify boundaries. Any anxieties there might be around the assessment can be dealt with and openness encouraged. It should be clearly stated that part of the process will be to liaise with other agencies. Time needs to be set aside at the end of the assessment for writing the report and allowing for any subsequent timescales of meetings, e.g. Initial Child Protection Conference.

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 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 importance of compiling a full [Chronology](http://trixresources.proceduresonline.com/nat_key/keywords/chronology.html) 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.

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

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

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

Working with extended families is also crucial to the assessment process and achieving positive outcomes for unborn children. Consideration should always be given to convening [Family Group Conferences](http://trixresources.proceduresonline.com/nat_key/keywords/family_group_conference.html) 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.

**4. Pre-birth planning**

The antenatal period provides a window of opportunity for practitioners and families to work together to:

* form relationships with a focus on the unborn baby;
* identify risks and vulnerabilities at the earliest stage;
* 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 the baby once born;
* identify if any additional assessments or referrals are required before birth; for example the use of the Early Intervention Single Assessment (EISA) or the perinatal mental health check;
* ensure effective communication, liaison and joint working with adult services that are providing on-going care, treatment and support to a parent(s);
* plan on-going interventions and support required for the child and parent(s);
* avoid delay for the child where a legal process is likely to be needed such as Pre- proceedings, Care or Supervision Proceedings in line with the Public Law Outline.

**5. Risk Factors**

**5.1 Parental risk factors** that may indicate an increased risk to an unborn child and which may mean that a pre-birth assessment is required:

* involvement in risky activities such as substance misuse and alcohol;
* perinatal/mental illness or support needs that may present a risk to the unborn baby or indicate that their needs may not be met;
* victims or perpetrators of domestic abuse;
* previously identified as presenting a risk, or potential risk, to children, such as having committed a crime against children;
* a history of violent behaviours;
* learning difficulties, severe physical or mental disability that significantly impede a person’s ability to provide care for themselves or others;
* historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have had children removed from their care;
* currently ‘Looked After’ themselves or were looked after as a child or young person (care leavers);
* a history of abuse in childhood;
* are teenage/young parents;
* recent family breakdown and social isolation/lack of social support;
* an inability to provide a secure and stable home base;
* female infant at risk of FGM;
* any other circumstances or issues that give rise to concern.

The list is not exhaustive and, if there are a number of risk factors present, then the cumulative impact may well mean an increased risk of significant harm to the child. If in doubt, professionals should seek advice about making a referral.

***Appendix 1: contains a Risk Estimation Matrix; a useful tool for the assessment of risk****.*

**5.2. Teenage Pregnancy (under 18)**

Being a young parent is not an automatic indicator of risk. However, the presence of some or all of the risk factors outlined in ***Appendix 1*** will require further assessment. The Midwife will refer all first time mothers, under the age of 20 and less than 28 weeks gestation to Healthy Early Years Service (HEYS).

**5.3. Teenage Pregnancy (under 16)**

All pregnant teenagers under the age of sixteen will be referred to Children and Young People’s Services for a statutory assessment of need and risk. Practitioners should explore whether significant harm has occurred and undertake a statutory assessment of need in relation to the unborn child.

**5.4. Late booking or concealed pregnancy**

Pregnant women with complex social factors are known to book later, on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes (NICE 2010).

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone; or a woman appears genuinely not aware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought. This can become apparent at any stage of the pregnancy. Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth may be unassisted and may carry additional risks to the child and mother's welfare.

**A late booking is defined as presenting for maternity services after 20 weeks of pregnancy**.

Where there is a late booking or a concealed pregnancy the health practitioner should complete an immediate assessment in order to identify which agencies need to be involved and make appropriate referrals. In the case of a concealed pregnancy a referral must be made to Children and Young People Services.

**6. Role of Health/Midwifery/GP Services**

Health professionals, particularly Midwives and GPs, are most likely to be in contact with expectant mothers and therefore in a key position to recognise risk factors. These health professionals are responsible for addressing the mother’s health needs and should share any relevant information with the network about any factors that may affect the mother’s parenting capacity.

It is important that there is a mutual exchange of information across the network when there are concerns about any of these factors.

When assessing risk, Midwives should gather relevant information about the mother during the booking in appointment and consider whether any aspects of any of the parental risk factors set out in **Section 5** .

The following issues may also have a significant impact on the child and, if so, how:

* social history;
* support from partners;
* family structure and support available (or potentially not available);
* whether the pregnancy is planned or unplanned;
* the feelings of the mother about being pregnant;
* the feelings of the partner/putative father about the pregnancy;
* the mother’s dietary intake and any related issues;
* any medicines or drugs, whether or not prescribed, taken before or during pregnancy;
* alcohol consumption;
* smoking;
* previous obstetric history;
* the current health status of other children;
* any miscarriages or terminations;
* any chronic or acute medical conditions of surgical history;
* the mother’s mental health history;
* whether the mother has been subjected to Female Genital Mutilation and/or breast ironing and the unborn child, or any related child, is considered at risk.

If the woman self refers to the Midwifery team to book her pregnancy, the GP should be notified and a health summary requested. This should then be sent to the hospital. This enables early identification of women who may have vulnerabilities and may need increased assessment and support. If a family has been identified as being in need of additional support, the Health Visitor should be contacted and a targeted antenatal appointment arranged. Health professionals can also contact Social Workers in the MAST team for advice.

The Health professional providing care for a family should attend multi-disciplinary meetings as requested. In the event that he/she is unable to attend best efforts should be made for someone else within the team to attend in his/her absence. Reports should be completed for all case conferences and sent to the email provided. To ensure best outcomes for the woman and her family, effective communication across the network is key. Contact details should be shared between the multi-disciplinary/multi-agency team to help facilitate this.

**7. Referral to Multi-Agency Screening Team (MAST)**

**Referrals to MAST should be made as early in the pregnancy as possible, usually at 12 weeks** when the pregnancy is confirmed as viable If risks or needs change or become apparent in the course of an EISA or intervention, the case can be referred to MAST at that point. Early referral allows Children and Young People Services and partner agencies to assess the family circumstances and make plans for intervention and support ahead of the baby’s arrival as set out in Section 3. The MAST will determine which services are best placed to offer support.

If a decision is made to progress to a statutory assessment of need, the assessment will determine whether the unborn baby will need to be afforded a Child Protection Plan, a Child in Need Plan or whether Early Intervention Services can manage concerns. In any of the following circumstances MAST will **always** progress the referral for a statutory social work assessment of need and risk to be undertaken:

* current perinatal mental illness that presents a risk to the unborn baby;
* previous unexplained death of a child whilst in the care of either parent;
* a parent or other adult in the household is a person identified as presenting a significant risk, or potential risk, to children. This may be due to domestic abuse, violence, substance/alcohol abuse, mental health or learning difficulties;
* children in the household/family are currently subject to a child protection plan or previous child protection concerns and there has been no change in the family’s circumstances since the concerns were identified;
* a sibling (or child in the household of either parent) has previously been removed from the household temporarily or by Court Order;
* serious concerns about parental ability to care for the unborn baby once born or other children;
* maternal risk factors e.g. denial of pregnancy, concealed pregnancy, avoidance of antenatal care (non-attendance at or inaccessibility for professional appointments), non-co-operation with specialist services (i.e health visiting service) and non-compliance with treatment with potentially detrimental effects for the unborn baby;
* street homelessness/chaotic lifestyle;
* teenager under 16 years old;

**8. Child Protection Concerns**

**8.1. Strategy Discussion/Meeting**

If there is reasonable cause to suspect an unborn baby is likely to suffer **significant harm,** a Strategy Discussion/Meeting will be convened. This will be co-ordinated and chaired by Children and Young People Services who will involve the Police and Health professionals, and any other professionals involved with the family.

The Strategy Discussion/Meeting will determine if there is evidence of risk of significant harm.

Where risk is identified a S47 enquiry will be initiated either jointly with Children and Young People Services and Police or Children and Young People Services as a single agency enquiry. The s47 enquiry will seek to ascertain the level of and source of risk to the unborn baby and any other children in the family and complete a **Single Assessment**.

**9. Single Assessment outcomes**

**9.1. Child in Need**

If the single assessment determines that there is no risk of significant harm but additional support is required Children and Young People Services will agree with the family and other agencies, a Child in Need (CIN) Plan with clear actions and outcomes to be achieved within timescales. The CIN Plan will be regularly reviewed with the family and multi-agency team to monitor progress being made.

**9.2. Child in Need of Protection**

If the assessment determines that there is sufficient concern of the likelihood of current or future significant harm, a pre-birth or Initial Child Protection Conference will be convened by Children and Young People Services to ascertain whether the unborn baby requires a Child Protection Plan to safeguard their welfare. **The Initial Child Protection Conference must take place no later than week** 30 of the pregnancy (unless late booking or concealed pregnancy).

The conference will determine whether the criteria is met for a Child Protection plan. The Child Protection plan will set out the work to be undertaken to mitigate risk, however, there will be a need for a separate plan to cover specific arrangements around the period of the birth known as the Safeguarding Birth Plan.

**9.3. Safeguarding Birth Plan**

Children and Young People Services are responsible for ensuring the multi-agency partnership formulate a plan to safeguard the baby at birth, together with the Named Midwife for Safeguarding.

The Safeguarding Birth Plan should detail the planning for delivery and the immediate post-natal period, including who will be notified upon the birth of the baby. The Plan will identify the roles and responsibilities of the professional network around the unborn baby and family.

The safeguarding birth plan must be disseminated to relevant professionals and relevant birthing units including the Emergency Duty Team (Out of Hours service provision within Children and Young People Services). The safeguarding birth plan should include contact numbers and names of professionals involved and the agreed arrangements for where the baby, once born, is to be discharged.

It is the responsibility of the Named Midwife for Safeguarding Children or the midwife from the complex social needs team who attends the CIN/Core group meeting to ensure that other health practitioners involved are informed of the safeguarding birth plan i.e obstetrician, neonatologist, GP, Health Visitors (HVs).

The Safeguarding Birth Plan should be shared with parents unless to do so is felt to put the mother or baby at increased risk of harm. Professionals will need to agree how the plan will be shared with parents.

**9.4. Post Birth Planning**

Following the birth of the baby, a longer stay in hospital may be necessary, particularly when there are medical needs. The professional network will need to agree how risks and needs are managed during this period; this may include issues relating to parental contact with the baby, feeding, supervision and visitor restrictions.

Where an assessment has determined that the baby will be at immediate risk of harm at birth, Children and Young People Services will make arrangements for the baby to be placed in alternative care and may apply to the court for the baby to be placed away from the birth parents. This may delay discharge from hospital and discussions should take place between Children and Young People’s Services and the hospital staff to agree timescales, contact arrangements and the management of risk during this period.

The Social Worker is responsible for communicating to the parents the decisions about the separation of children from their care. In most situations this will have been discussed ahead of the birth and the parents will have had an opportunity to seek legal advice and representation.

**10. Discharge Planning Meetings**

The discharge planning process should be initiated as soon as the mother is admitted or presents for delivery and all Midwives caring for her should have full access to and knowledge of the Safeguarding Birth Plan. Midwives have a safeguarding responsibility to all babies and will ensure that any protective action required within the hospital setting is managed following birth of the baby. The discharge plan will set out where the baby is to be discharged to, if not to parental care.

**Where babies are subject of a Child Protection Plan they should be delivered within the hospital setting and a Discharge Planning Meeting must take place before the baby leaves**. The following agencies must be invited to attend Discharge Planning Meetings (to be coordinated by Midwifery staff/safeguarding leads and the Social Worker) and should be represented in order for the meeting to proceed:

* Children and Young People’s Services Practice Manager or Team Manager/Social Worker;
* Paediatric Consultant (or specialist registrar/Neonatal Nurse Practitioner) where there are medical concerns with the baby;
* Named Nurse/Midwife Safeguarding Children or representative;
* Other relevant hospital staff involved in the care of the child/family;
* Health Visitor.

Other agencies may need to be involved in cases and attendance should be considered such as:

* Named Nurse/Safeguarding Children Nurse Community Trust;
* School Nurse;
* Police;
* Mental Health colleagues;
* Learning Disability colleagues;
* GP;
* Drug/alcohol agency;
* Domestic abuse services; and,
* any other key professionals that are in a position to support the safeguarding of the new-born.

If care proceedings have been initiated prior to discharge the Children’s Guardian must be invited and consideration given as to whether legal representatives should attend.

**Children and Young People’s Services will lead the Discharge Planning Meeting where there is a Child Protection Plan in place.**

An agreed multi-agency discharge plan will set out arrangements for the care and safety of the child following discharge from hospital into the community and will include actions, timescales and responsibility for actions, including:

* details of the child’s GP. Parents should be encouraged to register their baby with GP as soon as possible and inform professionals who this is likely to be;
* additional medical investigations requested including timescales for completion;
* documentation of any legal orders in relation to this child (with copies filed if available).

The Social Worker will ensure that the parents and any support person they choose will be informed when and where the meeting will take place. Where a baby is born prematurely it is reasonable to plan the discharge meeting 7 – 10 days prior to the earliest likely discharge date.

All agencies should aim to agree the baby’s discharge as soon as safely and practicably possible. It is preferable that newborn babies are not discharged at a weekend or on a bank holiday unless there is a consensus of opinion that it is safe and reasonable to do so and that sufficient midwifery/health visiting services are in place during this period to monitor the immediate period following discharge. However, consideration must be given to demand for acute medical beds on the Maternity Unit and on the Neonatal Intensive Care Unit particularly if the new-born has no acute medical needs. This must be documented in the child’s medical record and discharge plan.

The Discharge Planning Meeting must be fully documented and the minutes and agreed plan stored in the child’s records. A copy of this can be shared between the professionals attending the meeting and the parent(s).

**11. Removal of babies to local authority care prior to discharge**

**11.1** In circumstances where the local authority plans to apply to the courts for an Order to remove the baby to a place of safety following birth, it is the responsibility of the attending professional (normally the midwife) to inform CYPS and where appropriate, the police, when labour starts and when the baby is born. It will be necessary for a safety plan to be in place between the application being made and the date of the hearing. Police Protection arrangements may need to be considered as part of the safety arrangements and the police should routinely receive a copy of the multi-agency pre and post birth plan in these circumstances. If Police Powers of Protection are agreed these can last up to 72 hours, but this is not automatic and there should be agreement in place detailing how long this will be required for and recorded, as well as contingency plans in case police decide not to exercise their Powers of Police Protection.

**11.2 Facilitating Removal of Baby from Parent’s Care**

There is currently no available guidance outlining organisational and professional roles or responsibilities when removing babies from parents care which might include how and when the removal takes place, by whom, the correct process of doing so and the support mechanisms needed to support mothers and practitioners afterwards.

Each case should be assessed on an individual basis and where possible, with involvement from the mother/parents; in particular to ascertain her wishes in how this baby will be removed. There should be clear communication between the social worker, the midwife in charge of the mother’s care and where possible the Mother, to identify in advance, an appropriate place and who will facilitate the separation of baby from parents. Ensuring at all times that the needs of the baby are prioritised the parents’ wishes should be taken into account.

**11.3 Support for Parents**

Practitioners should understand that mothers who have a baby placed in alternative care, experience reactions that are akin to the grief and loss experienced by mothers whose babies have died (Marsh, 2014). Maternity Services should consider in each individual case, following discussion with the Mother and Social Worker, whether the taking of mementoes such as handprints, footprints etc. would be appropriate. Practitioners should also consider whether copies of mementoes should also be provided for the baby’s life story work.

The support needs of the mother should be actively considered within the discharge planning meeting.

**12. Working with fathers/partners**

Fathers play an important role during pregnancy and after. The National Service Framework for Children, Young People and Maternity Services (2004) states: ‘*The involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long wellbeing and outcomes of the child regardless of whether the father is resident or not. Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of children’* (NSF, 2004).

It is important that all agencies involved in pre and post-birth assessment and support fully consider the significant role of fathers and wider family members in the care of the baby, even if the parents are not living together and, where possible, involve them in the assessment. This should include the father's attitude towards the pregnancy, the mother and new-born child and his thoughts, feelings and expectations about becoming a parent.

Information should also be gathered about fathers and partners who are not the biological father at the earliest opportunity to ensure that any risk factors can be identified. A failure to do so may mean that practitioners are not able to accurately assess what the mother and other family members might be saying about the father's role, the contribution which they may make to the care of the baby and support of the mother, or the risks which they might present to them.

***Appendix 1 - Risk Estimation Matrix***

The matrix 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'. This matrix is to be used as a tool and is not intended to provide a comprehensive analysis of risk.

|  |  |  |
| --- | --- | --- |
| Factor | Elevated Risk | Lowered Risk |
| The Abusing Parent | • negative childhood experiences, including 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 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  • ostracised by the community • no relative or friends available  • family violence (e.g. spouse)  • frequent relationship breakdown/multiple relationships  • drug or alcohol abuse. | • 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. |
| 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 cooperating. | • 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 |

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Appendix 2 Proposed timeline for assessment

6-12 Weeks

Appointment booked with the Community Midwifery service. Where appropriate Midwife/other agency to undertake Early Intervention Single Assessment (EISA). If necessary, convene Team Around the Child meeting (TAC) in order to implement the Plan.

12-14 Weeks

If the criteria is met, in line with Thresholds, a Referral Form needs to be sent to Multi Agency Screening Team (MAST) for further screening. If following MAST checks it is deemed appropriate, a Single Assessment will be undertaken,

If the unborn baby has siblings who are already open to Children and Young People Services, the allocated Social Worker will complete a Pre-Birth Assessment.

16 Weeks

Referrals to specialist Health services or specialist Midwifery (if available) to be completed if mental health issues or substance misuse are identified. If required, a referral should be made to learning disability services or an advocacy service.

If the unborn baby is open to Children and Young People Services, a multi-agency meeting (CiN) will take place.

22-24 Weeks

Review TAC meeting takes place if Early Help services are being delivered. Decision whether Early Help offer remains appropriate or whether escalation is needed.

If referral is received after 22 weeks then a Strategy Discussion/Meeting will be held and s47 enquiry considered, if there are concerns that the unborn child is at risk of significant harm or Pre-Birth Assessment is finalised. If Pre-Birth Assessment has identified that baby is likely to suffer significant harm Children’s Social Care initiates a Strategy Meeting to include consideration of whether an Initial Child Protection Conference ICPC) is needed (within 15 days).

24-28 Weeks

ICPC to take place by week 30 of gestation. Children’s Social Care to ensure that child is discussed at the Legal Planning Meeting - if legal proceedings are considered to be needed (not CAFCASS Plus).

30-36 Weeks

Child Protection Plan implemented, to include Safeguarding Birth Plan

36-40 Weeks

Baby born (term).

**Appendix 3 : Agenda Template for Discharge Planning Meeting**

|  |  |  |  |
| --- | --- | --- | --- |
| Agenda Discharge Planning Meeting | | | |
| Name of Attendee | Position | | Signature |
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| Name of infant:    NHS number:    DOB:    Childs intended GP (If child residing with foster carer please leave blank and see appendix 1): | Mothers name:    DOB: Hosp number:    NHS number:    Address:        Contact telephone number:  GP Surgery: | | Partner’s details:    Partners contact number:    Additional services involved & contact details:    Situation |
| **Situation**  • Delivery and postnatal details  • Relevant medical Hx for mother and baby  • Relevant observations or anything of note | |  | |
| **Background**  • Family social situation and Hx Child Protection Y/N  • Any Children’s service plan | |  | |
| **Assessment**  • Outcome of social work assessment/court?  • Fit for discharge?  • Any additional medical investigations ongoing?  •Timescales for completion. | |  | |
| **Recommendations**  • Parental responsibility?  • Where will mother & baby be going home to? If baby going to foster care see separate form ‘Infants Placed into Foster Care’  • Actions to be taken and by whom/PN visits.  • Are all appropriate services in place from child’s holistic needs? | |  | |