BIRMINGHAM CHILDREN'S TRUST

Pre-Birth Assessment Multi-Agency Protocol

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Foreword

Research evidences that young babies are particularly vulnerable to abuse but that robust work carried out in the antenatal period can help to minimize harm if there is early assessment, intervention and support.

When agencies are able to anticipate risks and vulnerabilities for an unborn baby's health and wellbeing**,** such concerns should be addressed through a pre-birth assessment. Agencies should work together and share information when required, to support this process in accordance with the: Birmingham Early Help and Safeguarding Partnership (BEHSP) Consent, Information Sharing and Threshold Guidance

The aim of the assessment is to make sure that the risks and vulnerabilities are identified as early as possible, to take any action to protect the baby (and any other existing siblings), and to support parents to care for the baby safely. A common finding in a sample of cases of babies, who were subject to a serious case review, was that there had been failings in the pre-birth assessment process and, as a consequence, in the resulting interventions.[1]

There have been longstanding concerns about a relative lack of urgency in relation to the pre-birth process. This seems to extend through all the processes of pre-birth practice – the lack of urgency of professionals making pre-birth referrals, completing pre-birth assessments, putting support plans into place and convening pre-birth conferences where appropriate. This appears to be inherent in the psychology of pre-birth work in that professionals tend to think they have much more time than they actually have.

The essence of pre-birth work should focus on the quality of multi-agency involvement, information sharing, partnership working, and meaningful engagement and involvement with families. This is always true of children's mental and physical health but is particularly relevant in relation to pre-birth work. The family GP, midwife and health visitor all have critical roles to play in relation to vulnerable expectant mothers, alongside other statutory agencies and organisations working with family members. In December 2020 the Government updated the 'Working Together to Safeguard Children 2018' to expand the number of agencies that can work collaboratively with the Trust to support a more multi-agency approach.

Purpose

The purpose of this guidance is to ensure that a clear system is in place to respond to concerns for the welfare of an unborn child and to maintain clear and regular communication within and between partner agencies.

Scope

This joint protocol applies to all agencies but particularly to all Children's Services staff (including social care and education), police, health (including mental health and substance misuse) and relevant Adult Services.

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[1] Ofsted (2011) *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

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Definitions

Concerns for the welfare of an unborn child include:

- The mother's current behaviour such as known mental health concerns or substance/alcohol misuse or chaotic behaviour that poses a threat to the unborn baby.
- The mother's inability to care for the baby to an acceptable standard, e.g. due to a significant learning difficulty, previous neglect or other children subject to a Child Protection Plan or who have been removed from parental care.
- The behaviour of the father (or any other person including the mother) who poses a threat to the unborn baby, e.g. domestic abuse or known allegations or convictions for an offence against children under 18 years of age.
- The behaviour of the father (or any other person) who will impact on the ability of the mother to care for the baby to an acceptable standard.

The presence of one of these factors does not automatically require a referral but they highlight the need to consider the known pre-disposing factors to child abuse.

In a situation where the father is the main carer, the same issues could equally apply.

This guidance should be read in conjunction with Arranging the Adoption of a Relinquished Child; Guidance, Gifted Children; Good Practice in Assessment, Planning and Intervention; Specialist Assessment Service; and the relevant Chapters in the West Midlands Child Protection Procedures on Pre-Birth Procedures and Children of Parents Who Misuse Substances.

Adopting the Right Approach

When there are concerns about the future safety or welfare of an unborn child, assessments should be made in a timely manner and plans should be put in place to support the parents, extended family and friends.

Every effort should be made towards offering practical support so that the baby can be planned for safely, whilst bearing in mind the sensitivity of the situation.

Support should be respectful and convenient for the mother, partner and family to encourage their involvement in the pre-birth process, the focus of which is to support families to stay together wherever possible.

1. Introduction

1.1 Pre-birth assessments are a proactive means of analysing the potential risk to a new born baby when there is concern about a pregnant woman, her partner or ex-partner and where relevant, her immediate family.

1.2 The main purpose of a pre-birth assessment is to identify what the risks and potential needs of the unborn child and his/her family may be, whether the parent(s) are capable of changing so that the risks can be reduced and if so, what support they will need.

1.3 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 not giving parents a chance to parent their new-born child.

1.4 Research and practice experience suggest that a pre-birth assessment should be undertaken as early in the pregnancy as possible. The anxiety created by undergoing the process can adversely affect the attachment to the unborn child. This, in turn, can aggravate the strain of caring for a new baby. The ideal time to undertake a pre-birth assessment is in the second trimester.

1.5 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 identify the potential risk factors to the baby once born, and 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.

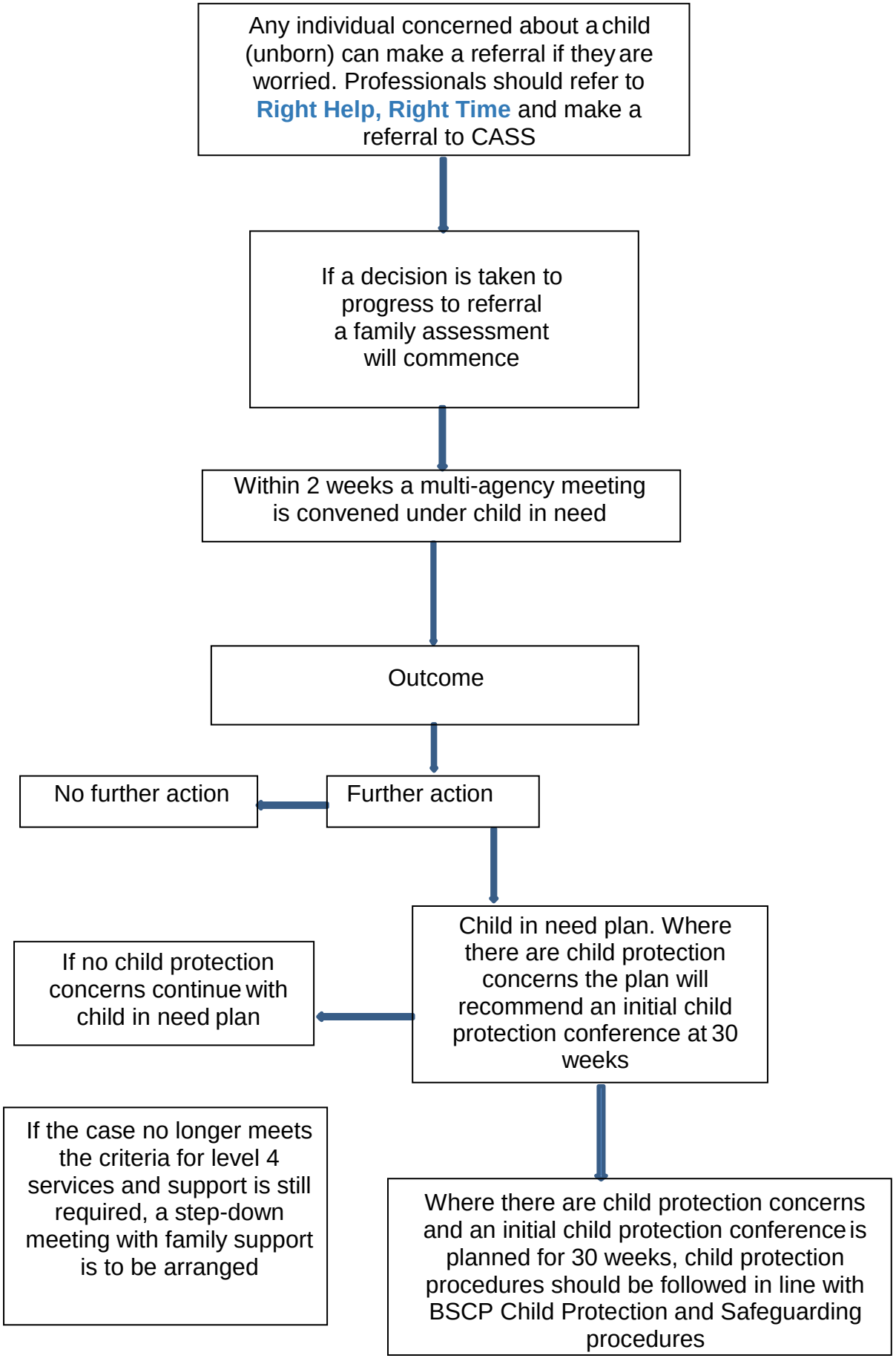
2. Raising a Concern About an Unborn Child

2.1 It is essential that when a professional has a safeguarding concern about an unborn child they gather as much information as is available from within their agency.

2.2 In December 2020 the Government updated the 'Working Together to Safeguard Children 2018' to stress the lawful processing and sharing of information to include agencies that can work with Social Workers under GDPR to support an effective early assessment process. A copy of the Trust's joint protocol can be accessed here: Birmingham Early Help and Safeguarding Partnership (BEHSP) Consent, Information Sharing and Threshold Guidance.

2.3 Families should be informed of concerns and any referrals made, unless it is felt that to do so would put a child, unborn baby, or other person at risk of harm.

2.2 Flowchart: Raising a Safeguarding Concern in Relation to an Unborn Child



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3. Pre-Birth Assessments

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

3.2 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.

3.3 Working Together to Safeguard Children 2018 refers directly to unborn children in the guidance for Initial Child Protection Conferences: "*If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth"*.

3.4 Hart (2009)[2] outlines the advantages of pre-birth assessment as providing an opportunity to:

- **identify and safeguard** babies most likely to suffer future significant harm;
- ensure that **vulnerable parents** are offered support at the start of their parenting role 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.

3.5 However, some potential disadvantages are that:

- parents may abscond or a mother may not alert health professionals when she has her baby;
- in some situations, the stress may have an adverse effect on the parents' mental or physical health;
- there may be a risk that a mother could feel pressured into harming herself and the unborn baby or terminating her pregnancy;
- the fear of losing the baby may jeopardise the attachment process between parent and child.

3.6 Hart (2009) 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?

<u>Where there is reason for doubt, a pre-birth assessment is required.</u>

[2] Hart, D 2009 in Horwath, J *the child's world; a comprehensive guide to assessing Children in Need* 2nd edition

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

i) A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children.
ii) A sibling or child in the household is subject to a Child Protection Plan.
iii) A sibling or child has previously been removed from the household either temporarily or by court order.
iv) There are significant domestic abuse issues.
v) The degree of parental substance misuse is likely to impact significantly on the baby's safety or development.
vi) The degree of parental mental illness/impairment is likely to impact significantly on the baby's safety or development.
vii) There are significant concerns around the parent's ability to self-care and/or to care for the child unsupported e.g. due to their age or a learning disability.
viii) Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child.
ix) A child aged under the age of 13 years is pregnant.
x) There has been a previous unexpected or unexplained death of a child whilst in the care of either parent or other household member.
xi) There are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.
xii) A concealed pregnancy.
xiii) Parent/s want to relinquish their baby. Additionally, a pre-birth risk assessment is required when parents change their mind about relinquishing their baby during the assessment process to be certain that they are fully able to care for their baby and have addressed their areas of previous uncertainty.

3.8 Where agencies or individuals anticipate that **prospective parents** may need support services to care for their baby or that the baby may be at risk of significant harm, a referral to Birmingham Children's Trust must be made at 12 weeks gestation or as soon as possible after.

3.9 In addition to the above, the following instances will also require a referral by the allocated Social Worker:-

- Young people known to Birmingham Children's Trust where the expectant mother is identified as having complex needs;
- Young people in care or open to leaving care teams.

3.10 A Family Group Conference should always be considered at an early stage especially where parents have had previous children removed from their care.

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Young People Looked After or Leaving Care

3.11 Levels of teenage pregnancy in the UK are high in relation to other European countries.

3.12 Teenagers who become parents are known to experience more educational, health, social and economic difficulties than young people who are not parents. Consequently, their children may be exposed to greater social deprivation and disadvantage.

3.13 Teenage mothers leaving care services experience similar difficulties to those faced by all young mothers however, they are less likely to have consistent, positive adult support and more likely to have to move.

3.14 Pre-birth assessments will also be considered when young men in care, or those leaving care, are known to be the father of an unborn child, irrespective of whether the mother herself is, or was, looked after.

4. The Pre-birth Assessment and Post Birth Planning

4.1 When undertaking a pre-birth assessment, completion of the Per-birth Assessment Tool (see Appendix 1) must be used in all cases to assist with structuring assessments for court.

4.2 Pre-birth guidance in Birmingham considers that the earlier the assessment is undertaken, the better the planning around the parents, extended family and the unborn child is. This includes early referral to Family Group Conference and where legal proceedings are considered to foster to adopt. A referral at 12 weeks of pregnancy is good practice. Child in need planning can therefore commence with a view to convening an initial child protection conference from 24 weeks of the pregnancy. Consideration at 24 weeks also needs to be given to referring the case to CAFCASS PLUS which is explained later in this guidance.

4.3 Where there is significant parental history, including current and/or previous child protection concerns relating to other siblings, starting the assessment around 12 weeks of the pregnancy provides an opportunity to both work more closely with parents and to analyse and reflect on the information available.

4.4 At the point of starting the assessment, a multi-agency child in need meeting should be held within 2 weeks in order to plan the Pre-Birth Assessment. The views, information and support available from partner agencies should be sought and incorporated into the assessment.

4.5 Additionally, if the outcome suggests the baby would not be safe with the parents then practitioners are provided with the time and opportunity to make clear and structure plans for the baby's future, and to set up support for the parents where necessary. Family Group Conferences should be considered in all cases where the assessment identifies serious concerns about the parent's capacity to care for the child long term so that the family can come together and identify whether an alternative family arrangement can be put

forward.

4.6 The pre-birth assessment will:

- Focus on the strengths and concerns for both parents, and all other members of the household and extended family members.
- Assess the family history of both parents, the fathers of any previous children and the extended family, along with any previous proceedings and previous expert reports/assessments including parenting assessments.
- Assess concerns about parental mental health, substance misuse or learning disabilities including previous involvement with mental health or substance misuse services.
- Assess parents' attitude and preparedness for the new baby's birth.
- Build good relationships with the family, especially the expectant mother, using a strengths-based approach, relationship-based practice and motivational interviewing and gain an understanding of the family systems.
- Consider what support the expectant mother and partner will need and find avenues for this support.
- Seek to engage support from the wider family and consider a Family Group Conference early in the assessment process where necessary, and identify the support needed for the family in order to safely parent the child.

4.7 There is a defined period for completion of the Family Assessment, which is 35 days, with a review point at 20 days (see Appendix 3*),* it is expected that the majority of these assessments will conclude at 35 days in order for a full and thorough assessment to be completed. **The aim is always to conclude where possible the pre-birth assessment to enable child in need planning to begin by around 27-30 weeks of the pregnancy. A birthing plan will need to be shared with the multi- agency professionals prior to the birth.**

4.8 The unborn baby's father and mother's current partner (if different) should be included in the assessment.

4.9 If the assessment does not indicate that the baby will be at risk of significant harm when born but may be a child in need, then the planning and provision of services will continue under s17 of the Children Act 1989.

4.10 If, however the assessment does indicate that the baby will be at risk of suffering significant harm, then a Child Protection Conference will be held at 24 weeks gestation.

4.11 The Child Protection Conference and any subsequent reviews will proceed as per all other conferences, the first review being held within 4 weeks of the baby's birth or in exceptional circumstances within 3 months, with the approval of the responsible Social Work Team Manager and Child Protection Co-ordinator.

4.12 If the assessment concludes that the parents, or extended family, are unable to meet their child's needs to the extent that the baby is considered to be in

immediate danger, the decision is made to proceed with a child protection plan for the unborn child. The name ("unborn" 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 the mother's record.

4.13 When the baby is born the midwife should inform the Social Worker.

4.14 The core group should meet before the birth, and also before the baby is discharged from hospital. The Core Group record should highlight the:

- Outcome of assessment.
- Pre/post birth plans, including Child Protection Plan.
- Managing non co-operation/disguised compliance.
- Removal at birth – if the plan is to remove the baby at birth, plans must be in place to fulfil the statutory requirements relating to Looked After Children and the preparation of foster carers if any post-birth health needs are likely.

4.15 Detailed written plans need to address the following:

- Who should the hospital contact when mother is admitted / in labour / baby delivered?
- Who will give consent for screening?
- What happens if the baby is born out of hours?
- What happens if the baby is born outside Birmingham; or the Social Worker is on leave or sick on the day of the birth?
- What level of contact / care (supervised or not) can the parents have, and who will assume responsibility for supervising care/contact?
- What is the plan in relation to breast-feeding?
- What needs to be in place for the baby to go home?
- Where will the baby go home to?
- Which professionals need to visit?
- Which day is each person going to visit?
- Does the child need to be seen every day or is it necessary to do an unannounced visit, and what is the contingency plan?
- What family support needs to be in place?
- What have family members agreed to do?
- Is the family part of the visiting schedule?
- Are the parents aware of the plan and what is their presentation/attitude?
- What possible family arrangements for care of the baby is in place?
- The expectations and process for reporting concerns in and out of working hours.
- How long the plan is in place for and when it will be reviewed?
- What are the arrangements for initiating legal proceedings?
- The intensive support required for mother and baby to live in the community, and any other specialist assessments.

All the information collected from answering the questions above should be written out clearly, so the expectations and instructions are known to all parties.

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4.16 Legal Planning Meetings will be convened by Birmingham Children's Trust when necessary; the recommendations of Legal Planning Meetings will be shared with the Core Group and any other relevant partner agencies as appropriate.

Public Law Outline

4.17 In cases where it has been agreed at the Legal Planning Meeting that work should be undertaken under the Public Law Outline framework, there should be as little delay as possible in sending out letters before Proceedings and holding Pre-Proceedings meetings. This is in order to avoid such approaches to the pregnant woman in the late stages of pregnancy and to work with the family to explore all options in order to preferably avoid initiating Care Proceedings. There is also an opportunity to commission specialist assessments at this stage.

4.18 Birmingham is part of the CAFCASS PLUS initiative. The aim of this is to involve CAFCASS Officers much earlier in case planning at the pre-proceedings stage so that decisions can be made more quickly about babies. Once a pre-birth risk assessment has been completed the Social Worker needs to discuss this with their Head of Service to consider inclusion into this scheme. If it is agreed that the case is appropriate for CAFCASS PLUS then a referral needs to be made to CAFCASS ideally at 24 weeks gestation, whilst referrals can be made 20-28 weeks any after 28 weeks will be accepted at the discretion of CAFCASS. Please see Appendix 2 for the letter to be sent to parents explaining and gaining consent for CAFCASS PLUS referrals.

4.19 Even when it is agreed that the Trust has decided to apply to the Family Court to seek removal of the child at birth, a Child Protection Conference should always be convened.

5. Vulnerable Groups

5.1 Mental Ill Health

5.1.1 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 also a cause for concern.

5.1.2 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".

5.1.3 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 mental health risk factors are identified, ongoing evaluation of risk is essential.

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5.2 Substance and Alcohol Misuse

5.2.1 Experienced practitioners report that most drug/alcohol using women have similar attitudes and motivations to pregnancy as non-drug/alcohol using women and it is important to note that most women with drug/alcohol problems are of childbearing age. However, those with drug/alcohol problems may also have poor general health, housing and financial problems.

5.2.2 Some pregnant drug/alcohol users do not come for antenatal care until late in pregnancy or when they are in labour. There are many reasons why drug/alcohol using women may present late to antenatal services. The local service may not be able to meet their specific needs, or it may be perceived to be inaccessible or their drug/alcohol use may place other demands on their time, which often take priority for the user.

5.2.3 Some may feel that it is better not to reveal their drug/alcohol use to antenatal care staff as they fear the attitudes of staff and the possible involvement of statutory services. Also due to the possibility of amenorrhea (the absence of periods) caused by the drug/alcohol use, the woman may not know that she is pregnant, or may not be clear about the duration of the pregnancy.

5.2.4 Many of these problems can be overcome if an appropriate service, which meets the needs of drug/alcohol using women, is available, easily accessible and well publicised.

5.2.5 Agencies in the community can play a key role in supporting these women in a range of ways. This includes identifying drug/alcohol use / pregnancy at an early stage, referring on to appropriate help and support, identifying risks, and providing support and advice around pregnancy and/or drug/alcohol use.

5.2.6 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 impact on the parent's capacity to care now and the sustainability of this throughout the child's care. Consideration need to be made towards:

- The pattern and impact of drug use and alcohol misuse;
- Whether this 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, and for the parenting of any other children in the household.

5.2.7 All pregnant women should be asked about their use of prescribed and non-prescribed drugs, both legal and illegal, as part of routine enquiries about general health during pregnancy. Time should be allowed for the exploration of the patient's and the professional's concerns about the risks for both the mother and the child. This needs to be done sensitively so that the woman is not deterred from seeking help, even if she continues to use.

5.2.8 However, practitioners should ensure that the woman and her partner are

aware of the impact of the following behaviours:

- The use of tobacco, street drugs, alcohol and some over the counter drugs, including the adverse effects of some medicines.
- Chaotic drug/alcohol use; e.g. polydrug use, erratic dosage precipitating withdrawals or intoxication.
- Injecting and sharing of injecting paraphernalia.
- Unprotected sexual activity.

5.3 Domestic Abuse

5.3.1 In a 2004 study examining the prevalence of domestic abuse and its' relationship both to complications in pregnancy and psychological health, the women questioned (on antenatal and postnatal wards) evidenced that around 23% had a lifetime experience of domestic abuse and 3% had experienced violence during the current pregnancy.[6] Further research reports that between four and nine women in every 100 are abused during their pregnancies and/or after the birth of their baby[7].

5.3.2 A recent significant study of over 13,500 women undertaken by Kings College, London's' Institute of Psychiatry[8] noted a strong link was found between antenatal violence and violence post-birth; 71% of women who experienced antenatal domestic violence pregnancy also experienced violence in the postnatal period. Of additional concern is the evidence of child behavioural problems recorded at 42 months of age looking at factors such as hyperactivity, emotion and conduct problems. Hence, continued exposure to domestic abuse once the child is born can impact on his or her emotional and cognitive development. The extent to which the violent partner also poses a direct physical threat to the child will need to be assessed.

5.3.3 Good practice indicates that 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.
- Information on what triggers violent incidents.
- The non-abusing/non-violent parent's recognition of the potential risks as a result of the history of or current domestic abuse/violent behaviour.

However, risk is often affected by dynamic factors and can therefore change suddenly. Professionals should therefore bear in mind that a piece of information currently not known could raise or lower the threshold of risk for a child.

5.3.4 During the pre-birth assessment increased risk factors may be prevalent, for example:-

- Domestic abuse incidents in the pregnancy;
- Parent/s may exhibit aggressive behaviour;
- There may be pregnancy complications that could lead to e.g. pre-term delivery resulting in a baby that will require a higher level of care.

5.3.5 It is essential that there is close liaison with the midwives and obstetricians in relation to these factors. It is also important to examine the history of previous children who have been removed from the parent(s) care. This 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.

5.4 Parents with Learning Disability

5.4.1 For the purposes of these procedures, a 'parental learning disability' refers to adults who are, or may become parents/carers for children and who meet the 3 core criteria which describes an individual as 'learning disabled' as follows:

- **Significant impairment of intellectual functioning**: i.e. individuals with a recognised low IQ score and below (reference: British Psychological Society and legal system). This is not a hard and fast rule as overall IQ scores can be subject to interpretation for a variety of different clinical reasons. In any event the interpretation of psychometric test scores are the remit of a chartered psychologist.
- **Significant impairment of adaptive / social functioning**: i.e. how an individual copes with every day demands of community living; impairment of adaptive / social functioning might be considered to be present if s/he needs assistance with survival (eating, drinking, clothing, hygiene and provision of basic comforts) or with social problem solving and social reasoning.
- **Age of onset before adulthood**: in order for an individual to be considered as 'learning disabled', impairment i.e. of intellectual adaptive / social functioning usually needs to have been present before the age of 18 years.

5.4.2 It is not always clear whether a parent/carer has a learning disability, and the following may assist recognition:

- Reference to medical records can offer evidence;
- Reference to educational records (where it is less than 5 years since leaving school) can also provide evidence e.g. Statement of Special Education Needs; Education, Health and Care Plan;
- Personal history involving attendance at special schools;
- Severe difficulties with literacy and/or numeracy;
- Enquiries made of the learning disability register maintained by Adult Social Care;
- A referral to a clinical psychologist.

5.4.3 Learning disabled parents may also experience additional stressors such as having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. Such stressors, when combined with parental learning disability, are more likely to lead to concerns about the care of children.

5.4.4 Parents with a learning disability may therefore need positive 'whole family' support to develop sufficient understanding, resources, skills and experience to meet the needs of their child. With effective, sustained support over time

adjusted to meet the changing developmental needs of a growing family, learning disabled parents are potentially able to provide good enough care for their child.

5.4.5 It is important to assess the needs and provide support for learning disabled parents as early as possible. To ensure that parents can understand what is happening and why, and are able to participate meaningfully, consideration should be given to the involvement of an advocate.

5.4.6 If any professional or agency has any concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby, a referral should be made to the Children's Trust in line with pre-birth procedures.

5.4.7 The GP and midwife must make referrals to the community team for people with learning disabilities for a joint assessment of the pregnant woman's needs, capacity for self-care and to provide adequate care for the baby. Subsequent assessment should be in accordance with pre-birth procedures, but the involvement of the Learning Disability Team is essential.

5.5 Concealed Pregnancy

The reason for the concealment of a pregnancy is a key factor in determining the risk to a child and that reason will not be known until there has been a multi-agency assessment.

Consideration should be given within the assessment to other potential risk factors, the aim of which is to enable professionals to reach a judgement about the nature and level of need and/or risk.

The Social Worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother, and father, are intending for the child.

When undertaking the assessment, the Social Worker should be mindful of the implications of a concealed pregnancy, which could:

- Lead to a fatal outcome (for both mother and/or child), regardless of the mother's intentions;
- Indicate uncertainty towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity;
- Result in a lack of antenatal care which can mean that any potential risks to the mother and child may not be detected. This could also lead to inappropriate advice being given to the mother, such as potentially harmful medications being prescribed by a medical practitioner who are unaware of the pregnancy;
- The health and development of the baby during pregnancy and labour may not have been monitored and abnormalities may not have been detected;

- Underlying medical conditions and obstetric problems will not be revealed;
- An unassisted delivery can be dangerous for both the mother and baby, due to complications that can occur during labour and delivery;
- A lack of maternal willingness or ability to consider the baby's health needs, or a lack of emotional attachment to the child following birth;
- If there is alcohol or substance misuse, there can be risks for the baby's development during the pregnancy and post birth;
- There may be implications for the mother revealing a pregnancy due to fear of reaction from family members or members of the community;

Additional Risk Factors

The assessment itself will consider a range of other factors:

- Previous concealed pregnancy is an important indicator in predicting risk of a future pregnancy being concealed;
- Previous termination, thoughts of termination and/or unwanted pregnancy;
- Loss of a previous child (i.e. adoption, removal under Care Proceedings);
- General fear of being separated from the child.

Further safeguarding measures include:

- Children under the age of 13 (a referral is required **in all circumstances** where the child is under 13);
- Children between the ages of 13 and 16 years;

Learning from Serious Case Reviews conducted by Local Safeguarding Children Boards have identified a number of lessons to be learnt to support young mothers as follows:

- Assessments of pregnant teenagers must take into account their family background.
- Both parents need to be supported. The father is as important as the mother and they need support to help them to become good parents.
- There should be a joined up (multi-agency) approach to teenage pregnancy and teenage parents with every agency understanding their role within it.
- Young teenage parents need to be supported in an environment in which they feel comfortable and supported. Adult-centred services may not achieve this without additional teenage-focused support.

Social Workers should consider the above points along with Appendix 1: Assessment of Parents and Potential Risks to Child.

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Appendix 1: Pre-Birth Risk Assessment Tool - An Assessment of Parents and Potential Risks to a Child

Part A: 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,**
c) **The context and circumstances in which the baby was conceived, and**
d) **The wishes and feelings of the child who is to be a parent.**

1	**Relationships**	• 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?

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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 assessment should be sought from professionals with relevant expertise.
9	**Communication**	• English not spoken or understood? • Deafness? • Blindness? • Speech impairment? 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? 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?

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		• 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 Regarding 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?

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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 regarding 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.

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21	**Any Other Issues that have the 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**	Is it realistic and appropriate?

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Part B: Overall Risk Assessment and Conclusions

Use should be made of the "Framework for Assessment" below. The assessment report should address the following issues:

1. **Concerns identified.**
2. **Strengths or mitigating factors identified.**
3. **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.
4. **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.
5. **What changes should ideally be made to optimise well-being of the child?**
   If there is a risk of significant harm to the child.
6. **What changes must be made to ensure safety and an acceptable level of care for child?**
7. **How motivated are the parents to make changes?**
8. **How capable are the parents to make changes? And what is the potential for success?**

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Appendix 2: Letter to Parents Concerning CAFCASS PLUS

To: Birmingham Children's Trust/Legal Services

Date
Reference:

Dear

Re: Your Unborn Baby

Birmingham Children's Trust is part of an initiative to work with parents before any Court proceedings are issued in respect of children. It is hoped that this way of working may sometimes avoid Court proceedings having to be issued, and in other cases, it is hoped that it will speed up the length of time it takes for cases to be dealt with by the Courts.

You have just been given a letter explaining that Social Workers involved with your family are so concerned about your unborn baby that they are arranging to meet with you to agree a plan to see if it is possible to improve things, so we do not have to go to Court.

Usually these meetings are attended only by you and your solicitor and by the Social Worker and their Team Manager. Under this initiative, an officer from the Children and Family Court Advisory Service and Support Service (CAFCASS) will also attend the meeting so that they can advise on what is in the best interests of your unborn baby. The CAFCASS officer may visit you and your family and/or the Social Worker before the meeting so that they can find out more about your situation.

The role of the CAFCASS officer is to represent the rights and interests of children in court proceedings and to make recommendations to the Court. The CAFCASS officers who are called Children's Guardians are completely independent of the Trust and are appointed by the Court. They do not always agree with the Trust's Social Workers or their plans for children.

We very much hope that by involving the CAFCASS officer now, they will be able to give advice which may possibly avoid Court proceedings, or which may speed up the Court process so that it does not last as long.

However, the CAFCASS officer cannot attend the meeting unless you are willing to agree to this happening. If you do not agree to it happening, then a CAFCASS officer would only become involved if Court proceedings were issued. If, however, you are happy for a CAFCASS officer to be involved at this early stage, could you please give us your written consent? You can do this by signing the copy letter that is attached to this letter and giving it to us.

If you already have a solicitor, please talk to them about whether or not you wish the CAFCASS officer to be invoked before you decide. If you do not have a solicitor yet, we can confirm that you are entitled to free legal assistance. There are solicitors in this area who are members of the Law Society's Children Panel and who specialise in this type of work. A list of the firms who have solicitors on the Children Panel is attached for your information.

I look forward to working with you.

Yours sincerely

Social Worker

I hereby consent to an officer appointed by CAFCASS attending a pre-proceedings meeting, referred to in the letter, before proceedings which I have received, and to Birmingham Children's Trust sharing information about me and my family with the officer before the meeting.

Signed……..

Date……

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Appendix 3: 20 Day Point of the Family Assessment Reflective Supervision

At the 20-day point of the family assessment, a reflective supervision should be undertaken by the Team Manager. Below is a checklist of what this should include:

1 The family history of both parents, the fathers of any previous children, the extended family.

2 Any previous court proceedings and any previous expert assessment reports, including parenting assessments.

3 Strengths of, and concerns, about each parent and extended family members.

4 Positive and negative factors in previous parenting, including any assessments made by other local authorities.

5 Strength of wider family support.

6 Parents' attitude to the new baby and preparedness for its birth.

7 Any concerns about parental mental health or learning disability, and current or previous involvement with mental health services.

8 Possibility of post-natal depression and help available if this arises.

9 The possible need for specialist services for the parents after the birth.

10 History of the parent's engagement with adult services.

11 History of the parent's engagement with health professionals.

12 Involvement with drug and alcohol services.

13 Evidence of previous and current domestic abuse.

14 Previous convictions.

15 Involvement with probation. Checks should include the National Probation Service and Community Rehabilitation Company.

16 Engagement with midwifery services.

17 Engagement with the Social Worker.

18 Engagement with ante-natal care. If the mother or both parents do not engage, professional curiosity is important in finding out the reasons.

19 Any history of previous children being removed by another local authority. A visit must be made to the other authority to read the case history so that we understand the reasons for the removal.

20 Discussion of the risk assessment addressing all identified risk and protective factors.

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Appendix 4: Further Reading

DfE (2018) Revised December 2020, *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children.*

Ofsted (2010) *Learning Lessons from serious case reviews 2009-2010.*

Ofsted (2011) *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011.*