# CAMBRIDGESHIRE AND PETERBOROUGH

# PRE-BIRTH PROTOCL 2019

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# 1. Introduction

It is critical, that all Local Children's Safeguarding Boards (LSCBs) and Children's services have robust procedures in place, both to identify the children most at risk and then to effectively manage their protection.

The very nature of the work dictates that the most successful preventative action is taken if these children are identified pre-birth. This early warning system can only operate in a meaningful way if there is an agreed interagency commitment to the importance of this area of Child Protection and that professionals work together to assess and manage the response to this high-risk group. As prescribed in Working Together (2015) the key agencies in terms of identification and intervention are Childrens Services, Maternity Services; Primary Care Services; Adult Mental Health; Community Drug and Alcohol Services; Probation; Police and Learning Disability Services.

The Guidance should support all professionals in identifying risk factors and assist in constructing meaningful plans in partnership with parents that will protect the unborn child from harm.

Where required, advocates and or language communication interpreters should be made available to the parents throughout the process.

This guidance aims to:

- Clarify what is meant by Pre-birth Child & Family assessments and the circumstances in which they should be used
- Set out the procedures in relation to them
- Provide a framework for the content of such assessments

# 2. Referral Stage

Any professional who becomes aware that a woman is pregnant and has cause to be concerned that the new-born baby may be at risk of significant harm and/or the parents would require significant levels of support to care for the child should make a referral to the Children Services as soon as possible **irrespective of the time of pregnancy**.

<u>A case must be referred if any of the following factors are present:</u>

- There is significant domestic violence or escalation during pregnancy and/or honour based violence.
- A parent has significant mental health difficulties/diagnosis. S/he may be subject to an enhanced CPA. (Care Programme Approach).
- A parent has moderate or severe learning disabilities.
- A parent misuses substance/s that will have a significant impact on the health and development of the baby.
- A parent has had a child previously removed from their care or has a child voluntarily accommodated.

- A parent is a current looked after child or was previously in care.
- A parent of 18 years and under where there are concerns about sexual exploitation, trafficking or abuse.
- Parent is previously suspected of fabricated or induced illness.
- A parent is suspected of being involved in a forced marriage
- A parent is suspected of being a victim or involved in spirit possession or witchcraft
- A parent whatever age is suspected or known to have been the victim of grooming and/or sexual exploitation and the putative father is unknown or known to be the one who groomed them
- The parent is a victim or involved in honour based violence
- Incest is suspected
- If the parent is known to move authorities in an attempt to avoid professionals
- A parent/relative or associate is some-one who may represent a risk to children, or has previously harmed a child. (This would include issues such as a violent history; significant criminal history; sexual offences against adults or children etc.)
- The baby once born will be living with or having contact with someone who may represent a risk to children (see above).
- A sibling is subject to a child protection plan.
- There are significant concerns about the home conditions, such that the baby may suffer physical neglect
- One or both parents' behaviour or circumstances during pregnancy indicates that they will be unlikely to protect or care for their baby appropriately e.g. living a chaotic lifestyle with no home base; significant emotional instability; lack of preparation/awareness of the impact of becoming a parent.
- Late booking for maternity care with an inadequate explanation

However when a pregnancy is discontinued whether through termination or miscarriage, consideration of referral to Children's Services should be made if there are any remaining safeguarding concerns relating to another child.

*This list is not exhaustive and if a professional is in doubt about making a referral, s/he should always seek advice.*

All referrers are required to complete a **Joint Referral form** and **email the Contact Centre.**

**Childrens Services**

**Peterborough**

Telephone: 01733 864170

Email: ReferralCentre.Children@cambridgeshire.gov.uk

Out of hours emergencies 01733 234724.

**Cambridgeshire**

Telephone: 0345 045 5203

Email: ReferralCentre.Children@cambridgeshire.gov.uk

Out of hours emergencies 01733 234724.

This referral will progress through MASH and onto the First Response Team for a Child & Family Assessment to be considered and the threshold for a Pre-birth Child & Family Assessment being met and started.

The benefit of clear information from the referrer will assist in determining thresholds, it being important, that the expected date of delivery (EDD) is ascertained from the referrer at the point of referral, with the details of the father of the child and if different the male partner of the mother. These should be recorded on Liquid Logic. In addition to any Multi-Agency Information sharing meeting held during the assessment stage, any unborn baby referred to Childrens Services who meets thresholds for a C&F Assessment will be reviewed by the Multi-Agency Unborn Tracking Panel. This Panel meets 4 weekly to provide an overview of all unborn babies referred to Childrens Services and to map and make recommendations to the Social Work Team to ensure the unborn baby is safeguarded and reviewed in line with this Guidance.

The Panel members include:

Chair – Group Manager from Children's Services

- Named midwife
- Named Nurse
- Lead Midwife
- Health Visitor Liaison
- Team Manager - Adoption service.
- Legal Services
- Business Support
- Lead Social Worker for the case being heard

Minutes and recommendations from the tracking meeting are recorded onto the child's Liquid Logic social care case file and any other recording system in use and reviewed by the Team Manager in supervision.

## 3. Assessment Stage

As with all other referrals received a decision to initiate a Child & Family Assessment will be made by the Team Manager in First Response or the Team where the referral is received and whether the assessment will be a Pre-birth assessment under this guidance.

All assessments should commence under s17 with the assessment completed within 45 working days and use of a chronology as an effective way to see what is happening as it helps identify patterns and issues – invaluable in assessing risk and when analysing the likely impact of events. At the 15 day Multi Agency Information Sharing meeting, consideration should be given to as to whether the criteria for an s47 investigation appear to be met. If so, the Team Manager needs to authorise this view and convene a strategy discussion with Police and Health on day 20 of the C&F Assessment.

If an s47 investigation is not appropriate, then the s17 assessment should continue to its conclusion and the needs of the UBB determined at that time (see flowchart).

The main purpose of a Pre-birth C&F assessment is to identify:

- What the needs of and risks to the new-born child may be;
- Whether the parent/s are capable of recognising these and working with professionals so that the needs can be met and the risks reduced;
- What support the parents may need;
- What plan is required to ensure the needs are meet and risks addressed.

There are three fundamental questions when deciding whether a pre-birth assessment is required:

- Is it likely the new-born 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
- Have previous Childrens Services involvement previously identified that a new baby would be at risk

The Team Manager will be responsible for determining which pathway the case then takes.

| Child In Need Route | Child Protection Route |
|---|---|
| Where threshold is met for an ongoing role for Childrens Services, a Pre-birth Child & Family Assessment should be undertaken. It is very important that this assessment involves relevant multiagency professionals directly in the assessment.<br>15 days after the assessment has started a Multi-Agency information sharing meeting should be held, led by the allocated Social Worker. All professionals involved in the care of the prospective baby/parents should make themselves available to attend. If individual practitioners cannot attend, a written report must be submitted. The purpose of the meeting is to ensure that all professionals are aware of the same information and contribute to the developing picture of the prospective parents and their parenting capacity. It is ultimately the role of the Social Worker to determine the levels of risk involved in any particular Pre-birth Child & Family Assessment, but there is an expectation that this is supported by non-judgemental, evidence-based information and advice from other professionals, especially those with an expertise in the areas of drug and alcohol; mental health and learning disability. The strengths of any prospective parents should be considered alongside concerns, and there should be an explicit focus on issues of equality and diversity for each family, and how these will influence their ability to care for a baby. It is crucial to involve health visitors and midwifery in the assessments. There should be at least one joint visit made with the health visitor and midwife during the course of | Potential risks to the unborn child should be flagged up as early as possible to inform effective planning from a strategy meeting at day 20 of the C&F Assessment and subsequent s47 enquiry and pre-birth Initial Child Protection Conference, in order to gather information at an early stage including relevant Police checks including from overseas if the parent has come from another country.<br><br>In cases where previous children have been removed from either parent and continue to be Looked After, or are a Care Leaver, the allocated Social Worker or Personal Advisor, must be invited to the Strategy Meeting in order to provide relevant background information and history. It is crucial to involve health visitors and midwifery in the strategy meeting to ensure full information is available to all agencies.<br><br>In cases where care proceedings have been conducted, the social worker should contact the Legal Department to request a copy of and read the legal bundle from those proceedings.<br><br>Any case of late presentation or referral may require immediate action, and may move straight to Child Protection or legal planning. |

| | |
|---|---|
| the assessment and other joint visits with the health specialist, such as the Family Nurse Partner and relevant agencies as appropriate.<br><br>If sufficient concerns emerge at any time during the assessment or from the Multi-Agency information sharing meeting, a Strategy Meeting should be requested from the relevant Team Manager within Childrens services, to determine if an s47 Child Protection enquiry should be commenced and pre-birth Child Protection Case Conference held.<br><br>Any case of late presentation or referral may require immediate action, and may move straight to Child Protection or legal planning. | |

**Late Bookings and Concealed Pregnancy**

For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 24 weeks of pregnancy and/or who are referred to Childrens Services social care after this point.

There are many reasons why women may not engage with ante-natal services or conceal their pregnancy, some of which may result in heightened risk to the child.

Some of the indicators of risk and vulnerability are as follows:

- 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.

N.B. This list is not exhaustive.

In cases where there are issues of late booking and concealed pregnancy, late referral or other identified immediate risk of significant harm it is extremely important that careful consideration is given to the reason for concealment, assessing the potential risks to the child and convening a Strategy Meeting as a matter of urgency.

Any plan arising from a Strategy Meeting should decide on the following:

- Timescales for completion of an Pre-Birth C&F Assessment which is not beyond 45 working days;
- Convening a Legal Planning Meeting to consider whether the Public Law Outline process should be commenced
- Contingency planning undertaken to look at alternative care and which will include a Permanency planning Meeting if PLO or Care Proceedings are instigated;

## Parental Non-Engagement

There are many reasons why expectant mothers may fail to engage with the assessment, some of which relate to the factors outlined above. For example, a parent suffering from mental health problems may be reluctant to attend appointments or be compliant with medication. It is extremely important that parental non-engagement does not become the reason for delaying the assessment and making multi-agency plans and contingency plans for the birth of the baby. Any assessment started from the point of referral must be completed by 45 working days.

## Pre-birth Initial Child Protection Conferences

There should be no delay in booking a Pre-birth Conference to ensure an appropriate protection plan is in place prior to the baby's birth as soon as the threshold for a Pre-birth Conference has been met.

## Child Protection Plan

If a decision is made that the baby needs to be the subject of a Child Protection Plan the plan must be outlined to commence prior to the birth of the baby. It is critical to use this time to assess the capacity of the prospective parents and their extended families to meet the needs of the UBB, both now and once it is born. Any PLO process will expect active assessment, possibly by external assessors, during this phase of intervention.

### Core Group

The first core group meeting will be designated a pre-birth planning meeting as well as addressing the Child Protection Plan. All essential professionals and the prospective parents should attend and a written plan constructed. This must consider:

- Practical arrangements for mother and baby-including post-natal ward monitoring
- Who will inform the Social Worker of the birth?
- Plans for out of hours/emergency birth
- Contact arrangements with parents and other family members
- Discharge plans and support package-including out of area as relevant e.g. if discharging to extended family or friends address for any period or specialist setting
- Management of parental non-co-operation
- Arrangements for legal proceedings/removal
- Parental attitudes to the plans
- Health and safety issues
- Ongoing assessment of parents

All subsequent Core Group/Pre-Birth Planning meetings should incorporate the above plan in its discussion and decisions.

### Pre-birth Review Child Protection Conference.

The first Review Conference should take place within one month of the child's birth or within three months of the date of the Pre-birth Conference whichever is sooner. It is important that the parents' capacity to change and reduce risk factors for the UBB are considered carefully at this CPC.

## 4. Public Law Outline

In cases where it has been agreed by a Head of Service that a Legal Planning Meeting should be undertaken and the Public Law Outline framework instigated, this should be started following the Pre-Birth Child Protection Conference. However if the baby is due within three months from the referral and the level of concerns are identified at the referral stage the Head of Service should be alerted for a Legal Planning meeting to be convened earlier where the threshold for Legal Planning is met. This will also trigger the instigation of Permanency Planning processes and if PLO or legal action is being progressed a Permanency Planning Meeting should be booked. Please see the Permanency Planning Procedures for further information.

## 5. Birth Planning & Safeguarding

If the unborn baby is the subject of Child Protection and/or PLO a Birth Plan should be written and implemented.

The purpose of the plan is to ensure the baby's protection and welfare at and immediately after birth so that all members of the hospital team are aware of the plans and actions expected. The plan should address:

- How long the baby will stay in hospital;
- How long the hospital will keep the mother on the ward;
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the e.g. parental substance misuse;
- The risk of potential abduction of the baby from the hospital particularly where the plan is to remove the baby at birth;
- The plan for contact between mother, father, extended family and the baby whilst in hospital. Consideration to be given to the supervision of Contact - for example whether Contact supervisors need to be employed;
- Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding;
- To plan for the baby upon discharge, where alternative care has been agreed, e.g. discharge to extended family members; mother and baby foster placement; foster care, supported accommodation;
- Contingency plans should also be in place in the event of a sudden change in circumstances;
- The Children's Emergency Duty Team (Out of Hours Service) Tel No: 01733 234724 should also be notified of the birth and plans for the baby.

All of these decisions will be guided by the level of intervention from the relevant pathways being Child In Need, Child subject to a Child Protection Plan and or subject to Public Law Outline procedures.

## 6. Birth and Discharge of a New-born Baby

The hospital midwife must inform the allocated social worker of the birth of the baby where agreed within the discharge plan and there must be close communication between all agencies around the time of labour and birth, with the allocated Social Worker informing the allocated/duty lawyer where legal action is planned.

## 7. Guidance on the Assessment

An assessment is not an exact science, but can be made as through 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

The content of a Pre-birth Child & Family Assessment will be formed by collating factual evidence, looking at relationships between parent/carers, between parents/carers and the child (whether born or unborn) and looking at how previous history shapes current experiences in the context of parents/carer circumstances. This is consistent with the Framework for Assessment of Children in Need and their Families and should be applied in conjunction with the assessment tools below to inform the assessment.

# Pre Birth Assessment Guidance for completion of the Pre-Birth Child & Family Assessment.

## 1) Introduction

This Guidance is designed to help professionals to carefully consider a range of themes and to consider issues that have potential for having a significant negative impact on the child in completing a Pre-birth Child & Family Assessment. The Template to use is the Child & Family Assessment but with an unborn baby this will result in a Pre-birth Child & family Assessment following this guidance to inform the relevant domains

The word "parent" should be interpreted as appropriate to mean the mother and father, the mother's partner, anyone with parental responsibility and anyone else who has or is likely to have day to day care of the child. It is crucial to involve everyone who is a potential parent or carer in the assessment.

## 2) General Guidance

Antenatal care begins as soon as the pregnancy has been confirmed and midwives continue care in the postnatal period for at least 10 days following birth. A booking interview with the community midwife takes place usually between 8-12 weeks gestation. It is at this interview that the midwife is able to assist women in their choices for childbirth and ensure they are informed of all the options available to them.

Women are given choices in early pregnancy of lead professional and place of birth:

Midwife-led care (MLC) means the midwife is the lead professional. All antenatal care would be conducted in the community and is often shared with the General Practitioner (GP). Women would have the choice of giving birth in the hospital under MLC or at home with midwives in attendance.

GP led care is less frequently offered and again all antenatal care is conducted in the community and is shared between GP and community midwife. The place of birth is rarely at home with the GP in attendance so most GP births occur in a low risk hospital environment.

Consultant led care is offered to women who have recognised health risk factors or who choose to see the consultant team. These pregnancies require additional surveillance both pre-birth and in labour. Care is shared between the community midwife, GP and a hospital consultant team consisting of midwives and doctors specialising in care of high risk pregnancy. Delivery of the baby will take place in the hospital.

The booking interview is a time for collection of information and an opportunity for the midwife and mother to plan her care in pregnancy. It is an ideal time for the midwife to assess health and social needs of families and to consider packages of care and support suitable for individual needs.

Antenatal appointments are arranged to suit the individual clinical needs of the mothers and the initial choices may change if complications of pregnancy arise. A collaborative approach between all health professionals is encouraged with direct midwife referral to obstetrician being available at all times.

In the case of home births all postnatal care is provided in the home by the community midwife. For births in hospital - with either the midwife, GP or obstetrician as the lead professional - initial postnatal care is provided by midwives and support staff on the maternity wards. Hospital stays are getting shorter with many women going home within a few hours of birth but generally 12-48 hours are the more normal lengths of stay. On transfer home care is undertaken by the community midwife for at least 10 days following the birth. Care can be extended to up to 28 days if a particular clinical or social need is identified. Liaison between the Health Visitor attached to the GP's surgery and community midwife usually takes place during the antenatal period with some Health Visitors making contact with the mother in pregnancy. Following the birth of the baby most Health Visitors arrange a primary visit at 10 days postnatal, which coincides well with the handover of care from the midwives.

## 3) Information Required from Midwife / Health Professional as Part of a Pre-Birth Risk Assessment

This section could be completed by an appropriate Health Professional and sent to the Social Worker to assist in the completion of the Pre-birth Child & Family Assessment. The central question is whether there is anything in the medical and obstetric history that seems likely to have a significant negative impact on the child? and if so, what?

### Medical and Obstetric issues

- Are there any aspects of any of the following items that seem likely to have a significant negative impact on the child? If so, what, and how?
- Whether pregnancy planned or unplanned?
- Feelings of mother about being pregnant?
- Feelings of partner / putative father about the pregnancy?
- Dietary intake - and related issues?
- Medicines or drugs - whether or not prescribed - taken before or during pregnancy?
- Alcohol consumption?
- Smoking?
- Previous obstetric history?
- Miscarriages and terminations?
- Chronic or acute medical conditions or surgical history?
- Psychiatric history - especially depression and self-harming?

## 4) Assessment of Parents and Potential Risks to Child

This section will be completed by the Social Worker - but they will draw on help from a range of other professionals regarding some aspects of it.

Particular care should be taken when assessing risks to babies whose parents are themselves children. Attention should be given to:

a) evaluating the quality and quantity of support that will be available within the family and extended family
b) the needs of the parent(s) and how these will be met
a) the context and circumstances in which the baby was conceived
b) the wishes and feelings of the child who is to be a parent.

### 1. Relationships

- Partner support?
- History of relationships of adults?
- Current status?
- Positives and negatives?
- Violence?
- Who will be main carer for the baby?
- What are the expectations of the parents re each other re parenting? Is there anything regarding "relationships" that seems likely to have a significant negative impact on the child? If so, what?

### 2. Abilities

- Physical?
- Emotional? (including self-control);
- Intellectual?
- Knowledge and understanding re children and child care?
- Knowledge and understanding of concerns / this assessment? Is there anything regarding "abilities" that seems likely to have a significant negative impact on the child? If so, what?

### 3. Social history

- Experience of being parented?
- Experiences as a child? And as an adolescent?
- Education?
- Employment?

Is there anything regarding "social history" that seems likely to have a significant negative impact on the child? If so, what?

### 4. Behaviour

- Violence to partner?
- Violence to others?
- Violence to any child?
- Drug misuse?
- Alcohol misuse?
- Criminal convictions?
- Chaotic (or inappropriate) life style?

Is there anything regarding "behaviour" that seems likely to have a significant negative impact on the child? If so, what?

If drugs or alcohol are a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

### 5. Circumstances

- Unemployment / employment?
- Debt?
- Inadequate housing / homelessness?
- Criminality?
- Court Orders?
- Social isolation?

Is there anything regarding "circumstances" that seems likely to have a significant negative impact on the child? If so, what?

### 6. Home conditions

- Chaotic?
- Health risks / insanitary / dangerous?
- Over-crowded?

Is there anything regarding "home conditions" that seems likely to have a significant negative impact on the child? If so, what?

### 7. Mental Health

- Mental illness?
- Personality disorder?
- Any other emotional/behavioural issues?

Is there anything regarding "mental health" that seems likely to have a significant negative impact on the child? If so, what?

If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

## 8. Learning Disability

Is there anything regarding "learning disability" that seems likely to have a significant negative impact on the child? If so, what?

If learning disability is likely to be a significant issue, more detailed PAMS assessment should be sought from professionals with relevant expertise in undertaking this type of assessment.

## 9. Communication

- English not spoken or understood?  Deafness or blindness  Speech impairment?
- Cultural issues

Is there anything regarding "communication" that seems likely to have a significant negative impact on the child? If so, what?

If communication is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

## 10. Support

- From extended family?
- From friends?
- From professionals?
- From other sources?

Is there anything regarding "support" that seems likely to have a significant negative impact on the child? If so, what?

Is support likely to be available over a meaningful time-scale?

Is it likely to enable change?

Will it effectively address any immediate concerns?

## 11. History of being responsible for children

- Convictions re offences against children?
- CP Registration?
- CP concerns - and previous assessments?
- Court findings?
- Care proceedings? Children removed?
- Current health status of other children?

Is there anything regarding "history of being responsible for children" that seems likely to have a significant negative impact on the child? If so, what?

If so also consider the following:

- Category and level of abuse;
- Ages and genders of children;
- What happened?
- Why did it happen?
- Is responsibility appropriately accepted?
- What do previous risk assessments say? Take a fresh look at these - including assessments re non-abusing parents;
- What is the parent's understanding of the impact of their behaviour on the child?
- What is different about now?

**12. History of abuse as a child**

- Convictions - especially of members of extended family?
- CP Registration?
- CP concerns
- Court findings?
- Previous assessments?

Is there anything regarding "history of abuse" that seems likely to have a significant negative impact on the child? If so, what?

**13. Attitude to professional involvement.**

- Previously - in any context?
- Currently - regarding this assessment?
- Currently - regarding any other professionals?

Is there anything re "attitudes to professional involvement" that seems likely to have a significant negative impact on the child? If so, what?

**14. Attitudes and beliefs re convictions or findings (or suspicions or allegations)**

- Understood and accepted?
- Issues addressed?
- Responsibility accepted?

Is there anything regarding "attitudes and beliefs" that seems likely to have a significant negative impact on the child? If so, what?

It may be appropriate to consult with the Police or other professionals with appropriate expertise.

**15. Attitudes to child**

- In general?
- Re specific issues?

Is there anything regarding "attitudes to child" that seems likely to have a significant negative impact on the child? If so, what?

### 16. Dependency on partner

- Choice between partner and child?
- Role of child in parent's relationship?
- Level and appropriateness of dependency?

Is there anything regarding "dependency on partner" that seems likely to have a significant negative impact on the child? If so, what?

### 17. Ability to identify and appropriately respond to risks?

Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

### 18. Ability to understand and meet needs of baby

Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

It may be appropriate to consult with Health professionals re this section.

### 19. Ability to understand and meet needs throughout childhood

Is there anything regarding this that seems likely to have a significant negative impact on the child? If so, what?

It will usually be appropriate to consult with relevant Health professionals re this section.

### 20. Ability and willingness to address issues identified in this assessment

- Violent behaviour?
- Drug misuse?
- Alcohol misuse?
- Mental health problems?
- Reluctance to work with professionals?
- Poor skills or lack of knowledge?
- Criminality?
- Poor family relationships?
- Issues from childhood?
- Poor personal Care?
- Chaotic lifestyle?

Is there anything regarding "ability and willingness to address issues" that seems likely to have a significant negative impact on the child? If so, what?

It will usually be appropriate to consult with other professionals re this section.

**21. Any other issues that have potential to adversely affect or benefit the child.**

E.g. one or more parent aged under 16? Context and circumstances of conception?

**22. Planning for the future**

- Realistic and appropriate?

## Overall Risk Assessment Analysis and Conclusions (with) Recommended Actions with Timescales

**a. Concerns identified;**

**b. Strengths or mitigating factors identified;**

**c. Is there a risk of significant harm for this baby?**

It is crucial to clarify the nature of any risk - of what? From whom? In what circumstances? etc. - and to be clear how effective any strengths or mitigating factors are likely to be in reality;

**d. Will this risk arise:**

a. Before the baby is born?
b. At or immediately following the birth?
c. Whilst still a baby (up to 1 year old)?
d. As a toddler? or pre-school? or as an older child?

If there is a risk that the child's needs may not be appropriately met.

**e. What changes should ideally be made to optimise well-being of child?** If there is a risk of significant harm to the child.

**f. What changes must be made to ensure safety and an acceptable level of care for child?**

**g. How motivated are the parent's to make changes?**

**h. How capable are the parent's to make changes? What is the potential for success?**

**i. What actions should the Local Authority take?**

To assist the social worker in assessing levels of risk present and to assist planning the right level of intervention a Framework of Risk Estimation to the baby is provided, as an adaptation of Martin Calder in 'Unborn Children: A Framework for Assessment and Intervention' of R. Corner's 'Pre-birth Risk Assessment: Developing a Model of Practice'

| | Elevated Risk | Lowered Risk |
|---|---|---|
| **The abusing parent** | • Negative childhood experiences, inc. abuse in childhood; denial of past abuse;<br>• Violence abuse of others;<br>• Abuse and/or neglect of previous child;<br>• Parental separation from previous children;<br>• No clear explanation<br>• No full understanding of abuse situation;<br>• No acceptance of responsibility for the abuse;<br>• Antenatal/post natal neglect;<br>• Age: very young/immature;<br>• Mental disorders or illness;<br>• Learning difficulties;<br>• Non-compliance;<br>• Lack of interest or concern for the child. | • Positive childhood;<br>• Recognition and change in previous violent pattern;<br>• Acknowledges seriousness and responsibility without deflection of blame onto others;<br>• Full understanding and clear explanation of the circumstances in which the abuse occurred;<br>• Maturity;<br>• Willingness and demonstrated capacity and ability for change;<br>• Presence of another safe non-abusing parent;<br>• Compliance with professionals;<br>• Abuse of previous child accepted and addressed in treatment (past/present);<br>• Expresses concern and interest about the effects of the abuse on the child. |
| **Non-abusing parent** | • No acceptance of responsibility for the abuse by their partner;<br>• Blaming others or the child. | • Accepts the risk posed by their partner and expresses a willingness to protect;<br>• Accepts the seriousness of the risk and the consequences of failing to protect;<br>• Willingness to resolve problems and concerns. |
| **Family issues (marital partnership and the wider family)** | • Relationship disharmony/instability;<br>• Poor impulse control;<br>• Mental health problems; | • Supportive spouse/partner;<br>• Supportive of each other;<br>• Stable, or violent; |

| | | |
|---|---|---|
| | • Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks);<br>• Lack of support for primary carer /unsupportive of each other;<br>• Not working together;<br>• No commitment to equality in parenting;<br>• Isolated environment;<br>• Ostracised by the community;<br>• No relative or friends available;<br>• Family violence (e.g. Spouse);<br>• Frequent relationship breakdown/multiple relationships;<br>• Drug or alcohol abuse. | • Protective and supportive extended family;<br>• Optimistic outlook by family and friends;<br>• Equality in relationship;<br>• Commitment to equality in parenting. |
| **Expected child** | • Special or expected needs;<br>• Perceived as different;<br>• Stressful gender issues. | • Easy baby;<br>• Acceptance of difference. |
| **Parent-baby relationships** | • Unrealistic expectations;<br>• Concerning perception of baby's needs;<br>• Inability to prioritise baby's needs above own;<br>• Foetal abuse or neglect, including alcohol or drug abuse;<br>• No ante-natal care;<br>• Concealed pregnancy;<br>• Unwanted pregnancy identified disability (nonacceptance);<br>• Unattached to foetus;<br>• Gender issues which cause stress;<br>• Differences between parents towards unborn child;<br>• Rigid views of parenting. | • Realistic expectations;<br>• Perception of unborn child normal;<br>• Appropriate preparation;<br>• Understanding or awareness of baby's needs;<br>• Unborn baby's needs prioritised;<br>• Co-operation with antenatal care;<br>• Sought early medical care;<br>• Appropriate and regular ante-natal care<br>• Accepted/planned pregnancy;<br>• Attachment to unborn foetus;<br>• Treatment of addiction;<br>• Acceptance of difference gender/disability;<br>• Parents agree about parenting. |

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| **Social** | • Poverty;<br>• Inadequate housing;<br>• No support network;<br>• Delinquent area. | • |
| **Future plans** | • Unrealistic plans;<br>• No plans;<br>• Exhibit inappropriate parenting plans;<br>• Uncertainty or resistance to change;<br>• No recognition of changes needed in lifestyle;<br>• No recognition of a problem or a need to change;<br>• Refuse to co-operate;<br>• Disinterested and resistant;<br>• Only one parent cooperating. | • Realistic plans;<br>• Exhibit appropriate parenting expectations and plans;<br>• Appropriate expectation of change;<br>• Willingness and ability to work in partnership;<br>• Willingness to resolve problems and concerns;<br>• Parents co-operating equally. |

# APPENDIX 1 PRE BIRTH PROCESS