MULTI-AGENCY

PRE-BIRTH ASSESSMENT PROTOCOL

Department/Service	Children's Social Care
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Approval Date	14 July 2020
Next Review Date	14 September 2024
Version Number	DRAFT v1

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DOCUMENT RECORD

Issue No.	Date of Issue	Review date	Reviewed by	Comments	Approved by	Approval Date
Final	28/12/2016	12/19			SMT	28/12/16
V1		N/A	MI	In consultation with health, mental health, police, and voluntary/community groups		
V2	09/06/20	N/A	LB	Technical and structural amendments		
V3	18/6/20	N/A	LB	Updates and procedural amendments		
V4	13/7/20	N/A	LB	Incorporate SMT feedback plus additions		
Final	14/7/20	14/7/21	LB	Incorporates comments from SBM/IR/RG/SMT	SBM, AD	14/7/20
Final v2	27/07/21	27/07/22	P&P Group	Changes to bring in line with London CP (Child Protection) Procedures	AD (Assistant Directors) Group	
Final v3			Comments from Health colleagues	Clarity given to points around referral / notification to midwifery services and inclusion of Pre-Birth Operational group		
Final v3.1	07/10/21		KP	Added clarification that a record for the baby must be started in their own right and support for care leavers must be recorded on the care leaver's record	AD Group	
V4	July 22	May 22	KP	No changes	Policy and Procedure Group	
2023 V1	December 2023	January 2027	KP	Updates to bring in line with Pan London procedures		

Contents:

1. Introduction

1.1 This guidance provides a framework for multi-agency working so that a clear system is in place to respond to concerns for the welfare of an unborn child and/or where there may be concerns following their birth. It sets out the role of agencies in referring expectant mothers to the most appropriate service for support, contributing to assessment and implementing any agreed plan of action to support families and safeguard and promote the welfare of the child, to ensure that timely decision-making and proportionate action and intervention takes place.

1.2 In Lambeth, we endeavour to keep children safely together with their families. We do this by ensuring that families receive the skilled support they need to help them look after their children safely. This is underlined by an ethos that supports social workers in undertaking relationship-based practice.

1.3 Approaching families with empathy, compassion and creativity, Lambeth social workers will use a strengths-based approach to transform lives. We seek to remain balanced in our judgment and to understand fully both the strengths that families have, and the risks. In every case, the welfare of the child is paramount supporting all the principles of Children at the Heart of Practice.

1.4 This guidance applies to all agencies in Lambeth, particularly Children's Services staff, Police, Health (including Mental Health) and relevant Adult Services.

1.5 This guidance should be read in conjunction with the London Child Protection Procedures[1], which offer detailed guidance in relation to this area of work. See Also: Multi-Agency Pre-Birth Safeguarding flow chart, and the Midwifery Pre-Birth Assessment flow chart available on the LSCP (Lambeth Safeguarding Children Partnership) website.

2. Principles

2.1 Pre-birth assessments require a multi-agency approach and driven by partnership working to ensure meaningful engagement with families. It is essential that professionals involve fathers, same-sex partners, other adults living in the household and close members of the extended family in the process of assessment to explore their potential role in caring for the child and whether they may pose a risk to the child before or after birth.

2.2 There are two fundamental questions when deciding whether a pre-birth assessment is required:

- Will the new-born baby be safe in the care of their parent(s)/carer(s)?
- Is there a realistic prospect of their parent(s)/carer(s) being able to provide adequate care throughout childhood?

[1] London Child Protection Procedures: https://www.londoncp.co.uk/index.html

2.3 Early referrals should be encouraged to ensure that:

- There is sufficient time to undertake a detailed assessment and make adequate plans for the baby's protection.
- Parents and their wider family support networks have time to contribute their ideas and solutions to any assessment to increase the likelihood of a positive outcome for the baby;
- Parents are not approached routinely in the latter stages of pregnancy, which is an already stressful time, and
- Services are provided in a timely way to facilitate optimum outcomes.

2.4 Within the service, where a young person known to Children's Social Care as a looked after child or care leaver becomes pregnant, social workers and personal advisers will work together to ensure that information is consistently shared across both the mother's case record and the unborn baby's case record. Wherever possible, joint visits will be undertaken, and personal advisers will be invited to core group meetings and/or CIN review meetings if the unborn baby becomes subject of a plan. **The SW must create the baby on Mosaic and linked to the care leaver or looked after child, whether they are mother or father. Support to be given to the young person as a parent must be clearly recorded on their record.**

2.5 Where an assessment is undertaken, the social worker must notify the maternity service firstly, that the assessment is taking place, and secondly that they are the allocated social worker. They will then stay in contact with the maternity services throughout the process (for example, inviting them to the meetings, sending copies of the assessments, notifying if there is a legal planning meeting, and the outcomes etc.).

2.6 Where a mother has previously had a child removed from them and is undergoing an assessment, a referral should be made with mother's consent to the Flourish Service for a consultation and further support and possible intervention. (Note: any professional can consult with Flourish even if they do not have consent to share details but need some reflective thinking space)

2.7 A pre-birth Operational Group chaired by the CAT Service Manager, attended by the named midwives in Guys and St Thomas's hospital and Kings College Hospital and relevant team managers meets regularly on the first Tuesday of the month to discuss pertinent issues and to discuss referrals for assessment.

3. Purpose

3.1 A pre-birth assessment is an assessment of need and any risk to the future safety of the unborn child with a view to making informed decisions about the child and family's future. The main purpose is to allow social workers and the wider professional network to identify:

- What the needs of, and risks to, the new-born child may be;
- Whether the parents can recognise these risks and working with professionals so that needs can be met, and risks reduced;

- What support parents may need to help strengthen parenting capacity;
- Plans for the child's care and decisions or interventions to address risk and keep the child safe in the present and long-term.

3.2 A pre-birth assessment would usually be required in the following circumstances (not exhaustive) and Professionals must make a referral to the Integrated Referral Hub (IRH)

- A child aged under 13 is found to be pregnant (see also Safeguarding Sexually Active Children Procedure and Safeguarding Children from Sexual Exploitation Procedure).
- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children (see also Risk Management of Known Offenders Procedure);
- A sibling or child in the household is, or was subject of a child protection plan (depending on the age gap of the sibling and when the original CP Plan was initiated);
- A sibling has previously been removed from the household either temporarily or by court order;
- The parent is a looked after child (see below 3.3);
- There are significant domestic abuse issues (see also Safeguarding Children Affected by Domestic Abuse Procedure);
- The degree of parental substance misuse is likely to impact significantly on the baby's safety or development (see also 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 also 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 or the degree of the parent's disability is likely to have a significant impact on the baby's safety (see also 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 also Fabricated or Induced Illness Procedure) or harming a child;
- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent;
- There are maternal risk factors e.g. denial of pregnancy, 3 or more failed appointments, non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby;
- There are contextual safeguarding concerns for one or both parent(s) (this can be a significant concern where young people may be targeted or at risk as it may also put the unborn baby at risk).

3.3 In the case of a care leaver or looked after child who is pregnant, a pre-birth assessment must always be considered but will not automatically be required, and their risk assessment must be updated in the light of the pregnancy

(whether the young person is the mother or the father/putative father). The support needs of anyone in this group will be considered on a case-by-case basis by the allocated social worker/personal adviser in consultation with their line manager to ensure appropriate support is agreed and provided. These discussions must be documented on Mosaic.

3.4 Where necessary, a child and family assessment will be completed by the Child and Family Assessment Team (CAT) (where known to CLA or Leaving Care) with input from the young person's Social Worker / Personal Adviser, Foster Carer and Supervising Social Worker where the young person is in a Fostering placement, or Key Worker where the young person is in residential care or semi-independent living. The Independent Reviewing Officer must always be contacted as part of the assessment and asked for their input into the assessment.

3.5 If a child or young person who is pregnant and already known within the Family Support and Child Protection Team (FSCP), the pre-birth assessment will be undertaken within the FSCP.

4. Multi-Agency Identification of Risks

4.1 Agencies in the community must play a key role in the identification of risk and provision of support through advice or referral for vulnerable expectant parents and their unborn child.

4.2 Health Services:

4.2.1 Health professionals, particularly midwives and GPs, are most likely to be in contact with expectant mothers and their partner, and therefore critical to identifying risk factors and making appropriate referrals to Children's Social Care. They have responsibility for addressing the mother's health needs and sharing relevant information with the network about factors that may affect parenting capacity. This also includes any concerns they may have about a putative father of an unborn. GPs should share all relevant social history with maternity services when they become aware that a woman has booked for maternity care.

4.2.2 Referrals should be made to Children's Social Care from booking (between 8-12 weeks). Consent to referral must be sought from the parent but if there are safeguarding concerns a referral may be made without consent if it is thought this is a proportional response to concerns.

4.2.3 Normally, pre-birth assessments are started after the 12th week of pregnancy. However, in exceptional circumstances, work could start with an expectant mother prior to this date and with her consent and started at 8 weeks gestation or at the point MASH/CSC are notified of the pregnancy. This is particularly relevant in circumstances, where there are long-standing concerns about the mother's parenting capacity. This is also particularly important where families may choose to self-refer early in the pregnancy and there is initially no action then subsequently a pre-birth assessment is started. Thought needs to be given to their understanding, to prevent inadvertently raising hopes. Research

shows that clarity and early intervention is proven to effectively help parents maintain care of their children.

4.2.4 When assessing risk, midwives should gather relevant information about the mother during the booking appointment and consider whether any aspects of any of the following risk factors may have significant impact on the unborn child and, if so, how.

4.2.5 Risk Factors to Consider:

- Family structure and wider network support available
- Whether the pregnancy is planned or unplanned
- The mother's feelings about being pregnant,
- The partner/putative father's feeling about the pregnancy,
- Mother's dietary intake and any related issues,
- Any medicines or drugs, whether prescribed or not, taken before or during pregnancy,
- Learning disabilities
- Alcohol consumption and smoking,
- Previous obstetric history,
- Current health status of other children,
- Any miscarriages or terminations,
- Any chronic or acute medical conditions, or surgical history,
- The mother's psychiatric history, especially depression and self-harming, personality disorder, or fabricated or induced illness of themselves or others,
- Whether the mother has been subjected to FGM (Female Genital Mutilation) (or related issues exist) and if any medical intervention is required to enable the mother to safely proceed with the delivery of her baby,
- Any contextual safeguarding concerns about either parent that might put the baby at risk.

4.3 Mental Health Services

4.3.1 Mental health professionals are responsible for identifying expectant service users and sharing relevant information with universal 0-19 public health nursing services as well as midwives, GPs, and social workers on how the service user's mental health diagnosis may affect parenting capacity, or how treatment may affect development of the unborn baby. This is vital for a more collaborative approach to meeting the needs of C&YP, especially for these vulnerable families on a targeted, specialist, bright beginnings, or complex need pathway. Health visitors and school nurses may both be working with the family which can strengthen the care provided when linked in with mental health services. This is relevant for all parents/ carers to enable liaison and information sharing with PHN services to identify any impact on the baby.

4.3.2 Professionals must be aware of the following, which may raise risks to unborn and new-born children:

- Where the nature or degree of risk in relation to a parent's mental health causes concern for the unborn or others;
- Parents who incorporate their (unborn) child into delusional thinking (for example severe anorexia nervosa);
- Parents who are not complying with medication or treatment;
- Where the (unborn) child is viewed with hostility;
- Where there is dual diagnosis (e.g. mental ill health together with substance misuse).
- Where there is a risk of self-harm or suicide.
- Where there have been previous concerns in relation to fabricated or induced illness in themselves or others in their care.

4.3.3 Identifying the needs of the child, when their parent, carer or expectant mother is experiencing mental health problems:

- How their mental health is impacting on the safety or welfare of any children in their care, or children who have significant contact with him/her
- Whether they have access to / engaging with the relevant support services
- Whether the child/young person is a young carer.

4.3.4 The birth of any new child changes relationships and brings new pressures to any parent or family. Agencies need to be sensitive and responsive to the changing needs of parents or carers with mental health problems and share these concerns appropriately with partners.

4.4 Substance Misuse

4.4.1 Substance Misuse agencies in the community can play a key role in supporting expectant mothers such as identifying drug/alcohol use in pregnancy at an early stage, referring on to appropriate help and support and providing needed advice and intervention. As with Mental Health, Substance misuse professionals are responsible for sharing relevant information with universal 0-19 public health nursing services as well as midwives, GPs, and social workers on how the expectant mother's substance misuse and accompanying treatment may affect parenting capacity or development of the unborn baby.

4.4.2 Professionals must consider:

- Patterns of substance misuse;
- Whether it can be managed in conjunction with caring for a new-born child;
- Whether parents are willing to attend treatment;
- Any dual diagnosis (substance misuse together with mental health problems);
- Consequences for the unborn baby of continued misuse of substances or withdrawal during pregnancy;
- Substance misuse by partners or others closely related to the (unborn) child.

- Safety issues in relation to the storage of drugs and whether the child is likely to come across them when ambulatory.

4.5 Domestic Abuse and Violence

4.5.1 Domestic abuse can pose a serious threat of physical harm to an unborn child and following birth. Exposure to domestic abuse can have a negative effect on the baby's emotional and cognitive development. Pregnancy is known to increase the risk of domestic abuse or lead to the escalation of existing abuse. The stress of caring for a new-born baby, particularly if the child is demanding or challenging, can also trigger domestic abuse and violence within the home (including FGM, honour-based abuse or forced marriage).

4.5.2 Professional partners must consider the following actions:

- Midwives are required to offer domestic abuse screening for women. It is an expectation that midwives will see all expectant mothers alone at booking so that they are able to raise the issue of domestic abuse safely and to allow disclosure. It is recognised best practice to repeat DA (Domestic Abuse) enquiry at 28 and 36 weeks and again in the immediate postnatal period;
- Domestic abuse services in Lambeth (GAIA) providing services for an expectant mother should support her to engage with midwifery services (GSTT (Guys & St Thomas Trust) refer to MOSAIC in house maternity DA service);
- Lambeth Police should ensure that, when attending domestic abuse callouts, they are aware of the presence of expectant mothers in the household, and share this information with the IRH Team, and GAIA.

4.5.3 Professionals who are working with expectant mothers experiencing domestic abuse and violence must carry out a SafeLives DASH risk checklist and the Barnardo's Domestic Violence Risk Assessment Matrix (DVRIM) (Midwives refer to MOSAIC who will undertake these risk assessments and will refer onwards to MARAC (Multi Agency Risk Assessment Conference if required) to decide on whether to make a referral, this especially applies where the mother may be minimising the impact of the abuse. Where there are concerns about domestic abuse and violence, the mother can be referred to GAIA for advice and support. A referral to the Multi Agency Risk Assessment Conference (MARAC) must also be considered where Domestic Abuse is a concern. Significant concerns about the effect of domestic abuse on the unborn child must be referred to the IRH, preferably by the person undertaking the risk assessment above.

4.6 Learning Disabilities

4.6.1 Parents with an elevated level of and/or significant learning disabilities can face many difficulties and challenges and will need an elevated level of support from the professional network. It is important that learning disabilities, in their widest understanding, are identified as soon as possible in the pregnancy to ensure an advocate is in place to support parents during the pregnancy and after birth.

4.6.2 Lambeth Learning Disability staff that become aware that a service user is pregnant should encourage the expectant mother to engage with midwifery services and must contact the named midwife and GP to share information about the service user. Where there are concerns about the capacity to consent to sexual activity, these should be referred to the police.

4.6.3 Midwives who believe that an expectant mother or father may have a learning disability or learning need that may impact on their capacity to parent, should notify public health nursing, health visitors, and contact Disability Services within Adult Social Care (Midwives at GSTT will contact GSTT LD specialist for confirmation of status.), to check if they are known to the service and contact the key worker so that collaboration and parent / PHN professional relationship can start as early as possible to understand the needs of the baby and their family. If the expectant mother is not known to the Learning Disability Service, but it is thought they could be eligible for a service, the midwife should make a referral to the Adult Learning Disability Service for an assessment.

4.6.4 Where there are significant concerns about parenting capacity, a referral must be made to the IRH. An early pre-birth assessment should take place with the Learning Disability key worker liaising with the Children's Social Worker in order to assess the expectant mother's parenting capacity and to plan what support will be needed once the baby is born and potentially to make a referral to Adult Services for a SOVA for the mother in the case of their vulnerability. The expectant mother's advocate should be involved in this assessment.

4.7 Young Mothers Under 19

4.7.1 Some young mothers may have difficulties in meeting their child's needs due to their own vulnerabilities. Young mothers not already known to Children's Social Care who are under the age of 19 should only be referred for a pre-birth assessment if the professional believes them to be vulnerable.

4.7.2 Where a young mother is already known to Children's Social Care as a child in need, a pre-birth assessment will always be undertaken where the child is under 16 and the Team Manager will decide whether to carry out a pre-birth assessment of a child over 16.

4.7.3 A pre-birth assessment must always be undertaken where the young mother is looked after by Lambeth. Where the expectant mother is 16 and over and care experienced or a care leaver and there are concerns about the parenting capacity the PA (Personal Advisor) / SW (Social Worker) will discuss with their team manager and consider making a referral to IRH for a pre-birth assessment where appropriate (Appendix A). Supervision discussions will help to identify the risks to both the young person and the unborn baby. **The baby of the care leaver must be created on Mosaic. Once created with their MOSAIC ID they must be linked to the care leaver. Support to be given to the care leaver as a parent must be clearly recorded on the care leaver's record and Pathway Plan.**

4.7.4 Pregnancy and birth are also likely to influence a young person's education and training opportunities, and this will need to be considered within the pre-birth assessment.

4.7.5 Health professionals should notify public health nursing service of pregnant young mothers under 19 or women under 24 (with added vulnerabilities) via gst-tr.earlyinterventionhealthvisitingservice@nhs.net for triage onto relevant specialist pathway using the notification form (Appendix B) OR via the GSTT / Evelina website. This is to ensure a health visitor can be allocated as early as possible and the young person can be triaged onto the appropriate care pathway for their needs.

4.7.6 Factors to Consider:

- Where a young mother lives in an unstable family home that is unlikely to be able to offer support;
- Where a young mother lives in isolation from any support networks;
- May have become pregnant because of child sexual exploitation;
- Is under the age of 13 (these cases must be referred to the police and to the IRH as it is a crime to have sex with a child under the age of 13);
- Is concealing the pregnancy from her family and/or is concerned about their parent's reaction to the pregnancy;
- Where the mother is under 16 years and the partner is over 18 years or there is a wider age difference;
- Has specific issues that make her more vulnerable, for example mental health difficulties/Learning difficulties.

5 Children looked after

5.1 A pre-birth assessment must always be completed where the young person is a child looked after (CLA) by Lambeth. However, it should not be an automatic decision to complete a pre-birth assessment in relation to the pregnancies of all care leavers or care experienced young people unless the thresholds are met as outlined above.

5.2 If the Section 47 threshold is met and a Strategy Meeting convened, a manager from the FSCP, CLA or Leaving Care (depending on where CLA is allocated) must be invited. The service where the CLA is allocated must provide a full written history and chronology of the young person for the Strategy Meeting. The meeting will consider the Care Plan for the young person and any additional resources needed to support the young person (and their carer) throughout the pregnancy.

5.3 **N.B.** If a young person is looked after by another Local Authority and living in Lambeth, then the allocated social worker from that Local Authority must be invited to the Strategy Meeting.

5.4 If the young person's placement is out of borough, the service where the case is allocated must refer case of the unborn to the relevant Local Authority and inform the Health Services in the area where the young person is placed.

5.5 The London Child Protection Procedures clearly state that 'where a child is a mother/expectant mother and is accommodated or subject to leaving care arrangements (potentially up to 25 years) and is placed by the originating authority in another borough, the authority in which the mother is living is responsible for the baby.' However, this is an area for discussion regarding case responsibility. It is therefore important that case responsibility is negotiated at an early stage by managers. The Quality Assurance Service should also be consulted in terms of agreeing Child Protection Conference arrangements in such cases.

5.6 Where a young person is looked after social workers must also inform and obtain the views of the IRO (Independent Reviewing Officers). This is to discuss the need potentially for an Early Review or Midway Review and the support that will be given to the young person and to seek the IRO's views and opinions as part of the assessment.

6. Pre-Birth Referral

6.1 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, they must refer to the IRH as soon as concerns are identified.

6.2 A referral made to the IRH will be screened within 1 working day to assess whether it meets the threshold for a pre-birth assessment. Referrals not meeting the threshold for assessment will be stepped-down appropriately to the Early Help Services, Health Visiting, Midwifery or any other identified community-based Services for support and intervention. Any risk assessments (for example CAADA DASH or DVRIM) completed will be shared with these professionals. The outcome of the referral must be shared with referrer in writing (within a week) who should be told the reason for decision and contact details if the plan is for Early Help support.

6.3 Further guidance on pre-birth referrals and assessments is provided in the London Child Protection Procedures.

6.4 A referral must be made at the earliest opportunity to:

- 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 to facilitate optimum home circumstances prior to the birth.

6.5 It is also important to note that Statutory Guidance[2] states that:

[2] ***Court orders and pre-proceedings For local authorities April 2014***

"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).

6.6 Although not all referrals will go on to require legal proceedings, some may benefit from PLO, and it is important to bear in mind the timescales laid out in the guidance as they will not be met unless referrals are made at an early stage in the pregnancy.

6.7 Concerns should be shared with prospective parent/s and consent obtained to refer to LA (Local Authorities) children's social care unless obtaining consent may place the welfare of the unborn child at risk e.g. if there are concerns that the parent/s may move to avoid contact with investigative agencies.

6.6 Following referral, there must always be consideration as to whether a strategy meeting is required and whether threshold for a Section 47 enquiry should be initiated.

7. Early Help Services in the Community

7.1 There are a range of Early Help Services available that can support with both practical support and financial advice, including housing. Please visit the information, advice, and guidance pages of the Family Service Directory: https://www.lambeth.gov.uk/children-young-people-and-families/families-information-service or St Michael Fellowship at: https://stmichaelsfellowship.org.uk/supporting-young-parents

8. Pre-Birth Assessment

8.1 A pre-birth assessment must be undertaken on all pre-birth referrals, where the threshold is met, as early as possible, preferably before 24 weeks of the pregnancy but as soon as the pregnancy is considered viable. This should focus on:

- Strengths and concerns about both parents and extended family members;
- Family history of both parents, fathers of any previous children and the extended family;
- Previous proceedings and any previous expert reports/assessments including parenting assessments;
- Concerns around parental mental health, substance misuse or learning disabilities including previous involvement with these services;
- Parental attitude to the new baby and preparedness for its birth;
- Building a good relationship with the family, particularly the expectant mother, through a strengths-based approach to gain understanding of family systems and dynamics;
- Support requirements for the expectant mother and partner and how these will be met and;

- Engagement from the wider family, potentially through family meetings / Family Group Conference where proceedings are being likely, and identification of help needed to safely parent the child.
- Any contextual safeguarding concerns for one or both parent(s)
- Co-operation or disguised compliance with the statutory services, particularly health services in relation to the unborn child.

8.2 The pre-birth assessment must be completed within 45 working days of the referral. All agencies working with the expectant mother and family are expected to contribute information to assess immediate and future risk and parenting capacity.

8.3 It is crucial to involve the midwives and Health Visitors in the pre-birth assessment. There should routinely be at least one joint visit made with the relevant Health visitor/midwife during the assessment, and other joint visits with relevant agencies as appropriate.

8.4 Professionals who are working with vulnerable expectant mothers and Social Workers who are completing pre-birth assessments must refer to the Lambeth Pre-birth Assessment Guidance (Appendix A) and use this as a guide to inform their risk and pre-birth assessment.

9. Pre-Birth Plans

9.1 Once the assessment is complete, a plan will be created based on the recommended actions. This plan will focus on the safety and wellbeing of the baby and of the mother using SMART (Specific, Measurable, Achievable, Realistic and Timebound) actions and timescales relevant to the plan. This plan will need to be multi-agency, agreed with the parent(s) of the baby, and shared with all the relevant agencies.

9.1 Child in Need Plan recommendation

9.1.1 If the pre-birth assessment indicates that the unborn child is likely to be a Child in Need (CIN), once born, the assessing social worker will convene a CIN Review within a maximum of 2 weeks of completing the pre-birth assessment. The meeting should be attended by all professionals working with the family to draw up a plan for the child, alongside the expectant parents which will be reviewed on a 6-weekly basis.

9.2 Child Protection Plan recommendation

9.2.1 If it is evident at the point of referral or during the completion of a pre-birth single assessment that there are reasonable grounds to believe that the unborn child may be likely to suffer significant harm, a multi-agency Strategy Meeting must be held within 72 hours. This is particularly urgent where the referral has been received after 24 weeks gestation, or where there has been an attempt by the mother to conceal the pregnancy (See Section 10 on Late Booking, Concealed Pregnancy and Non-engagement).

9.3 Strategy Meeting

9.3.1 The Strategy meeting will:

- Decide whether the threshold has been met for a child protection enquiry and what action should be taken;
- Decide what needs to be covered in the pre-birth assessment;
- Identify involvement and roles of agencies and professionals;
- Decide on how parents will be informed of concerns;
- Agree any actions from adult services in relation to parents;
- Consider the circulation of London-wide Hospital alerts where there is a risk of a mother absconding. Copies of such alerts to be sent to the Safeguarding midwife at the Hospital the mother is registered, and to the QA (Quality Assurance) – CP chairs for nationwide circulation and to EDT
- Agree any actions from the midwife and/or obstetrician immediately after the birth (these must be incorporated into the birth plan and all staff notified of concerns);
- Decide on the circumstances at birth under which Children's Social Care will seek an abridged ICO or an Emergency Protection Order from the court.

9.3.2 These strategy meetings must be held at the hospital in which the expectant mother has been booked, in line with the London Child Protection Procedures (although this may be held virtually). All strategy meetings or discussions **must** involve all relevant health partners, including GPs and Health Visitors and mental health services, to obtain their views on the threshold for s47, as well as any relevant information to inform the risk assessment. If adult substance misuse or mental health services or domestic abuse services have knowledge or information, they must also be invited. In cases where previous children have been removed by a local authority and continue to be Looked After, the allocated CLA social worker must be invited to the Strategy Meeting to provide relevant background information and history.

9.3.3 In line with the recommendations from the multi-agency Learning Lessons Summary re Baby N, a note taker must be agreed at the start of the meeting who will record key decisions and actions and then email to all participants and non-attendees to ensure transparent communication, decision-making and accountability against specific actions against a specific timescale.

9.3.4 If the child protection enquiry establishes that the unborn child has suffered and continues, or is likely to suffer significant harm, a pre-birth child protection conference will be convened by the social worker to be held within 15 working days of the strategy meeting. This should be after the pregnancy is over 20 weeks. Practitioners are advised to tick on "Assessment" as the outcome of the Strategy Meeting where the pregnancy is in the initial stages.

9.4 Pre-birth Child Protection Case Conference

9.4.1 Pre-birth conferences have the same status as an initial Child Protection Conference and need to be held as soon as possible after the pre-birth single assessment has been completed, and at least 10 weeks before the expected date of delivery, to allow as much time as possible for planning support to the baby and family. Where there is a known likelihood of a premature birth or

there is an extremely elevated level of concern, the conference must be held earlier. It is worth noting that drug using pregnant women are more likely to give birth prematurely, therefore early conferencing in such cases is vital.

9.4.2 A pre-birth conference must always be held where:

- A pre-birth assessment shows that the unborn child is suffering or likely to suffer significant harm;
- A previous child of the parent has died or has been removed from their care because of significant harm;
- A child is born into a family where children in the household are already subject to a child protection plan and;
- An adult or child who poses a risk to children lives in the household or is 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.

9.4.3 The following should always be invited to the child protection conference:

- Parents and their support (carers in the case of Care Leavers or CLA)
- General Practitioner
- Health Visitor, EIHV or Named Nurse for Community Services
- Allocated midwife / midwifery team Peri-natal team where appropriate
- Named Midwife for Safeguarding
- Community Child Health – Mary Sheridan Centre
- School Nurse where there are school-age siblings.
- Police Child Abuse Investigation Team
- Any other lead professionals or services working with the parents of the Unborn, including Mental Health services;
- Authorities outside Lambeth with direct involvement with the parents/(unborn) child.
- Supervising Social Worker (if the mother is a looked after child in foster care)
- Personal Adviser (where the mother or father is a care leaver or care experienced young person)
- Key worker if a care leaver is in residential care or semi-independent living.
- Faith leaders if appropriate

9.4.4 An invitation to the following agencies must be considered, when appropriate:

- Neo-Natal Special Care (for babies whose parents are substance users or where i.e. baby is likely to need additional neo-natal care)
- Drug and Alcohol Services

- Adult Mental Health Services
- Adult Social Services
- Probation/ Youth Offending
- Domestic Abuse Services

9.4.5 If the unborn child needs to be the subject of a child protection plan, the main cause for concern must determine the category of registration and it must be outlined to commence prior to the birth of the baby. A review conference must be held one month from the date of birth or 3 months from the date of the first conference, whichever is sooner, then every 6 months until the child protection plan is discharged, when the child then becomes CIN. Agencies should escalate if they have concerns around lack of progress and should be attending the Core Group Meetings.

9.4.6 In the event of an expectant mother going missing during a s47 investigation or when a pre-birth child protection plan has been drawn up, the allocated social worker should consider making a missing person's report. If the expectant mother is under 18, a missing person's report must be undertaken. In these circumstances an alert to other local authorities and hospitals must be made.

9.4.7 Where a looked after child is in a fostering placement and it is anticipated that they will be staying with their foster carer once the baby is born, the foster carer's approval may need to be updated so timings must be considered about returning to Fostering Panel to obtain a variation of approval prior to the birth.

10. Late Bookings, Concealed Pregnancy and Non-Engagement

10.1 For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 24 weeks of pregnancy.

10.2 There are many reasons why women may not engage with ante-natal/relevant services, or conceal their pregnancy, some of or a combination of which will result in heightened risk to the child.

10.4 It is vital that parental non-engagement does not become the reason for delaying the assessment and making multi-agency and contingency plans for the baby.

10.5 For further guidance, professionals may refer to the relevant section in the London Child Protection Procedures on ''Managing Work with Families Where There Are Obstacles and Resistance''

11. Legal Planning Meeting - Public Law Outline

11.1 Where it has been agreed at Legal Planning Meeting that work should be undertaken under the Public Law Outline framework, the Notice of intent Letters (Appendix 5) should be sent out within 72 hours to avoid delay in holding Pre-Proceedings meetings and to avoid approaching the expectant mother in the late stages of pregnancy, and to allow enough time to work with the family to explore all options in order to avoid initiating Care Proceedings.

FSCP should be invited to attend the LPM (Legal Planning Meeting) and Pre-Proceedings meetings.

11.2 In cases where there is recommendation to initiate Care Proceedings at birth, the social worker team must ensure that the paperwork is ready. The pre-birth Single assessment, full chronology and genogram must be available at the Legal Planning Meeting and there should have been a referral for a Family Group Conference (Appendix 6), when appropriate.

11.3 If there is a late referral that meets the threshold for legal planning, the Team Manager will request to convene an emergency Legal Planning Meeting.

11.4 Where Children's Social Care has an elevated level of concern about the safety and welfare of a new-born child if removed from the hospital by their parents, an application may be made to the court for an Emergency Protection Order/abridged ICO to direct that the child is not to be removed from the hospital. In such high-risk cases, agreement should be reached about the need for police protection and generation of CAD in advance of birth.

11.5 If the assessment indicates that legal proceedings may be required once the child is born, then CSC (Children s Social Care) will follow their internal process for seeking legal advice. Social care alone is responsible for the decision to initiate a pre-proceedings pathway under the Public Law Outline, but reliance is placed on professional partners providing relevant information pertaining to risks to children and strengths within the family support network, available to assist their decision making.

11.6 The decision to step a case up into a pre-proceeding's pathway can be made at any point where the assessment of risk indicates legal intervention is proportionate. A step-up can also step down and again the decision to do so is made by CSC.

11.7 The timing of CP and subsequent PLO (Public Law Outline) processes and any court application must allow adequate time and space for parents to prepare emotionally and practically for separation following birth and to consider alternative carers for baby within family and friends networks.

11.8 Professionals (and where appropriate, the family and friends' network) should work together to ensure consistent and clear messages are given to parents regarding LA decisions concerning the plan for baby after birth. Any changes or updates should be shared at the earliest opportunity and explanations given.

11.9 If a placement with alternative caregivers is likely to be part of the plan for the baby after discharge from the hospital, then an early alert must be placed with the fostering or connected carer teams so identification and assessments of alternative carers including Early Permanence Carers can be made prior to birth and a referral made for Adopt London South.

11.10 If care proceedings are to be issued on birth:

a. Parents should be told at a timely point and preferably at the earliest opportunity (if safe to do so), the process and plan and estimated timescales/timelines for actions produced including the timescales for any

legal process. Plans should be clear about birth arrangements, supervision of mother and baby after birth and management of risk and key actions. Ideally plans should be shared at Family Group Conference prior to birth if the parents' consent to this.

b. If any professional is concerned about a parent understanding of the process this, they must inform the social worker.
c. Where appropriate, parents should be given an opportunity to meet any proposed foster carers pre-birth.
d. Supervision on ward – must be proportionate and there must be a shared understanding of professional roles and responsibilities.
e. Parents must be given sufficient time to seek and receive legal advice pre-birth and post birth. Court documentation must be provided to parents with an appropriate period of notice to allow them sufficient time to prepare and access legal advice. This period takes account of any additional learning needs and language and communication preferences the parents may have.
f. Any first Court hearing must be planned and timed so that the parents have had the opportunity to obtain legal advice and representation and can participate fairly. Timing of the first hearing takes account of the mother's need to recover from the physical and emotional impact of labour. Mothers are fit for discharge home from 6-48 hours post birth.
g. Parents and midwives must be kept fully informed of details of any Court hearing.
h. Parents should be supported to attend Court including transport being arranged by the social worker if they want to attend in person and if not then they must be offered private and supported remote arrangements. Parents should also be offered support with transport to return from court to the hospital.
i. Sufficient time should be given to allow parents to notify identified members of the family and friend network of a court hearing should the parents wish for them to stay with the baby on the ward while they attend court.
j. In addition to their lawyer, parents with LD must be offered an independent advocate to support them through the first hearing.
k. There should be agreement between midwives and social workers about when the social worker will move the baby should the court grant an interim order requiring separation and parents should be included in this planning.
l. Wherever possible and safe to do so, the parents' wishes regarding the detail of the separation should be followed. If any of the parents' choices are not possible, the reasons for this should be made clear in advance.
m. Parents should be provided with precise information regarding the details of their first contact with their baby, post separation. This includes the date, time, and venue.

12. Planning for the birth meeting

12.1 If the decision of the Legal Planning Meeting is that the unborn baby should be the subject of Care Proceedings, a Planning for the birth Meeting must take place. This will usually be a virtual meeting. This is a professionals meeting which should be chaired by the Hospital Safeguarding Lead for Maternity Services or a member of the maternity safeguarding team. If the Safeguarding Lead Manager is unable to chair this meeting the line manager for the allocated social worker must chair the meeting.

12.2 This meeting must take place soon after the legal planning decision. The decisions of this meeting should be recorded on the patient's records by the lead midwife who will ensure that the midwives are fully apprised of the plan for the child.

12.3 The purpose of the meeting is to make a detailed plan for the baby's protection and welfare around the time of birth so that all members of the hospital team are aware of the plans.

12.4 The agenda for this meeting should address the following:

- How long the baby will stay in hospital (taking into consideration monitoring period for withdrawal symptoms for babies born to substance using mothers);
- How long the mother will remain on the ward; Log records of all concerns / visitors, etc., while the mother and baby are in hospital;
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the baby e.g., parental substance misuse; mental Health; domestic violence and abuse. Consideration should be given to the use of hospital security; informing the Police etc.;
- The risk of potential abduction of the baby from the hospital particularly where it is planned to remove the baby at birth;
- The plan for contact between mother, father, extended family, and the baby whilst in hospital. Consideration to be given to the supervision of contact - for example whether contact supervisors need to be employed;
- Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding;
- The plan for the baby upon discharge that will be under the auspices of Care Proceedings, e.g. discharge to parent/extended family members; mother and baby foster placement; foster care, EP carers and Adopt London South, supported accommodation;
- Where there are concerns about an unborn of a pregnant woman who intends to have a home birth, the Ambulance Service Lead should be invited to the Birth Planning Meeting;
- Police should be considered as a participant in the meeting, as their power of Police Protection may be required if care proceedings planned as mother may decline to come in with baby – issuing of a CAD is especially

useful to support the process (where this is required a strategy meeting must be convened);

- Contingency plans should also be in place in the event of a sudden change in circumstances;
- Hospital staff should be given clear instructions regarding any birth that is likely to occur over a weekend or Bank Holiday;
- The Children's Social Care duty (EDT) should also be notified of the birth and plans for the baby.

13. Discharge Meeting

13.1 The hospital midwives need to inform the allocated social worker and the Health Visitor of the birth of the baby and there should be close communication between all agencies around the time of labour and birth.

13.2 In cases where legal action is proposed or where the unborn child has been the subject of a Child Protection Plan, the allocated Social Worker should visit the hospital on the next working day following the birth. The allocated Social Worker should meet with the maternity staff prior to meeting with the mother and baby to gather information and consider whether there are any changes needed to the discharge and protection plan.

13.3 **The allocated Social Worker should keep in daily contact with the ward staff and visit the baby and the parents on the ward on alternate days to meet with the parents.**

13.4 If the baby is the subject of a Child Protection Plan, the Discharge Meeting (including the maternity service) should be held as soon as possible to draw up a detailed plan prior to the baby's discharge home. The Core Group or Conference should take place within 10 days of the baby's birth (or up to 20 days if the birth was complicated). Actions on the CPP (Child Protection Plan) should always be reviewed at the DPM and any actions from the DPM should be discussed at the Core Group or Conference.

13.5 If a decision has been made to initiate Care Proceedings in respect of the baby, the allocated Social Worker must keep the hospital updated about the timing of any application to the Courts. It is the expectation that the court application is ready and submitted on day baby is born or following morning depending on time of DOB (date of birth). The lead midwife should be informed immediately of the outcome of any application and placement for the baby. A copy of any Orders obtained should be given to the hospital prior or at the time of the discharge of the baby. Where a new-born child known to Children's Social Care subject of CP plans is to be discharged from hospital, the allocated social worker will convene a discharge meeting to ensure that it is safe for the child to leave the hospital and that plans are in place to support the family.

13.6 Identification is required from all practitioners including social workers / support workers when visiting the unit.

14. Case Transfer

14.1 IRH will be responsible for the initial screening of all pre-birth case transfer referrals, and thereafter a decision about allocation will be made within 24 hours of receipt of the referral.

14.2 If, at the point of referral, it is agreed that the child or young person is likely to need support for a longer period post assessment, they should be allocated to the FSCP team in order that relationships can be formed, and continuity of social worker maximised.

14.3 Cases where siblings of unborn children are already open to other services / teams or in care proceedings, will continue to be allocated within those services / teams. Where the court proceedings have concluded, the pre-birth assessment will be referred to the Child Assessment Teams (CAT).

14.4 In order to continue support to the family during the pregnancy, appropriate cases should transfer to the FSCP as soon as the Single Assessment has been completed. A seamless transfer will avoid delay of intervention and further assessments of the parents taking place.

15 Responsibilities

15.1 **Strategic Director, Children's Social Care** has responsibility for the strategic overview for the safeguarding of children and young people looked after by the London Borough of Lambeth. This includes responsibility for this protocol to ensure that pre-birth assessments are conducted where required.

15.2 **Director, Children's Social Care** will deputise for the Strategic Director and has day to day operational responsibility for CSC, ensuring adequate management processes are in place for CSC to carry out their safeguarding responsibilities. The Director will also have oversight of relevant policies and procedures, will monitor performance with the management team and has overall responsibility for the management of the pre-birth assessment protocol.

15.3 **Assistant Directors** have specific responsibilities to support staff in their management and decision-making processes in managing pre-birth assessments for children and young people and operational monitoring of all cases. Specifically, the AD, Early Help, Access, and Assessment will oversee the currency and implementation of this pre-birth protocol.

15.4 **Service Managers/Team Managers/Social Workers/Personal Advisors** have responsibility for safeguarding of Lambeth children and young people and specific responsibilities for the decision to undertake, and subsequently manage, pre-birth assessments. They will ensure appropriate liaison with partner agencies in applying the protocol.

15.5 **Child Protection Chairs** are responsible for overseeing the Child Protection review process and co-ordinating the resulting multi-agency plan.

15.6 **Independent Reviewing Officers** have specific oversight and monitoring responsibilities for children and young people under 18 years which includes the application of this protocol.

16. References

Community Care Inform https://www.ccinform.co.uk/

Research in Practice https://www.researchinpractice.org.uk/all/

London Child Protection Procedures https://www.londoncp.co.uk/

Lambeth Children & Young People's Procedures Online https://www.proceduresonline.com/lambeth/childcare

Lambeth Family Services Directory https://www.lambeth.gov.uk/children-young-people-and-families/families-information-service

St Michael's Fellowship https://stmichaelsfellowship.org.uk/supporting-young-parents

A framework for conducting pre-birth risk assessments by Martin C. Calder https://www.proceduresonline.com/cumbria/lscb/user_controlled_lcms_area/uploaded_files/pre-birth-risk-assessment%20pdf%20draft.pdf

Lambeth Children's Social Care Practitioners' Toolkit Hub https://lambeth.sharepoint.com/sites/ChildrensSocialCarePracticeandResources

Public Law Outline Procedures Online https://www.proceduresonline.com/devon/childcare/user_controlled_lcms_area/uploaded_files/The%20Public%20Law%20Outline%20guide%20%20for%20SW%20and%20Managers.pdf

LSCP Pre Birth Page:

https://www.lambethsaferchildren.org.uk/pre-birth?utm_campaign=651915e3-4875-414a-aa40-406c53cacb79&utm_source=so&utm_medium=lp

17. Legal and Procedural Framework

The Children Act 1989

Care Standards Act 2000

Appendix A – Practice Guidance for Social Workers

Social workers guide to Pre-Birth Assessments

Pre-Birth Assessment Tool

Research and experience indicate that young babies are extremely vulnerable to abuse and that work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm (Ofsted, 2011).

A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, consequently, in the resulting actions. These shortcomings ranged from cases where no pre-birth risk assessment had been carried out, even when agencies were aware of risk factors that would have justified an assessment, to other cases where the assessment was delayed, over-optimistic or of inadequate quality. Another message is the importance of not closing cases too quickly after the baby's birth (Ofsted, 2011).

1. Introduction

This assessment tool is designed to help professionals to carefully consider a range of themes and to tease out issues that have potential for having a significant negative impact on the child.

The word "parent" should be loosely interpreted as appropriate to mean the mother and father, the mother's partner, anyone with parental responsibility, and anyone else who has or is likely to have day to day care of the child.

It is crucial to involve everyone who is a potential parent or carer in the assessment.

Social Worker is advised to use this guidance together with the Multi Agency Birth Protocol.

<u>A Child and Family Assessment should be considered if any of the following are identified:</u>

- Where a previous child or children in the family have been removed because they have suffered harm.
- Where a Registered Sex Offender (or someone found by a child protection conference to have abused) has joined a family.
- Where concerns exist about a mother's ability to protect.
- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health difficulties or learning disabilities.

- Where alcohol or substance abuse is thought to be affecting the health and development of the expected baby.

- Where the expected parent is young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required.

- Where the parent to be is a Child Looked After (CLA) or is a Care Leaver. Importantly, this should include **both** prospective parents not simply the expectant mother.

The Local Authority will also be mindful at this early stage of the possibility that legal proceedings may need to be initiated either as a framework around a parent and baby foster placement or because separation of parent(s) and baby is recommended.

Circumstances indicating a Pre-Birth Assessment:

- **Always** if a previous child/young person has died unexpectedly in the care of the parents and the cause of death is a result of anything other than 'natural causes'
- **Always** if a previous child has been removed via Care Proceedings due to abuse or neglect or other Risk of Significant Harm or if they have a current child who is the subject of Care Proceedings or within a PLO process
- **Always** if the parents have a child living with them who is currently the subject of a Child Protection Plan
- **Always** if there is a current Sec 47 investigation on the unborn that is likely to lead to an Initial Child Protection Conference or Child in Need Plan
- **Always** if for any reason (in addition to the above) it is possible that the mother and newborn will need to be separated at birth and CSC will be part of the planning (not including a parent's request for adoption)
- **Should be considered** if either of the prospective parents is a Child Looked After (CLA) or Care leaver
- **Should be considered** if the parents have a child under 8 who was the subject of a child protection plan within the previous 18 months

2. Family Structure and Background

Is there anything regarding family structure / background that seem likely to have a significant negative impact on the child? If so, what?

It is essential that we establish full details of the immediate and extended family, including dates of birth, full names, and addresses, so that full checks can be done on relevant criminal and child protection history. It is also relevant when considering potential kinship carers should this issue arise throughout or as a conclusion to the assessment (see Calder, 2006). There are very real advantages to using eco-maps and genograms for this purpose.

3. Parenting Capacity

Is there anything regarding parenting capacity that seems likely to have a significant negative impact on the child? If so, what?

3.1 Health:

- General physical health of prospective parents including existing health conditions, relevant family health history and ability to recognise own health care needs.

3.2 Relationships / Social History:

- Experiences of being parented (positive/negative memories, main carer, parental relationships)
- Experiences as a child/adolescent (violence, abuse, neglect, care/control issues)
- Current relationship status with father of unborn child
- Who will be the main carer for the baby?
- What expectations do the parents have of each other regarding parenting?

3.3 Abilities:

- Physical
- Emotional (including self-control)
- Intellectual
- Knowledge and understanding about children and childcare
- Knowledge and understanding of concerns and the reason for assessment

3.4 Behaviour:

- Violence to partner, others or to any child
- Drug or alcohol misuse
- Criminal convictions
- Chaotic (or inappropriate) lifestyle

3.5 Communication:

- English not spoken or understood
- Presence of learning difficulty
- Deafness / blindness / speech impairment

3.6 Circumstances:

- Education
- Unemployment/employment
- Finances including benefits or debts
- Inadequate housing / homelessness
- Criminality / court orders
- Social isolation

3.7 Home conditions:

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

3.8 Dependency on partner:

- Choice between partner and child
- Role of child in parent's relationship
- Level and appropriateness of dependency

3.9 Support:

- From extended family or friends
- From professionals
- From other sources
- Nature of support available including detail around timescale, ability to enable change and effectiveness in addressing immediate concerns

3.10 Care of Previous Children: (including children of both parents/carers)

- Child-minding or involvement in caring for younger siblings
- Childcare course / school curriculum childcare content
- Present care arrangements where previous children have been removed
- Events during intervening period since previous removal of children
- Current health status of other children

3.11 Planning for the Future:

- Preparation for parenthood, e.g. environment, equipment, or birth plan
- Realistic / appropriate or unrealistic / inappropriate expectations
- Pregnancy Background
- Is there anything regarding pregnancy background that seems likely to have a negative impact on the child? If so, what?

3.12 Parents' Feelings:

- 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 care of the baby?

3.13 Family Perceptions:

- Perceptions of significant others about pregnancy and how these have been handled or responded to
- Expectations of adult family members and how these have been handled or responded to
- Cultural narrative around early pregnancy (teenage motherhood)
- Parents' understanding of their own cultural/family narrative around childbirth

3.14 Obstetric and Medical Information:

- Obstetric history including previous pregnancies, outcomes, or complications
- Booking history including date of booking, concealed pregnancy/reason for concealment, expected date of delivery and hospital/home care

- Attendance and engagement with ante natal care / midwifery / Health Visiting services
- Medicines or drugs – whether prescribed or not – taken before or during pregnancy
- Dietary intake and any related issues
- Alcohol consumption / smoking
- Chronic or acute medical conditions or surgical history
- Psychiatric history – especially depression and self-harming

This information should be provided by midwifery or an appropriate health professional.

4. Previous or Current Professional Involvement

Is there anything regarding previous or current professional involvement that seems likely to have a negative impact on the child? If so, what?

4.1 History of Responsibility for Children:

- Convictions for offences against children
- CP concerns and previous assessments
- CP Registration / subject to a CP plan
- Court findings
- Care proceedings and/or children removed

It is important to ascertain the parent(s) views and attitudes towards any previous children removed from their care, or where there have been serious concerns around safeguarding or parenting practice. Relevant questions may include:

- Do the parent(s) understand and acknowledge the seriousness of the abuse?
- Do the parent(s) give a clear explanation and accept responsibility for their role in the abuse?
- Do they blame others or the child?
- What was their response to previous interventions, and did they accept any treatment/counselling?
- What is different now for each parent since the child was abused and/or removed?

Relevant questions in cases where previous sexual abuse has been the issue include:

- What were 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 become known, e.g. disclosure by non-abusing parent, child, or professional suspicion?
- Did the non-abusing parent believe the child, and did they need help / support for this?
- What are the current attitudes towards the abuse and do the parents blame the child?
- Has the perpetrator demonstrated acceptance of responsibility and what treatment did they undertake?
- How did the parent(s) relate to professionals? What is their current attitude?
- Who else in the family / community network could help protect the new baby?

Additional factors to consider in cases where a child has been removed from a parent's care because of sexual abuse include:

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

5. Specific Issues of Concern

Is there anything regarding specific issues of concern that seems likely to have a negative impact on the child? If so, what?

5.1 Mental Health:

- Clarification and description of illness, e.g. depression, schizophrenia, personality disorder, psychosis
- Non-compliance with medication without medical supervision
- Potential risks regarding parenting capacity, including increased risk of abuse by psychotic parents when incorporated into delusional thinking
- Additional concerns from parents' mental health difficulties
- Evidence of difficulties in forming emotional attachments with previous children
- Co-morbidity (with drug / alcohol abuse, domestic abuse, learning difficulties)

This information should be provided by the adult mental health team or appropriate professional.

5.2 Domestic Violence:

- Nature of any violent/abuse incidents and frequency / severity
- Triggers for violent incidents
- Known to local DV services?

5.3 Drugs / Alcohol:

- Acknowledgement and details of the substance / alcohol abuse including extent of involvement in local drug culture
- Duration and pattern of usage/addition, e.g. experimental, recreational, chaotic, dependent
- Health implications and risks
- Engagement with Drug and Alcohol services and nature of any detox
- Presenting behaviour, e.g. passive, aggressive, resistant to support
- Aspects of drug use posing a risk to children, e.g. conflict with or between dealers, exposure to criminal activity
- Presence of a drug-free parent, supportive partner or relative

This information should be provided by adult drug and alcohol services or an appropriate professional.

5.4 Learning Disability:

- Consideration of the parent's intellectual functioning and subsequent ability to learn to respond to the needs of their child
- Psychological factors impacting on parenting ability, e.g. loss, mental illness, emotional issues resulting from trauma
- Some mothers with learning difficulties may not recognise they are pregnant – this should be considered if there are suspicions of concealing or having concealed a pregnancy

- Living skills assessment may be required – any joint planning and assessment should take place from the beginning

This information should be provided by the adult learning difficulties team or appropriate professional.

6. Risk Matrix

This information has been extracted from "A framework for conducting pre-birth risk Assessments" by Martin C. Calder[3].

Internal motivators.

I want to change.
I do not like things as they are.
I am asking for your help.
I have resources to help solve this.
I think you can help me.
I think things can get better.
I have other support, which I will use to encourage me.
I accept that I am doing something wrong.
I accept what you say needs to change.
I accept that others are right (family, friends, community, agencies).
You defining the problem clearly helps.
I understand what change will involve.
I accept that if I do not change, you will take my children away.
I can change if you do this for me.
I will do whatever you say.
I agree to do this so the family can be reconstituted.
It is your job to solve my problem.
You are my problem.
I am right and you are wrong.
I do not have any problems.

External motivator

It is important to assess their motivation to sustain any work that has been identified. Questions such as the following may help
workers:
• Why is it important that I change?
• Do I have the ability to change?
• What does change really mean? What will I have to do that I cannot do now? What will I not have to do that I do now?
• Who can help me change and in what way? and
• What (if anything) have I tried to change in the past, and was it successful? (Calder, 1997).

The Abusing parent:

Elevated risk:	**Lowered risk:**
- Negative childhood experiences, include abuse in childhood, denial of past abuse	- Positive childhood - Recognition and change in previous violent pattern

[3] Towards a Framework for conducting pre-birth risk assessments (M.Calder)
https://www.researchgate.net/publication/233280124_Towards_a_framework_for_conducting_pre-birth_risk_assessments/link/5bc5bd1c458515f7d9bf5919/download

- Violence abuse of others - Abuse and/or neglect of previous child - Parental separation from previous children - No clear explanation - No full understanding of abuse situation - No acceptance of responsibility for the abuse - Antenatal/post-natal neglect - Age: young/immature - Mental disorders or illness - Learning difficulties - Non-compliance - Lack of interest or concern for the child	- Acknowledges seriousness and responsibility without deflection of blame onto others - Full understanding and clear explanation of the circumstances in which the abuse occurred - Maturity - Willingness and demonstrated capacity and ability for change - Presence of another safe non-abusing parent - Compliance with professionals - Abuse of previous child accepted and addressed in treatment (past/present) - Expresses concern and interest about the effects of the abuse on the child

Non abusing parent:

Elevated risk:	**Lowered risk:**
- No acceptance of responsibility for the abuse by their partner - Blaming others or the child	- Supportive spouse/partner - Supportive of each other - Stable, or violent - Protective and supportive extended family - Optimistic outlook by family and friends - Equality in relationship - Commitment to equality in parenting

Family issues (marital relationship and wider family)

Elevated risk:	**Lowered risk:**
- Relationship disharmony/instability - Poor impulse control - Mental health problems - Violent or deviant network, involving kin, friends, and associates (including drugs, paedophile, or criminal networks) - Lack of support for primary carer /unsupportive of each other - Not working together - No commitment to equality in parenting - Isolated environment - Ostracised by the community - No relative or friends available - Family violence (e.g. Spouse / partner)	- Supportive spouse/partner - Supportive of each other - Stable, or violent - Protective and supportive extended family - Optimistic outlook by family and friends - Equality in relationship - Commitment to equality in parenting

- Frequent relationship breakdown/multiple relationships - Drug or alcohol abuse	

Expected child:

Elevated risk:	**Lowered risk:**
- Special or expected needs - Perceived as different - Stressful gender issues	- Easy baby - Acceptance of difference

Parent-baby relationship

Elevated risk:	**Lowered risk:**
- Unrealistic expectations - Concerning perception of baby's needs - Inability to prioritise the baby's needs above own - Foetal abuse or neglect, including alcohol or drug abuse - No ante-natal care - Concealed pregnancy - Unwanted pregnancy identified disability (non-acceptance) - Unattached to unborn baby - Gender issues which cause stress - Differences between parents towards unborn child - Rigid views of parenting	- Realistic expectations - Perception of unborn child normal - Appropriate preparation - Understanding or awareness of baby's needs - Unborn babies needs prioritised - Co-operation with antenatal care - Sought early medical care - Appropriate and regular ante-natal care - Accepted/planned pregnancy - Attachment to unborn baby - Treatment of addiction - Acceptance of difference-gender/disability - Parents agree about parenting

Social

Elevated risk:	**Lowered risk:**
- Poverty - Inadequate housing - No support networks - Delinquent area	

Future

Elevated risk:	**Lowered risk:**
- Unrealistic plans - No plans - Exhibit inappropriate parenting plans - Uncertainty or resistance to change - No recognition of changes needed in lifestyle - No recognition of a problem or a need to change - Refuse to co-operate - Disinterested and resistant - Only one parent co-operating	- Realistic plans - Exhibit appropriate parenting expectations and plans - Appropriate expectation of change - Willingness and ability to work in partnership - Willingness to resolve problems and concerns - Parents co-operating equally

7. Analysis and conclusions

Constructing a chronology can be helpful to begin analysing patterns and history. This should include using input from other agencies as well as social care history.

Use should be made of the “Framework for Assessment” The assessment report should address the following issues:

7.1 Concerns identified.

7.2 Strengths or mitigating factors identified.

7.3 Is there a risk of significant harm for this baby?
It is crucial to clarify the nature of any risk. What is the risk? Who poses the risk? In what circumstances might this risk exist? Be clear how effective any strengths or mitigating factors are likely to be in reality.

7.4 Will this risk arise:

- Before the baby is born?
- At or immediately following the birth?
- Whilst still a baby (up to 1 year old)?
- As a toddler? or pre-school? or as an older child?
- If there is a risk that the child’s needs may not be appropriately met.
- What changes should ideally be made to optimise well-being of child? If there is a risk of significant harm to the child?
- What changes must be made to ensure safety and an acceptable level of care for the child?

- How motivated are the parents to make changes?
- How capable are the parents to make changes? And what is the potential for success?

Appendix B: Referrals to the Bright Beginnings Pathway

The Bright Beginnings pathway is part of the Evelina Health Visiting Service that provides rapid assessment and enhanced support to families who have complex health and social care needs to improve health outcomes for children and families. Referrals can be made any time between pregnancy and 2 years after birth. Children can be seen on this pathway until their 5th birthday if they continue to meet the necessary criteria.

All parents/ families that meet the pathway criteria will be triaged and allocated to an Early Intervention Health Visitor (EIHV). In addition to the five mandated Healthy Child Programme contacts, families on the pathway will receive more structured continuity of care, continuous assessment, and individualised support through additional contacts at set points, as per the Bright Beginnings Contact Schedule.

Parents/carers/families can be referred to the service if they present one or more of the following risk criteria:

- Young parents aged 19 and under
- Significant mental health conditions (not issues of low mood alone)
- Domestic violence and abuse posing current risk or impact (including intimate partner violence, forced marriage, honour-based violence)
- Alcohol and substance misuse posing current risk or impact
- Parent with a learning disabilities or complex medical needs posing current risk or impact
- Parental history of safeguarding issues (Child Looked After, Child in Need or subject to a Child Protection Plan, gang affiliation, female genital mutilation, sexual exploitation, adverse childhood experiences) posing current risk or impact
- Concealed pregnancies posing current risk or impact

New referrals onto the pathway will only be accepted if the child is under 2 years of age. Referrals need to be made via email, using the attached referral form and can be made by any relevant professional/ agency, including:

- Perinatal Mental Health teams
- Children Social Care
- Maternity and Neonatal services
- Safeguarding Children teams/ MASH (Multi Agency Safeguarding Hub)
- General Practitioners
- Liaison Health Visitor/ Specialist Health Visitors
- Universal Health Visiting teams

Bright Beginnings Referral Form

Client Details	
First Name	
Family Name	
Date of Birth	
NHS Number	
Address	
Telephone/ mobile	
GP Name & Address	
Expected date of delivery *(if applicable)*	
Partner/ Significant Other Details *(If applicable)*	
First Name	
Family Name	
Date of Birth	
NHS Number	
Address ***(if not living with partner)***	
Telephone/ mobile	
Relationship with client	

Children's Details *(if applicable)*

	Name	DOB	NHS Number
1.			
2.			
3.			
4.			

Other family members in household			
	Name	**DOB**	**Relationship to client**
1.			
2.			
3.			
4.			

Reasons for Referral ***(please include details of any initial assessments carried out):***

Has a CAF/MARF been sent to Social Care? Yes □ No □	Date of referral:
Has the Safeguarding team been informed? Yes □ No □	Date of referral:

Involvement of other agencies/ practitioners		
Name	**Agency/ Designation**	**Contact details**

Date of initial assessment:

Referral discussed with client: Yes □ No
Comments *(if applicable):*

Eligibility Criteria for referral:

	Please Tick ☑
Young parents aged 19 and under	
Significant mental health conditions (not issues of low mood alone)	
Domestic violence and abuse posing current risk or impact (including intimate partner violence, forced marriage, honour-based violence)	
Alcohol and substance misuse posing current risk or impact	
Parent with a learning disabilities or complex medical needs posing current risk or impact	
Parental history of safeguarding issues (Child Looked After, Child in Need or subject to a Child Protection Plan, gang affiliation, female genital mutilation, sexual exploitation, adverse childhood experiences) posing current risk or impact	
Concealed pregnancies posing current risk or impact	

Has relevant information been sent to any other agencies/ practitioners:	Please Tick ☑
CAMHS (Child and Adolescent Mental Health Services)	
Safeguarding Children Team	
GP	
Health Visitor	
Midwife	
School Nurse	
Social Worker/Children's Social Care	
Other professionals/ services (please specify):	

Referrer Details

Name: **Signature:**

Designation: **Telephone:**

Your Email Address:

Please email your referral to: gst-tr.earlyinterventionhealthvisitingservice@nhs.net