



Joint Protocol and Practice Guidance on Pre-birth assessments

Women's Health
and

Children and Young People's
Services

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1. Introduction

A pre-birth assessment is a proactive means of analysing the potential risk to a new born baby when there are concerns about a pregnant woman and, where appropriate, her partner and immediate family.

The main purpose of a pre-birth assessment is to identify what the risks to the new born child may be, whether the parent(s) are capable of changing so that the risks can be reduced and if so, what supports they will need.

Pre-birth assessments are a source of anxiety not only for parents, who may fear that a decision will be made to remove their child at birth, but also for professionals who may feel that they are “playing God” and “not giving parents a chance”.

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

This guidance aims to:

- a) clarify what is meant by pre-birth assessments, their purpose and the circumstances in which they should be used;
- b) provide a multi-agency framework for the content of such assessments;
- c) provide a multi-agency framework for post natal management

2. Pre-Birth Assessments

A pre-birth assessment is essentially an assessment of the risk to the future safety of the unborn child with a view to make informed decisions about the child and family’s future.

Such assessments create ethical dilemmas for practitioners undertaking them. The bond between a mother and child is universally revered and practitioners may be reluctant to intervene, feeling that parents must be “given a chance”. However, the Children Act 1989 is clear that there are grounds for intervention if there is a likelihood of significant harm and that the needs of the child (in these situations unborn) are paramount.

Hart (2000) outlines the advantages of pre-birth assessment as providing an opportunity to:

- identify and safeguard the babies possibly most likely to suffer future significant harm;
- ensure that vulnerable parents are offered support at the start of their parenting career rather than when difficulties have arisen;
- establish a working partnership with parents before the baby is born;
- assist parents with any problems that may impair their parenting capacity.

There are, however, some potential disadvantages:

- parents may disappear or a mother may not come to hospital to deliver the baby;
- the stress may have an adverse effect on the parents' mental or physical health;
- a risk that a mother could feel pressurised into harming herself and the unborn baby or terminating her pregnancy;
- fear of losing the baby may jeopardise the attachment process between parent and child

Hart (2000) indicates that there are two fundamental questions when deciding whether a pre-birth assessment is required:

- will this new-born baby be safe in the care of these parents/carers?
- is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

Where there is reason for doubt, a pre-birth assessment is indicated.

Some parents will be aware of possible problems in caring for their child regarding their forthcoming child and may seek help from various agencies while others may be referred because of concerns identified by others. In the latter case, parents are unlikely to welcome the proposed assessment, there is a likelihood that the needs of the child would not be met without such intervention.

Pre-birth assessment would be required in the following circumstances:

- when a previous child has died in suspicious circumstances or suffered significant harm and been removed from the parents' care - this may be physical abuse, sexual abuse, emotional abuse or neglect;
- a sibling in the household is / was on the child protection register or has / had a child protection plan;
- where the prospective parent is a young person in the care of the local authority and aged 16 or under, or has a child protection plan;
- when the prospective parents behaviour or circumstances during pregnancy indicate they will be unlikely to protect or care for their baby appropriately. Examples might include:
 - a young couple, living a chaotic lifestyle with no home base, using drugs and alcohol to excess, refusing ante-natal care;
 - a young woman with learning difficulties who is unable to self care appropriately casting doubt on her ability to care for a vulnerable baby;
 - a woman, or couple, with chronic and disabling mental health problems e.g. schizophrenia, affective psychosis, severe substance abuse, personality disorder, obsessive compulsive disorder and eating disorders;
- where there is a high level of domestic abuse;
- when the parents' history suggests that the prospect of the baby being adequately cared for is bleak e.g. a history of early abuse which impacts on their behaviour as an adult, serious violence, of continued substance abuse unresponsive to treatment or serious psychiatric problems;
- when one of the prospective parents is an offender / or felt to be a risk to a child or with a conviction for abuse, including sexual abuse, against a child;
- when a multi-agency pre-discharge planning meeting identifies any of the above concerns and determines that a pre-birth assessment is required.

This list is not exhaustive and there may be other circumstances which may be potentially damaging to a new-born baby that will require a pre-birth assessment.

3. Procedures for Pre-Birth Assessments

Referral to Children and Young People's Service

Any professional who becomes aware that a woman is pregnant and has cause to be concerned that the new-born baby would be at risk of significant harm, or that the parent(s) would need substantial support to care for the child, should make a referral to Multi Agency Safeguarding Hub (MASH) as soon as possible. This includes women known to be using drugs during pregnancy.

MASH will manage the referral dependant on the presenting concerns, the referral will not be influenced by the length of pregnancy. A referral can be made and accepted early in the pregnancy when concerns have been identified. These will be responded to appropriately and assessments and other appropriate services commenced.

Midwives have a particularly important role in providing details of potential referrals in this arena. Practitioners in drug and alcohol clinics and mental health workers may also have early awareness of pregnant service users where there may be concerns about risk to a new-born baby.

GPs and health visitors are vital in contributing to pre-birth assessment. It is essential they share information in respect of mother and father's history: any known previous pregnancies, children, and mental health issues. The importance of history should never be underestimated; the most effective clue to the future lies in the past.

Information Sharing

Personal information about individuals held by professionals is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. However, the law permits disclosure of confidential information, without consent, if it is necessary to safeguard a child, or in this case, an unborn baby. The implication is that practitioners should discuss with potential parents and seek consent for the referral unless they have grounds for fearing that to do so would place the unborn child at risk

Children & Young People's Service social workers will undertake the usual checks including discussions with all other professionals involved with the prospective parent(s) and record this on an Initial Assessment.

4. The Timing of the Assessment

Following the analysis of the Initial Assessment a Core Assessment should be commenced.

The professional judgement of the social worker concluded in the core assessment may determine further enquiries are required under section 47, (Children Act, 1989). If the threshold for section 47 enquiries is not met but the professional judgement requires services to be delivered under section 17 (Children Act, 1989), a child in need meeting with the parent(s) and appropriate professionals must be held to draw up a plan.

The parent(s) can receive services and undertake additional parenting assessment to support their capacity to parent the baby on arrival and reduce a risk of significant harm in the future.

Undertaking the assessment early in the pregnancy provides parents with the opportunity to show evidence of change, therefore, a referral should be made to Children and Young People's Service when concerns arise however early in the pregnancy. If the outcome suggests the baby would not be safe with the parents then practitioners are provided with time and opportunity to make clear and structured plans for the baby's future, and set up support for the parents where necessary.

The Framework for the Assessment of Children in Need and their Families (2000) states that core assessments should be completed within 35 days of the strategy meeting. However, this timescale may need to be shortened for a pre-birth assessment depending on the timing of the referral and whether there is a risk of a premature birth. The aim is to conclude the assessment prior to delivery.

Where possible the unborn baby's father should be involved in the assessment.

If the assessment does not indicate that the baby will be at risk of suffering significant harm when born but may be a child "in need" then the planning and provision of services will continue under section 17 of the Children Act 1989.

Domestic Abuse

Where current or past domestic violence and abuse is identified a full CAADA/DASH risk assessment should be carried out in line with the MARAC operating protocol as pregnancy is a recognised heightened risk factor for victims.

Section 47

If the concerns indicate that there is a likelihood of significant harm then a strategy meeting must be held. The fact there may be several months before the expected delivery indicates that a strategy meeting would be more appropriate than a strategy discussion by telephone, (unless the baby is due imminently (e.g. concealed pregnancy)). The professionals who should be invited to attend include:

- Children & Young People's Service staff/social worker
- Relevant Adult Social Care staff if involved
- Police

- Referrer
- Midwife - it is particularly important that they are facilitated to attend
- Obstetrician
- Paediatrician if previous children known
- Health Visitor if previous children
- Other agencies involved with the parent(s) eg drug/alcohol, CPN
- GP

The strategy meeting should be held at the hospital responsible for the mother's ante-natal care to enable as many health professionals to attend.

The purpose of the strategy discussion is to decide whether there are grounds for section 47 child protection enquiries.

If the decision of strategy discussion is to undertake a section 47 enquiry, the meeting will draw up a plan as to what information needs to be gathered and which professionals and family need to be spoken to. Further strategy discussions may need to be held to consider information gathered and to update plans.

If, however, the assessment does indicate that the baby will be at risk of significant harm then an initial child protection conference must be convened to and an outline child protection plan.

Initial Child Protection Conference

Ideally, the conference should be held as early as possible prior to the expected birth.

The child protection conference, and subsequent child protection review conferences, will have the same status, and proceed in the same way, as other child protection conferences and reviews.

If the decision is made to proceed with a child protection plan for the unborn child, then the name ("Baby".....mother's name) and the due date of delivery should be entered on all electronic and hard copy records. The baby's record should be linked with any previous siblings known to agencies and the mother's record. When the baby is born the midwife should inform the social worker, who should inform the relevant Child Protection Chair.

The core group will meet 10 days following the initial child protection conference and at frequent intervals, as agreed in the child protection plan.

Post birth

A core group must be held before the baby is discharged from hospital, and the Child Protection Chair informed of the baby's arrival. The minutes must record:

- Outcome of any ongoing assessment;
- Post birth plans, including Child Protection Plan and any plan to remove child;
- Managing non co-operation.

Detailed written plans need to address:

- Who should the hospital contact when mum admitted / in labour / baby delivered?
- What happens if baby born out of hours?
- What level of contact / care [supervised or not] can the parents have?
- Who will supervise contact if it is required?
- What is the plan in relation to breast feeding?
- What are the arrangements for initial legal proceedings?
- Are the parents aware of the plan & what is their attitude?

If a decision to remove the baby at birth has been made, presentation to the resource Panel must be made as early as possible, following approval, a referral to the fostering service should be made for carers to be identified.

Midwifery and Health Services to be informed of area of possible placement.

Child Protection Review

Child protection review conferences' should take place within the agreed timescales in Devon's Child Protection procedures. A review must take place within 1 month of the child's birth.

A baby made subject to a child protection plan will remain on a child protection plan for a minimum of six months after birth.

If the child protection plan identified the need for a residential mother and baby placement, which has been agreed by the parent(s), the baby will be accommodated under section 20 (Children Act, 1989). In addition to being accommodated, the baby will remain on a child protection plan for a minimum of six months whilst parenting assessments take place.

APPENDIX 1

Guidance on the Content of the Pre-Birth Assessment

Assessment is not an exact science, but can be made as sound as possible if it includes the following three elements:

- what research tells us about risk factors
- what practice experience tells us about how parents may respond in particular circumstances
- the practitioners' professional knowledge of this particular family
- Any domestic violence and abuse should trigger increased concern for the victim as pregnancy is a recognised factor that can heighten abuse and place the victim at increased risk of significant harm

Lists of risk factors are helpful but not sufficient in themselves for assessment purposes and they need to be grounded in a theoretical framework.

The content of a sound assessment will be formed by looking at relationships – between parents/carers, between parents/carers and the child (whether born or unborn) – looking at how previous history shapes current experiences and the context within which people are living. This is consistent with the Framework for Assessment of Children in Need and their Families.

A key task in the preparation of a pre-birth assessment is to identify a fundamental baseline of acceptable parenting skills against which change can be monitored. This task is required to support any court proceedings which may take place at a later date.

The vital step when planning a pre-birth assessment is to review any previous history. This will entail reading the case files on any child/ren who have been removed from the parents care, ensuring that searches are done on any new partners in the household.

It is essential to construct a chronology of key events from the previous history, as repeated serious case reviews point to failures in drawing information together, analysing it and identifying patterns that, when seen together, change the perspective of the case. It is essential to include as much information from other agencies as possible and, if feasible, ask them to contribute to the chronology. The knowledge gained from the chronology will help direct the assessment.

Previous History

Reder and Duncan (1999) propose that maltreating parents may experience “care” and/or “control” conflicts in which the parents’ own experiences of adverse parenting left them with unresolved tensions that spilled over into their adult relationships:

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

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

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

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

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

- do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
- do they accept responsibility for their role in the abuse?
- do they blame others?
- do they blame the child?
- do they acknowledge the seriousness of the abuse?
- did they accept any treatment/counselling?

- what was their response to previous interventions? e.g. genuinely attempting to cooperate or tokenistically compliant?
- what are their feelings about that child now?
- what has changed for each parent since the child was abused/removed?

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

It will be also be important to ascertain the parents' feelings towards the current pregnancy and the new baby including:

- is the pregnancy wanted or not?
- is the pregnancy planned or unplanned?
- is this child the result of sexual assault?
- is severe domestic violence an issue in the parents' relationship?
- is the perception of the unborn baby different/abnormal? Are they trying to replace any previous children?
- have they sought appropriate ante-natal care?
- are they aware of the unborn baby's needs and able to prioritise them?
- do they have realistic plans in relation to the birth and their care of the baby?

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

- the ability of the perpetrator to accept responsibility for the abuse (this should not be seen as lessening the risk for additional children)
- the ability of the non-abusing parent to protect the fact that the child has been removed from their care suggests that there have been significant problems in these areas and pre-birth assessment will need to focus on what has changed and the prospective parent(s) current ability to protect.

Relevant questions when undertaking a pre-birth assessment when previous sexual abuse has been the issue include:

- the circumstances of the abuse: e.g. was the perpetrator in the household?, was the non-abusing parent present? the severity of the abuse?
- what relationship/contact does the mother have with the perpetrator (assuming the man as perpetrator - however, this is not always the case)?
- how did the abuse come to light? e.g. did the non-abusing parent disclose or conceal? did the child tell? did professionals suspect?
- did the non-abusing parent believe the child? did they need help and support to do this?
- what are current attitudes towards the abuse? do the parents blame the child/see it as her/his fault?
- has the perpetrator accepted full responsibility for the abuse? how is this demonstrated? what treatment did he/she have?
- who else in the family/community network could help protect the new baby?
- how did the parent(s) relate to professionals? what is their current attitude?

In circumstances where the perpetrator is the prospective father or is living in the household, where there is no acknowledgement of responsibility, where the non-abusing parent blames the child and there is no prospect of effective intervention within the appropriate time-scale, then confidence in the safety of the newborn baby and subsequent child will be poor.

Circumstances where the perpetrator is convicted for posing a risk to children and is already living in a family with other children, (albeit with social work involvement), should not detract for the need for a pre-birth assessment. In all assessments it is important to maintain the focus on both prospective parents, and any other adults living in the household and not to concentrate solely on the mother.

Mental Health Problems

Although most parents with psychiatric problems are able to care for their children appropriately, research has indicated that child-maltreating parents are often shown to have mental health problems e.g. depression, history of attempted suicide, schizophrenia etc. Non-compliance with medication without medical supervision is a cause for concern.

Children are at increased risk of abuse by psychotic parents when incorporated into their delusional thinking e.g. “(the baby) is trying to punish me for my sins”.

Practitioners will obviously seek to obtain a psychiatric assessment in these cases but must not become “paralysed” if that is not forthcoming. It is essential to continue the assessment based on the behaviour of the parent(s), not the diagnosis, and the potential risk of that behaviour to the new-born child. In addition, where there are mental health risk factors identified, ongoing reevaluation of risk is essential.

Substance Abuse

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

- the pattern of drug use and alcohol misuse
- whether it can be managed compatibly with the demands of a new-born child
- whether the parent(s) are willing to attend for treatment, and
- the consequences for the baby of the mother’s substance misuse during pregnancy e.g. withdrawal symptoms.

Violence

“Before the birth of the first child is an ideal time to provide support, so that new enriching habits can be established before bad habits have begun and become embedded”. (Tackling the roots of violence WAVE Report 2005)

A current and/or previous history of violence should be carefully evaluated. Detail should be obtained about:

- the nature of violent incidents,
- their frequency and severity, and
- information on what triggers violent incidents.

Research (Reder and Duncan, 1995, p.49; Reder and Duncan, 1999, pp. 62-71) has indicated that the risks are greater when a parent with unresolved care and control conflicts is caring for a baby with particular characteristics which may make him/her harder to care for e.g. a poor feeder or sleeper, constant crying, a disabled child etc. When a prebirth assessment is being done the child is, as yet, unborn and unknown but there may be clues e.g.

- antenatal depression
- the child may be at risk of a premature birth and therefore vulnerable and likely to stay in hospital for a period after delivery

- mother's misuse of substances may result in the child having withdrawal symptoms or foetal alcohol syndrome
- circumstances that may lead to the child being perceived as unwanted by either parent.

It is essential that there is close liaison with the midwives and obstetricians in relation to these factors.

Examination of the history of previous children who have been removed from the parent(s) care will indicate if there were particular characteristics which made that child harder to care for. It is essential to find out from the parent(s) what problems, if any, they identified in caring for that child.

Caring for a new born baby is difficult enough for any parent but can be particularly stressful if the parent(s) are isolated and do not have a network of support. It is important to identify whether partners are going to share responsibility or whether it will fall to one, usually the mother.

Research (Reder and Duncan, 1999, p.69) has indicated that when children have been abused the trigger may often be a family crisis e.g. loss of home or job, marital problems or upheavals, physical exhaustion etc. However, there are many other triggers and factors that will need to be considered within an assessment.

It is therefore important to identify the support networks that the parent(s) have, their financial and housing position. Clear guidelines are outlined in the Framework for Assessment of Children in Need and their Families.

Once the information has been collected it needs careful analysis. This should be a shared process with the other agencies involved, particularly the midwives and obstetricians. This will be primarily the task of the core group.

If the assessment identifies that there are clear risks to a newborn baby then key judgements will be:

- whether there is evidence of the parent(s)' capacity to change
- will the provision of support and services be sufficient to enable the parent(s) to care safely for their baby?
- will they be able to change in time for the baby's birth?
- whether the parents have appropriate support networks

If the completed assessment indicates that the newborn baby is likely to suffer significant harm then it should be presented to a child protection conference. Where a child is given a child protection plan at birth, a meeting must include the allocated social worker and all other relevant core group members.

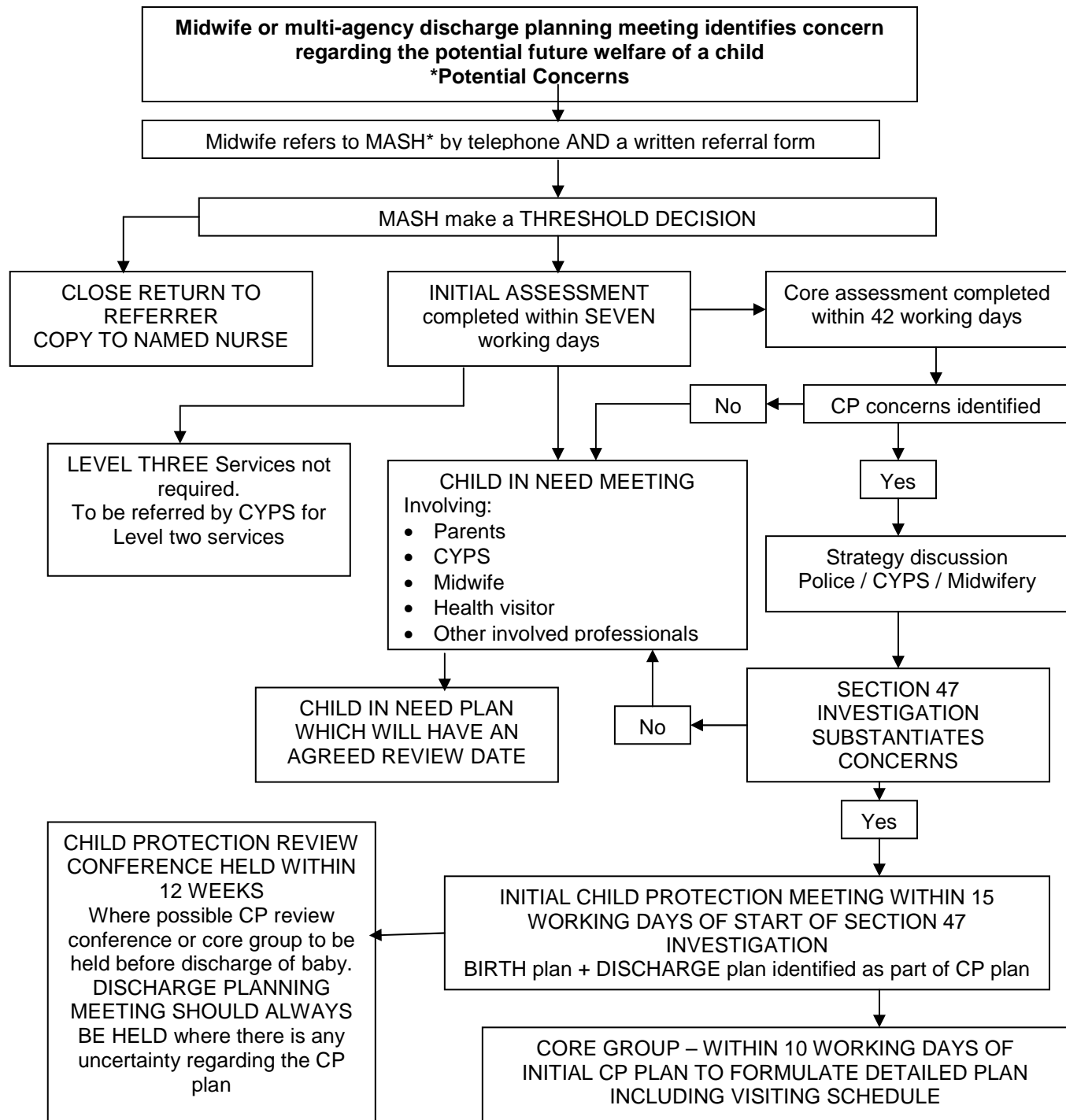
If the assessment concludes that the child should be removed at birth, the legal advice forum must be consulted and the Public law Outline process followed. There should be a clear plan outlining responsibilities and all parties must be aware of the arrangements prior to the child's birth. This will include clear guidelines on actions to be taken by hospital staff should the parents decide to try to remove the child from the hospital.

If the assessment concludes that the new born baby will not be at such risk but will be a child "in need" then planning and services should continue under s.17 of the Children Act 1989.

APPENDIX 2

MIDWIFERY / CHILDREN AND YOUNG PEOPLE'S SERVICES (CYPS) INVOLVEMENT

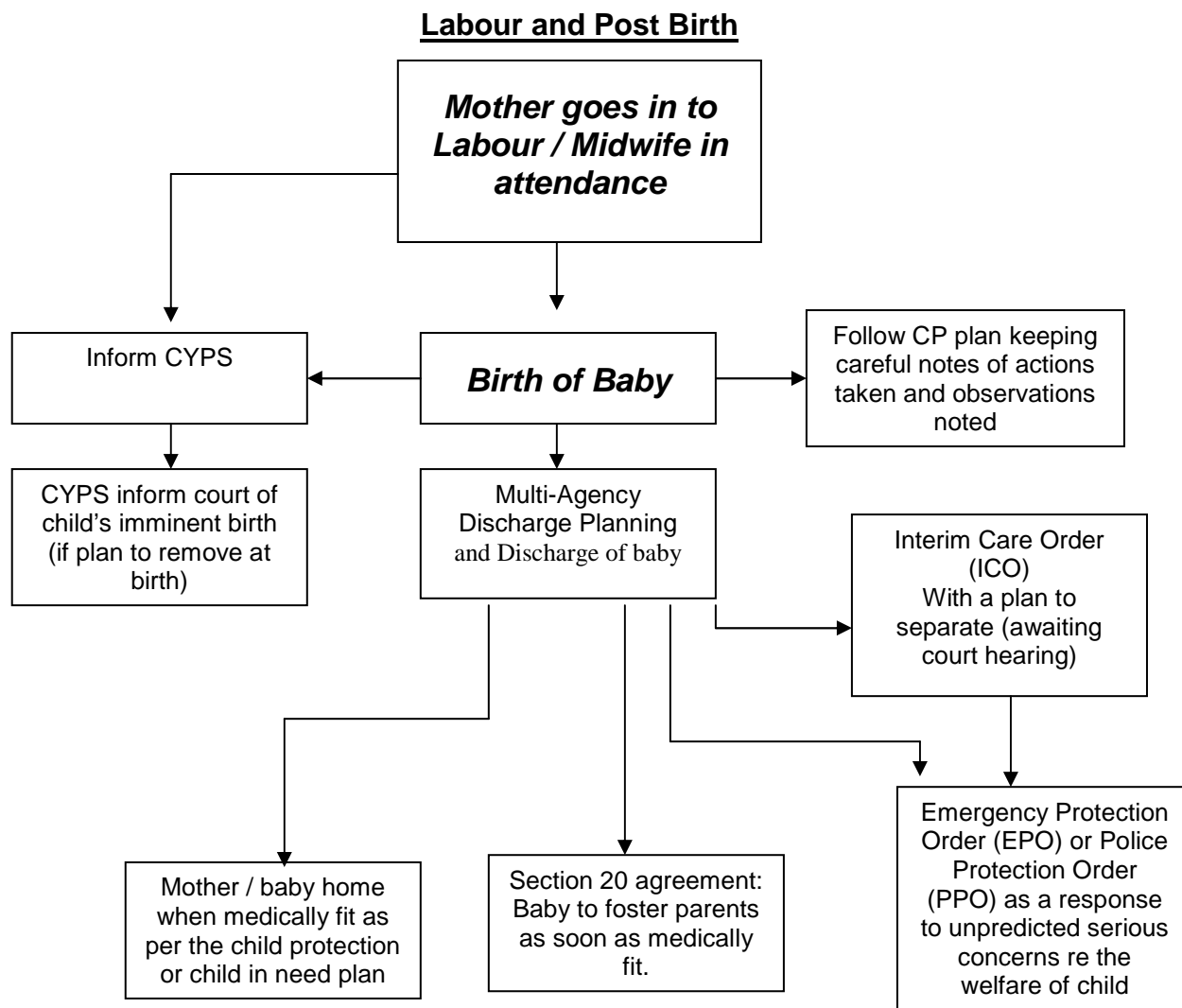
PRE-BIRTH



*MASH Multi-Agency Safeguarding Hub

APPENDIX 3

MIDWIFERY / CHILDREN AND YOUNG PEOPLE'S SERVICES (CYPS) INVOLVEMENT



Where babies cannot be cared for by parents as a result of Child Protection Planning and where there is a medical need for baby to be an inpatient, ie assessment scoring – baby to be admitted to a Neonatal (NNU) or Special Care Baby Unit (SCBU).

Contact arrangement for babies likely to be on NNU or SCBU to be decided at Child Protection Meeting.

APPENDIX 4

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