

HERTFORDSHIRE SAFEGUARDING CHILDREN BOARD

MULTI AGENCY PRE-BIRTH PROTOCOL (2013)

1. Introduction

Serious Case Reviews involving children under one year of age show a high percentage of those babies are fatally injured. A pattern is evident and relates to the following factors –

- ❖ physical vulnerability of the infant;
- ❖ its invisibility in the wider community and inability to speak for itself;
- ❖ the physical and psychological strain it places upon its caregivers.

It is critical, therefore, that all Local Children's Safeguarding Boards (LSCBs) have robust procedures in place, both to identify the children most at risk and then to effectively manage their protection.

- 1.2 The very nature of the work dictates that the most successful preventative action is taken if these children are identified pre- birth. This early warning system can only operate in a meaningful way if there is an agreed interagency commitment to the importance of this area of child protection, and that professional's work together to assess and manage the response to this high-risk group. As prescribed in Working Together (2013) the key agencies in terms of identification and intervention are Maternity Services; Primary care services; Adult Mental Health; Community Drug and Alcohol Services; Probation; Police, particularly Domestic Violence Officers; and Learning Disability Services.
- 1.3 These procedures are designed to better identify those babies most at risk and promote effective sharing of information. It will support all professionals in identifying risk factors and assist in constructing meaningful plans in partnership with the prospective parents that will protect the unborn child from harm.
- 1.4 Where required, advocates and or language communication interpreters should be made available to the parent throughout the process.
- 1.5 This guidance aims to:
 - Clarify what is meant by pre-birth assessments and the circumstances in which they should be used
 - Set out the procedures in relation to them, which should be read in conjunction with the [HSCB Safeguarding Procedures, Chapter 6.9, Pre Birth Assessment and Guidance](#) and Working Together 2013
 - Provide a framework for the content of such assessments
 - Set out the supports for all agencies to the process
 - It is not only Assessment Teams that conduct Pre-Birth Assessments, if there is already Children's Services involvement, the protocol must be followed as part of

current and on-going work which could include other children already being subject to child protection plans or proceedings. A Pre-Birth Assessment is not necessarily something that happens in isolation.

2. Pre Birth Assessments

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

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

A pre-birth assessment will look to answer these questions.

2.2 Some parents may refer themselves, as they have an understanding of the potential issues in relation to the unborn baby and are seeking help. Other prospective parents will need to be referred by others (including family and others in the community) because of concerns identified.

2.3 Pre-birth assessments are required in the following circumstances (please see Appendix 3 “Meeting the Needs of the Unborn Child in Hertfordshire”):

- There is significant domestic violence or escalation during pregnancy and/or honour based violence.
- A parent has significant mental health difficulties/diagnosis. S/he may be subject to an enhanced CPA. (Care Programme Approach).
- A parent has mild, moderate or severe learning disabilities.
- A parent misuses substance/s - likely to have a significant impact on the health and development of the baby.
- A parent has had a child previously removed from their care, has had contact restricted or has a child voluntarily accommodated.
- A parent is a current looked after child or previously in care
- A parent of 18 years and under with concerns about sexual exploitation, trafficking or abuse.
- A young person who is expectant or a prospective father and is already a service user (including Targeted Youth Service, Child Looked After Team or Safeguarding Locality and Family Support Team) should be referred to the Assessment Team, Specialist and Safeguarding Services, for consideration of the need for an assessment which is likely to be required.
- A parent is previously suspected of fabricated or induced illness.
- A parent is suspected of being involved in a forced marriage
- A parent is suspected of being a victim or involved in spirit possession or witchcraft
- A parent whatever age is suspected or known to have previously been the victim of grooming and/or sexual exploitation, and the putative father is unknown or known to be the person who groomed them.
- A parent is involved in gang activity or suspicion they are exploited by gangs.

- The parent is a victim or involved in honour based violence
- Incest is suspected
- If the parent is known to move authorities when professionals are involved.
- A parent /relative or associate is someone who may represent a risk to children, or has previously harmed a child. (This would include issues such as a violent history; significant criminal history; sexual offences against adults or children etc.).
- The baby once born will be living with or having contact with someone who may represent a risk to children (see above).
- A sibling is subject to a child protection plan.
- There are significant concerns about the home conditions, such that the baby may suffer physical neglect.
- One or both parents' behaviour or circumstances during pregnancy indicates that they will be unlikely to protect or care for their baby appropriately e.g. living a chaotic lifestyle with no home base; significant emotional instability; lack of preparation/ awareness of the impact of becoming a parent.
- Late booking for maternity care with an inadequate explanation.
- If a mother is undecided in relation to continuing with the pregnancy referral for pre-birth assessment could be deferred pending that decision, but no later than 16 weeks into the pregnancy.

However when a pregnancy is discontinued whether through augmentation or spontaneous process, consideration of referral to social care should be made if there are any remaining safeguarding concerns relating to a child.

This list is not exhaustive and individual factors that may usually fit more comfortably at targeted level may become more serious if there are a number of concerns grouped together. If a professional is in doubt about making a referral, s/he should always seek advice from their Safeguarding lead.

3. Procedures for Pre-Birth Assessments

- 3.1 Any professional who becomes aware that a woman is pregnant and has cause to be concerned that the new-born baby may be at risk of significant harm and/or the parents would require significant levels of support to care for the child should make a referral to the Children's Services as soon as possible.

Please see flowchart at Appendix 1. The referral should be made to:

**Hertfordshire County Council
Customer Service Centre**

PO Box 153
Stevenage
SG1 2GH

protectedreferrals.cs@hertscgcsx.gov.uk or

protectedreferrals.cs@hertfordshire.gov.uk

0300 123 4043

- 3.2 All professional referrers are required to complete the [Safeguarding electronic Referral form](#). Full details are required, including all demographic information, history of prospective parents and detailed reasons for the current concerns.

Of particular importance are details about all possible male carers. These are frequently missing from referral information and subsequently from the assessment itself. Any issues of drug and alcohol use should be included, and issues of violence, both in respect of risk to the child, but also to staff working with the family. Services that have paternal involvement only must have systems that routinely enquire about dependent children and refer accordingly in relation to risks e.g. Targeted Youth Support (TYS), Primary Care, Mental Health, SEARCH (Sexual Exploitation and Runaway Children group).

All referrals must include relevant historic, social and family issues of significance to inform any future risk assessment and /or referral, that criminal searches should be done on both parents and other possible carers, and that all decisions made about information sharing should be recorded

- 3.3 Whilst a verbal referral will be taken if there is an immediate risk to the unborn baby, pre-birth assessments should be planned pieces of work. Therefore, there is a clear expectation that a professional completes the referral with appropriate detail before the referral will be progressed.
- 3.4 Information in this process is shared under s47 of the Children Act 1989 and the Children Act 2004 (see Information Sharing and Confidentiality 1.1.8 for more detail on information sharing). This means that a professional is allowed to disclose information about their patient/client/service user if there is believed to be a need to safeguard a child or to determine the need to safeguard a child.

Practitioners should always inform the prospective parents of their intention to refer to social care, and seek consent. The only exception to this is if a professional has grounds for believing the unborn child (or in exceptional circumstances the pregnant woman) would be placed at risk if the referral were known or if there is evidence or a suspicion that the parent may become a flight risk.

- 3.5 Once the referral is received at the Hertfordshire County Council's (HCC) Customer Service Centre (CSC), a decision will be made about whether the case meets the threshold for assessment by Specialist Safeguarding Services. If it is felt that the needs can be more appropriately met at targeted level, the referral will be passed to the Targeted Advice Service (TAS). TAS will consider the presenting needs of the prospective parents, and offer advice and guidance to the referrer around those presenting needs. A Common Assessment Framework (CAF) may be appropriate, or extended family may be utilised to reduce concerns around parental coping strategies. If concerns continue, then a re-referral back to the CSC would be appropriate.

If Practice Manager of the Assessment Team, Specialist and Safeguarding Services, Children Services, makes a decision that a young person does not require an assessment, this should be recorded under the Management Decision in Case note tab on ICS, including a risk assessment and clear rationale.

- 3.6 If the referral meets threshold for Children's Safeguarding Specialist Service assessment, it will be accepted by one of the Safeguarding Assessment Teams in Children's Services. The referral will be considered under s47 of the Children Act, 1989, and a strategy meeting will be held once initial information gathering has taken place. Consideration needs to be given to the fact that if this referral is taken outside S47 enquiries, essential information from the police may be missing.
- 3.7 Once an assessment has been commenced, there will be a requirement that an inter-agency information sharing meeting is held within 15 working days. All professionals involved in the care of the prospective parents should make themselves available to attend. If individual practitioners cannot attend, a written report must be submitted. The purpose of the meeting is to ensure that all professionals are aware of the same information, and contribute to the developing picture of the prospective parents and their parenting capacity. It is ultimately the role of the CS Social Worker to determine the levels of risk involved in any particular pre-birth assessment, but there is an expectation that this is supported by non-judgemental evidence-based information and advice from other professionals, especially those with an expertise in the areas of drug and alcohol; mental health and learning disability. The strengths of any prospective parents should be considered alongside concerns, and there should be an explicit focus on issues of equality and diversity for each family, and how these will influence its ability to care for a baby.
- 3.8 The assessment must be completed within 45 working days. The discussions from the inter-agency information sharing meeting should be shared with the parents by the Social Worker, and at least three assessment visits should take place. At the end of the assessment, the Assessment Practice Manager will be responsible for determining which pathway the case then takes. There are 3 possible options:
- Concerns are allayed and/or can be managed at Level 2 in the community. The case will Step Down to a CAF, and be monitored by the appropriate Lead Professional. If necessary, the case can be re-referred if concerns re-emerge at a later stage.
 - If some concerns continue and there is uncertainty about parental co-operation, the case may return to Section 17 status. A Child in Need Plan will be developed, and the case will transfer into the Locality Team. The parents may be expected to comply with a variety of interventions, and the case may then either Step Down to Level 2 targeted services, or returns to Child Protection as necessary.
 - Significant concerns continue and it is felt that the new born baby will be at risk of significant harm. An Initial Child Protection Case Conference (ICPC) should be convened as soon as assessments are completed. This is typically at 20-25 weeks of the pregnancy, but may be sooner depending on when the unborn baby was referred.
- 3.9 The ICPC will require the attendance of all the involved professionals during the pregnancy and those to whom the case will transfer following the birth e.g. Locality Social Worker or Health Visitor. Reports will be expected from all relevant practitioners, which must address concerns around the pregnancy and/or parenting capacity as well as areas of strength. The resultant Child Protection Plan should consider carefully the ability to manage a Protection Plan in the community and whether this will provide sufficient safeguards for the new born baby.
- 3.10 The first core group meeting will be designated a pre-birth planning meeting. All essential professionals and the prospective parents should attend, and a written plan constructed. This must consider:

- Practical arrangements for mother and baby-including post natal ward monitoring
- Who will inform the Social Worker of the birth?
- Plans for out of hours/emergency birth
- Contact arrangements with parents and other family members
- Discharge plans and support package-including out of area as relevant e.g. if discharging to extended family or friends address for any period or specialist setting
- Management of parental non-co-operation
- Arrangements for legal proceedings/removal
- Parental attitudes to the plans
- Health and safety issues

All subsequent Core Group/Pre-Birth Planning meetings should incorporate the above plan in its discussion and decisions.

- 3.11 If the Assessment Team has concerns that the risks to the baby will be so serious that the baby cannot be protected in the care of its parents, in the community, they must consider the need for a Legal Planning Meeting at an early stage following the Pre Birth Assessment. This meeting should be held at around the time of the ICPC, and the relevant Locality Team should attend. The Public Law Outline meeting with parents should be arranged after the ICPC, but in good time before the birth. Prospective parents have a right to full information about the concerns professionals hold about their ability to parent a child, and a clear understanding of the action the Local Authority intends to take in regard to their child. This should be assessed with regard to flight risk.
- 3.12 Please see the Pre-Birth flowchart for ideal timelines to ensure assessments and action in reasonable timescales to allow both prospective parents and practitioners' time to address areas of concern and make appropriate preparations for the birth. Clearly, in terms of late presentation or concealed pregnancy, these timescales will need to be abridged in order to ensure that the new born baby is safeguarded. When a concealed pregnancy delivers at the hospital Social Care should always be informed and an assessment undertaken.

4. Guidance on the Content of the Pre Birth Assessment

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

- What research tells us about risk factors
- What practice experience tells us about how parents may respond in particular circumstances
- The practitioners' professional knowledge of this particular family

4.2 The content of a sound assessment will be formed by collating factual evidence, looking at relationships – between parent/carers, between parents/carers and the child (whether born or unborn) – looking at how previous history shapes current experiences and the context within which people are living. This is consistent with the [Framework for Assessment of Children in Need and their Families](#).

- 4.3 A key task in the preparation of a pre-birth assessment is to identify a fundamental baseline of acceptable parenting skills against which change can be monitored.
- 4.4 The vital step when planning a pre-birth assessment is to review any previous history. This will entail reading the case files on any child/ren that have been removed from the parents' care, ensuring that searches are done on any new partners in the household.
- 4.5 It is essential to construct a chronology of key events from the previous history, analysing it and identifying patterns that, when seen together, change the perspective of the case. It is essential to include as much information from other agencies as possible and, if feasible, ask them to contribute to the chronology. The knowledge gained from the chronology will help direct the assessment. This may include school or Connexions information about a parent,
- 4.6 Parents will be seen separately and together, to test out their parenting capacity and develop early engagement. One parent may be articulate and controlling, disempowering the other parent from making an open contribution to the assessment. A parent may require significant challenge when reviewing the professional and historical information.
- 4.7 If the parents have a dog, or other pet, the potential risk to the baby should be assessed and, the management of that risk will be addressed. Advice should be sought from a specialist service such as the RSPCA or a district/borough council dog warden.
- 4.8 Previous History
- 4.8.1 Practitioners should attempt to build up a clear history from the parents of their previous experiences in order to ascertain whether there are any unresolved conflicts and also to identify the meaning any previous children had for them and the meaning of the new born baby.
- 4.8.2 It will be particularly important to ascertain the parent(s) views and attitudes towards any previous children who have been removed from their care, or where there have been serious concerns about parenting practices. Relevant questions would include:
- Do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
 - Do they accept responsibility for their role in the abuse?
 - Do they blame others?
 - Do they blame the child?
 - Do they acknowledge the seriousness of the abuse?
 - Did they accept any treatment/counselling?
 - What was their response to previous interventions? e.g. genuinely attempting to cooperate or tokenistic compliance?
 - What are their feelings about that child now?
 - What has changed for each parent since the child was abused / removed?
- This list is not exhaustive. There will be particular issues for individual cases that require social workers and other practitioners to gather information about past history and review past risk factors.
- 4.8.3 It will be also be important to ascertain the parents' feelings towards the current pregnancy and the new baby including:
- is the pregnancy wanted or not?

- is the pregnancy planned or unplanned?
- is this child the result of sexual assault?
- is severe domestic violence an issue in the parents' relationship?
- is the perception of the unborn baby different/abnormal? Are they trying to replace any previous children?
- have they sought appropriate ante-natal care?
- are they aware of the unborn baby's needs and able to prioritise them?
- do they have realistic plans in relation to the birth and their care of the baby?

4.8.4 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.

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

- the circumstances of the abuse: e.g. was the perpetrator in the household? was the non-abusing parent present? the severity of the abuse?
- what relationship/contact does the mother have with the perpetrator? assuming the man as perpetrator - however, this is not always the case.
- how did the abuse come to light? e.g. did the non-abusing parent disclose or conceal? did the child tell? did professionals suspect?
- did the non-abusing parent believe the child? did they need help and support to do this?
- what are current attitudes towards the abuse? do the parents blame the child/see it as her/his fault?
- has the perpetrator accepted full responsibility for the abuse? how is this demonstrated? what treatment did he/she have?
- who else in the family/community network could help protect the new baby?
- how did the parent(s) relate to professionals? what is their current attitude?

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

4.8.7 Circumstances where the perpetrator is convicted for posing a risk to children (have they served a custodial sentence for sexual offences and did they participate in a treatment plan?) 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.

4.8.8 When a person 'who presents as a risk to children' has been previously assessed, the qualifications of the assessor and the quality of the assessment must be reviewed, as part of any current assessment.

4.9 Mental Health Problems

4.9.1 Although most parents with psychiatric problems are able to care for their children appropriately, research has indicated that child-maltreating parents are often shown to have mental health problems e.g. depression, history of attempted suicide, schizophrenia etc. Non-compliance with medication without medical supervision is a cause for concern.

4.9.2 Children are at increased risk of abuse by psychotic parents when incorporated into their delusional thinking e.g. "(the baby) is trying to punish me for my sins".

4.9.3 Practitioners will obviously seek to obtain a psychiatric assessment in these cases, but must not become "paralysed" if that is not forthcoming. It is essential to continue the assessment based on the behaviour of the parent(s), not the diagnosis, and the potential risk of that behaviour to the new-born child. In addition, where there is mental health risk factors identified, ongoing re-evaluation of risk is essential.

4.10 Substance Abuse

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

- The pattern of drug use and alcohol misuse and the likely impact on the baby/child as they grow/develop.
- Whether it can be managed compatibly with the demands of a new-born child
- Whether the parent(s) are willing to attend for treatment, and the consequences for the baby of the mother's substance misuse during pregnancy e.g. withdrawal symptoms.

4.11 Violence – consideration given to risk assessment for domestic violence and checks whether they are subject to a Multi Agency Risk Assessment Conference (MARAC) or Multi Agency Public Protection Arrangement (MAPPA) involvement.

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

- The nature of violent incidents
- Their frequency and severity, and
- Information on what triggers violent incidents.

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

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

parent

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

4.12 Other Concerns

4.12.1 A viability assessment will be undertaken of any adult who is not the child's parent, but who is expected to be part of a child protection plan to safeguard the child. This is typically a grandparent or member of the family and friends, with whom the plan is for the parent(s) and new born baby to live. The relative/friend who is given and accepts this role, will sign agreements to any Child Protection Plan, be invited to all Child Protection meetings, Core Group/Pre-Birth meetings and be consulted by the child's social worker.

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

4.12.3 Caring for a new born baby is difficult enough for any parent but can be particularly stressful if the parent(s) are isolated and do not have a network of support. It is important to identify whether partners are going to share responsibility or whether it will fall to one, usually the mother.

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

4.12.5 It is therefore important to identify the support networks that the parent(s) have their financial and housing position. Clear guidelines are outlined in the Framework for Assessment of Children in Need and their Families.

4.12.6 Once the information has been collected it needs careful analysis. This should be a shared process with the other agencies involved, particularly the midwives and obstetricians. This will be primarily the task of the inter-agency information sharing meeting and the core group.

Primary Care is in a unique position to be in possession of historic and current family and /or extended family information. Where significant social history or risk related issues are evident that would have potential impact on the unborn child or parenting ability to meet the child's needs it must be contained within any interagency and multi-agency communications and referrals.

4.12.7 If the assessment identifies that there are clear risks to a newborn baby then key judgements will be:

- Whether there is evidence of the parent(s)' capacity to change
- Will the provision of support and services be sufficient to enable the parent(s) to care safely for their baby?
- Will they be able to change in time for the baby's birth?
- Whether the parents have appropriate support networks

5. Support for the Pre Birth Assessment Process

- 5.1 Understanding and assessing risk correctly in pre- birth assessments is a complex process. In addition to this we have denial of pregnancy, concealment of pregnancy, substance misuse disorders, multiparity, and financial barriers to care are associated with a lack of seeking prenatal care

http://hertsscb.proceduresonline.com/chapters/p_rec_ch_abuse.html#no_prenatal_care

To assist practitioners in making informed judgements, a range of advice and guidance will be in place.

- 5.2 Monthly multi-agency meetings to discuss risk and assess unborn baby concerns will be held. They will initiate and review plans put in place to protect both mother and unborn. It will review ongoing assessments and address areas of delay or information gaps. The meeting will be chaired by the Named Safeguarding Midwife, who will agree the venue date and time of each and subsequent meetings. Should, in exceptional circumstances a meeting be cancelled then it is the responsibility of the Named Safeguarding Midwife (Chair) to reconvene the meeting within one working week.

- 5.2.1 In addition to the Named Safeguarding Midwife, mandated attendance is compulsory for both the Community Safeguarding Nurse and Social Care representative, (Practice Manager or Consultant Social Worker). Cover for attendance, passed to an appropriate colleague is a decision for each of the mandated members.

- 5.2.2 In light of the learning from serious case reviews consideration should be given to compulsory attendance to include any specialist service which applies to the mother or parent in the household please see below;

- for a parent affected by mental health attendance by the psychiatrist and or mental health social worker, specialist mental health midwives etc
- for a parent with Learning disability attendance by the Adult Learning Disability social worker
- parents affected by alcohol or substance misuse- Substance misuse worker CRI Spectrum should attend

- 5.2.3 Attendance is welcomed from teenage pregnancy co-ordinators, health visitors, drug and alcohol workers, Adult Mental Health workers and community midwives. As contribution to their learning development students will be allowed attendance with prior agreement from the Chair.

- 5.2.4 An attendance sheet will accompany the standardised Pregnancy and Complex Social Factors spreadsheet, which will also serve as the minutes of the previous meeting.

Any issues regarding attendance should be addressed through the established HSCB escalation process.

- 5.3 Social Care Safeguarding Advice: There will be a named lead pre-birth Social Worker based in each of the 11 Assessment Teams. This individual will be available to offer telephone consultations to other professionals, and to act as a mentor to other Social Workers completing pre-birth assessments. They can be contacted as follows:

Broxbourne and East Herts Assessment Team: 01992 588 101

Dacorum and St Albans Assessment Team: 01442 454 398

Stevenage and North Herts Assessment Team: 01438 843 700

Watford and Three Rivers Assessment Team: 01442 453 421

Welwyn/Hatfield and Hertsmere Assessment Team: 01438 844 762

- 5.4 Early Intervention & CAF Advice: For cases that do not meet the threshold for social care intervention, advice and guidance will be offered to practitioners by the Targeted Advice Service (TAS) in the first instance. Local support is available for CAF and Team Around the Child arrangements via the District Partnership Teams:

Broxbourne & East Herts: 01992 556382

Dacorum & St Albans: 01442 453927

Stevenage & North Herts: 01438 843373

Watford & Three Rivers: 01442 453127

Welwyn/Hatfield & Hertsmere: 01438 843032

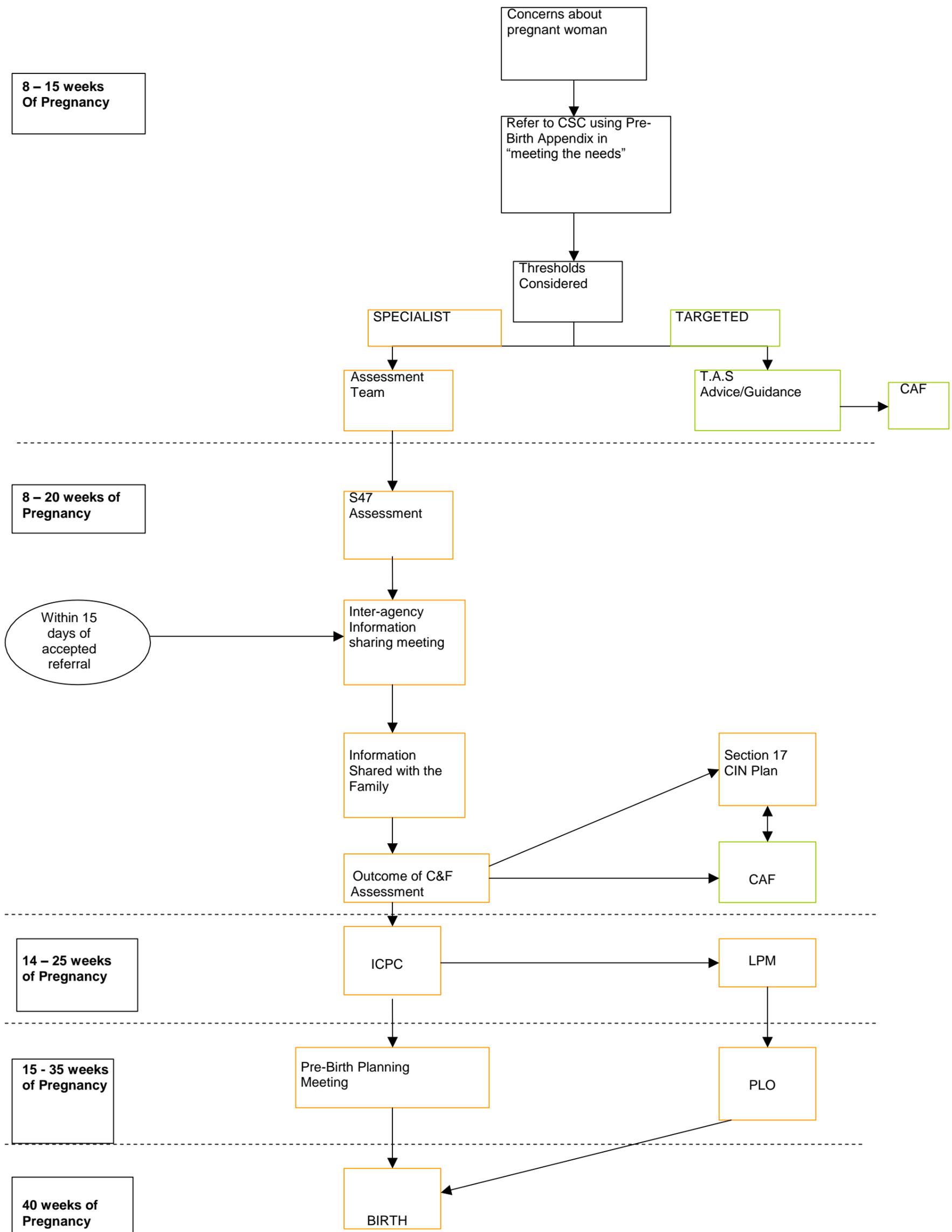
- 5.5 Regular re-evaluation of the plan, especially immediately after the birth, will be critical, and a re-referral into social care should be made if the situation deteriorates or professionals are in any doubt about the safety of the baby.
- 5.6 In case of disputes between professionals about how a case should be managed and/or under which process, professionals should follow the agreed dispute resolution procedures within their own agencies. Ultimately, a case may need to be discussed by the respective Heads of Service of the affected agencies.
- 5.7 Specific inter-agency Safeguarding training will be provided around pre-birth assessment through the HSCB Learning and Development programme, where this protocol will be fully explained.

Appendix 1 – Pre-Birth Flowchart

MULTI-AGENCY PRE-BIRTH PROTOCOL FLOWCHART

TIMELINE

PROCESS



Appendix 2 - Bibliography

Hertfordshire Safeguarding Children Board Safeguarding Procedures

Brandon, M, Howe, D, Belderson, P, Black, J, Dodsworth, J, Gardner, R and Warren, C (2008) Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003-2005, London, DCSF

Calder MC and Hackett S (eds.) (2003) Assessment in childcare: Using and developing frameworks for practice. Dorset: Russell House Publishing.

Hart, Di (2000), "Assessment Prior to Birth" in Horwath, Jan (Ed) (2000) The Child's World: assessing children in need - Reader, Department of Health, NSPCC, University of Sheffield

HM Govt (2010) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children, London, DCSF

HM Govt (Mar 2013) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, London, DFE

Reder, Peter and Clare Lucey (1995) "Significant Issues in the Assessment of Parenting" (1995) in Reder, Peter and Clare Lucey (1995) Assessment of Parenting: psychiatric and psychological contributions (1995) Routledge, London

Reder, Peter and Sylvia Duncan (1999), Lost Innocents: a Follow-Up Study of Fatal Child Abuse, Routledge, London

Ofsted (2008) Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31 March 2008, London, Ofsted

Ofsted (2009) Learning lessons from serious case reviews: year 2, London, Ofsted

Rose, W and Barnes, J (2008) Improving Safeguarding Practice: Study of Serious Case Reviews 2001- 2003, London, DCSF/Open University

Sinclair, R and Bullock, R (2002) Learning from Past Experience – A Review of Serious Case Reviews, London, DoH

Appendix 3 - Meeting the Needs of the Unborn Child

Unborn Children

Meeting the Needs of Children and Families in Hertfordshire



Identifying Risks and Needs for Unborn Children

In Hertfordshire we are developing integrated practice, where practitioners are building on how they work together to support children and families. This requires a shared understanding of service thresholds and responsibilities. For unborn babies, it is important that practitioners have guidance around the types of need requiring a specialist service and those requiring a targeted services approach, including the use of the Common Assessment Framework.

Identifying the needs of expectant mothers and unborn babies is not an exact science and the 'need indicators' that follow are a guide and are by no means exhaustive. There is no substitute for professional judgment and discussion with others and this guidance aims to assist practitioners and managers in determining levels of need and to consider the appropriate responses to address needs.

Principles

All practitioners working with and on behalf of children and families need to take responsibility for ensuring everything possible is done to prevent unnecessary escalation of issues or problems, seeking early intervention. Some guiding principles are that:

- The unborn child's needs come first
- The welfare and safety of unborn babies is everyone's responsibility
- A shared responsibility for achieving better outcomes, which means preventing escalation of need (early intervention and prevention)
- All agencies and services must work together and understand and appreciate each other's roles and responsibilities
- In assessing needs, the views of the parents must be sought and considered

- No-one must be discriminated against on the grounds of age, ethnicity, religious belief, faith, culture, class, sexual orientation, gender or disability

The Common Assessment Framework

Often, a single need can be met within universal services or can be met by way of additional services. However, where there are multiple needs, it is important that a holistic assessment is carried out, where everyone is clear about the needs and how each person contributes to addressing the needs (including the expectant parents). The inclusion of children, young people and their parents/carers is important as they have a key role in successful outcomes. Please refer to CAF Practitioner Guidance at: <http://www.hertsdirect.org/yrccouncil/hcc/csf/childrenstrust/integrated/> or use the search facility typing in 'Integrated Practice'

CAF is based on family consent, and if this is not forthcoming, you need to consider whether the refusal to take a CAF approach has consequences for the unborn child. If you are unsure about this, speak to your manager or safeguarding lead, who may decide to take advice via the Targeted Advice Service or via Social Care colleagues.

Safeguarding Children

It is the expectation that a CAF approach will have been taken to address needs **unless** the presenting unborn child's needs are so urgent or serious that they are at risk of significant harm. If in doubt, speak to your Manager or your safeguarding lead person(s). If they are unavailable, do not delay, contact Children Schools & Families on **0300 123 4043**. If a child or young person is at risk of immediate harm, call **999**. Please refer to HSCB Safeguarding Procedures at: <http://www.hertssafeguarding.org.uk/>

Level 1 : Universal

The needs are **emerging** and can be met within universal services (such as: maternity & midwifery, Children's Centre, Health Visitor, GP, Housing, leisure services, libraries, voluntary and community sector services). The emerging needs may require additional involvement of a single service to prevent escalation of needs. A CAF may be beneficial in some circumstances and professional judgement is required.

Level 2 : Targeted

The needs are **additional or complex** which can be met by involving targeted services, working alongside universal services. The needs may require the involvement of an additional service or may require a range of services and a multi-agency support plan by way of Common Assessment, Lead Professional and Team Around the Child (TAC). Contact details for CAF service representatives are available via the Multi-Agency Team (MAT) List:

<http://connect.hertsc.gov.uk/connect/organisation/csf/integratedpractice/?view=connect>
or search typing in "MAT List" on Hertsdirect or Compass.

CAF is required to conduct a holistic assessment of strengths and needs with children and families and to put in place a support plan. Working together with parents to address needs is important to improved outcomes. Parent's acknowledgement of concerns and acceptance of their part in the meeting their child's needs is critical and, at times, this requires some open discussion with parents in order to progress targeted support.

Levels 3 & 4 : Specialist

There are **high complex needs**, or of a **safeguarding** nature and can only be achieved by the involvement of specialist services. For unborn babies, specialist assessment may be required due to the level of concerns around parenting and/or environment, which suggests the unborn child will be at risk of suffering significant harm, once born (please see Needs Indicators)

If a CAF exists, the information in the CAF will support Specialist intervention.

Needs Indicators for Unborn Children

Level 1: Universal	Level 2: Targeted	Level 3 & 4: Specialist
Emerging Needs	Additional/Complex Needs	Safeguarding
<p>The mother is not accessing ante-natal care, and professional judgement has been made about the impact of this on the pregnancy.</p> <p>The mother has an eating disorder.</p> <p>The pregnancy suggests the child is likely to have some health needs.</p> <p>A parent has some financial difficulties.</p> <p>The pregnancy requires particular health intervention.</p> <p>A parent is isolated in the community, and struggling to access services due to specific needs e.g. interpreting services</p>	<p>The parents are experiencing relationship difficulties, some low-level domestic abuse</p> <p>A parent has mild learning disability.</p> <p>A parent has self-harmed during pregnancy.</p> <p>A parent has a mental health problem, but this is well managed and s/he is engaged in treatment.</p> <p>A parent has a substance misuse difficulty, but this is well managed and s/he is effectively engaging with services.</p> <p>A parent has had a short period of being looked after as a child.</p> <p>A parent was subject to child protection concerns as a child.</p> <p>A parent is between 15 and 18. There may be concerns about sexual exploitation, and specific needs e.g. education.</p> <p>The pregnancy suggests the baby is likely to have significant health and development needs.</p> <p>A parent has a significant physical disability or illness that is likely to impact on his or her parenting.</p>	<p>There is significant domestic violence and/or honour based violence. Mother has experienced Female Genital Mutilation.</p> <p>There is domestic abuse during pregnancy.</p> <p>A parent has significant mental health difficulties/diagnosis. S/he may be subject to an enhanced Care Programme Approach.</p> <p>A parent has moderate learning disabilities.</p> <p>A parent has severe learning disabilities.</p> <p>Both parents have mild or moderate learning disabilities.</p> <p>A parent has a substance misuse difficulty likely to have a significant impact on the health and development of the baby. The drug or alcohol misuse may be chaotic, and there may also be non-engagement with professionals.</p> <p>A parent has had a child previously removed from their care, has had contact restricted or has a child voluntarily accommodated.</p> <p>A parent has grown up in care.</p> <p>A parent is 14 and under. There are likely to be significant concerns about sexual exploitation or abuse.</p> <p>A parent is someone who may represent a risk to children, or has previously harmed a child. (This would include issues such as a violent history; significant criminal history; sexual offences against adults or children etc).</p> <p>The baby once born will be living with or having contact with someone who may represent a risk to children (see above).</p> <p>A sibling is subject to a child protection plan.</p> <p>There are significant concerns about the home conditions, such that the baby may suffer physical neglect.</p> <p>An expectant mother is reported missing, where concerns about safety of the unborn</p>

		<p>child.</p> <p>One or both parents behaviour or circumstances during pregnancy indicates that they will be unlikely to protect or care for their baby appropriately e.g. living a chaotic lifestyle with no home base; significant emotional instability; lack of preparation/awareness of the impact of becoming a parent.</p>
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