

North Yorkshire  
Safeguarding Children Board

# Pre-Birth Assessments

Practice Guidance

North Yorkshire  
Safeguarding  
Children  
Board



working together to safeguard children



## Pre-Birth Assessment – Practice Guidance – Pre Birth Risk assessment and planning

### 1.0. Introduction

- 1.1 Where an unborn baby is considered to be at risk of harm or likely to be in need of services from Children's Social Care when born, partners should make an immediate, timely referral to Children's Social Care. It is recognised that early referrals to CSC will result in detailed and well planned assessments which can inform the plan.
- 1.2 Referrals should be made using the agreed universal referral form (available as appendix one and in the main NYSCB and CYPS web sites) and supported by the North Yorkshire vulnerability checklist. The referral process states that where ever possible professionals should inform parents of their intention to make a referral unless this action would place the unborn child at risk of harm.
- 1.3 If an unborn child is considered to be at risk of immediate significant harm then NYSCB Child protection procedures should be followed and a strategy meeting convened without delay
- 1.4 47% of all Serious Case Reviews in 2008-09 involved children less than 1 year of age. 59% of those babies were fatally injured. This has been a pattern in Child Protection since records began to be kept, and seems to relate to 3 factors – physical vulnerability of the infant; its invisibility in the wider community and inability to speak for itself; and the physical and psychological strain it places upon its caregivers. It is critical, therefore, that all Local Children's Safeguarding Boards (LSCBs) have robust procedures in place, both to identify the children most at risk and then to effectively manage their protection.
- 1.5 The nature of the work dictates that the most successful preventative action is taken if vulnerable children are identified as early as possible, pre- birth. This early warning system can only operate in a meaningful way if there is an agreed interagency commitment to the importance of this area of Child Protection, and that professionals work together to assess and manage the response to this high-risk group.
- 1.6 The key agencies in terms of identification and intervention are midwifery services; Adult Mental Health; Community Drug and Alcohol Services; Probation; Police, particularly Domestic Violence Officers; and Learning Disability Services. These areas are regularly highlighted in the literature around Serious Case Reviews.

## 2.0 Aim of the Guidance

- 2.1 This guidance has been developed in conjunction with NYSCB partners and seeks to assist professionals when considering concerns relating to unborn children and to support social workers when undertaking an assessment of risk and need. It is designed to help professionals to carefully consider a range of themes and to identify issues that have potential for having a significant negative impact on the child. It draws extensively on the work of Martin C Calder – as described in “Unborn Children: A Framework for Assessment and Intervention” 2008.
- 2.2 The guidance recognises the importance of early referral to Children’s Social Care so that where there are concerns for the future safety or welfare of an unborn child, appropriate assessments can be made in a timely way and effective plans can be put in place to support the parents and safeguard the child prior to the birth, and ensure that robust multi-agency plans are in place.
- 2.3 The NYSCB recognises that there will be cases when referrals are made in late pregnancy or where babies are born prematurely. In such situations it may not be possible to complete the full pre-birth assessment, yet professionals caring for the mother and child need a clear plan about how to proceed. Every situation is different and professional judgement will be needed on the part of the assessors and those in the multi-agency network for the child and family, to decide on the additional information needed and to provide immediate support to meet identified need.
- 2.4 Referring in a timely manner 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. Early assessment and intervention enables the provision of support services so as to facilitate optimum home circumstances prior to the birth and provides sufficient time to make adequate plans for the baby’s protection where this is necessary and where the assessed risk is felt to be high. Clear analytical assessment will inform the long term permanence needs of these children and avoid delay when decision making is made prior to birth.
- 2.5 Any identified Child Protection concerns regarding an unborn child should follow the same NYSCB procedure as for any other child. A referral should be made to Children’s Social Care using the [“Referral Form To Children’s Social Care Or Disabled Children’s Service”](#).
- 2.6 Following referral, screening will be carried out by the Customer Contact Centre Screening Team and families will be directed to the appropriate agency for support. As part of the screening process it will be necessary to ensure that the relevant health professional is contacted in order to gather information to inform the decision making as to where the referral should be directed.
- 2.7 Pregnant mothers/fathers can be supported by a range of agencies depending on the initial screening of information available.

- 2.8 If a service is to be offered an assessment will be undertaken: If the unborn baby's needs are felt to be at levels 1 or 2 of the vulnerability checklist then a CAF will be appropriate. However where the concerns are more serious then a CSC assessment will be undertaken either under S17 or S47 of The Children Act, led by a CSC Social Worker. All practitioners should utilise this guidance to inform their assessments and specifically address salient issues within the case. Relevant information held by the Police; Named Nurse/Senior Nurse for Child Protection: midwifery services should be obtained and included in assessment and parents should be involved in planning as far as possible.
- 2.9 Throughout this process consideration should be given to identified risk and a multi-agency strategy meeting convened in line with NYSCB Child protection procedures as appropriate.
- 2.10 A referral should always to be made in the following circumstances:
- Where concerns exist regarding the parenting capacity of proposed parents. ability to protect;
  - Where alcohol or substance abuse is thought to be affecting the health of the expected baby, and is one concern amongst others;
  - Where the expectant parent(s) are very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required;
  - Where previous children in the family have been removed because they have suffered harm or been at risk of significant harm;
  - Where a person who has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child, has joined the family;
  - Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities;
  - Where the child is believed to be at risk of significant harm due to domestic violence.

### **3.0 Guidance on the Content of the Pre Birth Assessment**

- 3.1 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 and the practitioners' professional knowledge of this particular family
- 3.2 The content of a sound assessment will be formed by looking at relationships – between parent/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:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4003256](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4003256)

- 3.3 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. The assessment must include other agencies' views in particular health.
- 3.4 A 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.**
- 3.5 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.

#### **4.0 Previous History**

- 4.1 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.
- 4.2 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.
- 4.3 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.
- 4.4 Practitioners should attempt to build up a clear history from the parents of their previous experiences in order to ascertain whether there are any unresolved conflicts and also to identify the meaning any previous children had for them and the meaning of the new born baby. It will be particularly important to ascertain the parent(s) views and attitudes towards any previous children who have been removed from their care, or where there have been serious concerns about parenting practices. Relevant questions would include:

- do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
  - do they accept responsibility for their role in the abuse?
  - do they blame others?
  - Do they blame the child?
  - Do they acknowledge the seriousness of the abuse?
  - did they accept any treatment/counselling?
  - what was their response to previous interventions? e.g. genuinely attempting to cooperate or tokenistically compliant?
  - what are their feelings about that child now?
  - hat has changed for each parent since the child was abused/removed?
- 4.5 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.
- 4.6 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?
- 4.7 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) and the ability of the non-abusing parent to protect
- 4.8 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.
- 4.9 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 – it should not be assumed that this 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?

4.10 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.

4.11 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 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.

## **5.0 Mental Health Problems**

5.1 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.

5.2 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”. 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 re evaluation of risk is essential.

## **6.0 Substance Abuse**

6.1 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.

## **7.0 Violence**

7.1 A current and/or previous history of violence should be carefully evaluated. Detail should be obtained about: the nature of violent incidents, their frequency and severity, and information on what triggers violent incidents.

7.2 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 the following should be taken into consideration:

- 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

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

## **8.0 Other Concerns**

8.1 Examination of the history of previous children who have been removed from the parent(s) care will indicate if there were particular characteristics which made that child harder to care for. It is essential to find out from the parent(s) what problems, if any, they identified in caring for that child. caring for a new born baby is difficult enough for any parent but can be particularly stressful if the parent(s) are isolated and do not have a network of support. It is important to identify whether partners are going to share responsibility or whether it will fall to one, usually the mother.

8.2 Research (Reder and Duncan, 1999, p.69) has indicated that when children have been abused the trigger may often be a family crisis e.g. loss of home or job, marital problems or upheavals, physical exhaustion etc. However, there are many other triggers and factors that will need to be considered within an assessment. It is therefore important to identify the support networks that the parent(s) have, their financial and housing position. Clear guidelines are outlined in the Framework for Assessment of Children in Need and their Families.

8.3 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, with the oversight of an experienced worker and manager in order to ensure that a robust, evidence based assessment is formed with a clear plan as to how the child’s needs will be met.

## 9.0 Planning

- 9.1 Detailed plans must be made on the basis of the above assessment. These plans must include taking, or making every effort to take, all necessary action to protect a baby from any assessed risk of significant harm before, during or immediately after the birth. This should normally be done under Child Protection procedures. However where there is a risk of significant harm to the unborn child and concerns regarding the safety of the child within its family following birth, the CSC team should give early consideration to implementing a Public Line Outline Process pre-birth so that plans can be clear for the family upon the child’s birth.
- 9.2 If the assessment identifies that there are clear risks to a newborn baby then a strategy meeting should be convened. The strategy meeting will make a decision as to whether it is necessary for CSC to conduct section 47 enquiries. It will be critical to ensure that appropriate health professionals attend this meeting. The section 47 enquiry will gather information and form a balanced judgement as to whether there are substantiated concerns that the unborn child is likely to be at risk of harm.
- 9.3 If a decision is made following the section 47 enquiry, that the unborn child is at risk of significant harm, an Initial Child Protection Conference should be arranged within 15 working days.
- 9.4 The following framework is adapted from Martin Calder in “Unborn Children: A Framework for Assessment and Intervention” of R. Corner’s “Pre-birth Risk Assessment: Developing a Model of Practice”.

Factor	Elevated Risk	Lowered Risk
<b>The abusing parent</b>	<ul style="list-style-type: none"> <li>• Negative childhood experiences, inc. abuse in childhood; denial of past abuse</li> <li>• Violence abuse of others.</li> <li>• Abuse and/or neglect of previous child</li> <li>• Parental separation from previous children</li> <li>• No clear explanation</li> <li>• No full understanding of abuse situation</li> <li>• No acceptance of responsibility for the abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Positive childhood</li> <li>• Recognition and change in previous violent pattern</li> <li>• Acknowledges seriousness and responsibility without deflection of blame onto others</li> <li>• Full understanding and clear explanation of the circumstances in which the abuse occurred</li> <li>• Maturity</li> <li>• Willingness and demonstrated capacity and ability for change</li> <li>• Presence of another safe non-</li> </ul>

	<ul style="list-style-type: none"> <li>• Antenatal/post natal neglect</li> <li>• Age: very young/immature</li> <li>• Mental disorders or illness</li> <li>• Learning difficulties</li> <li>• Non-compliance</li> <li>• Lack of interest or concern for the child</li> </ul>	<p>abusing parent</p> <ul style="list-style-type: none"> <li>• Compliance with professionals</li> <li>• Abuse of previous child accepted and addressed in treatment (past/present)</li> <li>• Expresses concern and interest about the effects of the abuse on the child</li> </ul>
<b>Non-abusing parent</b>	<ul style="list-style-type: none"> <li>• No acceptance of responsibility for the abuse by their partner</li> <li>• Blaming others or the child</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts the risk posed by their partner and expresses a willingness to protect</li> <li>• Accepts the seriousness of the risk and the consequences of failing to protect</li> <li>• Willingness to resolve problems and concerns</li> </ul>
<b>Family issues (marital partnership and the wider family)</b>	<ul style="list-style-type: none"> <li>• Relationship disharmony/instability</li> <li>• Poor impulse control</li> <li>• Mental health problems</li> <li>• Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks)</li> <li>• Lack of support for primary carer /unsupportive of each other</li> <li>• Not working together.</li> <li>• No commitment to equality in parenting</li> <li>• Isolated environment</li> <li>• Ostracised by the community</li> <li>• No relative or friends available</li> <li>• Family violence (e.g. Spouse)</li> <li>• Frequent relationship breakdown/multiple relationships</li> <li>• Drug or alcohol abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive spouse/partner</li> <li>• Supportive of each other</li> <li>• Stable, or violent</li> <li>• Protective and supportive extended family</li> <li>• Optimistic outlook by family and friends</li> <li>• Equality in relationship</li> <li>• Commitment to equality in parenting</li> </ul>
<b>Expected child</b>	<ul style="list-style-type: none"> <li>• Special or expected needs</li> <li>• Perceived as different</li> <li>• Stressful gender issues</li> </ul>	<ul style="list-style-type: none"> <li>• Easy baby</li> <li>• Acceptance of difference</li> </ul>

<b>Parent-baby relationships.</b>	<ul style="list-style-type: none"> <li>• Unrealistic expectations</li> <li>• Concerning perception of baby's needs</li> <li>• Inability to prioritise baby's needs above own</li> <li>• Foetal abuse or neglect, including alcohol or drug abuse</li> <li>• No ante-natal care</li> <li>• Concealed pregnancy</li> <li>• Unwanted pregnancy identified disability (non-acceptance)</li> <li>• Unattached to foetus</li> <li>• Gender issues which cause stress</li> <li>• Differences between parents towards unborn child</li> <li>• Rigid views of parenting</li> </ul>	<ul style="list-style-type: none"> <li>• Realistic expectations</li> <li>• Perception of unborn child normal</li> <li>• Appropriate preparation</li> <li>• Understanding or awareness of baby's needs</li> <li>• Unborn baby's needs prioritised</li> <li>• Co-operation with antenatal care</li> <li>• Sought early medical care</li> <li>• Appropriate and regular ante-natal care</li> <li>• Accepted/planned pregnancy</li> <li>• Attachment to unborn foetus</li> <li>• Treatment of addiction.</li> <li>• Acceptance of difference-gender/disability</li> <li>• Parents agree about parenting</li> </ul>
<b>Social</b>	<ul style="list-style-type: none"> <li>• Poverty</li> <li>• Inadequate housing</li> <li>• No support network</li> <li>• Delinquent area</li> </ul>	
<b>Future plans</b>	<ul style="list-style-type: none"> <li>• Unrealistic plans</li> <li>• No plans</li> <li>• Exhibit inappropriate parenting plans</li> <li>• Uncertainty or resistance to change</li> <li>• No recognition of changes needed in lifestyle</li> <li>• No recognition of a problem or a need to change</li> <li>• Refuse to co-operate</li> <li>• Disinterested and resistant</li> <li>• Only one parent co-operating</li> </ul>	<ul style="list-style-type: none"> <li>• Realistic plans</li> <li>• Exhibit appropriate parenting expectations and plans</li> <li>• Appropriate expectation of change</li> <li>• Willingness and ability to work in partnership</li> <li>• Willingness to resolve problems and concerns</li> <li>• Parents co-operating equally</li> </ul>

9.5 If it is agreed that the unborn baby is made the subject of a Child Protection Plan, the Plan must be explicit about the actions to be undertaken and by whom, immediately following the baby's birth in order to ensure the baby's protection until the Review Child Protection Conference, and should address the following:

- Contingency arrangements if the Child Protection Plan does not progress as expected
- That legal advice should be sought where necessary. This means ensuring that a gateway meeting takes place between the team manager and legal adviser.
- That a copy of the Protection Plan and Conference minutes are to be sent to the Named Nurse for Child Protection and the Emergency Duty Team
- That if the baby is transferred or placed in a different hospital, a copy of the Child Protection Plan is to be sent immediately to the new venue

9.6 Where a child protection plan is made, Children's Social Care should convene a separate planning meeting with hospital staff to develop a comprehensive birth plan which should include:

- The name of any identified person who should not have contact with the baby;
- A statement to say whether the baby should go home with parent(s) or not;
- Where the plan is that the baby should not go home with the parent(s) the action to be taken should there be any attempt to remove the baby from the hospital, including consideration of Police Protection or Emergency Protection Order;
- Where the baby is not to go home with the parent(s), the contact arrangements and whether this is to be supervised and by whom;
- Where appropriate, details of alternative carers;
- That a copy of the Protection Plan and Conference minutes are to be sent to the Named Nurse for Child Protection and the Emergency Duty Team;
- That if the baby is transferred or placed in a different hospital, a copy of the Child Protection Plan is to be sent immediately to the new venue.
- Contingency arrangements if the Child Protection Plan does not progress as expected.