Croydon Safeguarding Children Board
and
Croydon Safeguarding Adults Board

Pre-Birth Assessment Multi-Agency Guidance

December 2016

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Guidance Summary

Research evidences that young babies are particularly vulnerable to abuse but that robust work carried out in the antenatal period can help minimise harm if there is early assessment, intervention and support.

When agencies are able to anticipate safeguarding risks and vulnerabilities for an unborn baby, such concerns should be addressed through a pre-birth assessment. The aim of this assessment is to make sure that the risks and vulnerabilities are identified as early as possible, to take any action to protect the baby (and any other existing siblings), and to support parents in caring for the baby safely. 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, as a consequence, in the resulting actions.[1]

There has been longstanding concern about the relative lack of urgency in relation to pre-birth practice. This seems to extend through all the processes of pre-birth practice – the lack of urgency of professionals making pre-birth referrals, completing pre-birth assessments, putting support plans into place, and convening pre-birth conferences where appropriate it appears to be inherent in the psychology of pre-birth work that professionals think that they have much more time than they actually have. The essence of pre-birth work has to be the quality of multi-agency involvement and partnership working, together with meaningful engagement and involvement with families. This is always true of safeguarding practice in general, but is particularly relevant in relation to pre-birth work; the family GP, the midwife , and the health visitor all have critical roles to play in relation to vulnerable expectant mothers, alongside other statutory agencies and organisations working with family members.

Purpose:

The purpose of this guidance is to ensure that a clear system is in place to respond to concerns for the welfare of an unborn child and to maintain clear and regular communication within and between partner agencies.

Scope:

This joint guidance applies to all agencies but particularly all children's services staff (including social care, early intervention and education), police, health (including mental health) and relevant adult services.

1 Ofsted (2011) *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

1. Introduction

1.1 Pre-birth assessments are a proactive means of analysing the potential risk to a new born baby when there is concern about a pregnant woman, her partner or ex-partner and where relevant, her immediate family.

1.2 Pre-birth Assessments can be undertaken at any time by any professional working within the staged model of intervention. The first stages of early help can be initiated by any practitioner across the partnership eg midwife at antenatal booking.

1.3 When concerns are significant or increase, the assessment can continue either as a multi-agency Croydon Early Help Assessment or a Social Care, Children and Families Assessment depending on the need of the family and the level of risk identified.

1.4 The main purpose of any pre-birth assessment is to identify what the risks and potential needs of the unborn child and his/her family may be, whether the parent(s) are capable of changing so that the risks can be reduced and if so, what supports they will need.

1.5 Pre-birth assessments can be a source of anxiety not only for parents, who may fear that a decision will be made to remove their child at birth, but also for professionals who may feel that they are not giving parents a chance to parent their new-born child.

1.6 Research and practice experience suggests that a pre-birth assessment should be undertaken as early in the pregnancy as possible. The anxiety created by undergoing the process may adversely affect the attachment to the unborn child. This, in turn, can aggravate the strain of caring for a new baby. The ideal time to undertake a pre-birth assessment is in the second trimester.

1.7 The justification for statutory intervention in a family's life is to safeguard and promote the welfare of children. However, in these cases as the child is unborn an assessment must attempt to identify the potential risk factors to the baby once born, and to predict whether that child will be safe. This is especially relevant, as research studies have shown that children are most at risk of fatal or severe assaults in the first year of life, usually inflicted by their carers.

1.8 Adult Services working with the parents of the unborn child will have a continued role in supporting the adult. They will need to undertake an assessment of the risks associated with any adult behaviour(s) that may impact on parenting capacity as part of an early help assessment. Adult services will need to work in partnership with all agencies supporting the family including health, children's social care and early help.

1.9 As Brandon et al notes "*Maintaining a focus on the child was specifically mentioned with regard (amongst other things) to keeping the unborn child in mind, especially when services are addressing the parents' needs*"[2]

[2] Brandon et al (2012) *New lessons from serious case reviews: a two year report for 2009-2011*

1.10 This guidance aims to clarify what is meant by pre-birth assessments, their purpose and the circumstances of undertaking them and should be read in conjunction with current Pan London Child Protection Procedures.

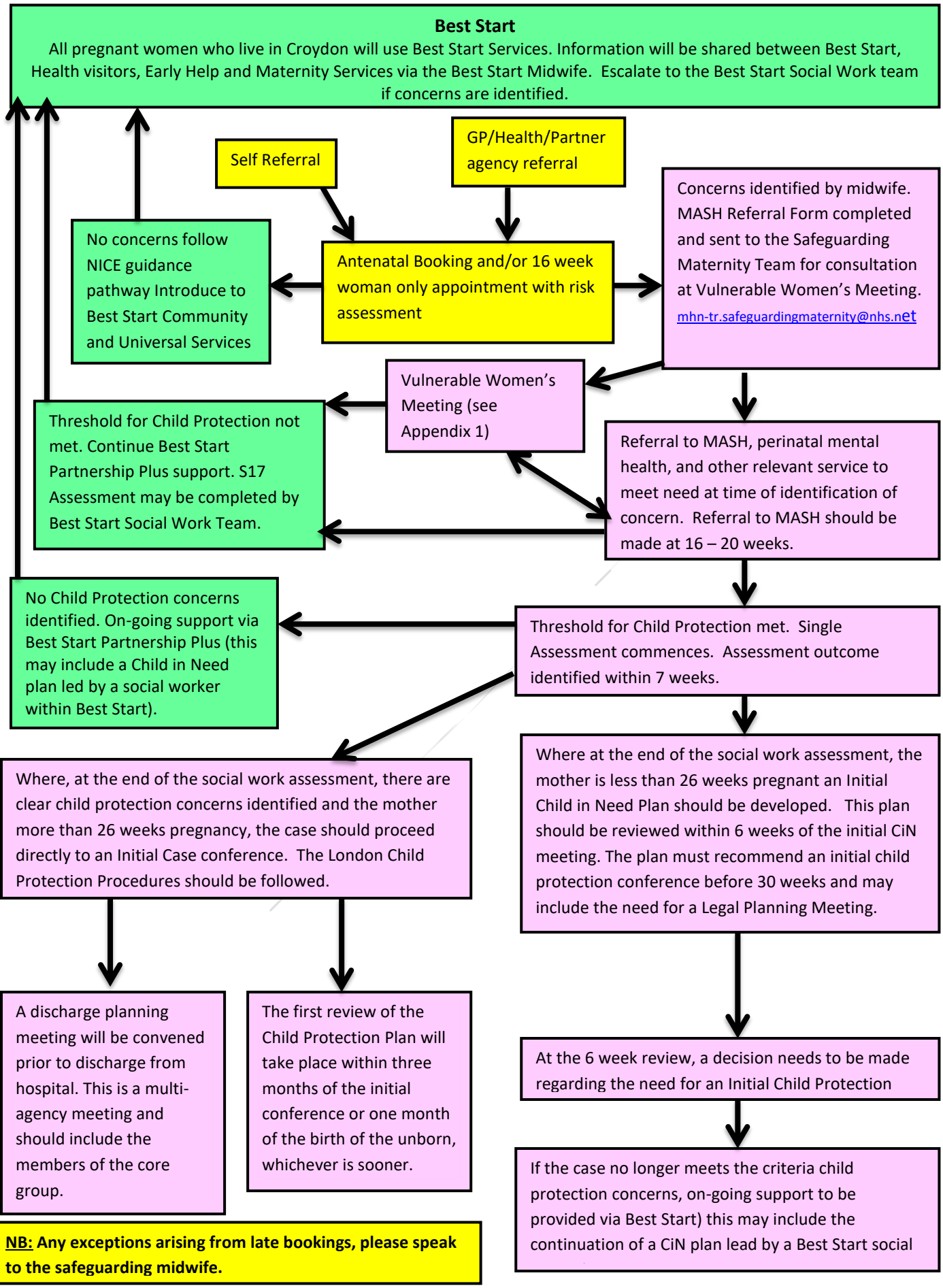
2. Raising a Concern About an Unborn Child

2.1. It is essential that professionals who have a safeguarding concern about an unborn child work with the family to gather as much information as possible. When completing assessments, professionals should also include all available additional information from within their agency. This includes the completion of the multi-agency Croydon early help assessment.
https://www.practitionerspacecroydon.co.uk/support-assessment/is-it-for-me-caf/

2.2. Families should be informed of concerns and any referrals made, unless it is felt that to do so would put a child, unborn baby, or other person at risk of harm.

2.3. For cases of high risk and particularly when there are concerns relating to flight of the Mother, a decision may be made by to raise a national alert. This decision will be taken by Children's Social Care.

See Appendix 1 for template for raising a national alert.


Best Start
All pregnant women who live in Croydon will use Best Start Services. Information will be shared between Best Start, Health visitors, Early Help and Maternity Services via the Best Start Midwife. Escalate to the Best Start Social Work team if concerns are identified.
Self Referral
GP/Health/Partner agency referral
No concerns follow NICE guidance pathway Introduce to Best Start Community and Universal Services
Antenatal Booking and/or 16 week woman only appointment with risk assessment
Concerns identified by midwife. MASH Referral Form completed and sent to the Safeguarding Maternity Team for consultation at Vulnerable Women's Meeting. mhn-tr.safeguardingmaternity@nhs.net
Vulnerable Women's Meeting (see Appendix 1)
Threshold for Child Protection not met. Continue Best Start Partnership Plus support. S17 Assessment may be completed by Best Start Social Work Team.
Referral to MASH, perinatal mental health, and other relevant service to meet need at time of identification of concern. Referral to MASH should be made at 16 – 20 weeks.
No Child Protection concerns identified. On-going support via Best Start Partnership Plus (this may include a Child in Need plan led by a social worker within Best Start).
Threshold for Child Protection met. Single Assessment commences. Assessment outcome identified within 7 weeks.
Where, at the end of the social work assessment, there are clear child protection concerns identified and the mother more than 26 weeks pregnancy, the case should proceed directly to an Initial Case conference. The London Child Protection Procedures should be followed.
Where at the end of the social work assessment, the mother is less than 26 weeks pregnant an Initial Child in Need Plan should be developed. This plan should be reviewed within 6 weeks of the initial CiN meeting. The plan must recommend an initial child protection conference before 30 weeks and may include the need for a Legal Planning Meeting.
A discharge planning meeting will be convened prior to discharge from hospital. This is a multi-agency meeting and should include the members of the core group.
The first review of the Child Protection Plan will take place within three months of the initial conference or one month of the birth of the unborn, whichever is sooner.
At the 6 week review, a decision needs to be made regarding the need for an Initial Child Protection
If the case no longer meets the criteria child protection concerns, on-going support to be provided via Best Start) this may include the continuation of a CiN plan lead by a Best Start social
NB: Any exceptions arising from late bookings, please speak to the safeguarding midwife.

3. Pre-Birth Assessments

3.1. A pre-birth assessment is essentially an assessment of the risk to the future safety of the unborn child with a view to making informed decisions about the child and family's future.

3.2. Working Together (2015) refers directly to unborn children in the guidance for Initial Child Protection Conferences: "*If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth*".

3.3. Hart (2009)[3] outlines the advantages of pre-birth assessment as providing an opportunity to:

- ***identify and safeguard*** *the babies most likely to suffer future significant harm;*
- *ensure that* ***vulnerable parents*** *are offered support at the start of their parenting role rather than when difficulties have arisen;*
- *establish a working* ***partnership with parents*** *before the baby is born;*
- ***assist parents*** *with any problems that may impair their parenting capacity.*

3.4. More recent research from Wallbridge (2012) notes:

> *The reason for conducting a thorough pre-birth assessment is not just to ensure the child's safety, but also to ensure that parents who are vulnerable and/or in difficulties, receive the kind of support and services they require in order to be able to parent effectively.*[4]

3.5. Hart (2009) indicates that there are **two** fundamental questions when deciding whether a pre-birth assessment is required:

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

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

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

3.7. A Children's Social Care Pre-birth assessment would be required in the following circumstances (see also, *London Child Protection Procedures)*:

- Concerns that the mother's current behaviour, e.g. known mental health concern or substance/alcohol misuse or chaotic behaviour poses a threat to the unborn baby.

[3] Hart, D 2009 in Horwath, J *the child's world; a comprehensive guide to assessing Children in Need* 2nd edition
[4] Wallbridge, S (2012) Guide to pre-birth assessments

- Concerns that the mother (or other primary carer, including the father) may not be able to care for the baby to an acceptable standard, e.g. significant learning disability, previous neglect or other children subject of child protection plan or have been removed from parental care.
- Concerns that the behaviour of a parent (or any other person who has regular contact with the parent/s) poses a threat to the unborn baby, e.g. domestic abuse or known allegation or conviction for offences against children less than 18 years of age.
- Concerns that the behaviour of a parent or any other person with significant contact with the family will impact on the ability of the primary carer/s to care for the baby to an acceptable standard.

The presence of one of these factors does not automatically require referral but they highlight the need to consider the known pre-disposing factors to child abuse.

Examples might include:

- Parent (s) living a chaotic lifestyle with no home base, using drugs and alcohol to excess, refusing ante-natal care;
- Previous history of neglect or abuse of a child(ren)
- Parent (s) with learning disabilities who is/are unable to self-care appropriately casting doubt on the ability to care for a baby;
- Parent(s) with chronic and disabling mental health problems e.g. schizophrenia, affective psychosis, severe substance abuse, personality disorder, obsessive compulsive disorder and eating disorders;
- High levels of domestic abuse;
- Parental history suggests that the prospect of the baby being adequately cared for is poor e.g. a history of early abuse, serious violence, of continued substance abuse unresponsive to treatment or serious psychiatric problems;
- One of the prospective parents is an offender / **or felt to be a risk to a child or** with a conviction for abuse, including sexual abuse, against a child.

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

3.8. When factors of concern have been identified for mothers booked at Croydon University Hospital they will follow the Vulnerable Women's Meeting pathway.

See Appendix 2 for Terms of Reference and Flowchart

3.9 Where agencies or individuals anticipate that **prospective parents** may need support services to care for their baby or that the baby may be at risk of significant harm, a referral to Children's Social Care must be made at 16 weeks gestation or as soon as possible after.

3.10 Where the expectant mother and / or father is/are an open case to a social worker in Children's Social Care, the unborn baby will require a separate assessment completed by their own allocated social worker. The social worker for the parent(s) must determine if a referral is needed in respect to concerns regarding the unborn child. It is expected that all relevant social workers collaborate in order to support the needs of the parents and child.

3.11 **Young People Looked After or Leaving Care**

3.11.1 Teenagers who become parents are known to experience more educational, health, social and economic difficulties than young people who are not parents. Consequently, their children may be exposed to greater social deprivation and disadvantage.

3.11.2 Teenage parents who are looked after or in leaving care services experience similar difficulties to those faced by all young parents. However, they are less likely to have consistent, positive adult support and more likely to have to move. A notification should be made to Family Nurse Partnership in respect to expectant mothers who are looked after or care leavers and who were confirmed to be pregnant before their 20th birthday. This referral should be made before the 16th week of pregnancy.

3.11.3 Where the expectant mother and / or father is a looked after young person or Care Leaver to another Local Authority and the mother is living within the London Borough of Croydon, services in Croydon, including Children's Social Care, have a duty to safeguard the unborn child. (Pre-birth assessments will also be considered when young men looked after or those in leaving care are known to be the father of an unborn child, irrespective of whether the mother herself is, or was looked after.)~~3.10.4~~. The allocated social worker for one or other of the parents would normally determine if a referral is needed in respect to concerns regarding the unborn child however, it is recognised that other professionals working with the parents may also initiate a referral.

3.11.4 Where a Croydon Looked after Child or Care Leaver is residing outside of the London Borough of Croydon is expecting a child, the local authority responsible for undertaking pre-birth assessment is that where the expectant mother is living.

3.11.5 The social worker for the unborn child should ensure that they maintain open communication with the allocated social workers for the parents and that the parents' social workers are invited to any professionals meetings to enable them to best support their young people.

4. The children's social care pre-birth assessment and post birth planning

4.1. Pre-birth guidance in Croydon considers that the earlier the assessment is undertaken the better the planning around the parents, extended family and the unborn child.

4.2. A sound assessment will include lessons from research regarding risk factors, what practice experience tells us about how parents may respond in particular circumstances, and the practitioners' professional knowledge of this particular family. It will collate factual evidence to evaluate relationships between parents/ carers and between parents/carers and the unborn baby, the impact of personal history on current experiences and the current context within which the family live. This is consistent with the Framework for Assessment of Children in Need and their Families.

4.3. If the ***outcome*** of the pre-birth assessment suggests the baby would not be safe with the parents then practitioners are provided with the time and opportunity to make clear and structured plans for the baby's future, and set up support for the parents where necessary. This includes allowing time to prepare for any legal proceedings required.

4.4. The pre-birth assessment will:

- Focus on strengths and concerns about both parents and extended family members,
- Identify a fundamental baseline of acceptable parenting skills against which change can be measured,
- Assess the family history of both parents and the extended family, previous proceedings and any previous expert reports/assessments including parenting assessments. The professional undertaking the assessment should gather information available to them regarding parents/fathers/new partners. For social workers particularly this will also include information held by the partnership and, if appropriate in other Local Authority areas.
- The assessing professional should ensure that they read case records / notes of any older child/ren who have received a service from them, including within another Local Authority, and construct a chronology, using input from other agencies where available, analyse and note patterns.
- Assess concerns about any issues impacting on the parents' ability to care for their child safely. This may include, but is not limited to, parental mental health, domestic abuse, substance misuse or parental learning or physical disabilities including previous involvement with mental health or substance misuse services
- Consider the relevance, if any, of any past history of either parent as having been Looked After or in receipt of Safeguarding services themselves.
- Assess parents' attitude to new baby and preparedness for its birth. The assessing professional should speak to both parents, where possible, (and also, mother's current partner if this person is not the father) together and separately.
- Build good relationships with the family, especially the expectant mother, using strength based approach, relationship based practice and motivational interviewing and gain an understanding the family systems.

- Consider what support the expectant mother and father / partner will require and find avenues for this support.
- Seek to engage support from wider family. Social Workers should consider holding a Family Group Conference early in the assessment process where necessary, and identify the support needed for the family in order to safely parent the child.

4.5. **Fathers and Other Significant Male Figures**

4.5.1. Findings from serious case reviews, local audits and research, have identified that fathers and significant male figures are conspicuously absent from assessment and planning processes. This is particularly relevant with pre-birth assessments where couples separate prior to the birth of their child and where mother may have started a relationship with a new partner.

4.5.2. It is important that all professionals undertaking pre-birth assessments fully consider the role of the father and any other significant male figure (including new partners).

4.5.3. It is important that any professional working with an expectant father or a man in a relationship with a woman who is pregnant by another man, consider any risks their client poses to the unborn child and shares these with the appropriate professionals.

4.6 Previous History

4.6.1 When undertaking a pre-birth assessment, **all** professionals working with the family at any stage should attempt to build a clear history of the parents previous experiences in order to ascertain whether there are any unresolved conflicts, particularly in respect to any children no longer in their care, and also to identify the meaning any previous children had for them and the meaning of the new born baby.

4.6.2 Additional consideration should be given to the parents' feelings towards the current pregnancy and the new baby relevant questions include:

- 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' (or couple's, if mother's current partner is not the putative father) relationship?
- Is the perception of the unborn baby different/abnormal? Are they trying to replace any previous children?
- Have they sought appropriate ante-natal care?
- Are they aware of the unborn baby's needs and able to prioritise them?
- Do they have realistic plans in relation to the birth and their care of the baby?

4.7 There is a defined period of 35 days for completion of the sSingle aAssessment, with a review point at 20 days. It is expected that the majority of these assessments will conclude at 35 days in order for a full and thorough assessment to be completed however, the aim should be to conclude the pre-birth assessment, where possible, to enable child in need/protection planning to begin by around 27-30 weeks of the pregnancy.

4.8 The unborn baby's father **and** mother's current partner (if different) should be included in the assessment.

4.9 If the assessment ***does not*** indicate that the baby will be at risk of significant harm when born but may be a child in need, then the planning and provision of services will continue under s17 of the Children Act 1989.

4.10 If, however the assessment ***does*** indicate that the baby will be at risk of suffering significant harm then a Child Protection Conference will be held at or before 30 weeks gestation.

4.11 The cChild pProtection conference and any subsequent reviews will proceed as per all other conferences, the first review being held within 4 weeks of the baby's birth.

4.12 If the decision is made to proceed with a child protection plan for the unborn child, then the name ("Unborn" mother's name) and the due date of delivery should be entered on all electronic and hard copy records. The baby's record should be linked with the mother's record.

4.13 The core group or child in need meeting should meet ***before*** the birth, and also ***before*** the baby is discharged from hospital. This later meeting will constitute the discharge planning meeting and all core group members should be invited.
The core group, child in need or discharge planning meeting record should highlight the:

- Outcome of assessment;
- Pre / post birth plans, including child protection plan;
- Managing non co-operation;
- Removal at birth – if the plan is to remove the baby at birth, plans must be in place to fulfil the statutory requirements relating to looked after children and the preparation of foster carers if any post-birth health needs are likely. The professional network should consider whether it is safe to advise the parent/ s of any plan for removal of the baby prior to making the court application.
- Ensure all agencies within the professional network for the family have a copy of the plan.

4.14 Detailed written plans need to address:

- Who should hospital contact when mother is admitted / in labour / baby delivered?
- Who will give consent for screening?
- What happens if baby is born out of hours?
- What level of contact / care (supervised or not) can the parents have, and who will assume responsibility for supervising care/contact?
- What is the plan in relation to breast-feeding?
- What needs to be in place for baby to go home?
- Where will baby go home to?
- Which professionals need to visit?
- Which day is each person going to visit?
- Does the child need to be seen every day or is it necessary to do an unannounced visit, and what is the contingency plan?
- What family support needs to be in place?
- What have family members agreed to do?
- Is the family part of the visiting schedule?
- Are the parents aware of the plan & what is their presentation/attitude?
- Possible family arrangements for care of the baby
- Expectations and process for reporting concerns in and out of working hours
- How long the plan is in place for and when it will be reviewed?
- What are the arrangements for initiating legal proceedings?
- The intensive support required for mother and baby to live in the community, and any other specialist assessments

All the information collected from answering the questions above should be written out clearly so expectations/ instructions are known to all parties. The multi-agency partnership will need to agree who takes responsibility for ensuring this is completed.

4.15 Legal planning meetings will be undertaken by children's services social care departments when necessary; the recommendations of legal planning meetings will be shared with the core group and any other relevant partner agencies as appropriate.

4.16 Even when it is agreed that the Local Authority have decided to apply to the family court to seek removal of the child at birth, a child protection conference should always be convened.

4.17 **Ante-Natal Care Received Outside the Borough**

4.17.1 If an expectant mother is booked to deliver in a hospital other than Croydon University Hospital, a referral should be made to the Croydon Health Services Vulnerable Women's Group in order to discuss any risks in a multi-agency environment and ensure that there is planning for community services that will be provided in Croydon.

Mhn-tr.safeguardingmaternity@nhs.net

5. Potential Indicators of Risk *(See also see London Child Protection Procedures)*

5.1. Mental Ill Health

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

5.1.2. 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 mental health risk factors are identified, on-going evaluation of risk is essential.

5.1.3. Depression and anxiety affect between 10 - 15% of women during pregnancy and in the first postnatal year. Whilst severe perinatal mental illnesses, requiring input from specialist perinatal services, are not common they can be unpredictable and symptoms may develop very rapidly (over hours or days); fluctuations are common and risks can be significant.

5.2. Perinatal Mental Illness

5.2.1. Postpartum psychosis is a severe mental illness that typically affects women in the week following birth and causes symptoms such as confusion, delusions, paranoia and hallucinations. The early postpartum period in particular is the time of highest risk in a woman's life for developing psychotic illness.

5.2.2. The effect of perinatal mental illness can be devastating if they are not recognised and treated promptly. Perinatal mental illness may affect any woman during pregnancy or the postpartum year. Women with a history of significant depressive illness or postnatal depression are at increased risk of this recurring in subsequent pregnancies.

5.2.3. For women identified as being at risk, the risks of illness can be reduced through careful monitoring, preventative treatment where appropriate and early intervention with specialist support if symptoms arise. If symptoms are recognised and treated promptly, the impact of illness can be minimised

5.2.4. Partners and other family members may require explanation and education regarding maternal mental illness and its accompanying risks.[5]

[5] *Getting it Right for Mothers and Babies. Closing the Gaps in Community, PNMHSs. NSPCC Scotland, Scotland Maternal Mental Health, April 2015.*

5.2.5. The following is a list of 'red flag signs' for severe maternal illness that require urgent senior psychiatric assessment.[6]

- Recent significant change in mental state of emergence of new symptoms.
- New thoughts or acts of violent self-harm.
- New and persistent expressions of incompetency as a mother or estrangement from the infant.
- Rapidly changing mental state.
- Suicidal ideation (particularly of a violent nature).
- Pervasive guilt or hopelessness.
- Significant estrangement from the infant.
- New or persistent beliefs of inadequacy as a mother.
- Evidence of psychosis.

5.2.6. Croydon has a Specialist Community Perinatal Mental Health Team which is a borough wide service based at the Bethlem Royal Hospital.

slm-tr.croydonperinatalteam@nhs.net

5.3. **Substance and Alcohol Misuse**

5.3.1. Experienced practitioners report that most drug/alcohol using women have similar attitudes and motivations to pregnancy as non-drug/alcohol using women and it is important to note that most women with drug/alcohol problems are of childbearing age. However, those with drug/alcohol problems may also have poor general health, housing and financial problems.

5.3.2. Some pregnant drug/alcohol users do not come for antenatal care until late in pregnancy or when they are in labour. There are many reasons why drug/alcohol using women may present late to antenatal services. The local service may not be able to meet their specific needs or it may be perceived to be inaccessible, their drug/alcohol use may place other demands on their time, which often take priority for the user.

5.3.3. Some may feel that it is better not to reveal their drug/alcohol use to antenatal care staff as they fear the attitudes of staff and the possible involvement of statutory services. Also due to the possibility of amenorrhoea caused by the drug/alcohol use, the woman may not know that she is pregnant, or may not be clear about the duration of the pregnancy.

[6] *Saving Lives, Improving Mothers Care published in 2015*

5.3.4. Many of these problems can be overcome if an appropriate service, which meets the needs of drug/alcohol using women, is available, easily accessible and well publicised.

5.3.5. Agencies in the community can play a key role in supporting these women in a range of ways. This includes identifying drug/alcohol use / pregnancy at an early stage, referring on to appropriate help and support, identifying risks, and providing support and advice around pregnancy and/or drug/alcohol use.

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

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

5.3.7. All pregnant women and significant others (including putative Fathers and Mother's partner, if different) should be asked about their use of prescribed and non-prescribed drugs, both legal and illegal, as part of routine enquiries about general health during pregnancy. Time should be allowed for the exploration of the patient's and the professional's concerns about the risks for both the mother and the child. This needs to be done sensitively so that the woman is not deterred from seeking help, even if she continues to use.

5.3.8. However practitioners should ensure that the woman and her partner are aware of the impact of the following behaviours:

- The use of tobacco, street drugs, alcohol and some over the counter drugs, including the adverse effects of some medicines;
- Chaotic drug/alcohol use; e.g. poly-drug use, erratic dosage precipitating withdrawals or intoxication;
- Injecting and sharing of injecting paraphernalia;
- Unprotected sexual activity

5.4. **Domestic abuse**

5.4.1. In a 2004 study examining the prevalence of domestic abuse and its' relationship both to complications in pregnancy and psychological health, the women questioned (on antenatal and postnatal wards) evidenced that around 23% had a lifetime experience of domestic abuse and 3% had experienced violence in the current pregnancy.[7] Further research reports that between four and nine women in every 100 are abused during their pregnancies and/or after the birth of the baby.[8]

[7] Bacchus, Loraine (2004) "Domestic violence and health" in Midwives Vol.7, no.4, April 2004 cited on Women's Aid site
[8] Taft, Angela (2002) Violence against women in pregnancy and after childbirth: Current knowledge and issues in healthcare responses Australian Domestic and Family Violence Clearinghouse Issues Paper 6 cited on Women's Aid site

5.4.2. A recent significant study of over 13,500 women undertaken by Kings College, London's' Institute of Psychiatry[9] noted a strong link was found between antenatal violence and violence post-birth; 71% of women who experienced antenatal domestic violence pregnancy also experienced violence in the postnatal period. Of additional concern is the evidence of child behavioural problems recorded at 42 months of age looking at factors such as hyperactivity, emotion, and conduct problems. Hence, continued exposure to domestic abuse once the child is born can impact on his or her emotional and cognitive development. The extent to which the violent partner also poses a direct physical threat to the child will need to be assessed.

5.4.3. Learning from a recent serious case review clearly notes the vulnerability of children living with domestic abuse:

"A pattern of domestic abuse and violence, alongside excessive alcohol use by Ms Luczak and her male partners, continued for much of the period of time from November 2006 onwards, and despite interventions by the Police and Children's Social Care, this pattern of behaviour changed little, with the child protection risks to the children in this volatile household not fully perceived or identified".[10]

5.4.4. Good practice indicates that 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;
- Information on what triggers violent incidents;
- The non-abusing/non-violent parent's recognition of the potential risks as a result of the history of or current domestic abuse/violent behaviour.

However risk is affected by dynamic factors and can therefore change suddenly. Professionals should therefore bear in mind that a piece of information currently not known could raise or lower the threshold of risk for a child.

5.4.5. During the pre-birth assessment increased risk factors may be prevalent for example:-

- Domestic abuse incidents in the pregnancy;
- Parent/s may exhibit aggressive behaviour;

5.4.6. It is essential that there is close liaison between all professionals in relation to these factors. It is also important to examine the history of previous children who have been removed from the parent(s) care. This will help professionals to identify if there were particular characteristics which made it harder for the parent(s) to successfully care for their previous child/ren. It is essential that professionals ask the parent(s) what problems, if any, they identified in caring for their previous child/ren.

5.5. **Parents with Learning Disability**

[9] Howard, L et al (2011) *Antenatal domestic violence, maternal mental health and subsequent child behaviour: a cohort study*
[10] Coventry LSCB 2013 *Serious Case Review Daniel Pelka Overview Report*

5.5.1. For the purposes of these procedures, 'parental learning disability' refers to adults who are, or may become parents/carers for children and who meet the 3 core criteria which describe an individual as 'learning disabled', i.e.:

- **Significant impairment of intellectual functioning**: individuals with an IQ of 70 and below (reference: British Psychological Society and legal system) – this is not a hard and fast rule; overall IQ scores can be subject to interpretation either way for a variety of clinical reasons – interpretations of psychometric test scores are the remit of a chartered psychologist.
- **Significant impairment of adaptive / social functioning**: i.e. how an individual copes with everyday demands of community living; impairment of adaptive / social functioning might be considered to be present if s/he needs assistance with survival (eating, drinking, clothing, hygiene and provision of basic comforts) or with social problem solving and social reasoning.
- **Age of onset before adulthood**: in order for an individual to be considered as 'learning disabled', impairment i.e. of intellectual adaptive / social functioning usually needs to have been present before the age of 18 years.

5.5.2. It is not always clear whether or not a parent/carer has a learning disability, and the following may assist recognition:

- Reference to medical records can offer evidence
- Reference to educational records (where it is less than 5 years since leaving school) can also provide evidence e.g. Statement of Special Education Needs/ Education Health and Care Plans (EHCPs)
- Personal history involving attendance at special schools
- Severe difficulties with literacy and/or numeracy
- A referral to a clinical psychologist or an educational psychologist.

5.5.3. Learning disabled parents may also experience additional stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. Such stressors, when combined with parental learning disability, are more likely to lead to concerns about the care of children.

5.5.4. Parents with a learning disability may therefore need positive 'whole family' support to develop sufficient understanding, resources, skills and experience to meet the needs of their child. With effective, sustained support over time adjusted to meet the changing developmental needs of a growing family, learning disabled parents are potentially able to provide good enough care.

5.5.5. It is important to assess the needs and provide support for learning disabled parents as early as possible. To ensure that parents are able to understand what is happening and why, and are able to participate meaningfully, consideration should be given to the involvement of an advocate.

5.5.6. If any professional or agency has any concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby, a referral should be made to Children's Social Care in line with pre-birth procedures.

5.5.7. The GP and midwife must make referrals to the community team for people with learning disabilities for a joint assessment of the pregnant woman's needs, capacity for self-care and to provide adequate care for the baby. Subsequent assessment should be in accordance with pre-birth procedures, but the involvement of the Learning Disability Team is essential.

5.6. **Parental Physical Disability**

Parents with a physical disability may need additional support in caring for their baby. A referral to Early Help may be indicated but in some circumstances, a referral to MASH may need to be considered.

5.7. **Other Parental Risk Factors**
(Please refer to London Child Protection Procedures and local procedures for further information and guidance).

http://www.londoncp.co.uk/

5.7.1. Professionals should give consideration to any other parental risk factors that my impact on the parent(s) ability to provide safe parenting for their unborn child including:

- Parent(s) affected by clinical issues such as HIV and FGM.
- Parent(s) for whom there are concerns regarding Child Sexual or other Exploitation (i.e. County Lines).
- Parents who are believed to have been victims of trafficking or modern slavery.
- Parents who have expressed beliefs regarding witchcraft and spirit possession.
- Parents who are at risk of radicalisation.
- Parents where there are concerns re forced marriage.
- Parents where there are concerns re honour based violence.

5.8. **Concealed Pregnancy**

5.8.1. If the pregnancy has been concealed then consideration should be given within the assessment to other potential risk factors.

5.9. **Unborn Baby Where Sibling is Subject of a Child Protection Plan**

5.9.1. If a sibling group is already subject of a child protection plan and the mother is pregnant the allocated social worker for the siblings must undertake a pre-birth assessment and convene a strategy discussion and S47 Enquires in respect of the unborn baby, prior to presentation at an Initial child protection conference (which will be a review conference for the siblings).

The unborn baby cannot be made subject of a child protection plan without this process being undertaken to provide the evidence that the unborn baby's needs meet the threshold for the ICPC and to ensure that the evidence and decision making is fully recorded on the unborn baby's CRS file.

5.9.2. If the unborn baby is made subject of a child protection plan in this way, the CP flag will appear on his or her CRS record (local authority records) and his or her name will be added to the child protection list sent to partner agencies. This is an essential protection for the baby/unborn baby.

6. Targeted Messages

6.1. **Female Genital Mutilation (FGM)**

Women who are identified as having undergone FGM or are from (or in a relationship with someone from) communities where FGM is prevalent should be referred to the Croydon Health Services Vulnerable Women's Group so that multi-agency consideration can be given to any risks to the unborn child (and possibly other family members). Where there are significant concerns, a referral may be made directly to MASH. As a minimum, all women where FGM has been identified as a risk will be supported through the Best Start FGM pathway (to be confirmed). The Croydon FGM risk assessment tool can be used to assist professionals to identify risk.

See Appendix 2 for the FGM pathway and FGM risk assessment tool

6.2. **Sudden Infant Death Syndrome (SIDS)**

6.2.1. 'Sudden Infant Death' is the term used to describe the sudden and unexpected death of a baby that is initially unexplained. Just under 300 babies and toddlers still die every year of SIDS in the UK.

6.2.2. Babies born to mothers below the age of 20 are four times more likely to die of SIDS than those born to mothers aged 20 and over according to the latest figures on unexplained deaths in infancy, released by the Office for National Statistics. Other identified risk factors include:

- Over-crowding
- Domestic violence
- Co-sleeping
- Smoking
- Alcohol and other substance misuse
- Poverty
- Previously known to services

6.2.3. Although the cause of SIDS is not known, there are steps that can be taken to reduce the risk:

- Safe sleep position and environment, Infant on their back, in a cot/moses basket in same room as parent for six months.

- Parents/carer should not sleep with their infant/toddler, including on a sofa or armchair, especially if parents/carer has been drinking alcohol, taking drugs or are a smoker
- Not exposing infant/toddler to secondary smoke.
- Do not let infant/toddler get too hot or cold
- Keep infant/toddler's head uncovered
- Safe use of infant sling Promotion of maternal health in pregnancy to reduce low birth weight and prematurity
- Increase parental/care awareness of care of unwell infant/toddler.

6.2.4. The lead professional working with the family should explore with the parents/family to identify the presence to any risk factors and provide guidance and support the parent/s/family to enable a reduction of these risk factors. This may be through Best Start provision

See Appendix 3 for the Best Start SIDS Pathway (waiting to be confirmed)

Appendix 1
National Alert Template

LONDON BOROUGH OF CROYDON
MATERNITY ALERT

Date of Notification:				
DETAILS OF UNBORN CHILD				
Name	EDD	M/F	CRS No	Ethnic origin / Preferred language
DETAILS OF FAMILY MEMBERS				
Relationship	Name	DOB	CRS No	Ethnic origin / Preferred language
ADDRESSES				
HOSPITAL WHERE MOTHER HAS REGISTERED				
BACKGROUND INFORMATION/REASONS FOR CONCERN				

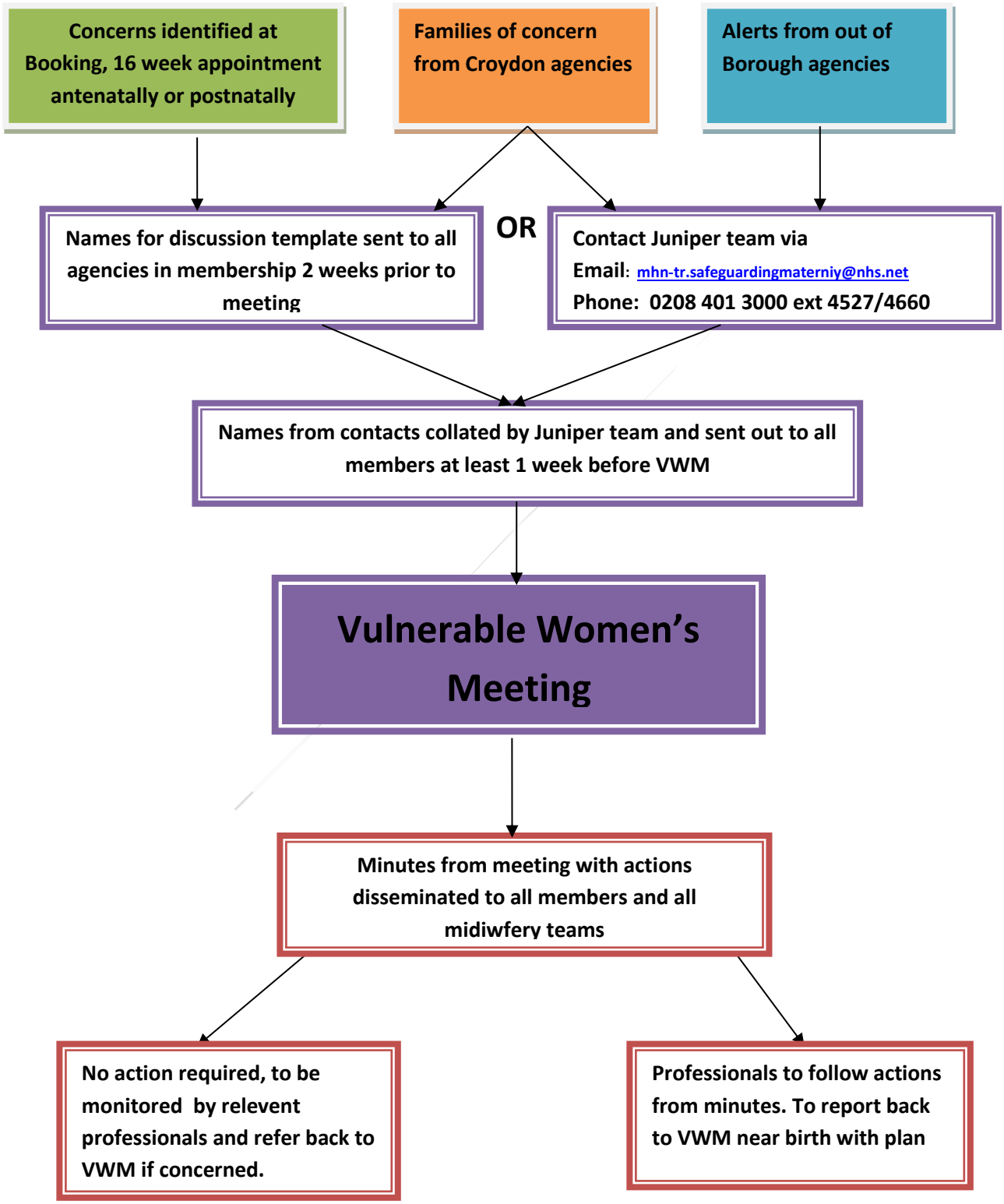
WHAT IS THE BIRTH PLAN?
WHO TO CONTACT WHEN BABY IS BORN
Out of hours contact information
Croydon Emergency Duty Team Tel: 020 8726 6400

CIRCULATION

Copies of this form should be sent electronically to ChildrensAssessmentTeam@croydon.gov.uk

Appendix 2
Vulnerable Women's Meeting Workflow and Terms of Reference

Vulnerable Women's Flowchart



Croydon Health Services NHS
NHS Trust

Vulnerable Women's Meeting

Terms of Reference

The Vulnerable Women's Meeting has the operational function of providing a safeguarding forum for midwives caring for vulnerable pregnant women, their unborn babies and their family as a whole. This provides assurance to the Director of Midwifery, the Trust Board, Croydon Clinical Commissioning Group and Croydon Safeguarding Children's Board, that Midwifery meets its responsibilities in relation to safeguarding / protecting unborn babies and their families.

Objectives:

- To provide a multiagency meeting to discuss and plan care for vulnerable pregnant women and their children.
- To provide a group safeguarding supervision forum for midwives.
- To provide a multiagency response to safeguarding unborn babies and their families.
- To discuss all women regardless of gestation, antenatally or postnatally, with safeguarding concerns.
- To develop and maintain a list of vulnerable pregnant women.
- To provide a list of all cases to be discussed to the relevant agencies in advance of the meeting.
- Attendees to provide the meeting with up to date information regarding the client from their agency.
- Attendees to disseminate the information and decisions taken within their own agency and make arrangements for documentation and filing of information in the client's records.
- All participants to action decisions agreed at the meeting, document in their client's record and feed back in future meetings when required.
- Lead midwifery teams responsible for each vulnerable woman will be agreed at the meeting.
- The minutes will be recorded electronically and circulated as a password protected document via secure email addresses to attendees. These minutes will include actions to be taken and by whom.

Accountability and Reporting Arrangements

- The Vulnerable Women's Meeting is accountable to the Safeguarding Children Steering Group, which reports to the Adults at Risk and Safeguarding Children Governance Group on a bi-monthly basis.

Membership:

- Named Midwife for Safeguarding
- Lead Midwife for Safeguarding, Perinatal Mental Health and Substance and Alcohol Misuse.
- Lead Midwife for Safeguarding and Young Parents.
- Midwife for Homeless and Marginalised Women
- Midwifery Managers on a rotational basis.
- Community Midwives Team Leaders or leads for safeguarding in the teams
- Individual midwives to discuss their specific cases
- Hope Ward – midwife representative
- Mary Ward – midwife representative
- SCBU – nurse representative
- Antenatal Clinic – midwife representative
- Liaison Health Visitor
- Perinatal Community Psychiatric Nurses
- MASH Social Work lead for Unborn Babies.
- Early Help Co-ordinator
- Independent Domestic Violence Advocate for CUH
- Health Visitor for Perinatal mental health
- Representative from Family Nurse Partnership
- Nurse for Learning Disability – when discussing specific woman with learning disabilities

Quorum:

- All midwifery teams are required to send a representative every month to discuss vulnerable women/families within their team's catchment area.

Frequency:

- The meeting will be held on the first Tuesday of the month.

Monitoring Effectiveness

- An annual audit of the outcomes/impact for safeguarding vulnerable families will be undertaken in line with the terms of reference.

Key indicators

- Children Act 1989 and 2004
- Pregnancy and Complex Social Factors NICE Guidelines (2010)
- Working Together to Safeguard Children, 2015
- Safeguarding Vulnerable People in the NHS: Accountability and Assurance.
- Framework (2015),

Review of Terms of Reference

Terms of Reference will be reviewed annually and ratified by the Safeguarding Committee.

Ratified Date:

Review Date:

References

Children Act 1989, London: HMSO

Children's Act 2004, London: HMSO

National Institute for Health and Clinical Excellence (NICE) in clinical guideline 110 - Pregnancy and Complex Social Factors: a Model for Service Provision for Pregnant Women with Complex Social Factors. (2010)

Working together to safeguard children (HM Government, 2015)

Safeguarding Vulnerable People in the NHS: Accountability and Assurance. Framework (2015)

Appendix 3
Female Genital Mutilation ~~Best Start Workflow and~~ risk assessment


Croydon FGM Risk Assessment Appendix


Croydon FGM Risk Assessment Leaflet A

FGM Best Start Workflow (waiting to be confirmed).

Appendix 4
Sudden Infant Death Syndrome – Best Start Workflow

Appendix 5
Bibliography

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