

HARINGEY
LOCAL SAFEGUARDING CHILDREN
BOARD

PRACTICE GUIDANCE ON PRE-BIRTH
ASSESSMENTS



1. Introduction

- 1.1 A pre-birth assessment is a proactive means of analysing the potential risk to a new born baby when there are concerns about a pregnant woman and, where appropriate, her partner and immediate family.
- 1.2 The main purpose of a pre-birth assessment is to identify what the risks to the new born child may be, whether the parent(s) are capable of changing so that the risks can be reduced and if so, what supports they will need.
- 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 "playing God" and "not giving parents a chance".
- 1.4 The justification for statutory intervention in a family's life is to safeguard and promote the welfare of children. However, in these cases the child is as yet unborn and assessment must attempt to predict whether that child will be safe. This is especially relevant, as research studies have shown that children are most at risk of fatal or severe assaults in the first year of life, usually inflicted by their carers.
- 1.5 This guidance aims to: -
 - clarify what is meant by pre-birth assessments, their purpose and the circumstances in which they should be used;
 - confirm the all London procedures agreed by Haringey Local Safeguarding Children Board in relation to pre-birth assessments;
 - provide a framework for the content of such assessments

2. Pre-Birth Assessments

- 2.1 A pre-birth assessment is essentially an assessment of the risk to the future safety of the unborn child with a view to make informed decisions about the child and family's future.
- 2.2 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.
- 2.3 Hart (2000) outlines the advantages of pre-birth assessment as providing an opportunity to:
 - identify and safeguard the babies possibly most likely to suffer future significant harm;
 - ensure that vulnerable parents are offered support at the start of their parenting career rather than when difficulties have arisen;

- establish a working partnership with parents before the baby is born;
- assist parents with any problems that may impair their parenting capacity.

2.4 There are, however, some potential disadvantages:

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

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

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

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

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

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

- when a previous child has died in suspicious circumstances or suffered significant harm and been removed from the parents' care - this may be for physical abuse, sexual abuse, emotional abuse or neglect;
- a sibling in the household **is / was** on the child protection register or has a child protection plan;
- where the prospective parent is a young person in the care of the local authority and aged 16 or under, or has a child protection plan;
- when the prospective parents behaviour or circumstances during pregnancy indicate they will be unlikely to protect or care for their baby appropriately. Examples might include:
 - a young couple, living a chaotic lifestyle with no home base, using drugs and alcohol to excess, refusing ante-natal care;

- a young woman with learning difficulties who is unable to self care appropriately casting doubt on her ability to care for a vulnerable baby;
- a woman, or couple, with chronic and disabling mental health problems e.g. schizophrenia, affective psychosis, severe substance abuse, personality disorder, obsessive compulsive disorder and eating disorders;
- where there is a high level of domestic violence;
- when the parents' history suggests that the prospect of the baby being adequately cared for is bleak e.g. a history of early abuse, serious violence, of continued substance abuse unresponsive to treatment or serious psychiatric problems;
- when one of the prospective parents is an offender / **or felt to be a risk to a child or** with a conviction for abuse, including sexual abuse, against a child;

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

3. Procedures for Pre-Birth Assessments

- 3.1 These procedures are consistent with, and must be read in conjunction with, the pan-London Child Protection Procedures 2007.
- 3.2 Any professional who becomes aware that a woman is pregnant and has cause to be concerned that the new-born baby would be at risk of significant harm, or that the parent(s) would need substantial support to care for the child, should make a referral to The Children & Young People's Service Referral & Assessment Team as soon as possible. This includes women known to be using drugs during pregnancy.

The referral should be made to the office below:

Referral & Assessment Team

Hornsey Town Hall Annexe
The Broadway
Crouch End
London
N8 9JJ

Duty Phone Numbers: 020 8489 1856/1821/5402/5403
Duty Fax No: 020 8489 1751

- 3.3 Midwives have a particularly important role in providing details of potential referrals in this arena. Practitioners in drug and alcohol clinics and mental health workers may also have early awareness of pregnant service users where there may be concerns about risk to a new-born baby.
- 3.4 GPs and health visitors are vital in contributing to pre-birth assessment. It is essential they share information in respect of mother and father's history: any known previous

pregnancies, children, and mental health issues. The importance of history should never be underestimated; the most effective clue to the future lies in the past.

- 3.5 Personal information about individuals held by professionals is subject to a legal duty of confidence and should not normally be disclosed without the consent of the subject. However, the law permits disclosure of confidential information, without consent, if it is necessary to safeguard a child, or in this case, an unborn baby. The implication is that practitioners should discuss with potential parents and seek consent for the referral unless they have grounds for fearing that to do so would place the unborn child at risk (see 2.4 above).
- 3.6 Children & Young People's Service social workers will undertake the usual checks outlined in the London Child Protection Procedures including discussions with all other professionals involved with the prospective parent(s).
- 3.7 If the concerns indicate that there is a likelihood of significant harm then a strategy discussion should be held. The fact there may be several months before the expected delivery may indicate that a strategy meeting would be more appropriate than a strategy discussion by telephone. The professionals who should be invited to attend include:
 - Children & Young People's Service staff/social worker
 - Relevant Adult Social Care staff
 - Police
 - Referrer
 - Midwife - it is particularly important that they are facilitated to attend
 - Obstetrician
 - Health Visitor if previous children
 - Other agencies involved with the parent(s) eg drug/alcohol, CPN
 - Legal representative (if considered appropriate)
 - GP - Paediatrician
- 3.8 The strategy meeting should be held at the hospital responsible for the mother's ante-natal care.
- 3.9 The purpose of the strategy discussion is to decide whether there are grounds for a pre-birth assessment i.e. s.47 child protection enquiries.
- 3.10 If the decision of strategy discussion is to undertake a s.47 enquiry, the meeting will draw up a plan as to what information needs to be gathered and which professionals and family need to be spoken to.

4. The Timing Of The Assessment

- 4.1 Undertaking the assessment during early pregnancy (between 15 to 20 weeks) provides parents with the opportunity to show evidence of change. If the outcome suggests the baby would not be safe with the parents then practitioners are provided with time and opportunity to make clear and structured plans for the baby's future, and set up support for the parents where necessary.
- 4.2 The Framework for the Assessment of Children in Need and their Families (2000) states that core assessments should be completed within 35 days of the strategy meeting. However, this timescale may need to be shortened for a pre-birth assessment depending on the timing of the referral and whether there is a risk of a premature birth. The aim is to conclude the assessment prior to delivery.
- 4.3 Where possible the unborn baby's father should be involved in the assessment.
- 4.4 If the assessment does not indicate that the baby will be at risk of suffering significant harm when born but may be a child "in need" then the planning and provision of services will continue under s.17 of the Children Act 1989.
- 4.5 If, however, the assessment does indicate that the baby will be at risk of significant harm then a child protection conference must be convened to decide on any statutory action and an outline child protection plan. The conference should be held at the hospital responsible for the antenatal care.
- 4.6 Ideally, the conference should be held at least 10 weeks prior to the expected birth, or earlier if the baby is likely to be premature.
- 4.7 The child protection conference, and subsequent child protection review conferences, will have the same status, and proceed in the same way, as other child protection conferences and reviews.
- 4.8 If the decision is made to proceed with a child protection plan for the unborn child, then the name ("Baby".....mother's name) and the due date of delivery should be entered on all electronic and hard copy records. The baby's record should be linked with the mother's record. When the baby is born the midwife should inform the social worker, who should inform the Service Manager, Child Protection & Planning.
- 4.9 The core group will meet before the birth, and before the baby is discharged from hospital. An Action Plan should record:
- Outcome of assessment;
 - Pre / post birth plans, including Child Protection Plan;
 - Managing non co-operation;
 - Removal at birth?
- 4.10 Detailed written plans need to address:
- Who should hospital contact when mum admitted / in labour / baby delivered?
 - What happens if baby born out of hours?
 - What level of contact / care [supervised or not] can the parents have?
 - What is the plan in relation to breast feeding?
 - What are the arrangements for initial legal proceedings?
 - Are the parents aware of the plan & what is their attitude?

- 4.11 The first child protection review conference should take place within 1 month of the child's birth unless further assessment is needed, where one further month will be granted. This will be sanctioned by the Service Manager Child Protection & Planning.

5. Guidance on the Content of the Pre-Birth Assessment

- 5.1 Assessment is not an exact science, but can be made as sound as possible if it includes the following three elements:
- what research tells us about risk factors
 - what practice experience tells us about how parents may respond in particular circumstances
 - the practitioners' professional knowledge of this particular family
- 5.2 Lists of risk factors are helpful but not sufficient in themselves for assessment purposes and they need to be grounded in a theoretical framework.
- 5.3 The content of a sound assessment will be formed by looking at relationships - between parents/carers, between parents/carers and the child (whether born or unborn) - looking at how previous history shapes current experiences and the context within which people are living. This is consistent with the Framework for Assessment of Children in Need and their Families.
- 5.4 A key task in the preparation of a pre-birth assessment is to identify a fundamental baseline of acceptable parenting skills against which change can be monitored.
- 5.5 The vital step when planning a pre-birth assessment is to review any previous history. This will entail reading the case files on any child/ren who have been removed from the parents care, ensuring that searches are done on any new partners in the household.
- 5.6 It is essential to construct a chronology of key events from the previous history, as repeated serious case reviews point to failures in drawing information together, analysing it and identifying patterns that, when seen together, change the perspective of the case. It is essential to include as much information from other agencies as possible and, if feasible, ask them to contribute to the chronology. The knowledge gained from the chronology will help direct the assessment.
- 5.7 Previous History
- 5.7.1 Reder and Duncan (1999) propose that maltreating parents may experience "care" and/or "control" conflicts in which the parents' own experiences of adverse parenting left them with unresolved tensions that spilled over into their adult relationships:

Care conflicts: arise out of experiences of abandonment, neglect or rejection as a child, or feeling unloved by parents. They show in later life as excessive reliance on others and fear of being left by them; or, its counterpart, distancing themselves from others; intolerance of a partner's or child's dependency; unwillingness to

prepare antenatally for an infant's dependency needs; or declining to respond to the needs when the child is born.

Control conflicts: are based on childhood experiences of feeling helpless in the face of sexual or physical abuse or 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.

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

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

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

- do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
- do they accept responsibility for their role in the abuse?
- do they blame others?
- do they blame the child?
- do they acknowledge the seriousness of the abuse?
- did they accept any treatment/counselling?
- what was their response to previous interventions? e.g. genuinely attempting to co-operate or tokenistically compliant?
- what are their feelings about that child now?
- what has changed for each parent since the child was abused/removed?

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

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

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

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

- the ability of the perpetrator to accept responsibility for the abuse (this should not be seen as lessening the risk for additional children)
- the ability of the non-abusing parent to protect

The fact that the child has been removed from their care suggests that there have been significant problems in these areas and pre-birth assessment will need to focus on what has changed and the prospective parent(s) current ability to protect.

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

- the circumstances of the abuse: e.g. was the perpetrator in the household?, was the non-abusing parent present? the severity of the abuse?
- what relationship/contact does the mother have with the perpetrator (assuming the man as perpetrator - however, this is not always the case)?
- how did the abuse come to light? e.g. did the non-abusing parent disclose or conceal? did the child tell? did professionals suspect?
- did the non-abusing parent believe the child? did they need help and support to do this?
- what are current attitudes towards the abuse? do the parents blame the child/see it as her/his fault?

- has the perpetrator accepted full responsibility for the abuse? how is this demonstrated? what treatment did he/she have?
- who else in the family/community network could help protect the new baby?
- how did the parent(s) relate to professionals? what is their current attitude?

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

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

5.8 Mental Health Problems

5.8.1 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 a cause for concern.

5.8.2 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".

5.8.3 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 there are mental health risk factors identified, ongoing reevaluation of risk is essential. There is a separate LSCB Joint Protocol on this issue.

5.9 Substance Abuse

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

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

There is separate LSCB Practice Guidance on this issue.

5.10 Violence

5.10.1A current and/or previous history of violence should be carefully evaluated. Detail should be obtained about:

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

There is separate London LSCB Guidance on domestic violence, available on www.londonscb.gov.uk .

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

- Antenatal Depression
- the child may be at risk of a premature birth and therefore vulnerable and likely to stay in hospital for a period after delivery
- mother's misuse of substances may result in the child having withdrawal symptoms or foetal alcohol syndrome
- circumstances that may lead to the child being perceived as unwanted by either parent

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

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

5.13 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.

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

- 5.15 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.
- 5.16 Once the information has been collected it needs careful analysis. This should be a shared process with the other agencies involved, particularly the midwives and obstetricians. This will be primarily the task of the core group.
- 5.17 If the assessment identifies that there are clear risks to a newborn baby then key judgements will be:
- whether there is evidence of the parent(s)' capacity to change
 - will the provision of support and services be sufficient to enable the parent(s) to care safely for their baby?
 - will they be able to change in time for the baby's birth?
 - whether the parents have appropriate support networks
- 5.18 If the completed assessment indicates that the newborn baby is likely to suffer significant harm then it should be presented to a child protection conference and thought given to consulting with Haringey's Legal Department. Where a child is given a child protection plan at birth, a meeting must include the allocated social worker and all other relevant core group members.
- 5.19 If the assessment concludes that the child should be removed at birth, there should be a clear plan outlining responsibilities and all parties must be aware of the arrangements prior to the child's birth. This will include clear guidelines on actions to be taken by hospital staff should the parents decide to try to remove the child from the hospital.
- 5.20 If the assessment concludes that the new born baby will not be at such risk but will be a child "in need" then planning and services should continue under s.17 of the Children Act 1989.

Appendix 1 Bibliography

1. London Child Protection Procedures, 3rd edition 2007
2. Department of Health, Department for Education and Employment, Home Office (2000) Framework for the Assessment of Children in Need and their Families
3. DfES (2006), Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children
4. Hart, Di (2000), "Assessment Prior to Birth" in Horwath, Jan (Ed) (2000) The Child's World: assessing children in need - Reader, Department of Health, NSPCC, University of Sheffield, [chapter 17 or 19 by Hedy Cleaver also looks at when parental issues impact on parenting which is a good reference]
5. Reder, Peter and Clare Lucey (1995) "Significant Issues in the Assessment of Parenting" (1995) in Reder, Peter and Clare Lucey (1995) Assessment of Parenting: psychiatric and psychological contributions (1995) Routledge, London
6. Reder, Peter and Sylvia Duncan (1999), Lost Innocents: a Follow-Up Study of Fatal Child Abuse, Routledge, London
7. Lucey, Clare and Peter Reder (1995) "Balanced Opinions" in Reder, Peter and Clare Lucey (1995) Assessment of Parenting: psychiatric and psychological contributions (1995) by, Routledge, London
8. Corner, Reginald (1997) Pre-Birth Risk Assessment in Child Protection Social Work Monographs, UEA, Norwich
9. Dent, Renuka Jeyarajah (editor) (1998) Dangerous Care: Working to Protect children , The Bridge Child Care Development Service, London
10. Hagell, Ann (1998) Dangerous Care: Reviewing the risks to children from their carers PSI and The Bridge Child Care Development Service, London