Multi-Agency Pre-Birth Guidance

2022 -2024

METROPOLITAN POLICE

NHS South West London Integrated Care Board

Wandsworth Safeguarding Children Partnership

The Brighter Borough Wandsworth

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Contents

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1. Introduction

The complexity, sensitivity, and potential difficulty of this area of work is recognised by the Wandsworth Safeguarding Children Partnership (WSCP). This practice guidance has been produced to support and safeguard the wellbeing of unborn children. Its purpose is to support the multi-agency partners conduct their work to the highest standards. It has been updated in response to learning from Child Safeguarding Practice Reviews (CSPRs) and changes to the London Safeguarding Children Procedures.

The London Safeguarding Children Procedures (LSCP section 6) offers detailed guidance in relation to this area of work and reference should always be made to it. This guidance emphasises specific issues for Wandsworth staff but reflects the LSCP and Working Together to Safeguard Children 2018.

It is also crucial that professionals look at diversity and culture, care experienced people, engage fathers, same sex partners, surrogate parents, and other adults living in the household in the process of assessment to explore their potential role in caring for the for the baby and identifying risk factors.

Appendix 1 provides additional support to workers carrying out complex assessments. Full details of the LSCP are on the London Safeguarding Children Procedures website.

2. Purpose and scope of the guidance

This guidance provides a framework for multi-agency working where there are concerns about the welfare of an unborn child and/or there may be concerns following the birth.

The WSCP seeks to ensure that all professionals are clear and well informed about their safeguarding responsibilities; they know when and how to refer vulnerable unborn children, and when assessments and child protection conferences are needed. The guidance is to ensure that responses are **timely and have the required urgency**, it is recognised that working with pre-birth situations that workers think that they have much more time than they have. Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the baby may have suffered, or be likely to suffer, significant harm, as soon as the concerns are identified workers should refer to Local Authority (LA) children's social care.

It sets out the role of agencies in referring an expectant parent to the most appropriate agencies for support, including referral to the Wandsworth MASH, the referral may not result in a pre- birth assessment, contributing to any assessment and implementing any

agreed plan of action to support families, and safeguard and promote the welfare of the child.

All members of the children's workforce in Wandsworth, particularly midwifery, adult mental health, substance misuse, police, domestic abuse, and adult learning disabilities service, should follow the guidance.

3. Recognising Risks for Unborn Children

Where there are concerns about the safety and welfare of an unborn child, a pre-birth assessment must be undertaken as early as possible so that all relevant professionals can plan effectively to promote their welfare following birth.

Professionals must consider making a referral to Wandsworth MASH in the following situations, however, the outcome may not be a pre- birth assessment:

- A previous child of the parent has suffered significant harm and has been removed from the parent's care or died in suspicious circumstances
- A brother/sister is subject to care proceedings or is looked after
- A brother/sister in the household, or if parents live in separate households, is or was subject to a child protection plan
- The parent or another adult in the household is known to pose a risk to children
- The parents are under the age of 18 and/or a care leaver and is vulnerable
- The parent's lifestyle and behaviour during pregnancy may harm the unborn child or raises concerns about future care of the child. Some areas of risk are not exclusive:
- Substance misuse impacts on parenting
- Parent has enduring and/or severe mental ill health
- Domestic abuse and family violence
- Homelessness and chaotic lifestyles that impacts on parenting
- Parental learning disabilities that impact on parenting
- The unresolved impact of parents own experience of being abuse
- One parent is a risk to children
- A concealed /denied pregnancy, no engagement with ante-natal services
- Female Genital Mutilation [FGM] risk assessment indicates that the baby is at risk

Professionals should refer to the LSCP for further details of indicators of risk and protective factors for the unborn.

4. Information gathered by health professional

Health professionals, including adult mental health professionals, particularly midwives, are most likely to be in contact with an expectant parent and therefore in a key position to recognise risk factors. Midwives should be professionally curious regarding safeguarding assessments during pregnancy. A mother's engagement for maternity care is monitored. Repeated non-attendance for antenatal appointments or concealed pregnancy should be escalated as a potential safeguarding risk for the mother and her baby. General practitioners are responsible for meeting the parent's health needs and should share relevant information with the network about any factors that may affect the parent's parenting capacity. There should be professional curiosity if parent is not registered with a GP.

When assessing risk, midwives should undertake a holistic assessment and gather relevant information about the parents during the antenatal booking in appointment. Assessments should consider whether any aspects of any of the following issues may have a significant impact on the child and, if so, how.

- Support from partners; details of the father of the unborn and confirmation of whether there are different fathers of existing children
- Whether either parent is known to Police for a crime that has safeguarding implications
- Family structure and if support is available or not
- Whether the pregnancy is planned or not, and routinely ask about surrogacy and any fertility treatment
- Whether there has been a previous concealed /denied pregnancy
- The feelings of the parent's, partner of the pregnancy
- The parent's dietary intake and any related issues
- Any medicines or drugs, whether prescribed, taken before or during pregnancy
- Alcohol consumption of mother before and during pregnancy
- Whether parents have suffered trauma / adverse childhood experiences
- Whether parents are smokers or use substances (Mother asked for consent to perform urine toxicology at the booking appointment)
- Previous obstetrics history, including place of birth for existing children

- The current health status of other children, and where and with whom they live
- Other agencies involved with mother/father of the baby/partner/family:
  - Family Nurse Practitioner
  - Mental Health Services
  - Probation or prison services
  - Women's Refuge
  - Community Drug or mental health teams
- Any miscarriages or terminations
- Accommodation issues
- Any chronic or acute medical conditions of surgical history
- The parent's psychiatric history, a history of major mental disorder or learning needs/disability
- Asylum seeker or recent migrant to UK
- Whether the parent has been subjected to Female Genital Mutilation and if medical intervention is required to enable the parent to safely deliver the baby
- Routine enquiry into experiences of domestic abuse

Late referrals for maternity care are risk assessed as to the reason/s for late presentation. Where parents report having received maternity care at another hospital or abroad, parents are asked for evidence of this. Where there are safeguarding concerns, midwives will contact the previous hospital to ascertain any safeguarding concerns for the unborn baby.

Hospital staff can also contact the hospital social work team for advice and families can be raised at the maternity safeguarding professional's meeting if appropriate.

Where undiagnosed or untreated mental health or substance misuse problems midwives and GPs should ensure they are referred on for appropriate treatment and supported to engage with Specialist Midwife / Perinatal Mental Health Services where appropriate.

If a child is known to Wandsworth Children Social Care, midwives and obstetricians should notify the allocated social worker as soon as the baby is born or the emergency out of hours team if child is born out of hours.

Adult mental health services should have named nurses/doctors/professionals for safeguarding children within their agency and seek advice from them if necessary.

5. Pre-Birth Referral

a) Professionals should discuss concerns with their safeguarding lead or senior colleague prior to referral, or if further advice is needed, they can contact the MASH on **020 8871 6622** for advice.

b) Where any agency or individual considers that a prospective parent may need support services to care for their baby, or that the baby may be at risk of significant harm, then they **must** refer to Children's Services as soon as the concerns are identified. Referrals should be made to the Multi-Agency Safeguarding Hub (MASH) on **020 8871 6622.** If you are a professional making a referral you should complete the Multi-Agency Referral Form (MARF).

c) The MASH will decide on the outcome of the referral within 24 hours and will notify the referrer of the outcome.

d) If the child meets the level of need (threshold) for a social work service because the unborn child may be a child in need or at risk of harm, then the referral will be passed on to a social work team for a pre-birth assessment. If the right service for the family is Early Help, the referral will be passed to the Early Help Service. In all situations the MASH will contact the referrer to discuss the referral.

e) If the parent(s) are best supported through Early Help Services, the MASH will ask Early Help to contact the family and the referring agency. Where Children's Services are the right service for the parent(s), as the unborn child may be a child in need or at risk of harm, then the referral will be passed on to a social work team for a pre-birth assessment.

f) Where concerns exist regarding the parenting capacity of prospective parents' ability to protect.

g) Where alcohol or substance abuse is thought to be affecting the health of the expected baby.

h) Where the prospective parent(s) are under eighteen or care experienced a dual assessment of their own needs as well as their ability to meet the baby's needs is required.

i) Where previous children in the family have been removed because they have suffered harm or been at risk of significant harm.

j) Where a person who has been convicted of an offence against a child or is believed by child protection professionals to pose a risk to a child, has joined the family.

k) Where there are professional concerns regarding parenting capacity, particularly where the parents have either severe mental ill health problems or learning disabilities.

l) Where the child is at risk of significant harm due to domestic abuse.

m) Where the potential concerns focus upon, or are related to, the prospective parent's mental ill health, drug/alcohol use, learning disability or physical disability, then the Adult Services workers have a key role in relation to referral to Children's Services.

n) It is important to refer such prospective parents to Children's Services at the **earliest opportunity** to:

    1. Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby's circumstances prior to the birth.
    2. Provide enough time to make adequate plans for the baby's protection.
    3. Provide enough time for a full and informed assessment.
    4. Avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time.
    5. Provide enough time to mobilise protection from within the family's own resources.
    6. Enable the early provision of support services to facilitate optimum home circumstances prior to the birth.

o) **Concerns about consent to share information by the parents should not be a barrier to the professional network and guidance should include advice about how to overcome any barriers which may arise because of consent issues.** Where possible, share information with consent and when possible, respect the wishes of those who do not consent to having their information shared.

p) Under GDPR and Data Protection Act 2018 **you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk**. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.

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

unborn child. The health visitor / family nurse partnership has a critical role and responsibility in relation to Family Health Needs Assessments:

The roles of the GP and the midwifery services are clearly critical ones in relation to making appropriate referrals to Children's Services. They are likely to identify vulnerable prospective parents, particularly in relation to domestic abuse, substance misuse, mental ill-health, and young parents.

- Consulting with relevant midwifery services and GPs
- Early assessment as to avoid potential risks and future need
- Referral to Children's Services
- Targeting those families who are potentially most at risk

r) Ensure that the risk assessment is thorough and appropriate (Appendix 1).

s) Some parents-to-be are late in acknowledging/ conceal or deny their pregnancies to agencies. Accessing maternity services at a late stage in the pregnancy is of significant concern and should be explored as part of the assessment. It is important, in such situations, that agencies begin working together in relation to pre-birth assessments with urgency. Any woman who does not book and arrives to hospital in labour should be referred to Social Care. For any parent who books late (over 20 week) or changes hospital very later in the pregnancy there needs to be curiosity as to the reasons for this.

t) In a concealed pregnancy, a woman is aware of the pregnancy but may avoid or not tell professionals or may hide the fact she is not accessing antenatal care. In a denied pregnancy the woman is unable to accept the reality of the pregnancy.

u) When concealed/denied pregnancy is suspected, it is difficult to know the stage or gestational date of the pregnancy. A concealed pregnancy is defined as one where the pregnancy is first confirmed at more than 24 weeks gestation – this may be late in pregnancy, in labour, or after the birth of the baby.

v) A woman who presents at, for example, 22 weeks, is not considered to have concealed her pregnancy but may have additional needs or vulnerabilities and should be offered appropriate assessment and support. For any woman who books late professionals should be concerned and curious for the reasons for this particularly if she doesn't have a GP or the antenatal history is vague. Appendix 3

w) There can be considerable anxiety and stigma attached to the processes of referring vulnerable adults to Children's Services in such pre-birth situations. Prospective parents are likely to feel anxious about such referrals and will need to understand the concerns. Professionals may be anxious about being unable to engage parents post

referral, with some parents even moving to avoid contact. These factors should not however be used as reasons not to refer to Children's Services.

x) Parental Substance Misuse can compromise children's health and development from conception onwards. Maternal drug use during pregnancy can seriously affect foetal growth and development, although assessing conclusively the impact is usually impossible. This document includes the following recommendations:

1. Every maternity unit should ensure that it provides a service that is accessible to, and non-judgemental of, antenatal clients misusing substances, and able to offer high quality care aimed at minimising the impact of the parent's substance misuse on the pregnancy and the baby. This should include the use of clear evidence-based protocols that describe the clinical management of substance misuse during pregnancy and neonatal withdrawals.

2. Pregnant substance misusers should be routinely tested with their informed consent for HIV, Hepatitis B and Hepatitis C, and appropriate clinical management provided, including Hepatitis B immunisation for all babies of intravenous drug users.

3. Every maternity unit should have effective links with community health care, social work children and family teams, mental health, learning disabilities, and addiction services that can enable it to contribute to safeguarding the longer-term interests of the baby.

Where there are immediate safeguarding concerns a strategy meeting will be arranged by Children's Services. The strategy meeting or discussion will include the Police, Children's Services, Midwifery Services and any other key professional who us is involved in the families' lives.

6. Pre-Birth Assessment

A pre-birth assessment should be undertaken as early as possible, preferably starting no later than 16 weeks into the pregnancy where there are complex concerns, which enables us to create a positive relationship with families as early as possible, and complete preferably before 24 weeks.

Involvement of both parents and other significant adults is crucial to the assessment. Although fathers sometimes seem invisible, research suggests[1] over 90% of fathers may attend scans or be around at the time of their child's birth. Background and other checks should be made as early as possible.

Wherever parents are likely to need support to enable them to meet their new-born baby's needs a family meeting, or a Family Group Conference, early on in the relationship with the family must be arranged. If necessary, the assessment of alternative family carers be arranged before baby's birth.

For young people in the care of the local authority who are expecting a child, the pre-birth assessment should not be completed by the young person's allocated worker but by another worker. For care experienced adults who are expecting a child and there are concerns, if a pre-birth assessment is needed, this should not be completed by their personal advisor.

We value the input of the personal advisor in supporting the young person throughout the assessment. There should be joint supervision with Future First (leaving care team) at the beginning of the assessment to support planning towards the best quality assessments.

If assessment shows that the unborn child is likely to be a child in need once born, the assessing social worker will convene a Child in Need meeting within two weeks of completing the pre-birth assessment. The meeting should be attended by all the professionals working with the child and family and will draw up the child's plan.

A strategy meeting/discussion should be held when:

a) A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children (see Risk Management of Known Offenders).
b) Brothers/sisters in the household is subject of a child protection plan.
c) Brothers/sisters has previously been separated from the parent either temporarily or by court order.
d) The parent is currently a looked after child.
e) Where a brother /sister has died.

[1] The Myth of Invisible Men (publishing.service.gov.uk) Section 9.2

f) There are significant domestic violence or abuse issues in the household that are likely to impact significantly on the baby's safety or development (see Safeguarding Children Affected by Domestic Abuse).

g) The degree of parental substance misuse is likely to impact significantly on the baby's safety or development (see Parents who Misuse Substances).

h) The degree of parental mental illness / impairment is likely to impact significantly on the baby's safety or development (see Parenting Capacity and Mental Illness).

i) There are significant concerns about parental ability to self-care and/or to care for the child e.g. unsupported, young or learning disabled parents (see Parenting Capacity and Learning Disabilities).

j) Any other concern exists that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child (see Fabricated or Induced Illness) or harming a child.

k) A child aged under 13 is found to be pregnant (see Safeguarding Sexually Active Children and Safeguarding Children from Sexual Exploitation).

Following referral there should always be consideration as to whether a strategy meeting is required and whether threshold for a Section 47 enquiry should be initiated. (S.47 requires agreement with other agencies such as police, health practitioners, and education practitioners). All strategy meetings or discussion must include health partners, police and other agencies involved. This should include GPs.

It is recommended that wherever possible a face-to-face strategy meeting should be held, or alternatively this can take place virtually using a secure platform (e.g., MS Teams / Zoom). If adult substance use or mental health services or domestic abuse, Learning Disability services have knowledge or information they must be invited.

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

When domestic abuse is a concern during pregnancy a referral to the Multi Agency Risk Assessment Conference (MARAC) should be made.

Assessments of parenting capacity and risk to a baby need to take account of a parent's own experience of being parented including any experience harm, abuse, loss, and separation. This must include evaluation of the experience of fathers irrespective of whether they plan to reside with the parents and baby.

Any agency can request that a pre-birth child protection conference be convened if they consider that the unborn child may be at risk of significant harm. Where there is professional disagreement regarding the threshold for a conference there should be a conversation with the safeguarding leading within own home organisation. See section 8 Resolving Professional Difference.

7. Pre-Birth Child Protection Conference

This is an initial child protection conference concerning an unborn child. A pre-birth child protection conference should always be convened where there is a need to consider if a multi-agency child protection plan is required for an unborn child. This decision will usually follow from a pre-birth assessment. A pre-birth conference should be held when:

a) Criteria

1. A pre-birth assessment gives rise to concerns that an unborn child may be at risk of significant harm
2. A previous child has died or been removed from parent/s care because of significant harm
3. A child is to be born into a family or household that already has children subject of a child protection plan
4. An adult or child who is at risk to children resides in the household or is known to be a regular visitor
5. The impact of parental risk factors such as mental ill-health, learning or physical disabilities, substance misuse and domestic abuse, raise concerns that the unborn child may be at significant risk of harm
6. A parent under 18 years of age about whom there are concerns regarding their ability to self-care and /or to care for the child

b) Timing

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

c) Attendance of Professionals at a Child Protection Conference. The following agencies should always be invited:

- General Practitioner
- Health Visitor *(If it is not clear which health visitor will have responsibility for the child, the invitation should be sent to the Named Nurse for Community Services)*
- Family Nurse Partnership
- Specialist Safeguarding Midwives (Named Midwife at St Georges / other hospitals)
- School Nurse.
- Police Investigation / Public Protection Team (require five working days' notice)

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

- Neo-Natal Special Care (for babies whose parents who misuse substances or where a baby is likely to need additional neo-natal care)
- Drug Services
- Mental Health Services and perinatal mental health team
- Adult Social Services
- Probation
- Domestic Abuse services
- Housing and Regeneration Department (HRD)
- Adult Learning Disability Team

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

- The Specialist Nurse for Children Looked After
- The allocated Social Worker / Personal Advisor for the looked after young person/care leaver
- Teenage Midwifery Clinic (Jade Team St Georges) or Safeguarding midwife at hospital family is booked with
- Health Visiting or Family Nurse Partnership Nurse (if working with family).
- Parents or carers - *These should be invited as they would be to all child protection conferences and should be fully involved in plans for the child's future. Where the parents are young or have additional vulnerabilities their support needs should be addressed. If the parents have their own social worker or support from Adult Services or Leaving Care Service, they should also be invited*

d) The Child Protection Plan

If a decision is made that the baby needs to be the subject of a Child Protection Plan (CP Plan), the main cause for concern must determine the category of registration and a CP Plan must be outlined to commence prior to the birth of the baby. The plan must include reference to the need for a Core Group Meeting as soon as the baby is born and prior to discharge. The Core Group and the discharge planning can be combined into one meeting.

Police have the following responsibilities in relation to the adoptions of a CP Plan: -
Women who are subject to a pre-birth CP Plan will have a Marker created for the duration of the CP Plan (on Police National Computer PNC.

Police will record decisions and minutes from the CP conference to include a clear briefing within their reports which details information held, and potential actions required by police. Police to flag address on police systems of unborn child and alert the safer-neighbourhood team as to the existence of the CP Plan.

The London Safeguarding Children Procedures and Working Together to Safeguard Children (WTSC) 2018 should be followed in respect of the making and reviewing a Child Protection Plan.

e) Alert Letters

It is sometimes necessary to send 'alert letters' to other local authorities, or to all hospitals in London where it is felt that the prospective parent may present at another hospital to try to avoid the involvement of Wandsworth agencies. See Appendix 6

f) Missing Persons

In the event of a pregnant parent going missing during a s47 investigation or when a pre-birth CP Plan has been made, the allocated Social Worker should discuss making a missing person's report. If the pregnant parent is under 18 a missing person's report must be made. In these circumstances an alert to other Local Authorities and hospitals must be made. For more information see:

- The London Safeguarding Children Procedures Children Missing from Care, Home, and Education (2014)
- Children who run away or go missing from home or care (2014)
- WSCP Missing from Home and Care Protocol (2022)

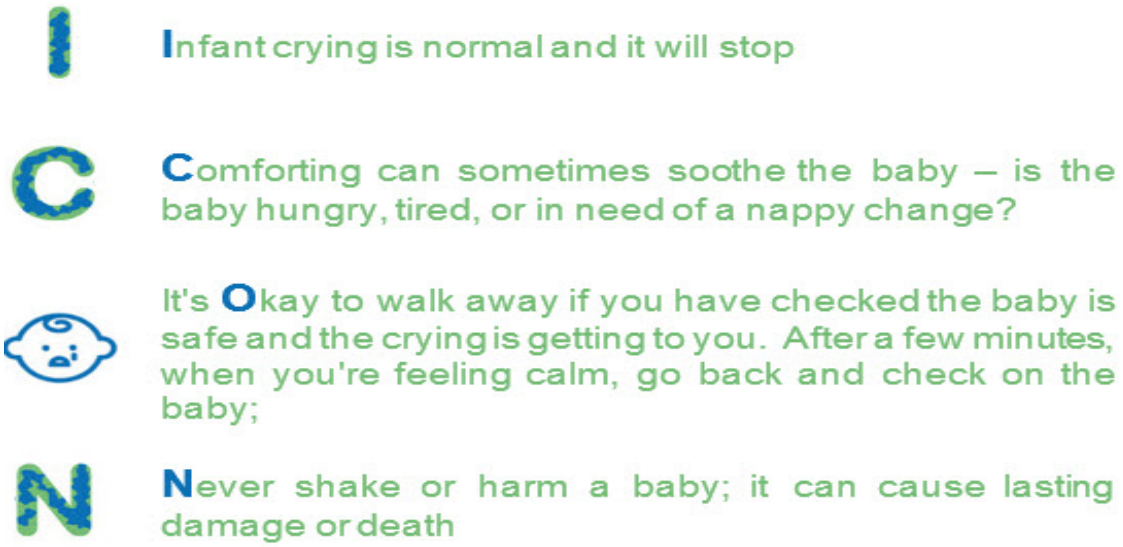
g) Discharge planning Meeting

Where a new-born child has a child protection plan, or the child has a Child in Need Plan and the family is in agreement, the allocated social worker, in consultation with the professional network, will convene a discharge from hospital planning meeting to ensure that it is safe for the child to be discharged from the hospital and that safety plan are in place to continue to support the family. A record of the Discharge Planning Meeting as either a Core Group or Child in Need Meeting will be distributed within 24 hours of the meeting, with parents receiving a copy, unless this could cause risk to parent being discharged. It will be the responsibility of children's social care to make a record of this meeting. ***Discharge Planning Meeting template to be used see Appendix 4***

The meeting will be convened by the social worker and the relevant midwife and/or the named midwife for safeguarding at the hospital. The meeting should be attended by all relevant professionals involved in providing services for the child and parent on discharge, including the community midwife, health visitor, family nurse partnership and GP.

The meeting should look at:

- Voice and needs of the new-born baby
- Support from the baby's maternal/ paternal family and friends
- Engage and support with the father
- Whether a safety plan/contingency plan is in place
- Arrangements if the child is to be placed with foster carers or in a parent and baby placement, or admitted with its mother to a Mother and Baby Unit [MBU] for mothers with severe mental health difficulties
- Where the child will be going home, suitability of the living arrangements and confirm information/discussion around Safe Sleeping, coping with a Crying Baby, ICON and feeding



More information and a wealth of resources are available on the ICON Cope website www.iconcope.org

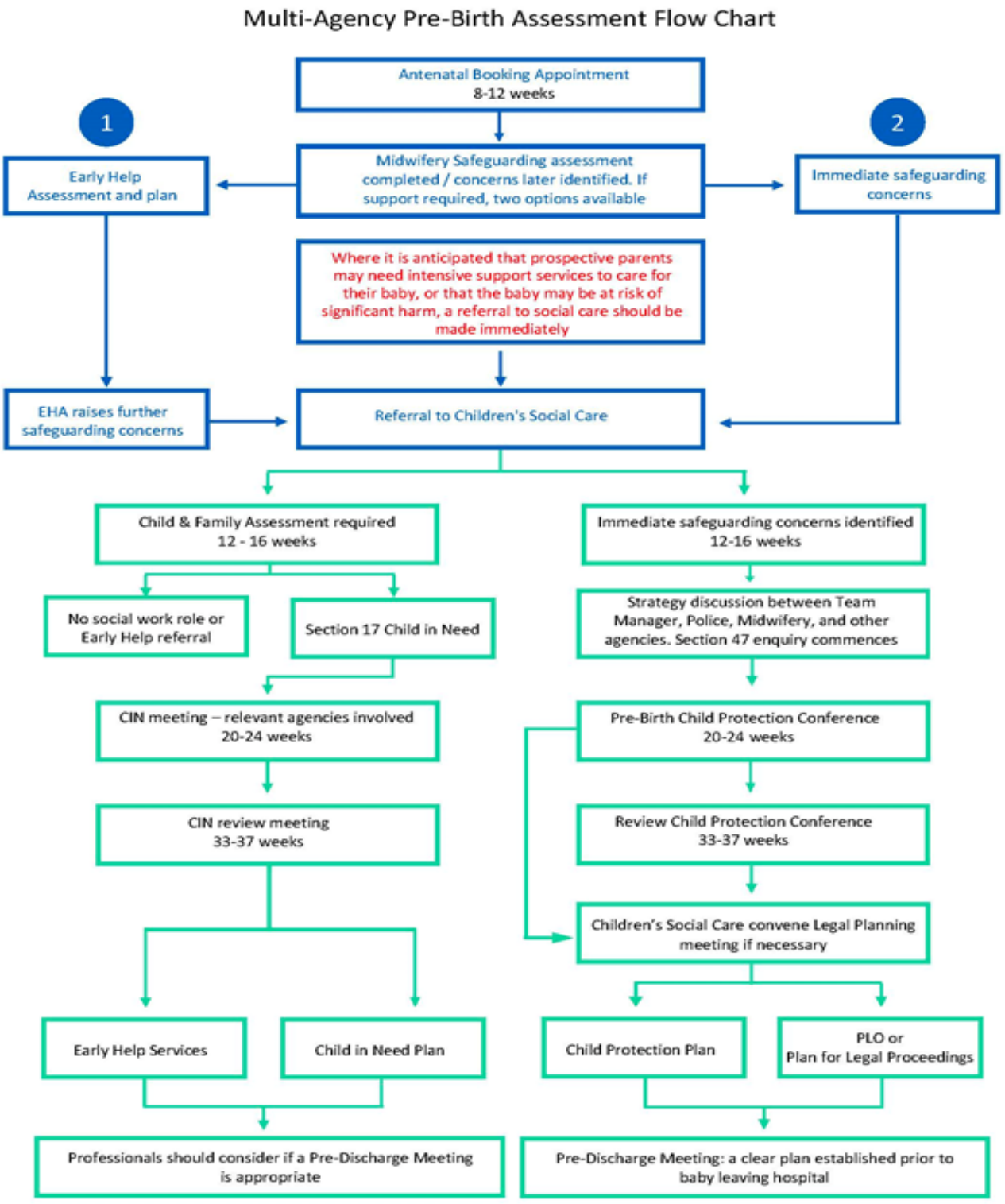
Where there is disagreement between medical staff and parents on the discharge plan it should be escalated to the safeguarding professionals within the agency prior to discharge.

Should the child be on a CP Plan social worker to update Police Conference Liaison Officer [PCLO] details of date of birth, name, current address, details of discharge planning meeting and current safety pan for the child in order that police records are up to date.

8. Resolving professional differences

In the event that professionals or agencies have any disagreements in connection with this policy or decisions around unborn babies. In the first instance there needs to be a professional conversation to address this. If not resolved this will be resolved under the WSCP escalation policy and can be found on the WSCP Website.

9. Appendix 1.
Multi-Agency Pre-Birth Assessment Flowchart



10. Appendix 2. Pre-Birth Assessment Tool

This additional guidance is provided to support Social Workers undertaking pre–birth assessments. Other professionals may also find it useful.

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

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

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

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

- The needs of the young father /other parent
- What is their lived experience of own childhood/parenting?
- Are there additional psychosocial factors to take into consideration?
- Consideration of other adults in the household
- Evaluating the quality and quantity of support that will be available within the family (and extended family)
- The needs of the parent(s) and how these will be met
- The context and circumstances in which the baby was conceived.
- The wishes and feelings of the young person who is to be a parent

Pre– Birth Assessment

The list below should not act as an assessment "script" but as a support for conversation and consideration for assessment. The basis of the assessment should be:

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

   Social history

- Experience of being parented (positive/negative memories, both carers even if they do not live together, parental relationships)
- Experiences of being parented as a child /adolescent (abuse, neglect, care/control/ history of adverse childhood experience or trauma)
- Education / employment
- Previous history of child protection intervention (convictions – especially members of extended family, unsubstantiated allegations, court findings, previous Child Safeguarding Practice Reviews (CSPR, Local CSPR or Serious Case Review)
- Parents' understanding of their own cultural/family narrative around childbirth
- Influence of significant others about being pregnant and how they have handled or responded to these perceptions.
- What is the cultural narrative around early pregnancy (teen parent)?
- Support network and what does this really look like in the context of the pregnancy
- What are the views of other adult family members?
- Is there familial history of significant /severe mental ill health. Perinatal mental ill health associated with the post-partum period?

2. **Communication**

- English not spoken or understood/ interpreter required.
- Deafness (partial/profound, interpreter required).
- Blindness.
- Speech impairment.
- Learning needs confirmed / assessed

3. **It is important to ascertain the parents' feelings towards the current pregnancy and the new baby including:**

- Is the pregnancy concealed /denied?
- Is the pregnancy wanted or not?
- Is the pregnancy planned or unplanned?
- Is this child the result of sexual assault/ coercion or abuse?
- Was termination of pregnancy considered?
- Bonding with the pregnancy and baby
- Is domestic abuse an issue in the parents' relationship?
- Does the perception of the unborn child raise concerns?
- Have they sought appropriate antenatal care?
- Are they aware of the unborn baby's needs and able to prioritise them?
- Do they have realistic plans in relation to the birth and their care of the baby and what does this look like?

Practitioners should attempt to build up a clear history from the parents of their previous experiences to ascertain whether there are any unresolved conflicts and to identify the meaning any previous children had for them and their feelings towards the unborn baby.

4. History of being responsible for children

- Unsubstantiated Allegations/Convictions re: offences against children
- Subject of CP plan / CiN plan
- CP concerns – and previous assessments
- Court findings
- Care proceedings and/or children removed
- Category and level of abuse
- Ages and genders of children
- Is responsibility appropriately accepted?
- What do previous risk assessments say? Take a fresh look at these – including assessments re: non-abusing parents.
- What is the parent's understanding of the impact of their behaviour on the child?
- What is different about now?

5. It will be particularly important to ascertain the parent(s) views and attitudes towards any previous children who have been removed from their care, or where there have been serious concerns about the parenting practices. Relevant questions might include:

- Do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred?
- Do they accept responsibility for their role in the abuse?
- Do they blame others?
- Do they blame the child?
- Do they acknowledge the seriousness of the abuse?
- Did they accept any treatment/counselling?
- What was their response to previous interventions? E.g., genuinely attempting to cooperate or lack of clarity and engagement
- What has changed for each parent since the child was abused and/or removed?
- Context and circumstances of conception

6. 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.

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

- The circumstances of the abuse: e.g., was the perpetrator in the household?
- Was the non-abusing parent present?
- What relationship/contact do the parents have with the perpetrator?
- How did the abuse become known? E.g., did the non-abusing parent disclose or conceal; did the child tell; did professionals suspect?
- Did the non-abusing parent believe the child? Did they need help and support to do this?
- What are current attitudes towards the abuse? Do the parents blame the child/see it as her/his fault?
- Has the perpetrator accepted full responsibility for the abuse? How is this demonstrated? What treatment did he/she have?
- Who else in the family/community network could help protect the new baby?
- How did the parent(s) relate to professionals? What is their current attitude?

NB: In circumstances where the sexual abuse perpetrator is the prospective father/parent 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 timescale, then confidence in the safety of the new-born baby and subsequent child will be poor.

Circumstances where the perpetrator is convicted of posing a risk to children and is already living in a family with other children, (albeit with social work involvement), should not detract from the need for a pre-birth assessment. **In all assessments it is important to maintain the focus on both prospective parents and any other adults living in the household and not to concentrate solely on the parents.**

8. The unborn child's health and development

- Ante-natal care: medical and obstetric history (to be provided by midwifery)
- Confirmation of pregnancy (planned or unplanned?)
- First ante-natal appointment (late booking)
- Engagement with maternity services including GP and midwife-led care Midwife Led Care (MLC)
- Feelings of parent about being pregnant/feelings of partner/putative father
- Previous obstetric history (including miscarriages, terminations, still birth)

9. Parenting of the child / young person

- Relationships
- History of relationships of adults, current status, positives, and negatives
- Violence
- Who will be main carer for the baby?
- Parents expectation regarding each other's parenting capacity and parenting of existing children

10. Is there anything regarding "relationships" that seems likely to have a significant negative impact on the child?

Detail should be obtained about:

- Nature of any violent/abusive incidents
- Their frequency and severity
- Information on what triggers violent incidents
- The non-abusing/non-violent parent's recognition of the potential risks because of the history of or current domestic abuse/violent behaviour.
- Teenage pregnancy – gangs, sexual exploitation, criminal exploitation

11. Dependency on partner

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

12. Behaviour

- Violence to partner and/or violence to others?
- Violence to any child
- Drug misuse and/or alcohol misuse
- Offending behaviour (nature/number of criminal convictions / unsubstantiated allegations)
- Chaotic (or inappropriate) lifestyle

13. Abilities of Parent's

- Physical health
- Emotional health (including self-control)
- Suspected learning needs
- Knowledge and understanding re: children and childcare
- Knowledge and understanding of concerns / this assessment

14. Ability and willingness to address issues identified in assessment

- Violent behaviour
- Drug misuse / alcohol misuse
- Mental ill health problems
- Reluctance to work with professionals
- Poor parenting skills or lack of knowledge
- Criminal behaviour
- Poor family relationships
- Unresolved issues from childhood that impacts on parenting
- Poor personal hygiene
- Lack of awareness of danger

15. Attitude to professional involvement

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

- Previously – in any context
- Currently – regarding this assessment
- Currently – regarding any other professionals

16. Attitudes and beliefs re: convictions / findings (or suspicions/allegations)

- Understood and accepted
- Issues addressed
- Responsibility accepted lack of insight into the concerns and risk

17. Planning for the future

- Realistic and appropriate expectations
- Unrealistic, inappropriate expectations

18. Specific issues of concern

(Domestic violence, alcohol and/or substance misuse, chronic mental ill health difficulties, significant learning difficulties etc.)

- Medicine/drugs – prescribed or otherwise - used before and/or during pregnancy
- Chronic/acute medical conditions or surgical history
- Mental ill health history especially depression and self-harming

19. Mental ill health

Parental mental illness does not necessarily have an adverse impact on a child's developmental needs, but it is essential to always assess its implications for each child in the family. Many children whose parents have mental ill health may be seen as children with additional needs requiring professional support, and in these circumstances the need for an Early Help assessment should be considered.

Where a parent has enduring and/or severe mental ill health, children in the household are more likely to suffer significant harm. Significant harm is defined as a situation where a child is likely to suffer a degree of harm which is such that it requires a compulsory intervention by child protection agencies into the life of the child and their family.

19.1 A child likely to suffer significant harm or whose well-being is affected could be a child

- Who features within parental delusions?
- Who is involved in his / her parent's obsessional compulsive behaviours?
- Who becomes a target for parental aggression or rejection?
- Who has caring responsibilities inappropriate to his / her age (see Young Carers).
- Who may witness disturbing behaviour arising from the mental illness (e.g., self-harm, suicide, uninhibited behaviour, violence, homicide)?
- Who is neglected physically and/or emotionally by an unwell parent?
- Who does not live with the unwell parent, but has contact (e.g., formal unsupervised contact sessions or the parent sees the child in visits to the home or on overnight stays)?
- Who is at risk of severe injury, profound neglect, or death?

Or s/he could be an unborn child:

- Of a pregnant parent with any previous major mental disorder, including disorders of schizophrenic, any affective or schizo-affective type; also, severe personality disorders involving known risk of harm to self and/or others

19.2 The following factors may impact upon parenting capacity and increase concerns that a child may be suffering, or likely to suffer, significant harm:

- History of mental health problems with an impact on the sufferer's functioning.
- Unmanaged mental health problems with an impact on the sufferer's functioning.
- Maladaptive coping strategies.
- Misuse of drugs, alcohol, or medication.
- Severe eating disorders.
- Self-harming and suicidal behaviour.
- Lack of insight into illness and impact on child, or insight not applied.
- Non-compliance with treatment.
- Poor engagement with services.
- Previous or current compulsory admissions to mental health hospital.
- Disorder deemed long term 'untreatable', or untreatable within time scales compatible with child's best interests.
- Mental health problems combined with domestic abuse and/or relationship difficulties.
- Mental health problems combined with isolation and/or poor support networks.
- Mental health problems combined with criminal offending (forensic).
- Non-identification of the illness by professionals (e.g., untreated post-natal depression can lead to significant attachment problems).
- Previous referrals to LA children's social care for other children.

20. Drug and Alcohol *(information can be provided by Drug and Alcohol Services)*
Is there anything regarding “drug and alcohol misuse” that seems likely to have a significant negative impact on the child?

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

21. Learning disabilities *(information can be provided by Adult Learning Difficulty Team and* ***London SCP Parenting Capacity and Learning Disabilities***

21.1 Parental learning disabilities do not necessarily have an adverse impact on a child’s developmental needs, but it is essential to always assess the implications for each child in the family. Parents with learning disabilities may need support to develop the understanding, resources, skills, and experience to meet the needs of their children. Such support is particularly necessary where the parent/s experience the additional stressors of:

- Social exclusion.
- Having a disabled child (see Disabled Children Procedure);
- Experiencing domestic abuse (see Safeguarding Children Affected by Domestic Abuse Procedure).
- Having poor mental health (see Parenting Capacity and Mental Illness Procedure).
- Having substance misuse problems (see Parents who Misuse Substances Procedure).
- Having grown up in care (see Children Living Away from Home Procedure, Foster care and Children Living Away from Home Procedure, Residential care).

In most cases it is these additional stressors, when combined with a parent's learning disability that are most likely to lead to concerns about the care their child/ren may receive. Where a parent has enduring and/or severe learning disabilities, children in the household are more likely to suffer significant harm through emotional abuse, and /or neglect, but also through physical and /or sexual abuse.

21.2 The following factors may contribute to a child having suffered, or being more likely to suffer, significant harm:

- Children of parents with learning disabilities are at increased risk from inherited learning disability and more vulnerable to psychiatric disorders and behavioural problems, including alcohol / substance misuse and self- harming behaviour
- Children having caring responsibilities inappropriate to their years placed upon them, including looking after siblings (see **Young Carers Procedure**);
- Neglect leading to impaired growth and development, physical ill health, or problems in terms of being out of parental control.
- Mothers with learning disabilities may be targets for men who wish to gain access to children for the purpose of sexually abusing them

21.3 LA children's social care, vulnerable adult's services and other agency services must undertake a multi-disciplinary assessment including a specialist learning disability and other assessments, to determine whether parents with learning disabilities require support to enable them to care for their child/ren. Such assessments will also assist in considering whether the level of learning disability is such that it may impair the health or development of the child for an adult with learning disabilities to be the primary carer. Assessments should also consider:

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

22. The unborn child's home and community

22.1. Circumstances

- Unemployment / employment
- Finances including benefits, any debts
- Inadequate housing / homelessness
- Social isolation

22.2. Home conditions

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

22.3. Support

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

23. Diversity / Culture

- Impact diversity or culture may have that may increase or reduce risk

This list is not exhaustive. There will be issues for individual cases that require social workers and other practitioners to gather information about history and review past risk factors. See Guidance: Family History Quick Guide.

24. Social Worker's analysis of the current situation

24.1 A sound analytical assessment will provide a good picture of the child, their parent/s/carers, and their story. Use the analysis to give the reader an understanding of why the assessment is being undertaken and be clear about the individual unborn child's needs. Consider the seriousness of the needs identified and be clear about what success will look like and what will happen/impact on the child if the outcomes are not achieved (danger statement).

24.2 State clearly what work will be done to support the family to make the changes they need to make?

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

Show 'your working.'
How have you used the information available to reach certain conclusions?
Be free of jargon, especially words and phrases that will mean little to the family.

11. Appendix 3. Risks linked to concealed or unbooked pregnancy

There are occasional cases – often well publicised – where women appear to have been unaware of their pregnancy until the unexpected arrival of a baby but adjust quickly to the arrival of a new baby and can parent safely and effectively.

However, in general the risks and issues are very similar for concealed and denied pregnancies, which cannot always be distinguished, and comprehensive assessment and support must be offered.

- Where a woman has not accessed antenatal care, the risk of pregnancy complications, illness and even death for mum and baby are increased – maternal deaths are rare, but when they do occur, a significant proportion are associated with concealed pregnancy
- Pregnancy may be concealed deliberately because agencies already have concerns about the safety of the new-born in the care of parents, and concealment is part of a deliberate effort to prevent removal of the baby. This may relate to previous involvement in CSC and the removal of other children
- Some women, vulnerable or young women, may conceal or deny a pregnancy because of fear of parental and wider social responses. For some women, pregnancy outside marriage may carry stigma or even risk and is concealed. The woman's family may oppose her choice of partner Very vulnerable women, particularly those who have been trafficked or exploited, may not be able to access antenatal care
- Concealment and denial of pregnancy may be linked to mental health difficulties or learning difficulties, and more broadly may reflect ambivalence to the pregnancy, and potential future difficulties in prioritising the baby's needs, or in bonding with the baby. Careful assessment of family history and functioning is required to establish whether the baby can be safely cared for by parents

Response

It is critical that professionals are curious about the following factors which in isolation may not raise concerns but together and triangulated are significant and should be discussed with a safeguarding lead

- Late booking particularly when coinciding with self-referral
- Choice of hospital outside of local area or different from where previous children were born
- Absence or vague information about woman's GP or previous HV contact
- Inconsistent information given to different midwives or services
- Missed ante natal appointments
- Physical appearance inconsistent with denial of drug or alcohol use

12. Appendix 4.
Multi-agency Discharge Planning Meeting Record

A discharge planning meeting will be convened by the hospital to ensure that it is safe for the child to be discharged from the hospital and that plans are in place to continue to support the family. The meeting should be attended by all relevant professionals involved in providing services for the child and parent on discharge.

If a Core group meeting is planned, then the discharge and core group meeting should be combined as one meeting.

Any case where there is disagreement between medical staff and parents on the discharge plan are to be escalated to the safeguarding professionals within the agency. Refer to section 8 Resolving Professional Differences.

Concerns about consent to share information by the parents should not be a barrier to the professional network and guidance should include advice about how to overcome any barriers which may arise as a result of consent issues.

Under GDPR and Data Protection Act 2018 **you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk**. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so.

Multi-Agency Maternity Discharge Planning Meeting Record

Child's Name		*Child's DOB*		**Child's NHS No.**	
Mother's name		*Mother's DOB*		**Mother's NHS No.**	
Father's name		*Father's DOB*		**Father's NHS no.** (if known)	
Does father have parental responsibility?				Yes / No	
Ethnicity of child / parents					
Discharge Address:			**Is this family's actual address** (*if not state type of residence*):		
Contact Number		**Other contact numbers**			
Date of meeting		**Location of meeting**			

Meeting Chair		Minute taker	

NB: Baby's Social Worker / Midwife / Health Visitor / Family Nurse must be invited to the meeting

Name of attendee	Role of attendee	Email / Phone Number

1) Baby's health and any special requirements. (Does baby have specific health or feeding needs?)

2) Mother's health, family history any special requirements e.g., **mental health, carer leaver, previous concerns,** learning **needs that may affect how she will be able to care for her baby?**

3) Are there any concerns about baby's care or safety when s/he leaves hospital? (Do parents/carers have specific needs, do the parents/carers smoke, drink alcohol, or use any other substances? Is there any violence or aggression in the family home or risks in the home e.g., pets?**) Suitability of the living arrangements/safe sleeping arrangements** e.g., **co-sleeping**

4) What plans have been made to keep baby safe and well? (If there is a Family Group Conference plan/CiN/or a Child Protection Plan, what needs to happen?)

5) Are there any restrictions about who can visit the baby?

6) Are there any other children or adults within the home?

Visiting and Contact Plan – contingency plan

Who will visit baby / contact family (include role)	When and how often (include date/s)

Further Discussion

7) Who has shared and discussed information about Safe Sleeping with parents/carers?

Date of next meeting	Location of next meeting

A copy of the Discharge Planning meeting must be placed in the parent/ child's medical notes and the agency records of any other parties to this meeting.

This document MUST be circulated to all parties within 48hrs of meeting taking place by meeting Chair

12. Appendix 5. Safeguarding Alert from Named Midwife Network (St Georges Template)

Safeguarding Alert from Named Midwife Network

Name of Trust/Organisation: St George's University Hospitals NHS Foundation Trust

Name of Referrer: Ruth Oki / Lorraine Cleghorn

Contact Details: maternitysafeguardingteam@stgeorges.nhs.uk ruth.oki@stgeorges.nhs.uk / lorraine.cleghorn@stgeorges.nhs.uk (0208 725 1984 / 07920 418 311)

Date of Alert:

Name of the individual concerned	**Any known aliases:**
Last known address:	**GP:**
Phone Number:	**Social Worker:**
Partner:	Out –of –Hours Duty SW –
Telephone Number	

Date of Birth:	**EDD**

Brief indication of the concern (e.g., welfare of mother or baby, missing person)

13. Appendix 6. Multi-Agency Contact Details

MASH	020 8871 6622	MASH@wandsworth.gov.uk
Adult Learning Disabilities	020 8871 7707	Adult Social Care Online Contact Form
Children Planning & Review Service	020 8871 7208	
CLCH Single Point of Access Service	033 0058 1679	clcht.wandsworthspa@nhs.net
Early Help Team	020 8871 8454	targetedfamilysupport@richmondandwandsworth.gov.uk
Family Rights Group	080 8801 0366	office@frg.org.uk
Future First	020 8871 6733	ffinfo@richmondandwandsworth.gov.uk
Hospitals		
Chelsea & Westminster Hospital	020 3315 8000	
Croydon University Hospital	020 8401 3000	
Kings College Hospital	020 3299 9000	
Kingston Hospital	020 8546 7711	
South London and Maudsley NHS Foundation Trust	020 3228 6000	
South West London & St Georges Mental Health Trust	020 3515 5000 / 020 3513 6848	
St Georges Maternity Safeguarding Team	020 8266 2920 / 020 8725 1984	
St Georges Safeguarding Team Business Support	07973 729405 / 07973 730237	
St Thomas Hospital	020 7188 7188	
Midwifery Services	020 8725 1677	
Substance Misuse Services (Adults) (Children)	020 3228 1777 07770573131	
Out of Hours	020 8871 6000	