Wandsworth Safeguarding Children Board

Practice Guidance in relation to Pre-Birth Assessments and Pre-Birth Child Protection Conferences

Revised October 2016
Practice Guidance in relation to Pre-Birth Assessments and Pre-Birth Child Protection Conferences

Table of Contents

1. Introduction ........................................................................................................................................2
2. Pre-Birth Referral .............................................................................................................................3
3. Pre-Birth Initial Assessments ..............................................................................................................5
4. Pre-Birth Child Protection Conferences ..........................................................................................6
5. Quick referral flowchart (London CPP 2.7)* ....................................................................................9
Appendix 1. Assessment tool for Social Workers* ..............................................................................10

1. Introduction

The complexity, sensitivity and potential difficulty of this area of work is fully recognised by the Wandsworth Safeguarding Children Board (WSCB). This practice guidance has been produced to support and safeguard the wellbeing of unborn children. Its purpose is to support the multi agency partner carry out their work to the highest standards. It has been revised and updated in response to learning from a Serious Case Review.

The WSCB seeks to ensure that all professionals are clear and well informed about their safeguarding responsibilities: they know when and how to refer vulnerable unborn children; and when assessments and child protection conferences are required. The guidance is intended to ensure that responses are timely and have the required urgency as it is recognised that to be inherent in the psychology of working with pre-birth situations that workers think that they have much more time than they actually have.

The London Child Protection Procedures (LCPP) offer detailed guidance in relation to this area of work and reference should always be made to them. This guidance reflects the LCPP and Working Together to Safeguard Children 2015.

The local guidance emphasises specific issues for Wandsworth staff.

Appendix 1 provides additional support to Social Workers carrying out complex assessments

Full details of the LCPP are at:
www.londoncp.co.uk/chapters/referral_assess.html?zoom_highlight=pre-birth#prebirth
2. Pre-Birth Referral

a) Where any agency or individual considers that a prospective parent may need support services to care for their baby, or that the baby may be at risk of significant harm, then they must refer to Children’s Services as soon as the concerns are identified. Referrals should be made to the Multi Agency Safeguarding Hub (MASH) on 020 8871 6622.

b) Where the potential child protection concerns focus upon, or are related to, the prospective parent’s mental health, addictive behaviour, learning disability or physical disability, then the Adult Services workers have a key role in relation to referral to Children’s Services.

c) It is very important to refer such prospective parents to Children’s Services without delay for the following reasons:

- Provide sufficient time to make adequate plans for the baby’s protection;
- Provide sufficient time for a full and informed assessment;
- Avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time;
- Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby;
- Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.
- Provide sufficient time to mobile protection from within the family’s own resources.

Legal Proceedings

Although not all referrals will go on to require legal proceedings, it is important to bear in mind the timescales laid out in the guidance as they will not be met unless referrals are

“Where the local authority is considering proceedings shortly after birth, the timing of the sending of the pre-proceedings letter or letter of issue should take account of the risk of early birth and help to ensure that discussions and assessments are not rushed. Ideally the letter should be sent at or before 24 weeks.” (p 19).
**[1] Court orders and pre-proceedings For local authorities April 2014**

*(London CPP, 2.6.3)*

d) Concerns should be shared with prospective parents by the referring agency wherever possible (unless it is considered that this action may in itself place the welfare of the unborn child at risk).

e) In relation to the role of the health visitor with vulnerable families, ante-natal contact is crucial in establishing an early professional relationship with a family, and enabling an assessment to take place of the level of health visiting intervention required to promote the welfare of the unborn child.

The health visitor has a critical role and responsibility in relation to:

- Liaising with relevant midwifery services and GPs.
- Early assessments as to potential risks and future need.
- Referrals to Children’s Services.
- Targeting those families who are potentially most at risk.

f) Ensure that the risk assessment is thorough and appropriate – see the tool at 6 below.

g) It is recognised that some mothers-to-be are very late in acknowledging their pregnancies to agencies; it is very important, in such situations, that agencies begin working together in relation to pre-birth assessments with urgency.

h) It is recognised that there can be considerable anxiety and stigma attached to the processes of referring vulnerable adults to Children’s Services in such pre-birth situations – prospective parents may feel very anxious that their child may be taken away; professionals may be anxious about prospective parents disengaging or even moving to avoid contact; there may also be anxiety that agencies may focus on the areas of concern or potential concern, without equally recognising the strengths and supports within families as well as the supports which can be offered within the professional network. These factors should not however be used as reasons not to refer to Children’s Services.

i) It is well documented that parental problem drug use can, and often does, compromise children’s health and development from conception onwards. Maternal drug use during pregnancy can seriously affect foetal growth, although assessing conclusively the impact is usually impossible. The document includes the following recommendations:

(i) Every maternity unit should ensure that it provides a service that is accessible to, and non-judgemental of, pregnant problem drug users, and able to offer high quality care aimed at minimising the impact of the mother’s drug use on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of drug misuse during pregnancy and neonatal withdrawals.

(ii) Pregnant female drug users should be routinely tested with their informed consent for HIV, Hepatitis B and Hepatitis C, and appropriate clinical management provided, including Hepatitis B immunisation for all babies of drug injectors.
(iii) Every maternity unit should have effective links with community health care, social work children and family teams and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

3. Pre-Birth Initial Assessments

A pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, preferably before 20 weeks, and when appropriate, a strategy meeting / discussion held, where

- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children (see Risk Management of Known Offenders Procedure);
- A sibling in the household is subject of a child protection plan;
- A sibling has previously been removed from the household either temporarily or by court order;
- The parent is a looked after child;
- There are significant domestic violence issues (see Safeguarding children affected by domestic abuse and violence Procedure);
- The degree of parental substance misuse is likely to impact significantly on the baby’s safety or development (see Parents who Misuse Substances Procedure);
- The degree of parental mental illness / impairment is likely to impact significantly on the baby’s safety or development (see Parenting Capacity and Mental Illness Procedure);
- There are significant concerns about parental ability to self care and / or to care for the child e.g. unsupported, young or learning disabled mother; (see Parenting Capacity and Learning Disabilities Procedure)
- Any other concern exists that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child (see Fabricated or Induced Illness Procedure) or harming a child;
- A child aged under 13 is found to be pregnant (see Safeguarding Sexually Active Children Procedure and Safeguarding Children from Sexual Exploitation Procedure).

(London CPP 2.6.5)

a) The London Child Protection Procedures suggest that a professionals’ or strategy meeting should be convened as soon as practicable following the receipt of a referral, and that the expected date of the delivery will determine the urgency for the meeting.
Consideration of the need to initiate a s47 enquiry should follow the procedures described in *Child protection enquiries Procedure*. *(London CPP 2.6.6)*

Following referral there should always be consideration as to whether a strategy meeting is required and whether threshold for a Section 47 enquiry should be initiated. All strategy meetings or discussion must include health partners. Their views must be obtained upon the threshold for a s47 as well as any relevant information that will inform the risk assessment.

It is recommended that where ever possible a face to face strategy meeting should be held. If adult substance use or mental health services or domestic abuse services have knowledge or information they must be invited.

Wherever possible when the pre-birth assessment has been carried out by Children’s Services and presented to a pre-birth planning meeting at which relevant professionals and the parents-to-be (and family members) are invited. This pre birth planning meeting should agree a plan to safeguard the unborn and support the parents. Where a pre birth child protection conference is planned the planning meeting should agree an interim plan until the conference takes place.

b) It is expected that the pre-birth planning meeting will be held early in the assessment process. This enables agencies to share information, enables Children’s Services to share their assessments, ensures that all agencies are aware of the situation, enables further assessments in relation to a prospective parent's capabilities to begin, enables the early provision of support services, and considers whether or not to recommend the need for a pre-birth child protection conference to the Council’s. Child Protection Unit. In Wandsworth this the Safeguarding Standards Service

c) Any agency can request that a pre-birth child protection conference be convened if they consider that the expected child may be at risk of significant harm. Where there is professional disagreement regarding the threshold for a conference the WSCB escalation policy should be followed.

**4. Pre-Birth Child Protection Conferences**

a) **Criteria**

A pre-birth child protection conference should be held where:

- A pre-birth assessment gives rise to concerns that an unborn child may be at risk of significant harm.
- A previous child has died or been removed from parent/s as a result of significant harm.
• A child is to be born into a family or household which already have children subject to a child protection plan.
• An adult who has been identified as posing a risk to children resides in the household or is known to be a regular visitor.
• The impact of parental risk factors such as mental ill-health, learning or physical disabilities, substance misuse and domestic violence, raises concerns that the unborn child may be at risk of significant harm.
• There are concerns regarding a young vulnerable mother and her ability to care for herself and/or care for her baby.

b) **Timing**

The pre-birth conference should take place as soon as practical and wherever possible at least 10 weeks before the due date of delivery, so as to allow as much time as possible for planning support for the baby and family. Where there is a known likelihood of a premature birth, the conference should be held earlier.

c) **Attendance of Professionals at a Child Protection Conference**

The following agencies should always be invited:

- General Practitioner
- Health Visitor - If it is not clear which health visitor will have responsibility for the child, the invitation should be sent to the Named Nurse for Community Services.
- Ante-Natal Clinic Midwives
- Community Midwives
- Named Midwife for Safeguarding (at St. George’s Hospital)
- Community Child Health
- Woking Close Family Centre
- Family Nurse Partnership
- Family Recovery Project (FRP)

An invitation to the following agencies should always be considered (depending on the individual circumstances)

- Neo-Natal Special Care (for babies whose parents are substance users)
- Delivery Unit at the hospital where the prospective parent is booked
- Drug Dependency Unit
- Adult Mental Health Services
- Adult Social Services

If a Young Person Looked After by Children’s Services or a Care Leaver is pregnant, then the following professionals should be invited:

- The Specialist Nurse for Children Looked After.
- Teenage Pregnancy Adviser at St. George’s Hospital.
- The allocated Social Worker for the looked after young person/care leaver.

- **Parents or carers** - These should be invited as they would be to all child protection conferences and should be fully involved in plans for the child’s future. Where the
parents are young or have additional vulnerabilities their support needs should be addressed

d) The Child Protection Plan

If a decision is made that the baby needs to be the subject of a Child Protection Plan, the main cause for concern must determine the category of registration and a child protection plan must be outlined to commence prior to the birth of the baby.

The London CPP and WTSC 2015 should be followed in respect of the making of a plan.

e) Alert Letters

It is sometimes necessary to send ‘alert letters’ to other local authorities, or to all hospitals in London where it is felt that the prospective mother may present at another hospital, possibly to try to avoid the involvement of Wandsworth agencies.

Missing Persons

In the event of a pregnant mother going missing during a s47 investigation or when a pre-birth child protection plan has been made then the allocated Social Worker should discussing making a missing persons report. If the pregnant mother is under 18 a missing persons report must be made.

In these circumstances an alert to other Local Authorities and hospitals must be made.

For more information see:

The London Child Protection Procedures, Section 3. Children Missing from Care, Home and Education:  
http://www.londoncp.co.uk/chapters/ch_miss_care_home_sch.html?zoom_highlight=missing

Statutory guidance: Children who run away or go missing from home or care, 2014  
https://www.gov.uk/government/publications/children-who-run-away-or-go-missing-from-home-or-care
5. Quick referral flowchart (London CPP 2.7)*

*Note that all references to ‘common assessment’ should read ‘Early Help Assessment’ for Wandsworth cases.

Where professionals are unsure about making a referral they should refer to the Threshold of Need Guide: This can be downloaded here:  
http://www.wscb.org.uk/wscb/downloads/file/95/wscb_threshold_for_intervention

They can also ask for a professional consultation with a manager in the MASH team.
Appendix 1. Assessment tool for Social Workers

Pre-birth assessment tool

Introduction

This tool draws extensively on the work of Martin C Calder as described in ‘Unborn Children: A Framework for Assessment and Intervention’ in Assessment in Child Care, Using and Developing Frameworks for Practice Russell House Publishing 2003.

Assessment is not an exact science, but can be made as sound as possible if it includes the following three elements:

a) What research tells us about risk factors;

b) What practice experience tells us about how parents may respond in particular circumstances;

c) The practitioners' professional knowledge of this particular family.

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

a) Evaluating the quality and quantity of support that will be available within the family (and extended family);

b) The needs of the parent(s) and how these will be met;

c) The context and circumstances in which the baby was conceived; and

d) The wishes and feelings of the child who is to be a parent

All child and family assessments should be completed using a signs of safety approach considering with the family what is working well, what people are worried about and what should happen, with consideration of complicating factors.

Pre – Birth Assessment

The list below should not act as an assessment “script” but as a support for conversation and consideration for assessment. The basis of the assessment should be the Department of Health assessment triangle and the analysis recorded in the Wandsworth child and family assessment form.

Summary of child and family history, including any previous or current professional involvement

Social history

• Experience of being parented (positive/negative memories, main carer, parental relationships)

• Experiences as a child /adolescent (abuse, neglect, care/control issues)

• Education / Employment
• History of abuse as a child (Convictions – especially of members of extended family, CP Registration/subject to CP plan, CP concerns including unsubstantiated allegations, Court findings, Previous assessments)

• Parents’ understanding of their own cultural/family narrative around childbirth

• Perceptions of significant others about her being pregnant and how she has handled or responding to these perceptions

• What is the cultural narrative around early pregnancy (teen mum)

• What are the expectations of adult family members, if any and how has she responded to these expectations (Aunties and Uncles)

Communication

• English not spoken or understood/ interpreter required

• Deafness (partial/profound, interpreter required)

• Blindness

• Speech impairment

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 child 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 antenatal 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?

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 their feelings towards the unborn baby.

History of being responsible for children

• Convictions re: offences against children

• CP Registration/subject to CP plan

• CP concerns – and previous assessments

• Court findings
• Care proceedings and/or children removed
• Category and level of abuse
• Ages and genders of children
• What happened?
• Why did it happen?
• Is responsibility appropriately accepted?
• What do previous risk assessments say? Take a fresh look at these – including assessments re: non-abusing parents.
• What is the parent’s understanding of the impact of their behaviour on the child?
• What is different about now?

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 the parenting practices. Relevant questions might 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 has changed for each parent since the child was abused and/or removed?
• Context and circumstances of conception

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.

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?
• What relationship/contact does the mother have with the perpetrator?
• 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?

NB: In circumstances where the sexual abuse 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.

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.

The unborn child’s health and development
Ante-natal care: medical and obstetric history (to be provided by midwifery)
  • Confirmation of pregnancy (planned or unplanned?)
  • First ante-natal appointment
  • Engagement with maternity services including GP and midwife-led care (MLC)
  • Feelings of mother about being pregnant/feelings of partner/putative father
  • Previous obstetric history (including miscarriages, terminations, still birth)

Parenting of the child / young person
Relationships
  • History of relationships of adults, current status, positives and negatives
  • Violence
  • Who will be main carer for the baby?
  • Parents expectation regarding each other’s parenting capacity

Is there anything regarding “relationships” that seems likely to have a significant negative impact on the child? Detail should be obtained about:
  • Nature of any violent/abusive 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.

Dependency on partner
• Choice between partner and child
• Role of child in parent’s relationship
• Level and appropriateness of dependency

Behaviour
• Violence to partner and/or violence to others?
• Violence to any child
• Drug misuse and/or alcohol misuse
• Offending behaviour (nature/number of criminal convictions)
• Chaotic (or inappropriate) life style

Abilities of Parent’s
• Physical
• Emotional (including self-control)
• Intellectual
• Knowledge and understanding re: children and child care
• Knowledge and understanding of concerns / this assessment

Ability and willingness to address issues identified in assessment
• Violent behaviour
• Drug misuse / alcohol misuse
• Mental health problems
• Reluctance to work with professionals
• Poor skills or lack of knowledge
• Criminality
• Poor family relationships
• Issues from childhood
• Poor personal care
• Chaotic lifestyle

Attitude to professional involvement
  • Previously – in any context
  • Currently – regarding this assessment
  • Currently – regarding any other professionals

Is there anything re “attitudes to professional involvement” that seems likely to have a significant negative impact on the child?

Attitudes and beliefs re: convictions / findings (or suspicions/allegations)
  • Understood and accepted
  • Issues addressed
  • Responsibility accepted

Planning for the future
  • Realistic and appropriate expectations
  • Unrealistic, inappropriate expectations

Specific issues of concern (domestic violence, alcohol and/or substance misuse, chronic mental health difficulties, significant learning difficulties etc.)
  • Medicine/drugs – prescribed or otherwise - used before and/or during pregnancy
  • Chronic/acute medical conditions or surgical history Appendix A
• Psycho-social History
Psychiatric history especially depression and self-harming

**Mental health (information to be provided by Mental Health Team)**

Is there anything regarding “mental health” that seems likely to have a significant negative impact on the child?

• Clarification of mental health status (including hospital admittance)
• Description of illness (depression, schizophrenia, personality disorder, psychosis)
• Consideration of 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”
• Non-compliance with medication without medical supervision
• Potential risks in relation to parenting capacity
• Additional concerns posed by both parents having mental health difficulties
• Evidence of difficulties in forming emotional attachments with previous children
• Co-morbidity (with drug/alcohol abuse, domestic abuse, learning difficulties)
• Psychiatric assessment informing practice

**Drug and alcohol (information to be provided by Drug and Alcohol services)**

Is there anything regarding “drug and alcohol misuse” that seems likely to have a significant negative impact on the child?

• Acknowledgement of the substance/alcohol abuse
• Details of substance used/preference; cost, how is money obtained?
• Storage of drugs, paraphernalia and/or alcohol
• Duration and pattern of usage/addiction (experimental, recreational, chaotic, dependent)
• Health implications and risks (incl. HIV, Hep B and C)
• Engagement with Drug and Alcohol services (committed, tokenistic, realistic etc.)
• Drug/alcohol screening
• Detox (community/residential, success or otherwise)
• Behaviour (presenting as passive, aggressive, resistant to support etc.)
• Extent of involvement in local drug culture
• Is there a drug free parent, supportive partner or relative? Appendix A
• Could other aspects of drug use constitute a risk to children (e.g. conflict with or between dealers, exposure to criminal activities related to drug use)?

**Learning disability (information to be provided by Adult Learning Difficulty Team)**

Is there anything regarding “learning disability” that seems likely to have a significant negative impact on the child?

- Joint planning and assessment should take place from the outset
- Consideration of the parent’s intellectual functioning (cognitive ability)
- Consideration of the parents’ ability to learn to respond to the needs of their child and the time-scale over which this learning is required to take place, will be an important aspect of the assessment
- Psychological factors impacting on parenting ability, e.g., loss, mental illness, emotional issues resulting from trauma
- Functional assessment (living skills assessment) may be required
- Some mothers with learning difficulties may not recognise that they are pregnant, and this should be considered if there are suspicions that they are concealing or have concealed a pregnancy

**The unborn child’s home and community**

**Circumstances**

- Unemployment / employment
- Finances including benefits, any debts
- Inadequate housing / homelessness
- Court Orders (including any current/historical in relation to previous children)
- Social isolation

**Home conditions**

- Chaotic (including frequency of people coming and going)
- Children regularly left in care of friends/acquaintances
- Health risks / insanitary / dangerous
- Over-crowded

**Support**

- From extended family/friends
- From professionals
- From other sources
- Nature of support; available over a meaningful time-scale, likely to enable change, effectiveness in addressing immediate concerns
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.

**Social Worker's analysis of the current situation**
A sound analytical assessment will provide a good picture of the child, their parent/s/carers and their story. Use the analysis to give the reader an understanding of why the assessment is being undertaken and be clear about the individual unborn child’s needs. Consider the seriousness of the needs identified and be clear about what success will look like and what will happen/impact on the child if the outcomes are not achieved (danger statement). State clearly what work will be done to support the family to make the changes they need to make.

Base these thoughts around a signs of safety approach, what are we worried about? What is working well and what needs to happen? What might ‘get in the way’ of success (complicating factors).

Use your analysis to show your understanding of the family history and the way that the history may have contributed; include an analysis of what we don’t yet know and adopt an open-minded and questioning approach – ie: is this the only way of understanding this? Make explicit the underpinning knowledge (ie: child development knowledge, attachment etc) and the prediction about the likely impact on the child if the identified needs are not met.

- Show ‘your working’; how you have used the information available to reach certain conclusions? And be free of jargon, especially words and phrases that will mean little to the family.