



Health and  
Social Care

**Guidance for the Safeguarding Process Prior  
To and Immediately After The Birth Of A Baby  
Where There May Be Risks of Significant Harm**

January 2016

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**Regional Guidance for the Safeguarding Process Prior To and Immediately After The Birth Of A Baby Where There May Be Risks of Significant Harm.**

<b>Name</b>	<b>Date</b>	<b>Reason For Changes</b>	<b>Version</b>
Claire Fulton	30.10.13	Original Document	1.0
Claire Fulton	07.11.13	Updates after meeting with Workstream 1 UNOCINI Development Group 07.11.13	1.1
Claire Fulton	10.06.14	Update after Regional CSI Co-ordinators Meeting	1.2
Claire Fulton	03.07.14	Update after Regional CSI Co-ordinators Meeting (01.07.14) and Workstream 1 UNOCINI Development Group (03.07.14)	1.3
Claire Fulton	25.07.14	Update further to additional feedback from Southern and South Eastern Trusts	1.4
Claire Fulton	05.08.14	Update after Regional CSI Co-ordinators Meeting	1.5
Claire Fulton	03.12.14	Update after CSI Co-ordinators Meeting further to WHSCT and NHSCT requests	1.6
Claire Fulton	08.01.14	Update after feedback from BHSCT	1.7
Claire Fulton	14.01.14	Update after CSIB Implementation Group Meeting	1.8
Claire Fulton	11.02.14	Revision of referral further to CSIB Implementation Group Meeting	1.9
Claire Fulton	10.12.15	Revision of guidance following post-implementation issues being raised. Agreed changes at CSIB Implementation Group Meeting 09.12.15	2.0

## **1.0 Introduction**

1.1 A pre-birth assessment is essentially defined as ‘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’.

1.2 Research indicates that young babies are particularly vulnerable to abuse but that work carried out in the ante-natal period can help minimise harm if there is early assessment, intervention and support. The main purpose of a pre-birth risk assessment is to identify what the risks to the new born child may be, whether the parent(s) have the capacity to change so that the risk can be reduced and, if so, what supports will be required.

## **2.0 Purpose of the Guidance**

2.1 The guidance will provide clarity to staff in relation to the pre-birth risk assessment pathway, the assessment process and their individual and collective roles and responsibilities within the process

## **3.0 Target Audience**

3.1 Whilst this guidance has been developed to assist Social Workers in their recording of safeguarding issues and the ante-natal period, this guidance is also relevant to those professionals who are involved with families about whom there are concerns in the antenatal period such as Midwives, Health Visitors, General Practitioners, Paediatric and Obstetric Medical Staff and Children’s Social Workers.

3.2 The guidance is appropriate for professionals such as those from Adult Mental Health, or Learning Disability Services or Community Addiction Services who may be/have been involved with families because of particular needs which the parent/proposed carer may have.

## **4.0 Equality, Human Rights and Disability Discrimination Act**

4.1 This guidance has been drawn up and reviewed in light of Section 75 of The Northern Ireland Act (1998) which requires the Trust to have due regard to the need to promote equality of opportunity. It has been screened to identify any adverse impact on the 9 equality categories and no significant differential impact was identified. Therefore an Equality Impact Assessment is not required.

## **5.0 Alternative Formats**

5.1 This document can be made available on request on disc, larger font, Braille, audio-cassette and in other minority languages to meet the needs of those who are not fluent in English.

## **6.0 Sources of advice in relation to this document**

6.1 The Author of the guidance, responsible Assistant Director or Director as detailed on the title page of the document should be contacted with regard to any queries on its' content.

## **7.0 The Pre-Birth Referral Pathway**

7.1 When a safeguarding concern is identified in the ante natal period by any professional involved with the client/family a referral (Appendix 1) should be made to the appropriate children's social work team.

7.2 Referrals about unborn babies should be made **by the 18th week of the pregnancy**, unless it has not been possible to meet this timescale, for example, because the pregnancy has been concealed. Referring at this time:

- Provides sufficient time for a full and informed assessment;
- Avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time;
- Enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome;
- Enables the provision of support services so as to facilitate optimum home circumstances prior to the birth;
- Provides sufficient time to make adequate plans for the baby's protection, where this is necessary.

7.3 New referrals (where mother is not known to Social Services) for expectant mothers should be submitted to the Single Point of Entry (Duty) Gateway Team with responsibility for the area in which the client resides.

7.4 The Expectant Mother Referral (Appendix 1) should be used for any mother aged over 18 years of age. For mothers aged under 18 years, a UNOCINI referral should be completed instead.

7.5 New referrals received at Single Point of Entry will be passed to the Locality Gateway Team for completion of an initial assessment.

7.6 If the referrer is aware that social services are already involved with the client/ family in any capacity, for example, Family Intervention Team, Looked After Child Team, 16 + Team, Young People's Partnership or the Team for Children with Disabilities, telephone contact should be made with the case co-ordinator in that team to discuss the administration of the case. The relevant Social Worker will record the information shared as a Significant Event (REC 4).

7.7 In circumstances where it is identified that a pre-birth risk assessment should be commenced and the expectant mother is already known to the Family Intervention Service or the Looked After Children Service, the pre-birth assessment should be completed by the current social worker. Onward transfer to another social work team will be determined by the outcome of the pre-birth assessment and as per the criteria outlined above. Where it is assessed that on-going social work involvement is required, case transfer will be progressed where appropriate at the pre-birth case conference or case planning meeting.

7.8 Where a young person currently receiving support from 16 Plus Service becomes pregnant and there are child care/ child protection concerns, the responsible social worker will liaise with the relevant Family Intervention Team and forward an initial assessment, recorded on a REC4, with recommendations in respect of the unborn baby.

7.9 This referral is entered as a 'pre-birth safeguarding concern' against the mother and the detail of the referral is captured on a REC4 (Significant Event) within the mother's record.

## 8.0 The Pre-Birth Assessment and Planning Process

8.1 When a social worker in any social work team receives a referral identifying a concern in relation to the future care which an ante natal mother may give to either her unborn child and/or to her new born child, it is a social work responsibility to undertake an initial assessment. **The purpose of this will be to clarify the information provided at point of referral and to ascertain if threshold of risk is met.** This process will involve engagement with the multi-disciplinary team.

Whilst this initial contact is held within the mother's record (as she is the only one at this point that has parental responsibility) it should include any concerns pertaining to both parents, if known. As a concern in pregnancy is significant, this will be recorded as a **Significant Event (REC 4)** and will be completed within **10 working days**.

Within this, the Social Worker should include:

- An outline of previous Social Work involvement (if applicable)
- Any initial information pertaining to early ante-natal care and an expected date of confinement (EDC) – this allows for robust planning and timescales
- Current family relationships
- Extended family supports
- Brief outline of the risks apparent, if relevant

An exemplar of the Significant Event can be found in Appendix 2.

8.2 For **new referrals (no current Social Work involvement)** and, if the initial assessment identifies risk factors as outlined in ACPC Regional Child Protection Policy and Procedures ref. 6.10, the Social Worker will liaise with the Senior Social Worker in order to arrange the transfer of the case to the appropriate receiving team, taking cognisance of Trusts' transfer processes from Gateway to Family Support and Intervention.

**8.3 This transfer will comprise the Pre-Birth Planning Meeting.**

8.4 **Note:** Where a pregnancy has been concealed and the referral is made post 35 weeks gestation, the procedures cannot be followed due to timescale restraints. The case should remain with the appropriate team and a proportionate pre-birth risk assessment, using the format in Appendix 4 should be completed and the case

progressed pending the outcome of the risk assessment, for example, pre-birth child protection conference or family support meeting.

## **9.0 The Pre Birth Planning Meeting**

9.1 The meeting will:

- Include the parent(s), relevant Team Manager/s and Social Worker/s (as per Transfer Policy), referrer (if appropriate), Health Visiting, Midwifery, and any other key professionals.
- Parents should be invited, unless there is a valid reason to exclude them.
- Identify clearly the causes for concern in terms of the ante natal mother, and any potential risks for the unborn child and the new born child.
- Decide whether or not a full pre-birth risk assessment is required, having considered the information known alongside the Threshold of Needs.
- Decide whether the matter should be referred for a Pre-Birth Child Protection Conference. The earliest date for this is 24 weeks gestation of the unborn child.
- Identify the specific areas requiring assessment, which professional is responsible for each aspect and determine the timeframe for the assessment
- Establish the date of the next multi-disciplinary meeting.

9.2 Where the meeting decides not to proceed to a full pre-birth risk assessment, consideration should be given to developing a Pre-Birth Family Support Plan.

## **10.0 Completion of the Pre Birth Risk Assessment and Pre-Birth Child Protection Conference Report**

10.1 The detail of the pre-birth risk assessment described at Appendix 3 has been developed from the work of Martin Calder (2008). This should ordinarily take place between 14 and 24 weeks gestation, however time may be limited if a pregnancy is concealed. Each professional identified at the Pre-Birth Planning Meeting as needing to contribute to the assessment will individually collate, record and analyse information about the aspect of the family for which they have professional expertise.

10.2 The detail of the assessment will be recorded in the Pre-Birth Risk Assessment Report (Appendix 4) and held against the mother's record. This risk assessment report will become the Report for the Family Support meeting or the pre-birth Child Protection Conference, dependent on its outcome. The domains are not mutually



exclusive and it will require a high level of effective multi-disciplinary communication, facilitated by the Case Co-ordinator, to ensure that the maximum amount of information is available to facilitate the pre-birth planning process. This will ensure the best outcomes for the child and his parents/ carers.

10.3 The ACPC Regional Policy and Procedures does not provide specific guidance on when to commence a Pre Birth Risk Assessment but does state that a Pre Birth Initial Child Protection Case Conference should not be held before 24 weeks gestation of the unborn child.

## **11.0 The Pre-Birth Child Protection Conference**

11.1 The aim of the Pre-Birth Child Protection Conference is to enable professionals with particular expertise (even if they are not currently involved with the family), those most involved with the family, and the family itself to assess all relevant information and plan how to safeguard the unborn child and promote his or her welfare. There must be representation from the midwifery services, health visiting and other professionals as appropriate.

11.2 At this meeting, agreement will be sought regarding the Parental Plan; and the Proposed Child Protection Plan and the need for agreement regarding categories of registration, if appropriate, at birth.

11.3 The discussion from the Pre-birth Child Protection Conference will be recorded at the end of the report, alongside the Parental Plan and Proposed Child Protection Plan.

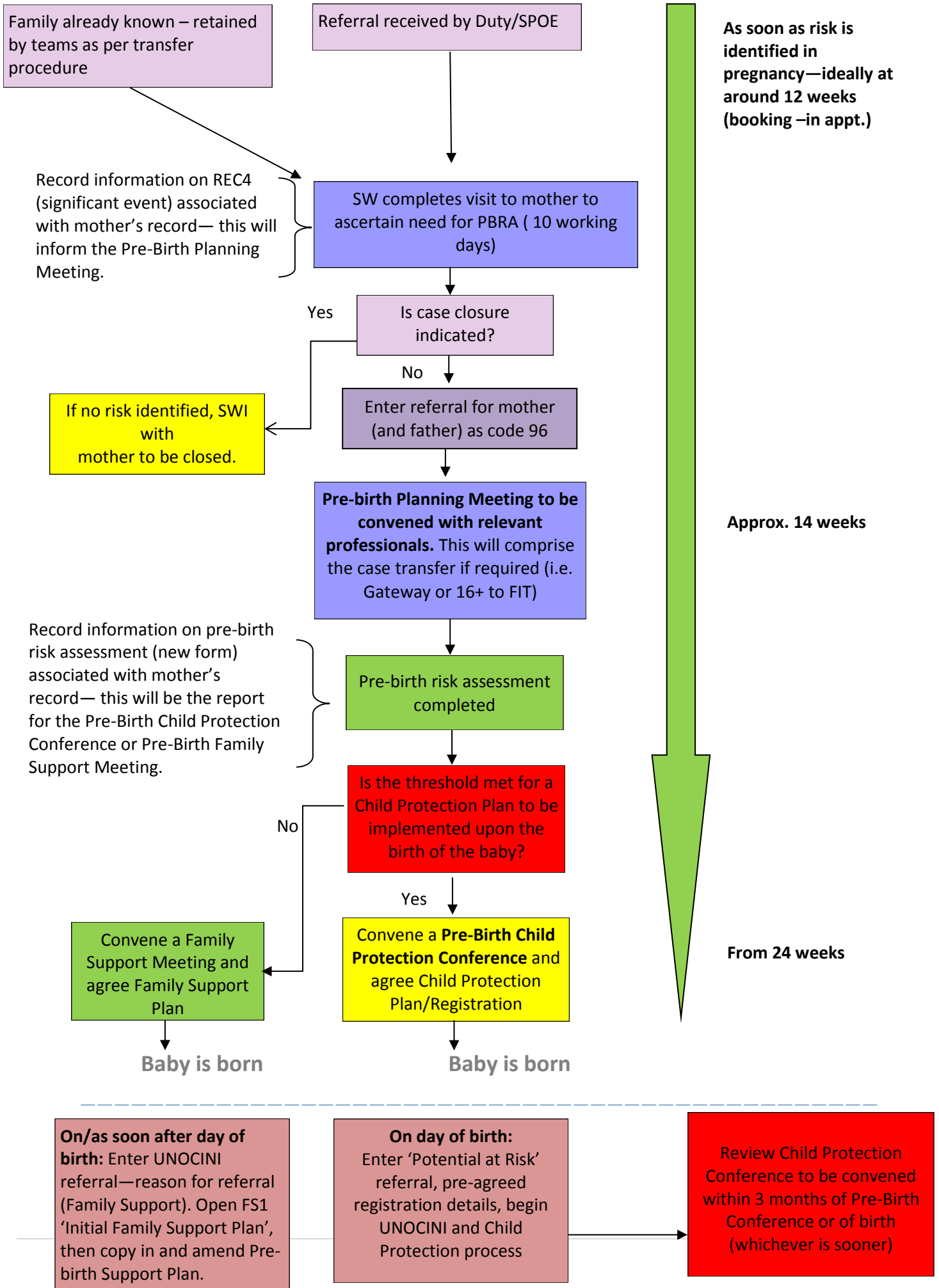
## **12.0 Actions To Be Taken Upon Birth Of The Baby**

12.1 Upon the birth of the baby, it is the co-ordinating Social Worker's responsibility to enter the child as 'potential at risk' referral and ensure registration is updated, further to the outcome of the Pre-Birth Child Protection Conference.

12.2 It is important to remember to update the child's religion and ethnicity as this information is required for quarterly reporting and Corporate Parenting.

12. 3 The Proposed Child Protection Plan will be used to begin the UNOCINI Child Protection process.

**Figure 1: Proposed Pre-Birth Risk Referral, Planning and Assessment Process**



## References

Calder, M.C. (2003) Unborn Children: A Framework for Assessment and Intervention. In: Calder, M.C. and Hackett, S., eds. Assessment in Child Care Using and Developing Frameworks for Practice. Dorset: Russell House Publishing

Corner, R. (1997) Pre-Birth Risk Assessment in Child Protection. Social Work Monographs, Norwich: University of East Anglia

Hart, D. (2010) Assessment Prior to Birth. In: Horwath, J., ed. The Child's World, Assessing Children in Need. London: Jessica Kingsley Publishers

<http://www.communitycare.co.uk/articles/11/09/2012/118486/how-research-on-pre-birth-assessments-should-affect-practice.htm>

### Expectant Mother Referral

Section 1: Expectant Mothers Details			
Surname:		EDC (if known):	ID No.
Forename:			
Known As:		HCN:	
		Referral Code: 96	
Address:		Previous Address:	
Postcode:			
Telephone No:		Previous Postcode:	
Mobile No:		Locality:	
Date of Birth:		Gender	
GP Name:		GP Tel No:	
GP Address:		GP Email Address:	
GP Postcode:			
Does the Expectant mother have a Disability?	If Yes, What Disability: (& source of diagnosis)	Other Special Needs:	
Nationality:		Ethnic Origin:	
Religion:		Country of Origin:	
Language Spoken:		Communication Support:	
Interpreter <input type="checkbox"/>	Signer <input type="checkbox"/>	Document Translator <input type="checkbox"/>	

**Section 2a: Referrer's Details**

<b>Name of Referrer:</b>	<b>Designation:</b>
<b>Address:</b>	<b>Date of Referral:</b>
<b>Postcode:</b>	<b>Contact Details:</b>

**Section 2b: Reason for Referral**

**Section 2c: Immediate Actions**

**Are Immediate /Actions necessary?**

**Section 3a: Primary Carers & Other Household Members (Incl. non-family members)**

	Member 1	Member 2	Member 3	Member 4
Last Name:				
Alternative Last Name:				
First Name:				
Telephone No:				
Mobile No:				
Date of Birth:				
Relationship to Expectant mother:				
Language Spoken:				
Nationality:				
Communication Support:	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details

**Section 3b: Significant Others (Incl. family members who are not members of the expectant mothers household)**

	Other 1	Other 2	Other 3	Other 4
Last Name:				
Alternative Last Name:				
First Name:				
Address:				
Postcode:				
Mobile No:				
Date of Birth:				
Relationship to Expectant Mother:				
Language Spoken:				

<b>Nationality:</b>				
<b>Communication Support:</b>	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details	<input type="checkbox"/> Interpreter <input type="checkbox"/> Signer <input type="checkbox"/> Doc. Trans Details

**Section 4a: Summary of Referrer's Previous Involvement**

Empty space for summary of referrer's previous involvement.

**Section 4b: Referral Consent**

<b>Is the expectant mother aware the referral is being made?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Does the expectant mother consent to the referral?</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>If NO, please explain</b>	
Empty space for explanation.	



**Section 5: Additional Information: Agencies Currently Working with the Expectant Mother**

**Agency and Contact Details**

**Name:**

**Role:**

**Tel No:**

**Email:**

**Name:**

**Role:**

**Tel No:**

**Email:**

**Name:**

**Role:**

**Tel No:**

**Email:**

**Name:**

**Role:**

**Tel No:**

**Email:**

**Name:**

**Role:**

**Tel No:**

**Email:**

**Name:**

**Role:**

**Tel No:**

**Email:**

## Appendix 2: Exemplar Significant Event at Gateway

<b>SIGNIFICANT EVENT</b>	
Client Name : Janet Jones	SOSCARE No : 012345
Details of Significant Event	
Date Reported : 12 <sup>th</sup> December 2014	Time Reported : 12:00
Type of contact : Referral	Who was involved : Lisa Smith, Hospital Midwife
Date of Event : 11 <sup>th</sup> December 2014	Nature of Event : Ante-Natal Booking Appointment – safeguarding concern for unborn baby.
<p>Detail of Event :</p> <p><b>Referral Information:</b></p> <p><b>ISSUE</b> Miss Jones disclosed at booking interview that she had a drug addiction. She has been taking methadone for two and a half years. Reports that she has now stopped taking methadone about 6wks ago. Miss Jones did not mention self –harm but this was very evident on both lower arms. Miss Jones has been known to SS in the past. Her brother is currently in prison due to drug related offences.</p> <p><b>RISK</b> Miss Jones has no other children. She is currently 8wks pregnant. EDC is 24.07.15. Miss Jones reports that she is in a relationship, and her partner is very supportive and has never been involved in drug. Miss Jones does have a Flat but often lives/stays with her grandmother Lucy Jones. Miss Jones does not have a good relationship with her own mother, but sees her dad regularly.</p> <p>I am concerned that Miss Jones does not have a lot of support and therefore is at risk of taking drugs again. She was agitated and anxious at the booking interview.</p>	
Professional Response	
Date of Response : 19 <sup>th</sup> December 2014	
Type of Response : home visit clarify referral information and ascertain threshold of risk	Who was involved : Miss Tate, mother of unborn baby Mr Hampton, father of unborn baby Claire Smith, Social Worker

Details:

### **Child's Needs**

#### **Health and Development**

Ms Jones has been attending her antenatal appointments appropriately. She disclosed to the midwife at the antenatal booking appointment that she had been addicted to methadone for 2 1/2 years. She ceased when she found out she was pregnant and appears to be doing well. Expected due date is 24<sup>th</sup> July 2015. The GP advised that Ms Jones is attending her antenatal appointments appropriately and agreed that she appears to be doing well in terms of refraining from substance misuse. He agreed to make a referral to Social Services if he has reason to believe that Ms Jones is using illegal substances in the future.

#### **Education and Learning**

Ms Jones and Mr Hampton have been buying items to promote the baby's learning. They will endeavour to stimulate the baby appropriately and the health visitor will provide advice about same.

#### **Identity, self-esteem, and self-care**

Baby Jones will rely on her parents for her care needs to be met. The health visitor will provide advice about good care routines. Mr Hampton is a Roman Catholic and Ms Jones is of Church of Ireland faith. The advice that they will give consideration to the baby's religion but that it is not an issue. Ms Jones is considering living with her mother when the baby is born but Mr Hampton will be greatly involved.

#### **Family Relationships**

Ms Jones and Mr Hampton report a good relationship. The both advise that they were initially shocked about the pregnancy but have now come to terms with the news and are looking forward to the baby's arrival and are making preparations.

#### **Parent/Carer's Capacity**

##### **Basic Care and Ensuring Safety**

Ms Jones has advised that she no longer uses illicit drugs. She advised that she found it easier to cease the substance misuse than she had envisaged. She currently resides in supported living and staff there monitor and support her progress. Ms Jones's key worker advised that she is attending her appointments appropriately and is not using drugs. He advised that she is making preparations in terms of buying essential items for the baby. Mr Hampton had been addicted to cannabis and had previously used extensively. Mr Hampton advised that he weaned himself off cannabis and that he did not feel the need to attend addiction support services. The key worker in the supported housing complex advised that Mr Hampton very rarely uses cannabis and has distanced himself from friends and relatives who continue to misuse substances. The Social Worker advised Ms Jones and Mr Hampton that he is not to be in contact with the baby if ever under the influence of cannabis. Ms Jones advised that she no longer self-harms and attended a self-harm group in Craigavon Hospital for support to address these behaviours. Ms Jones is considering moving in with her mother when she has to leave the supported housing - one month before the birth of the baby. A previous Social Services assessment indicates that Ms Jones' mother was deemed to be appropriate and protective of her younger daughter when Ms Jones was using drugs.

#### **Emotional Warmth**

Both parents appear to be looking forward to the birth of their first baby. Ms Jones had informed the health visitor that she was beginning to feel anxious about the birth and she has subsequently been attending antenatal breathing classes.

#### **Guidance, Boundaries and Stimulation**

The health visitor will advise the couple about appropriate routines. Ms Jones's grandmother Lucy Jones is supportive. Ms Jones is considering living with her mother in preparation for the birth of the baby. These extended family members will provide guidance and support to the new parents.

#### **Stability**

Ms Jones had previous difficulties with substance misuse and self-harming. She appears to have ceased using mephodrone since becoming pregnant and attended a self-help group in her local Hospital for support in relation to self-harming.

#### **Environmental Factors**

##### **Family History, Functioning and Well-Being**

Previous referrals in relation to Ms Jones are when she was a minor:-

19/01/2006 referred by relative - reason - other. closed 21/01/06

31/01/07 referred by police - reason - child care problem. Closed 13/02/07 - Closed file indicates that Ms Jones was referred by PSNI after witnessing an older male exposing himself from an upstairs window.

Referrals in relation to Ms Jones since becoming an adult:-

22/09/11 referral from hospital nurse - re. hospital referral. case closed 30/09/11

**Analysis :**

Ms Jones disclosed to the midwife that she had a Mephadrone addiction and she stopped using when she found she was pregnant. She had also self-harmed and with supports she is now doing well. She has attended antenatal appointments appropriately and is reported not to have used drugs since. Her partner had been a heavy user of cannabis and the key worker reports that he has reduced his use immensely and now very rarely uses. The couple have agreed that the baby should not be exposed to anyone who under the influence illicit substances.

The couple need to be highly commended regarding the positive changes to their lifestyle choices since Ms Jones became pregnant. It is still early days for the couple and whilst they have some extended family support, the pressure of a newborn baby may create tensions. Additionally Mr Hampton continues to use cannabis, albeit sporadically.

The family have agreed that they would like some additional support, particularly in the early stages after birth as they recognise the commitment required to parent a newborn baby appropriately.

**Action taken or required :**

Gateway Team Manager reviewed assessment and agreed that threshold not met for pre-birth case conference. Agreed to proceed with Family Support Planning.

Is C.P. Investigation being undertaken?: Yes  No

Restricted : Yes  No

Signed: Claire Smith

Date: 24<sup>th</sup> December 2014

Date Completed: 24<sup>th</sup> December 2014

## Appendix 3: Guidance to Completing a Pre-Birth Risk Assessment

### **Antenatal Care: Medical and Obstetric History.**

When considering these issues it is important to be aware that the named lead midwife will have provided the expectant mother with choices about the place of birth and type of care they would like to receive. A booking interview is carried out at around 8-12 weeks of pregnancy.

During the interview the lead midwife, responsible for the patients care, collects information which will build into a full medical and social history. When all the data is collated the midwife is able to assist the women in making informed choices about the care she receives and advises on the suitability of her choices. The midwife will discuss with the women the pattern of care which is most suited to her needs. A holistic approach, taking into account the women's social history will be provided. This needs to be incorporated into the pre-birth assessment.

In accordance with 'Healthy Child, Healthy Futures', the midwife and health visitor will be involved during the pregnancy. They will advise the parents about keeping the baby healthy and well. Together they will assess any specific needs and will commence the family health assessment. This will inform the pre-birth risk assessment.

### **Social History**

When planning a pre-birth assessment it is vital to review any previous history. This will include; the quality of their parenting; their early life experiences; social, educational, medical, marital, occupational, criminal (and sexual) history. Consideration should be given to any complications during the pregnancy and birth; any developmental issues and milestones; peer and sibling relationships; school performance; family relationships; drug and alcohol abuse; general impulsivity; anger levels; self-esteem; social skills and competence; and past psychiatric history.

This will entail **reading the case files** on any siblings/children including those any have been removed from the parents care. In addition searches must be done on any new partners in the household or those who are playing a significant role in the life of the family, particularly checking if they have children with whom they no longer live with and/or have contact to ascertain the reasons for this.

A chronology of significant events must be included within the Pre Birth Safeguarding Report.

Practitioners must be mindful that repeated serious case reviews point to failures in drawing information together, analysing it and identifying patterns that, when seen together, actually changes the perspective of the case. It is essential that agency colleagues contribute fully to this process.

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 by the adult distancing themselves from others; being intolerant 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 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. as a consequence of the mother being raped, 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.

The Social Worker 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.

Area's for enquiry when completing a social history should include;

### *Family of origin*

- Both parent's culture of origin.
- Parental criminal/ ante-social behaviour
- The extent of any parental alcohol and substance misuse and its consequences for them and their family.
- Presence and degree of any parental conflict including physical violence.
- What caused this violence? Who was it directed towards?,
- What were the consequences of that violence then and now?
- What did their parents enjoy doing together?
- Extent of parental separations and family bereavements?
- Family interests and activities?
- Allocation of roles and responsibilities?
- Family demonstration of feelings?

### *Childhood*

- The nature and quality of family relationships and the type and adequacy of role modelling.
- What was it like to be a child in their family home?
- Who was special to them and who cared for them the most?
- What was their place in the family?
- Were they abused or neglected, if so, who by, for how long?
- What was the emotional and behavioural consequence for them?
- Had there been any referrals to professional agencies?
- Any periods of time in local authority care?

### *School*

- Mainstream or special schooling?
- Subject to any statement of special educational needs?
- Any academic difficulties, behaviour or attainment issues?
- School achievements, aptitude, abilities and qualifications?
- Existence of any attendance issues?
- Reasons for any changes in schooling, moves or exclusions etc?
- Any other significant events?

### *Occupational/social/recreational history*

- Degree of success in establishing adult relationships, social, intimate, employment and the degree of satisfaction with these?
- Employment history, evidence of any dismissal and extent to which this may indicate social incompetence, problems with authority or substance misuse?
- Types of jobs, performance, satisfaction and level of responsibility and dependability.
- Types of leisure activities/hobbies/clubs etc and extent to which these reflect their social skills and self image?

### *Criminal history*

- Number of previous offences? (one of the best predictors of future abuse is the number of previous offences)
- Are the offences against people or property, social rule violations e.g. drink driving?
- What is the frequency, circumstances and motivation of the offending behaviour?
- When did they become known to the Police/other criminal agencies? What were the circumstances?
- Details of previous disposals and the responses to these?
- Are they entrenched in their behaviour and what does this mean for the expectant baby?
- Is there evidence of escalation in criminal behaviour?
- What were their modus operandi and antecedent conditions or behaviours?
- Details of victim; ages, offences and consequences for the adult/child?

### **Current Family Structure and Sources of Support**

It is essential to establish the full details of the immediate and extended family and that relevant child protection checks are completed as a means of aiding the assessment and future care planning, if required.

It is important that consideration is given to the family strengths and their potential ability to harness these to produce positive change for the unborn child, as well as the risks that may be prevalent within the household. Examples of relevant questions would include

- What is the family's culture now and that of their origin?



- How the parents met?
- Why they stay together?
- How their relationship has developed and changed?
- The positive and negative attributes that exist within the relationship?
- Individual parents physical/emotional/intellectual abilities?
- Previous parental experiences i.e. number of children?
- Extent of disputes and violence in previous relationships?
- Extent of abuse substance misuse in previous relationship?
- Potential impact of previous problematic adult relationships on couple?
- Parents hopes, aspirations, strengths and talents?
- Parents range of support networks?
- Extent to which parents engage with professional agencies?
- Parent's ability to use family strengths to produce positive change?

### **Attitudes to Previous Interventions**

It is 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 the parenting practices. Examples of 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 about that child now?
- What has changed for each parent since the child was abused or removed?

It is 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 pregnancy the result of sexual assault?
- Is domestic abuse an issue in the parents' relationship?
- Is the perception of the unborn baby different/abnormal? Are they trying to replace any previous children?
- Have they sought appropriate 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?

### **Existence of Previous Abuse and Acceptance of Responsibility**

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

- The ability of the perpetrator to accept responsibility for the abuse although 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 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?
- 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 timescale, then confidence in the safety of the newborn baby and subsequent child will be poor.

Circumstances where the perpetrator is convicted of posing a risk to children and is already living in a family with other children, (albeit with social work involvement), should not detract from 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.

### **Non-Abusing Parents Ability to Protect**

When considering capacity of non-abusing parents to protect it is important to assess their own personal history and particularly their understanding in and perception as regards the abuse perpetrated by the partner. Smith, 1994 cited from Calder (2003) poses a number of relevant questions including:

- How critical or uncritical are they regarding their partner's abusive behaviour?
- To what extent were they party to or aware of their partner's abusive behaviour?
- What has changed regarding their understanding of past abuse
- To what extent do they accept responsibility for failure to protect or collusion with the abuse?
- What is the non-abusing parent's position regarding the abuse/conviction both at the time and now?
- What information do they have regarding the abuse and who provided it?
- Can additional information be provided to move the parent from any disbelieving position?
- What feelings do they have to the child? E.g. anger, sympathy, blame?
- To what extent does the non-abusing partner accept that their partner was responsible for the abuse?
- To what extent can the non-abusing partner work with Children's Social Care and other agencies?
- Could/can they choose their unborn child over abusing partner?
- To what extent is the non-abusing partner dependent on the abuser?

- How vulnerable is the non-abusing partner?
- Do they have a history of violent or abusive relationships?
- Does the non-abusive partner have other vulnerabilities i.e. disability, ill health, or other condition that isolates them from help?
- To what extent do they recognise the existence of future risk to the unborn child
- What is their ability to manage this?
- What level of knowledge do they have re the impact sexual offending behaviour in general and specific to partner?

### **Understanding Of Expectant Baby's Needs And Ability To Meet Them**

When looking at the parents capacity to understand and meet their new born baby's needs. Consideration should be given to the expertise of Health Visiting and Midwifery in carrying out this task and those relating to practical preparation for the baby and parental insight into the development of routines and baby's basic needs.

Other relevant questions would include:

- What are the social and cultural expectations of the family?
- What are the ethnic expectations of the family role and interventions?
- What are the family roles for women, children, men and elders?
- What is the response to ethnic history?
- What is the impact of any racism?
- What is the impact of class and social position?
- Is the family integrated/marginalised/powerful/powerless?
- What belief systems and values influence role expectations, define and set limits of acceptable behaviour?
- What are the key support structures?
- Which are the key relationships within the immediate and extended family?
- What life cycle stage are the family at/ what are the risks and challenges?
- What solutions are used to manage family conflict?
- How have the parents both individually and together responded to their expected baby?
- To what extent are the parents developing a sense of attachment to their expected baby?
- How do the parents build relationships and whose responsibility to they feel it is?

- What understanding do the parents have of their expected baby's basic needs?
- Do the expectant parents have the capacity to provide 'good enough parenting' to the expected baby?

### **Contributing Risk Factors**

#### *Mental Health Problems*

Although most parents with mental health needs 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".

Calder (2003) notes that the practitioner needs to be aware that:

- Parental illness affects children, but not necessarily adversely.
- Mental illness can affect the capacity of parents to parent and the resulting parent/child relationship.
- Parents may not be able to address the needs of their *newborn* child safely or adequately as a result of their illness.
- Caring for children affects the mental health of the parent. The challenges of parenting can precipitate and influence parental mental illness.
- Children's mental health and development needs have an impact on parental mental health.

If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise. While the practitioner will need to obtain a mental health assessment in these cases it is important not to 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 need to include the risk to unborn to new-born child. In addition, where there are mental health risk factors identified, on-going reevaluation of risk is essential.

There it is suspected that a prospective parent may have a learning difficulty that may result in significant harm to the new born child a more detailed assessment should also be sought from professionals with the relevant experience.

### *Substance and Alcohol Misuse*

Social workers must always use the expertise with community alcohol and substance misuse teams as well as other relevant health professionals when considering the implications of drug and alcohol misuse on the unborn child and the impact post-delivery.

‘While drug or alcohol misuse is not in itself a contra-indication that the parent(s) will be unable to care safely for the baby, excessive parental substance and alcohol misuse is likely to have a detrimental impact on the unborn child’. Cleaver et al (1999).

The Social Worker will need to give consideration to the following:

- What type of substances is the prospective parent/s dependent upon?
- What is the route/amount/duration/pattern of the substance misuse?
- 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.
- The history of parental substance misuse, current dependency.
- Any evidence of being incapacitated/comatose or paranoid/overtly psychotic?
- Is the prospective parent engaged with drug and alcohol services?
- Motivation to engage with drug and alcohol services?
- What is the prospective parent/s understanding of the potential effects of their substance misuse on the unborn and new born child?
- Can parental substance misuse be managed compatibly with the demands of a new-born child?
- What has been the impact of parental substance misuse been on other children/sibling within the household?

### *Domestic abuse and other violent behaviours*

A current and/or previous history of domestic abuse and or violent behaviour should be carefully evaluated. When addressing these issues it is recommended that Maddie Bell's Domestic Violence Risk Assessment model is used.

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 see 'Domestic Abuse assessment' in tools.

Some babies may be more difficult to care for than others (Reder and Duncan, 1995, p.49; Reder and Duncan, 1999, pp. 62-71). Research 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.

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 with the result of a baby that will require a higher level of care

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.

### **Home Environment**

Current living arrangements, including amenities and facilities and the impact mental health and or substance misuse may have upon this; type of accommodation, including owner occupier, tenant (consider rent arrears), temporary; the exterior of the accommodation and immediate surroundings; the interior of the accommodation with specific reference to the child's individual living arrangements; water, heating, sanitation, cooking facilities, sleeping arrangements, cleanliness, hygiene, safety; or if homeless, reasons for this.

### **Support Networks**

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 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 (Reder and Duncan, 1999, p.69). 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.

### **Parent's potential for and motivation for change**

#### *Future plans of the parent(s)*

This will include the degree of realism of the parents' plans for the future; have they considered the impact of a future child on their relationship/ lifestyle? Is it safe for the child to be placed with the parents?

Parental capacity and motivation for change is a critical part of the pre-birth assessment and is critical to future care planning.

### **Analysis/Conclusion**

Once the information has been gathered through the pre-birth assessment process it needs to be written up in a final report on the template found at Appendix 4 of this document.

Critical to the final report is a detailed and robust analysis. It is important to recognise that analysis is far more than a description or summary of the assessment. The aim of the assessment is to accurately identify the level of anticipated risk and look at whether this risk is manageable or not. (Calder, p. 82 2008).

The analysis needs to be logical, evidenced based and must focus on the impact of parental capacity and environmental factors on the unborn child. It needs to consider both



parental strengths and weaknesses and any reoccurring patterns of parental behaviour. The analysis should draw some conclusions as to the parents motivation to change and what actions need to be taken to either safeguard the child or provide the necessary levels of support to enable the unborn child to thrive once born and fulfil their full potential.

Finally the Pre-Birth Safeguarding Report should make clear recommendations to aid future planning. This will be captured in the Proposed Safeguarding Plan. It is these recommendations that will be considered post birth by a Child Protection Case Conference and subsequent Core Group Meetings, a Child in Need Meeting or the Court.

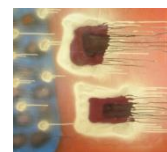
The outcome of the Pre-Birth Risk Assessment should be shared with parents and all agencies involved with the assessment.

## Appendix 3: Pre-Birth Child Protection Conference Report

### UNOCINI

PBRA

*Understanding the Needs of Children in Northern Ireland*



### PRE-BIRTH CHILD PROTECTION CONFERENCE REPORT

Child Protection Conference Date:

#### Unborn Child/ren Details

Proposed Surname at Birth	EDD	Ethnic Origin	Home Address (at birth)
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#### Family Composition

Name	DOB	Relationship to Unborn Child	PR?	Address
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#### Significant Others

Name	DOB	Relationship to Unborn Child	PR?	Address
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Family GP:

Family Midwife:

Family Health Visitor:

### **Dates Parents/Carers Seen for Completion of Pre-Birth Assessment**

Name:

Date(s) seen:

### **Multi-Agency Involvement**

Agency:

Person:

### **Specialist Assessment(s)**

Agency:

Purpose of Assessment:

### **Significant Events**

Date

Event

### **Pre-Birth Risk Assessment**

#### ***Ante Natal Medical And Obstetric History***

#### ***Social History***

#### ***Current Family Structure And Sources Of Support***

#### ***Attitude To Previous Intervention (If Appropriate)***

#### ***Attitude To Current Pregnancy***

***Existence Of Previous Abuse And Acceptance Of Responsibility***

***Non-Abusing Parent's Ability To Protect***

***Understanding of Expectant Baby's Needs and Ability to Meet Them***

***Contributing Risk Factors***

***Home Environment***

***Support Networks***

***Parents' Potential And Motivation To Change***

**Analysis**

***What needs have you identified?***

***What strengths have you identified?***

***What existing and/or potential risks have you identified?***

***What resilience and protective factors have you identified?***

**Conclusions**

***What are your conclusions?***

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**PRE BIRTH CHILD PROTECTION CONFERENCE MEETING OUTCOME**

**Areas of Discussion**

**Agreed Parental Plan**

The baby will have a Child in Need Plan / Child Protection Plan (delete as appropriate) ( see below) due to risk of .....

Risk issues for:      mother ,    baby ,    staff ,    during hospital stay ,    on return home ,

- Little / no extra support or observation required
- Mother and baby to be placed together on Post Natal Ward.
- Observation, assessment and support required with caring for baby
- Mother and baby to be placed together on Transitional Care Unit/Mother & Baby Unit for a maximum of 5-7 days
- Baby to be placed on Transitional Care Unit or Neo-natal Unit and all contact for .....  
.....to be arranged / supervised by

Children's Services

- It is proposed to place Baby with alternative carers/ Foster Carers as soon as possible once medically fit for discharge from hospital and any legal process has been completed

**Other relevant information**

A brief history of issues to include *eg proposed legal status of baby, risk of aggression or violence, restricted contact for family members etc*

**Specific discharge details**

*Please inform Children's Services /RESWS prior to discharge*

Should any emergency situation arise contact Police by dialling 101 or 999

Date:

Signature:

Copies to Parents, Social Worker, Regional Emergency Social Work Service, Midwife, Liaison Midwife, Ambulance Service and Police in child protection cases.

## Recommendations and Proposed Child Protection Plan

Recommendation Regarding Proposed Registration of baby upon birth (including category)

Recommendation Regarding Composition of Core Group

### Proposed Child Protection Plan

<u>Child's Needs</u>	<u>Planned Action</u>	<u>Desired Outcome</u>	Responsibility
			Target Date
<u>Parental Capacity</u>	<u>Planned Action</u>	<u>Desired Outcome</u>	Responsibility
			Target Date
<u>Environmental Factors</u>	<u>Planned Action</u>	<u>Desired Outcome</u>	Responsibility
			Target Date
Has Specialist Assessment been considered?			Yes <input type="checkbox"/> No
If yes please specify (offered/accepted/provided)			<input type="checkbox"/>
Has Family Group Conference been considered?			Yes <input type="checkbox"/> No
If yes please specify (offered/accepted/provided)			<input type="checkbox"/>

### About the Person Completing/Coordinating the Pre-Birth Risk Assessment

Name:

Position:

Agency:

Signature:

Date:

Supervising Manager:

Signature:

Date:

### About Other People Contributing to the Pre-Birth Risk Assessment

Name:

Position:

Agency:

Signature:

Date:

Name:

Position:

Agency:

Signature:

Date:

Name:

Position:

Agency :

Signature:

Date:

Name:

Position:

Agency:

Signature:

Date: