

# **Pre Birth** **Assessment;** **Guidance and** **process.**

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## **Being pregnant:**

Being pregnant in our society is seen as an exciting and lovely time for a person. People are given attention by others (often whom they don't know) there are plans made, and emotionally many parents dream and think about the future child and their aspirations for their child.

It is also a time that can cause women to feel unwell, physically and emotionally. For some parents, being pregnant or being the father is not a time of happiness, but a time of concern.

Whatever the situation, being pregnant is a major life event. It creates emotions within us all and can be a time of great happiness but also great anxiety.

This is the context we must remember we are assessing people within. We should not presume that a parent to be is feeling excited and pleased. But we should understand that emotions will be heightened and the prospect of being assessed by a social worker, for many will place a great anxiety upon them.

## **National Overview:**

Sitting within the context of general child and family social work assessment, pre-birth assessment has received limited research attention and occupies a small section of the assessment literature base.

Corner (1997) pre-dates current legal and procedural guidance but does identify that pre-birth assessment is complex partly because the foetus has no legal status.

On-going research at the University of Dundee highlights the importance of multi-agency work in pre-birth assessment. The research looks at a multi-agency pre-birth assessment team in Scotland working with families where there are significant concerns about drug and alcohol use.

This research has highlighted the importance of midwifery and adult-based professionals in the process of assessment, particularly in relation to supporting maternal engagement in the process. Moreover the wider professional perspective is invaluable in providing in-depth knowledge upon which to base child protection decision making.

Removing a baby at birth for child protection reasons impacts on attachment and bonding. However, allowing a baby to be discharged from hospital to a family who are unable to provide appropriate protection may result in irreparable harm to, or even the death of, the baby. The importance of good, clear pre-birth assessment cannot, therefore, be understated.

## **The impact research should have on practice**

One of the first practice challenges for social workers completing a pre-birth assessment is the procedural contradictions which suggest pre-birth assessment

should be treated as per any other assessment whilst the legal power to intervene is not applicable until birth.

It is important for social workers to recognise this contradiction and to realise that to complete a good assessment it is important to focus on parental engagement and make use of the duration of the pregnancy to work with the family and with the professional network around them.

It is here that the role of the health colleagues such as midwives of Family Nurse Partnership is crucial as they are in a position to form a supportive relationship with the mother to enable her to recognise the importance of ensuring the baby is safe.

Recent evidence on the levels of damage caused in utero, and in early months means that the immediate post-birth period can be crucial in terms of the child's optimal development and the opportunity to form secure attachments between parent/carer and child (Sunderland 2006, Allen 2011).

A preventative assessment that can more accurately predict risks post-partum should be considered the ultimate in early intervention to assess the level of neglect or ill treatment a new-born infant might be subjected to, and will also help to identify the assets and strengths that parents have which can be further developed

However, 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 and at the earliest opportunity. It may be possible to begin intervention during the pregnancy that can make a contribution to healthy development pre-birth and reduce the risks and improve parental behaviours for when the baby is born.

## **INTRODUCTION**

Research and experience indicate that very young babies are extremely vulnerable to abuse and that work carried out in the ante-natal period to assess risk and to plan intervention will help to minimise harm. A pre-birth assessment is a proactive means of analysing the potential risk to a new-born baby when there are concerns about a pregnant woman and/or the birth father, and where appropriate, her partner and immediate family.

The purpose of a pre-birth assessment is to identify any potential risks to the new born child, assess whether the parent(s) are capable of changing so that the identified risks can be reduced and if so, what supports they will need. The pre-birth assessment must be of sufficient depth to inform future care planning.

It must take into account family strengths and safety as well as the future danger / risks and any harm to ensure that the new born baby receives the necessary level of support to achieve their full potential and be protected from immediate and future harm.

Pre-birth assessments are 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. However, the Children Act 1989 is clear that there are grounds for intervention if there is a likelihood of significant harm and that the needs of the child (in these situations the unborn child) are paramount.

It is important that the reasons for the assessment are made clear to the parents at the outset and that there is clarity of understanding between professionals as to the purpose of the pre-birth assessment process. Care must be given to working collaboratively with parents as a means of drawing together a balanced assessment with due consideration of parental strengths and capacity to change as well as areas of concern. However, it is critical that the needs of the unborn child remain at the centre of the assessment as opposed to those of the parent/s. There needs to be good consistent dialogue between professionals, recognition of the strengths and expertise that individual practitioners bring to the process and constant focus that the needs of the unborn child are paramount.

In West Sussex County Council we work using a risk assessment practice framework of Signs of Safety, with a theoretic base of attachment and trauma.

Constructive working relationships between professionals and family members and between professionals themselves, is the heart of effective practice in responding to situations where children suffer abuse.

Using the framework of Signs of Safety to understand danger, harm, strengths and safety and to work with the family and their networks is the approach adopted. The use of shared and clear language within signs of safety should allow parents to fully understand what worries people have about their potential care of their baby, and what can be done to reduce those worries.

The signs of safety approach seeks to create a constructive culture around child protection practice. Central to this is the use of specific tools and processes where professionals and families members can engage with each other in partnership to address situations of child abuse and maltreatment.

The three main principles of Signs of Safety practice can be applied within our comprehensive pre-birth assessment framework:

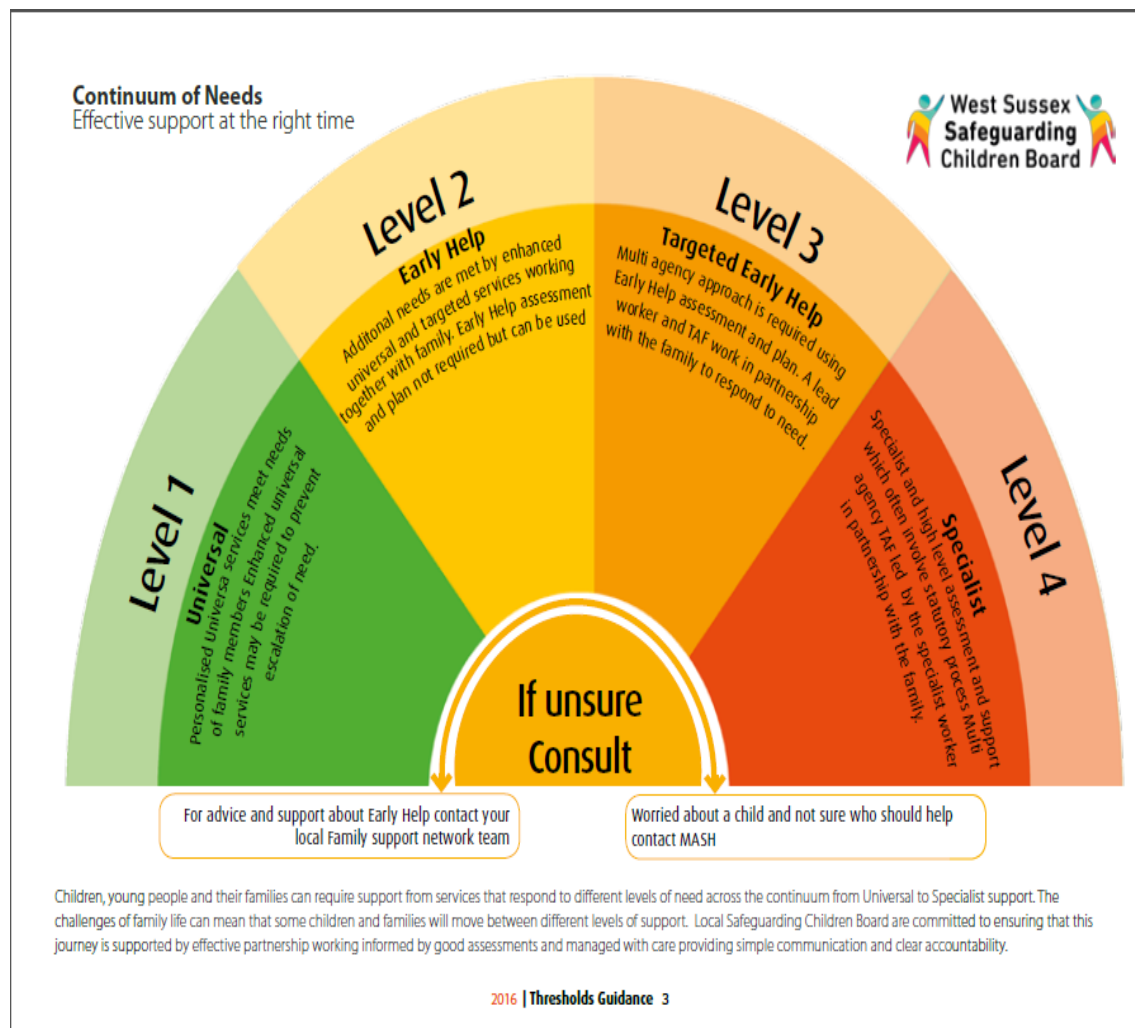
- Working relationships
- Think critically / adopt a stance of inquiry
- Land grand aspirations in everyday practice.

This guidance aims to clarify what is meant by pre-birth assessments, their purpose, and the circumstances in which one needs to be considered. This guidance should be read together with LSCB procedures.

### WEST SUSSEX SIGNS OF SAFETY PRACTICE FRAMEWORK



## West Sussex Continuum of Need



The West Sussex Continuum of Need provides a framework for professionals who are working with children, young people and their families. It aims to help professionals identify when a child may need additional support to achieve their full potential through a graduated response from universal, early help, targeted early help or specialist services.

It describes a continuum of help and support that addresses need across the spectrum of children's ages, needs, family functioning and the environment they live in. It also provides descriptors for each level of need, giving examples of some of the indicators that suggest a child or young person may be in need at each level of support. The document therefore reflects how local services provide support for children along a continuum, and illustrates the principle that services become increasingly targeted and specialist as the child's level of need increases.

The link below takes you to the full Continuum of Need document and should be used alongside the pre-birth guidance:  
<http://www.westsussexscb.org.uk/wp-content/uploads/WS1953-Threshold-Guidance-2016-May-FINAL.pdf>

## **Pre-birth assessment within the Child and Family Assessment Framework**

The following are the circumstances where the MASH should outcome the referral for a Child and Family Assessment (CFA) and this is passed to the **Assessment and Intervention Service**. This would be because as whilst there are concerns that require a level 4 children social care assessment these concerns at point of referral are not such that raises serious issues of significant harm.

Equally if either one or a combination of these factors indicates significant harm then the referral should be outcome for a full pre-birth assessment and passed to the **Family Support and Protection Service**.

- **Where a child is likely to suffer significant harm as a result of parenting capacity in relation to:**
  - (a) The parent (s) have a mental health condition
  - (b) The parent (s) have a learning disability
  - (c) There are concerns about domestic violence in either the present, or in the previous relationship (s) of either parents
  - (d) One of both parents or members of the network have convictions or has been the subject of criminal investigations for offences of either a violent or a sexual nature
  - (e) Where alcohol or substance abuse is thought to be affecting the health of the expected baby.
  - (f) A parent previously suspected of fabricated or inducing illness in a child.

### **Categories of when a comprehensive pre- birth assessment is required:**

The following are the circumstances in which a full pre-birth assessment should be undertaken. The decision to undertake a comprehensive pre-birth assessment may be because of one significant incident, or a series of less significant incidents. In situations where a number of the above factors are known to co-exist, the pre- birth assessment must consider the potential impact of the cumulative risk factors on the unborn child as well as on the baby when it is born. Where the expectant mother / proposed carers are under 18 years of age, the assessment should consider their own needs in addition to their ability to meet the baby's needs.

- **Where a child in the family has previously been removed from either parent due to suffering significant harm.**
- **Where there has been a previous unexplained death of a child or unexplained serious injury to a child whilst in the care of either parent.**
- **Where a child in the home is on a Child Protection Plan or one of the parents is on a child protection plan.**

- **Where either parent is currently a Child Looked After or Care Leavers under the age of 25 years old.**
- **Where either parent is under 16 years of age.**
- **Where the pregnancy has been concealed.**
- **Where a parent has requested to relinquish the child upon birth.**

### **Description of Categories**

**Parents who have had a previous child removed (or who have previous children no longer living with them):** Even if previous children of the parents have recently been removed, the parents' ability to meet the needs of their unborn child may need to be reassessed.

The unborn child may be to a new, more responsible, and supportive partner; the parents may have successfully tackled their drug and alcohol misuse; or the removal of previous children may be some years ago, and parents have matured, and/or are able to acknowledge and appreciate their previous failings.

Calder (2000) provides a useful framework for considering families where there has been previous abuse stating that:

"The abuse of previous children is not a bar to caring for future children, although the parents' attitude to that abuse and their attitude towards the child is a factor where there would need to be significant change."

**Parents with mental health problems:** Parents, especially those with a diagnosed mental illness who are receiving drug treatment, and including mothers with a history of post-natal depression should be considered for a pre-birth assessment.

The ability of mothers who are suffering from severe depression or psychosis to interact and be emotionally available for their child may be limited, and thus have an effect on optimal conditions to promote maternal attachments.

Social workers for both the parents and the unborn child should attend care planning meetings for the adult which are called by adult mental health services, and adult mental health services should take responsibility for inviting children's services social workers to these meetings. However, if a children's services social worker becomes aware that a care planning meeting is taking place they should ensure their attendance at such meetings, and consult any joint protocols on working together between adult and children's services which have been developed locally.

Parents who take prescribed medication for their psychiatric illness may have unconfirmed fears about the impact on the unborn child. Medical review of



medication may need to occur to allay parents' fears, and prevent premature cessation of medication, which could increase the risks of parental mental illness reoccurring.

**Parents with drug and/or alcohol problems:** Drug or alcohol misuse in pregnancy can pose serious developmental problems to the unborn child such as pre-term delivery, low birth weight, or in severe cases neonatal withdrawal symptoms and foetal alcohol syndrome.

Hidden Harm (DOH) estimated that 1 per cent of all deliveries were to mothers with problem drug use and 1 per cent of deliveries were to mothers with severe difficulties with alcohol. These figures do not include fathers, and may be an underestimation in some areas of the country.

In addition to the physical effects on the foetus, the consequences of a drug or alcohol using lifestyle can impact on all areas of a child's social and emotional development (Cleaver et al 2011, Kroll & Taylor 2003, Harbin & Murphy 2000).

Some areas will have specialist maternity services or specialist midwives to assist in assessment and support for what may be perceived as "high risk parents". Screening tools and additional specific guidance of the types of questions that professionals need to ask parents who are misusing substances are provided in many safeguarding board policies and protocols, many based on what were previously known as the SCODA (Standing Committee on Drugs and Alcohol) guidelines. The SCODA questionnaire is attached to this guidance as Appendix 1.

The Solihull drug use screening tool (DUST) can be found here:

[http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20\(Update%20In%20Progress\)/New%20and%20updated%20procedures%20\(Will%20be%20added%20to%20main%20procedures%20update\)/dust%20\(2\).pdf](http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20(Update%20In%20Progress)/New%20and%20updated%20procedures%20(Will%20be%20added%20to%20main%20procedures%20update)/dust%20(2).pdf)

**Parents where there is a history of domestic abuse:** Domestic abuse in pregnancy can pose severe physical risks to the health of both mother and child. Women's Aid indicates that domestic abuse can either begin, or increase, when women are pregnant. There may be an indirect impact on both the woman's reduced attendance at antenatal care, or increased difficulties with her mental health which in turn can impact on their ability to bond with and care for their child (Cleaver et al 2011). 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.

The domestic violence identification matrix can be found here:

[http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20\(Update%20In%20Progress\)/New%20and%20updated%20procedures%20\(Will%20be%20added%20to%20main%20procedures%20update\)/Domestic%20Violence%20risk%20identification%20matrix.pdf](http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20(Update%20In%20Progress)/New%20and%20updated%20procedures%20(Will%20be%20added%20to%20main%20procedures%20update)/Domestic%20Violence%20risk%20identification%20matrix.pdf)

**“The toxic trio:”** Many parents who are referred in pregnancy may come under several categories mentioned above, recently dubbed the “toxic trio”. Parental substance misuse, parental mental illness and domestic abuse combined will have potential ill effects on all aspects of a child’s health and development.

**Parents with a learning disability:** A learning disability should not preclude a person from becoming a parent. It may depend on the severity of the disability, the level of family support, and services available. The pre-birth assessment should focus on how the disability impacts on the adults’ ability to parent, and the provision of services and support that may assist them to do so.

**Young parents:** It is arguable whether a pre-birth assessment is indicated purely on the grounds of youth, and each case would need to be considered on its merits, depending on: whether any of the factors above were present; the level of support from extended family; and the extent to which the young parents themselves may have suffered abuse as a child, for example are they care leavers?

**Mothers who have received little or no antenatal care (because of concealed pregnancy; late presentation; or failure to attend appointments and engage with antenatal services):** A pre-birth assessment would not always be indicated in such circumstances, but should always be considered, particularly in those mothers where any of the above criteria applied, or the parent appeared to be leading a transient lifestyle where contact with services appeared to be actively avoided.

### **Workflow process from Referral through to assessment**

- All referrals from a professional or member of the public regarding a concern or worry about an unborn baby need to be made to West Sussex Multi Agency Safeguarding Hub (MASH).
- For a majority of cases, the most appropriate, and proportionate, point to make a referral to Children’s Social Care is at 12 weeks gestation, when the pregnancy has been confirmed through an ultrasound scan.
- The MASH will consider the referral in line with the West Sussex Continuum of Need document and the identified categories for considering when a comprehensive pre-birth assessment is required.
- The MASH will undertake relevant information sharing to determine the next steps required.

- The MASH decision may be to offer targeted early help support, or they may feel that a level 4, children social care assessment is required, and recommend a Child and Family Assessment. However when applying the above categories in line with gathering information a decision may be made that a full comprehensive pre-birth assessment is required.
- At the point of referral in the MASH if the Practice Manager believes that based on the information gathered there is a likelihood that Child in Need (Section 17) interventions will be required then they will outcome the referral for a Child and Family Assessment (CFA) and this will be allocated to the **Assessment and Intervention Service**. (see flow chart below)
- At point of referral in the MASH if the Practice Manager believes that based on the information gathered there are significant concerns about the safety of the unborn baby and there is a likelihood that there will be a need for a Pre Birth Child Protection Conference and or the potential to consider court proceedings in the future then a full comprehensive pre-birth assessment is required and this will be allocated directly to the **Family Support and Protection Service**. (see flow chart below)
- The full pre-birth assessment is a 12 week process and will need to be expedited if the referral is post 25 weeks pregnancy. Decisions about sec 47/Legal proceedings can be considered earlier in the process if late referral, lack of consent or premature labour.
- If the CFA is started in **Assessment and Intervention** and concerns increase then the Group Manager needs to decide whether a full comprehensive pre-birth assessment is required. This will be completed in the **Assessment and Intervention** service, to avoid unnecessary change of workers. At the conclusion of the full pre-birth assessment depending upon the outcome the case with transfer or close (as outlined in the flow chart below)
- If the full pre-birth assessment is completed in the **Family Support and Protection (FS&P)** service and the outcome is to consider interventions via a Child and Family Plan (Section 17) then this will remain within the **FS&P** service, ideally with the same social worker. (as outlined in the flow chart below)
- The above process is in place to avoid unnecessary changes of workers. It is also designed to avoid delayed assessments and delayed interventions to families.

- The above process is also in place to ensure professional's ownership of the work as the matter is not simply to assess and then pass responsibility. It is to provide an analytically and reasoned assessment with interventions running alongside to ensure effective safety planning for unborn and babies once born.
- If the MASH receive a late referrals meaning there is limited time to complete a full pre-birth assessment the above process needs to be followed. However the case needs to be highlighted to the relevant **Group Manager** and this needs to be overseen by a **Group Manager** in either **CAI / FS&P** to ensure there is a clear agreement of what assessment work needs to be undertaken and what the safety plan is once the baby is born.

## Flow diagram of Process from Referral – CFA in the Assessment and Intervention Service



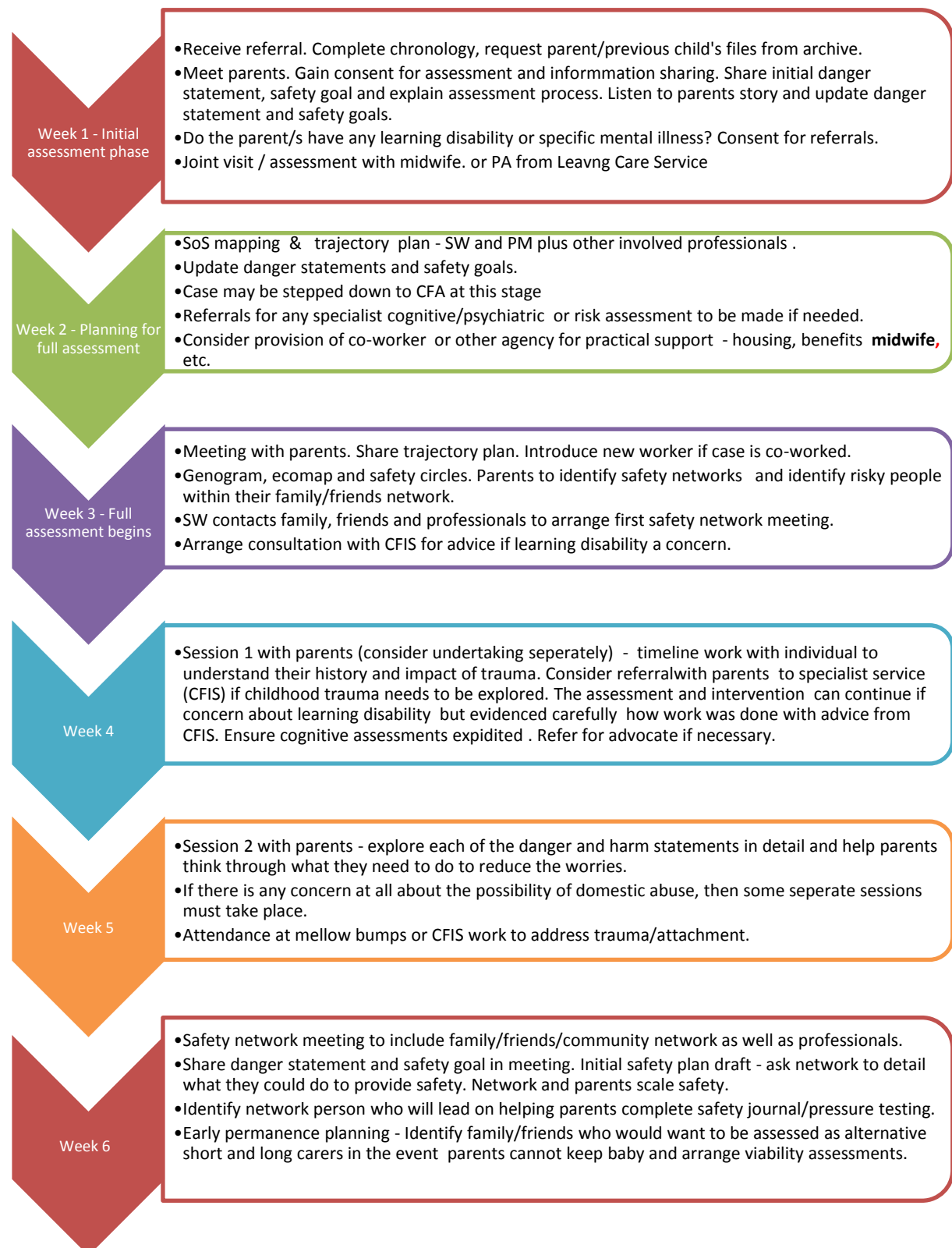
**NB** - This Process diagram needs to be considered in line with all CSC processes and procedures and timeframes for ICPC / PLO / LPM and permanency planning meetings.

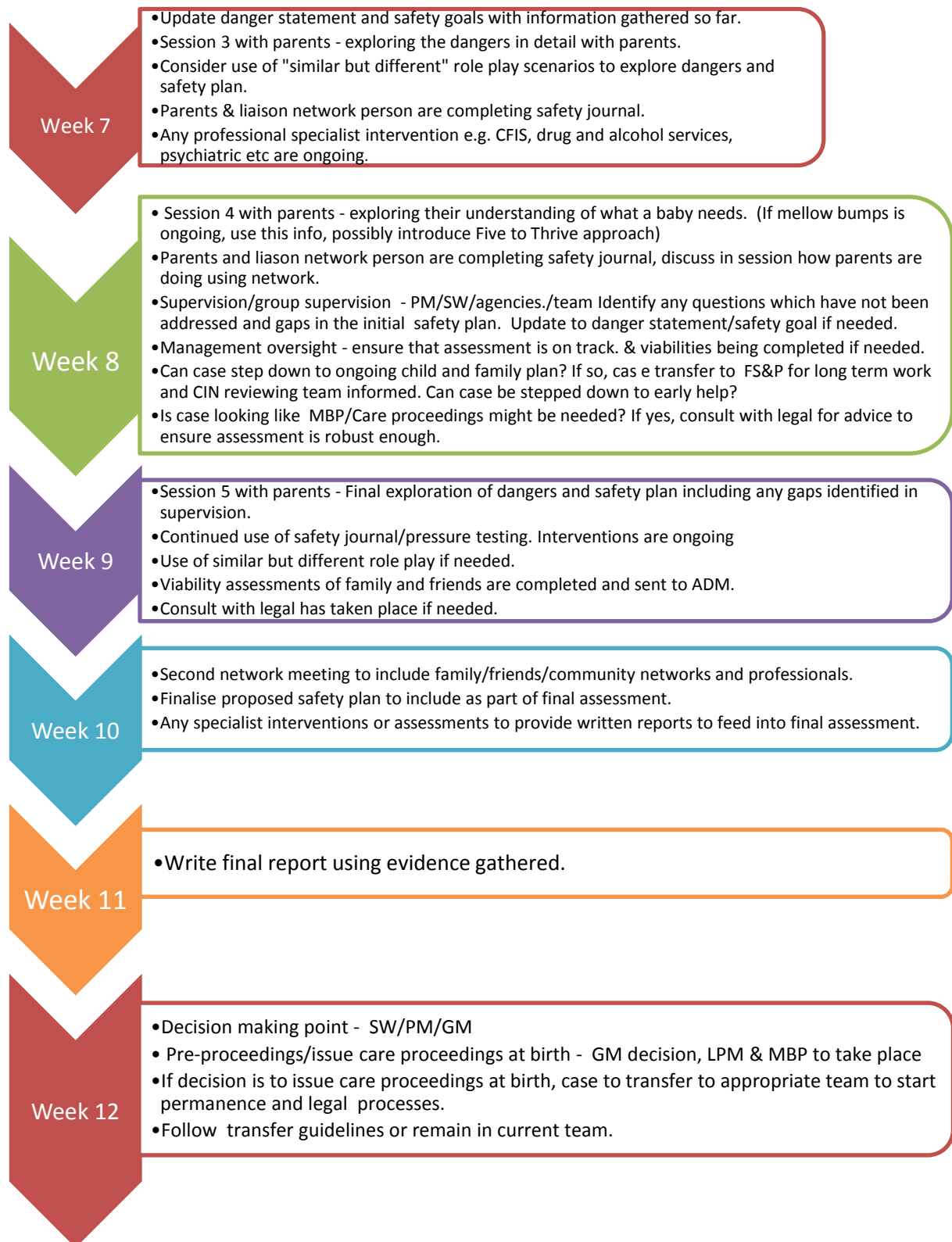
- The flow diagram cannot necessarily be followed if the referral is a late presentation.

**Flow diagram from Referral to Full pre-birth Assessment within the Family Support and Protection Service.**



## Process to follow to complete the 12 week pre-birth assessment







## PRE BIRTH ASSESSMENT - Tracking Tool

The pre-birth tracking tool should be used in supervision between manager and supervisee to ensure that the assessment is timely and relevant milestones / tasks are being completed.

Unborn baby.....

EDD

Number of weeks to completion of PBA

Name of SW

Name of PM

Name of GM

Name of SL

Start date of PBA

What happens if you don't have all of the weeks available (because of a late notification) and you can't follow all of the steps in the process described above?

Week of Assessment	ACTIVITY	PROGRESS	IMPACT	ACTIONS?
Week 1				
Week 2				
Week 3				
Week 4				
Week 5				
Week 6				
Week 7				
Week 8				
Week 9				
Week 10				
Week 11				
Week 12				
Management sign off.				

# Comprehensive Pre-Birth Assessment & Intervention Guidance

## 1. Introduction

This guidance is designed to support social workers undertaking a **comprehensive pre-birth assessment (with intervention)** in identified circumstances and should be read and used alongside the Pre-birth assessment Process Map. This guidance is compatible with the Signs of Safety approach which should always be at the foundation for our practice.

The word "parent" should be loosely interpreted as appropriate to mean the mother and father (whether together or apart), the mother's partner, anyone with parental responsibility, and anyone else who has or is likely to have day to day care of the child. It is crucial to involve everyone who is a potential parent or carer in the assessment.

This tool draws extensively on the work of Martin C Calder – as described in "Unborn Children: A Framework for Assessment and Intervention".  
<http://ww.russellhouse.co.uk/pdfs/assinchildcare.pdf>

### 1) Initial referral

Referrals when there are concerns about an unborn child should be made to the MASH at the earliest possible stage.

The optimum time for professionals to refer any unborn about which they have significant safeguarding concerns is at 12 weeks gestation (usually following the first ultrasound scan). This allows for a full and comprehensive assessment and intervention package to take place by the time the mother is 27 weeks pregnant and subsequent decision making and intervention to be based upon the best evidence.

If there is concern about concealed pregnancy or lack of engagement with antenatal services, referral should be made as soon as the professional becomes aware.

All referrals regarding unborn children should be made to the MASH, for the case to be opened on Frameworki. In cases where the unborn child's siblings are already open to Children's Social Care, the unborn child will be allocated to the current social worker for the siblings. An assessment will be undertaken relating to the unborn child, to ensure that the needs of the baby are considered, but also the impact of a new baby within the existing family structure.

MASH screening will make the decision whether to take no further action, recommend an early help plan, or refer to children's social care via one of the following options:

- i) Child and family assessment under Section 17 where there are issues of need will be allocated to a social worker in the Assessment and Intervention Service.
- ii) Immediate Section 47 investigation (where there are child protection concerns and the mother is more than 25 weeks pregnant).

iii) Full pre-birth assessment from a social worker in Family Support and Protection Service. **(see detailed criteria)**

## **2) Pre birth Assessment within Child and Family Assessment Framework**

When the MASH decision is for an assessment of an unborn child to be undertaken through a Child and Family Assessment, it is expected that a full and thorough assessment will be completed, in line with practice standards. The analysis of the safety and wellbeing of the baby once born should take into account the history of both parents, and any other carers identified. If it is considered that as a result of the assessment, further information and assessment and intervention is required, the social worker and Practice Manager need to discuss which framework and support will best meet the families needs.

If it is considered that the family can safely and robustly meet the needs of the baby with the support of universal services and/or Early Help, clear communication must be made with the relevant agencies, and open discussions held with the family to ensure they are aware of ongoing planning.

### **3) Full Assessment & Intervention following MASH screening.**

The full pre-birth assessment and intervention is aimed to be a 12 week process undertaken *prior* to decision making about the direction of the case. This is to allow families whose unborn child/ren are in the most high risk situations the best possible opportunity to show that they can provide safety and care for their baby once it is born and throughout that child's life, and for social workers to be able to make plans using the best evidence available.

In the event that, at the end of the assessment and intervention, the most difficult decision has to be made and permanence outside the family via adoption is considered to be the only option, this process is designed to provide the best evidence to the Court and avoid any delay for the baby in achieving permanence.

However if the referral is late on in pregnancy or the baby is likely to be very early, then this process will need to be expedited and undertaken whilst following the Section 47 process and with legal intervention if needed.

At any stage in the process a decision can be made to convene a section 47 investigation or seek legal advice, if, for example, the due dates are changed or the baby becomes unwell and may be born early, or the parents disengage from the assessment.

Conversely, if at any point concerns are reduced and there are not considered to be child protection concerns, then the assessment can be ended and stepped down to child and family planning or Early Help.

### **3) Initial visit & decision making.**

The social worker will make contact with the parents to arrange an initial visit in week one. During this visit they will share the initial danger statement, safety goal and complete a mapping and genogram/ecomap with the parents and any other network people present. This ideally could be a joint visit with the midwife and/or FNP nurse, and if the pregnant mother or putative father is looked after or a care leaver, with the young person's social worker or PA.

Informed consent for the assessment and information sharing should be sought at this first visit and this should also include consent to take photographs for the assessment, including of home conditions if relevant.

Following the initial visit to the family, by week 2 the social worker and practice manager, along with input from other professionals involved must make a decision whether to continue with the full assessment or whether concerns are reduced or other immediate action needs to be taken. They should do this using the Signs of Safety risk assessment methodology.

If concerns are reduced such that the case is considered to meet the criteria of Section 17, Child and Family Plan this should be clearly discussed with the family and professional network and a Family Network Planning meeting arranged.

In this scenario the matter should remain with the same allocated social worker in Family Support and Protection.

If the first visit reveals ongoing concerns of a child protection nature, then the full assessment continues.

If the parents do not consent to the full assessment or information sharing, and there are child protection concerns, then a multi-agency strategy meeting must be convened and the section 47 investigation process followed. The full assessment can be re-started if the parents then choose to engage during/following Section 47 process.

It is vital that the Pan Sussex guidance is adhered to within this process

[Pan Sussex Guidance Flowchart – Action following a Strategy Discussion](#)

#### **4) Continuing the assessment**

This section is designed as guidance for what areas need to be covered when gathering information for the assessment. Refer to the Signs of Safety process map for suggestion of the timing of the sessions.

Individual sessions with the parents exploring these areas are key for a well-rounded picture, however it should be ensured that the greatest focus is on those areas which have been identified as risk factors and developed into danger statements and safety goals, and helping the parents with the support of their networks, to reduce the worries in these areas, by creating a safety plan, and make sure that they can be sustained in the long term.

If there is a concern about domestic abuse or sexual offending, then some sessions must be undertaken separately, and relevant risk assessments should be completed as part of the wider assessment. When there is a concern regarding domestic violence, the CAADA DASH risk assessment tool should be completed with the family

[https://www.westsussex.gov.uk/media/2020/caada\\_dash\\_risk\\_identification\\_checklist.pdf](https://www.westsussex.gov.uk/media/2020/caada_dash_risk_identification_checklist.pdf)

If there are concerns relating to neglect, practitioners should use the Graded Care Profile Tool to identify the level of possible risk.

[Graded Care Profile - User Manual](#)

[Graded Care Profile - Scoring Sheet and Explanatory Tables](#)

If the parents are attending sessions with CFIS, for example mellow bumps, Five to Thrive, or work relating to childhood trauma, or a PAMS assessment is being undertaken, then this information may cover some of these areas and should be integrated into the assessment.

**Suggested areas to cover in the assessment (use professional judgement to ensure information gathered during assessment is proportionate to risk and timeliness):**

- i) Name and Expected Date of Delivery: e.g. Unborn Baby .....EDD: 01.01.17
- ii) Family Structure/Composition: Names, addresses, dob, relationships with extended family members. This should include a genogram and combined ecomap.
- iii) Reason for Assessment: written in the form of the initial danger statements and safety goals, and initial scaling should be included, to measure progress.
- iv) Sources of Information: Include dates of visits to family members and who was seen. Names of professionals who were consulted along with dates, as well as any records that have been consulted.
- v) Ante-Natal Care: Medical and Obstetric History. The central question is whether there is anything in the medical and obstetric history that seems likely to have a significant negative impact on the child.

### **Assessment of parents aged under 18**

Particular care should be taken when assessing risks where the prospective parents are themselves children i.e, under the age of 18 years and in particular if they are themselves Children Looked After.

Attention should be given to evaluating the quality and quantity of support that will be available within the extended family and friends network, the needs of the parent(s) and how these will be met, the context and circumstances in which

the baby was conceived, and the wishes and feelings of the child (or children) who are to become parents.

If the prospective parent is a Child Looked After then attention should be paid to their long term plan and how assessing for independence should incorporate the thinking of 'independence with responsibility for a child'.

### **Discussions should consider:**

- Partner support
- Whether this was a planned or unplanned pregnancy
- Feelings of mother about being pregnant
- Feelings of partner / putative father about the pregnancy
- Any issues about dietary intake
- Any issues about medicines or drugs taken before or during pregnancy
- Alcohol consumption
- Smoking
- Previous obstetric history
- Current health status of other children
- Miscarriages and terminations
- Chronic or acute medical conditions or surgical history
- Psychiatric history – especially depression and self-harming (see NHS Self harm document:

[http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20\(Update%20In%20Progress\)/New%20and%20updated%20procedures%20\(Will%20be%20added%20to%20main%20procedures%20update\)/NHS%20Self%20Harm.pdf](http://teamspace.westsussex.gov.uk/teams/CSC/PI/Shared%20Documents/CSC%20Policy%20Procedures%20and%20Practice%20Guidance%20(Update%20In%20Progress)/New%20and%20updated%20procedures%20(Will%20be%20added%20to%20main%20procedures%20update)/NHS%20Self%20Harm.pdf) )

- Housing/Finance

### **Relationships**

- History of relationships of parents
- Current status
- Positives and negatives
- Violence
- Who will be main carer for the baby?
- What expectations do the parents have of each other re: parenting?

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

### **Abilities**

- Physical
- Emotional (including self-control)
- Intellectual

- Knowledge and understanding about children and child care
- Knowledge and understanding of concerns and the reason for assessment

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

### **Social history**

- Experience of being parented
- Experiences as a child, and as an adolescent
- Education
- Employment

Is there anything regarding “social history” that seems likely to have a significant negative impact on the child? If so, what?

### **Behaviour**

- Has there been any violence in the relationship?
- Violence to others?
- Violence to any child?
- Drug misuse?
- Alcohol misuse?
- Criminal convictions?
- Chaotic (or inappropriate) life style?

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

If drugs or alcohol are a significant issue, more detailed assessment should be sought from professionals with explicit experience in these fields.

### **Circumstances**

- Unemployment / employment
- Debt
- Inadequate housing / homelessness
- Criminality
- Court Orders
- Social isolation

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

### **Home conditions**

- Are they chaotic?
- Does the home pose a health risk / unsanitary / dangerous?
- Over-crowded?

- Is the home a temporary one or is it a foster placement with an uncertain long term plan?

Is there anything regarding “home conditions” that seems likely to have a significant negative impact on the child? If so, what?

### **Mental Health**

- Mental illness?
- Personality disorder?
- Any other emotional/behavioural issues?

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

If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

### **Learning Disability**

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

If learning disability is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

### **Communication**

- English not spoken or understood?
- Deafness?
- Blindness?
- Speech impairment?

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

If communication is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise.

### **Support and safety planning – quality and quantity**

- From extended family
- From friends
- From professionals
- From other sources

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

Is support likely to be available over a meaningful time-scale?



Is it likely to enable change?

Will it effectively address any immediate concerns?

### **History of being responsible for children**

- Are there any convictions for offences against children?
- CP Registration/ Child Protection Plan
- CP concerns – and previous assessments?
- Court findings?
- Care proceedings? Children removed?

Is there anything regarding “history of being responsible for children” that seems likely to have a significant negative impact on the child? If so, what?

It so also consider the following:

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

### **History of abuse or trauma as a child**

- Convictions – especially of members of extended family?
- CP Registration
- CP concerns
- Court findings
- Previous assessments

Is there anything regarding “history of abuse” that seems likely to have a significant negative impact on the child? If so, what?

### **Attitude to professional involvement.**

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

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

### **Attitudes and beliefs re convictions or findings (or suspicions or allegations)**

- Understood and accepted?

- Issues addressed?
- Responsibility accepted?

Is there anything regarding “attitudes and beliefs” that seems likely to have a significant negative impact on the child? If so, what? It may be appropriate to consult with the Police or other professionals with appropriate expertise.

### **Attitudes to child**

- In general
- Re specific issues
- Expectations of what having a baby means/ how it will alter their lives

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

### **Dependency on partner**

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

Is there anything regarding “dependency on partner” that seems likely to have a significant negative impact on the child? If so, what?

### **Ability to identify and appropriately respond to risks?**

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

### **Ability to understand and meet needs of baby**

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

### **Ability to understand and meet needs throughout childhood**

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

### **Ability and willingness to address issues identified in this assessment**

- Violent behaviour
- Drug misuse

- Alcohol misuse
- Mental health problems
- Reluctance to work with professionals
- Poor skills or lack of knowledge
- Criminality
- Poor family relationships
- Issues from childhood
- Poor personal care
- Chaotic lifestyle

Is there anything regarding “ability and willingness to address issues” that seems likely to have a significant negative impact on the child? If so, what?

**Any other issues that have potential to adversely affect or benefit the child.**

e.g. one or more parent aged under 16 Context and circumstances of conception

### Risk Estimation

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Framework taken from an adaptation by Martin Calder in 'Unborn Children: A Framework for Assessment and Intervention' of R. Corner's 'Pre-birth Risk Assessment: Developing a Model of Practice'.

Factor	Elevated Risk	Lowered Risk
The abusing parent	<ul style="list-style-type: none"> <li>• Negative childhood experiences, inc. abuse in childhood; denial of past abuse;</li> <li>• Violence abuse of others;</li> <li>• Abuse and/or neglect of previous child;</li> <li>• Parental separation from previous children;</li> <li>• No clear explanation</li> <li>• No full understanding of abuse</li> </ul>	<ul style="list-style-type: none"> <li>• Positive childhood;</li> <li>• Recognition and change in previous violent pattern;</li> <li>• Acknowledges seriousness and responsibility without deflection of blame onto others;</li> <li>• Full understanding and clear explanation of the circumstances in which the abuse occurred;</li> <li>• Maturity;</li> </ul>

	<p>situation;</p> <ul style="list-style-type: none"> <li>• No acceptance of responsibility for the abuse;</li> <li>• Antenatal/post natal neglect;</li> <li>• Age: very young/immature;</li> <li>• Mental disorders or illness;</li> <li>• Learning difficulties;</li> <li>• Non-compliance;</li> <li>• Lack of interest or concern for the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Willingness and demonstrated capacity and ability for change;</li> <li>• Presence of another safe non-abusing parent;</li> <li>• Compliance with professionals;</li> <li>• Abuse of previous child accepted and addressed in treatment (past/present);</li> </ul> <p>Expresses concern and interest about the effects of the abuse on the child.</p>
<b>Non-abusing parent</b>	<ul style="list-style-type: none"> <li>• No acceptance of responsibility for the abuse by their partner;</li> <li>• Blaming others or the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts the risk posed by their partner and expresses a willingness to protect;</li> <li>• Accepts the seriousness of the risk and the consequences of failing to protect;</li> <li>• Willingness to resolve problems and concerns.</li> </ul>
<b>Family issues (marital partnership and the wider family)</b>	<ul style="list-style-type: none"> <li>• Relationship disharmony/instability;</li> <li>• Poor impulse control;</li> <li>• Mental health problems;</li> <li>• Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks);</li> <li>• Lack of support for primary carer /unsupportive of each other;</li> <li>• Not working together;</li> <li>• No commitment to equality in parenting;</li> <li>• Isolated environment;</li> <li>• Ostracised by the community;</li> <li>• No relative or friends available;</li> <li>• Family violence (e.g. Spouse);</li> <li>• Frequent relationship breakdown/multiple relationships;</li> </ul>	<ul style="list-style-type: none"> <li>• Supportive spouse/partner;</li> <li>• Supportive of each other;</li> <li>• Stable, or violent;</li> <li>• Protective and supportive extended family;</li> <li>• Optimistic outlook by family and friends;</li> <li>• Equality in relationship;</li> <li>• Commitment to equality in parenting.</li> </ul>

	<ul style="list-style-type: none"> <li>• Drug or alcohol abuse.</li> </ul>	
<b>Expected child</b>	<ul style="list-style-type: none"> <li>• Special or expected needs;</li> <li>• Perceived as different;</li> <li>• Stressful gender issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Easy baby;</li> <li>• Acceptance of difference.</li> </ul>
<b>Parent-baby relationships</b>	<ul style="list-style-type: none"> <li>• Unrealistic expectations;</li> <li>• Concerning perception of baby's needs;</li> <li>• Inability to prioritise baby's needs above own;</li> <li>• Foetal abuse or neglect, including alcohol or drug abuse;</li> <li>• No ante-natal care;</li> <li>• Concealed pregnancy;</li> <li>• Unwanted pregnancy identified disability (non-acceptance);</li> <li>• Unattached to foetus;</li> <li>• Gender issues which cause stress;</li> <li>• Differences between parents towards unborn child;</li> <li>• Rigid views of parenting.</li> </ul>	<ul style="list-style-type: none"> <li>• Realistic expectations;</li> <li>• Perception of unborn child normal;</li> <li>• Appropriate preparation;</li> <li>• Understanding or awareness of baby's needs;</li> <li>• Unborn baby's needs prioritised;</li> <li>• Co-operation with antenatal care;</li> <li>• Sought early medical care;</li> <li>• Appropriate and regular ante-natal care;</li> <li>• Accepted/planned pregnancy;</li> <li>• Attachment to unborn foetus;</li> <li>• Treatment of addiction;</li> <li>• Acceptance of difference-gender/disability;</li> <li>• Parents agree about parenting.</li> </ul>
<b>Social</b>	<ul style="list-style-type: none"> <li>• Poverty;</li> <li>• Inadequate housing;</li> <li>• No support network;</li> <li>• Delinquent area.</li> </ul>	
<b>Future plans</b>	<ul style="list-style-type: none"> <li>• Unrealistic plans;</li> <li>• No plans;</li> <li>• Exhibit inappropriate parenting</li> </ul>	<ul style="list-style-type: none"> <li>• Realistic plans;</li> <li>• Exhibit appropriate parenting expectations and plans;</li> <li>• Appropriate expectation of</li> </ul>

	<p>plans;</p> <ul style="list-style-type: none"> <li>• Uncertainty or resistance to change;</li> <li>• No recognition of changes needed in lifestyle;</li> <li>• No recognition of a problem or a need to change;</li> <li>• Refuse to co-operate;</li> <li>• Disinterested and resistant;</li> <li>• Only one parent co-operating.</li> </ul>	<p>change;</p> <ul style="list-style-type: none"> <li>• Willingness and ability to work in partnership;</li> <li>• Willingness to resolve problems and concerns;</li> <li>• Parents co-operating equally.</li> </ul>
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**Framework for Practice: Risk Estimation**

Framework taken from an adaptation by Martin Calder in 'Unborn Children: A Framework for Assessment and Intervention' of R. Corner's 'Pre-birth Risk Assessment: Developing a Model of Practice'.

Factor	Elevated Risk	Lowered Risk
<b>The abusing parent</b>	<ul style="list-style-type: none"> <li>• Negative childhood experiences, inc. abuse in childhood; denial of past abuse;</li> <li>• Violence abuse of others;</li> <li>• Abuse and/or neglect of previous child;</li> <li>• Parental separation from previous children;</li> <li>• No clear explanation</li> <li>• No full understanding of abuse situation;</li> <li>• No acceptance of responsibility for the abuse;</li> <li>• Antenatal/post natal neglect;</li> <li>• Age: very young/immature;</li> <li>• Mental disorders or illness;</li> <li>• Learning difficulties;</li> <li>• Non-compliance;</li> <li>• Lack of interest or concern for the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Positive childhood;</li> <li>• Recognition and change in previous violent pattern;</li> <li>• Acknowledges seriousness and responsibility without deflection of blame onto others;</li> <li>• Full understanding and clear explanation of the circumstances in which the abuse occurred;</li> <li>• Maturity;</li> <li>• Willingness and demonstrated capacity and ability for change;</li> <li>• Presence of another safe non-abusing parent;</li> <li>• Compliance with professionals;</li> <li>• Abuse of previous child accepted and addressed in treatment (past/present);</li> <li>• Expresses concern and interest about the effects of</li> </ul>

		the abuse on the child.
<b>Non-abusing parent</b>	<ul style="list-style-type: none"> <li>• No acceptance of responsibility for the abuse by their partner;</li> <li>• Blaming others or the child.</li> </ul>	<ul style="list-style-type: none"> <li>• Accepts the risk posed by their partner and expresses a willingness to protect;</li> <li>• Accepts the seriousness of the risk and the consequences of failing to protect;</li> <li>• Willingness to resolve problems and concerns.</li> </ul>
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	<ul style="list-style-type: none"> <li>Stressful gender issues.</li> </ul>	
<b>Parent-baby relationships</b>	<ul style="list-style-type: none"> <li>Unrealistic expectations;</li> <li>Concerning perception of baby's needs;</li> <li>Inability to prioritise baby's needs above own;</li> <li>Foetal abuse or neglect, including alcohol or drug abuse;</li> <li>No ante-natal care;</li> <li>Concealed pregnancy;</li> <li>Unwanted pregnancy identified disability (non-acceptance);</li> <li>Unattached to foetus;</li> <li>Gender issues which cause stress;</li> <li>Differences between parents towards unborn child;</li> <li>Rigid views of parenting.</li> </ul>	<ul style="list-style-type: none"> <li>Realistic expectations;</li> <li>Perception of unborn child normal;</li> <li>Appropriate preparation;</li> <li>Understanding or awareness of baby's needs;</li> <li>Unborn baby's needs prioritised;</li> <li>Co-operation with antenatal care;</li> <li>Sought early medical care;</li> <li>Appropriate and regular antenatal care;</li> <li>Accepted/planned pregnancy;</li> <li>Attachment to unborn foetus;</li> <li>Treatment of addiction;</li> <li>Acceptance of difference-gender/disability;</li> <li>Parents agree about parenting.</li> </ul>
<b>Social</b>	<ul style="list-style-type: none"> <li>Poverty;</li> <li>Inadequate housing;</li> <li>No support network;</li> <li>Delinquent area.</li> </ul>	



<b>Future plans</b>	<ul style="list-style-type: none"> <li>• Unrealistic plans;</li> <li>• No plans;</li> <li>• Exhibit inappropriate parenting plans;</li> <li>• Uncertainty or resistance to change;</li> <li>• No recognition of changes needed in lifestyle;</li> <li>• No recognition of a problem or a need to change;</li> <li>• Refuse to co-operate;</li> <li>• Disinterested and resistant;</li> <li>• Only one parent co-operating.</li> </ul>	<ul style="list-style-type: none"> <li>• Realistic plans;</li> <li>• Exhibit appropriate parenting expectations and plans;</li> <li>• Appropriate expectation of change;</li> <li>• Willingness and ability to work in partnership;</li> <li>• Willingness to resolve problems and concerns;</li> <li>• Parents co-operating equally.</li> </ul>
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## 5) Intervention

Assessment in itself can be a form of intervention if done with skill. However it is equally important to ensure that any intervention needed is provided without delay to afford parents, carers, family and friends the best chance to care for their baby.

One of the key facets of assessment is capacity to change, and by offering interventions during the assessment the social worker will be supporting the family to make any changes needed to keep their baby safe while analysing capacity to change by how successful those interventions are in moving towards the safety goals.

All interventions must be agreed with the family as part of safety planning and must be focused on achieving the safety goals. Attendance at services/sessions is not a measure of success in itself.

The pre-birth process map shows the different interventions which should take place during the assessment period using the Signs of Safety model alongside an understanding of attachment and developmental trauma. These include the following which *must* take place:

- Family/friends safety network meetings
- Safety planning using Signs of Safety/resolutions approach
- Development of words and pictures explanation
- Family genograms/ecomaps and safety circles
- Family timeline

In addition, the following interventions may prove useful and should be considered during trajectory planning/supervision and in network meetings:

- Similar but different role play sessions  
CFIS specialist interventions – attachment and trauma work, mellow bumps, one to one parenting work or pre-birth group work, PAMS assessment/intervention, healthy relationships work, Five to Thrive approach to positive behaviours of parents. Online resources for five to thrive are available at:  
[www.westsussex.gov.uk/fivetothrive](http://www.westsussex.gov.uk/fivetothrive) and  
<https://beta.hertfordshire.gov.uk/services/schools-and-education/childcare-and-advice-for-parents/parents-and-family-support/my-babys-brain/my-babys-brain.aspx>
- Specialist risk assessment - domestic abuse, sexual abuse/offending  
When there is a concern regarding domestic violence, the CAADA DASH risk assessment tool should be completed with the family  
[https://www.westsussex.gov.uk/media/2020/caada\\_dash\\_risk\\_identification\\_checklist.pdf](https://www.westsussex.gov.uk/media/2020/caada_dash_risk_identification_checklist.pdf)
- Protective parenting work including for extended family/friends
- Practical interventions e.g. housing support, benefits (may be provided by another agency or by child and family worker)
- Cognitive assessment
- Psychiatric assessment/intervention
- Drug/alcohol specialist intervention
- Special guardianship assessment – legal advice or practical advice may be needed for those applying for special guardianship
- Parenting support from family nurse partnership
- Clarification of support/intervention from social worker or young people's service is parent-to-be is looked after or a care leaver, or subject to a child protection or child in need plan themselves.

## **5) Finalising the analysis, safety plan and decision/recommendations.**

The final written assessment should be completed using the **pre-birth** template as guidance and must be written in plain language throughout, based on evidence, and of a high quality which would be acceptable should the case have to proceed to Court. The domains of the framework for assessment of children in need should be considered in undertaking the assessment, but proportionality needs to be applied when writing the assessment to make it meaningful and individual to each child and families situation.

Where any research has been used as a form of intervention or to inform the assessment, references should be provided as an appendix. It should be

uploaded to the pre-birth assessment episode on framework following management quality assurance.

If other specialist assessments have been commissioned, information from those should be included where available. However if they are not completed in time, the pre-birth assessment should still be completed and refer to any gaps.

Any viability assessments of family members should be considered as part of the full assessment.

Any Signs of Safety mapping documents completed with the family during the period of the assessment process, and any completed or proposed safety plans, should also be provided as appendices and uploaded to the pre-birth assessment episode on Frameworki.

Throughout the assessment and intervention period, the social worker will have been working with the parents, extended family/friends and other agencies to identify any potential harm, complicating factors, and any safety and strengths which will mitigate against future harm. This should formulate the basis of the analysis which will be in the form of an updated danger statement, safety goals and final scaling of how safe everyone thinks that the child will be when they are born. The assessment including the scaling should take the child's safety in its whole family context, and is not an assessment of parenting capacity alone.

1. Danger statements – what are we worried about now and in the future?
2. Safety goals – where do we need to be to not have any worries?
3. Scaling – on a scale of 0-10, how safe will this child be when they are born and in the future, based on what we know now? Everyone involved should be asked to scale at the final network meeting and these scales and the reasons for them should be included as part of the analysis.
4. Safety plan – include the family involved safety plan as an appendices.

### **Conclusions and Recommendations**

The social worker should write an overarching statement of whether they think that the baby will be at risk of significant harm once it is born, and if so why. If the baby is considered at risk of ongoing harm, this would need to include a statement about why a family/friends involved safety plan to protect the child has not been successful or had the desired impact.

If a baby is not considered to be at risk of future harm, why is this and what is the plan to keep the baby safe in the future?

The social worker should make recommendations for any further work to take place with the parents and/or family networks to establish future safety including the need for a safety/birth plan and discharge planning meeting.

The social worker should make recommendations about who should care for the baby when it is born and if this is not the parent/s then what action needs to be taken by whom.

The social worker should make recommendations about any statutory/legal or child protection processes to be followed, or recommendations for child and family plan or step down to early help.

The parents and other family/friends views on the recommendations should be included as these should not be a surprise to the parents and should already have been discussed.

## **6) MANAGEMENT OVERSIGHT**

Day to day decision making and management oversight is the responsibility of the practice manager. Any significant decisions relating to process should follow the guidance as set out in "The way we work" document.

Supervision will be provided to the social worker by the practice manager in accordance with supervision procedures.

Additional decision making points using the Signs of Safety group supervision model are set out in the "process map" but can occur at any other time considered necessary.

In order to ensure the drift does not occur, the social worker will complete the pre birth tracking document at the end of each week and this will be sent to the practice manager and group manager. If there is drift or delay occurring for any reason, a three way meeting will be held the following week between the social worker, practice manager and group manager to make a decision on the way forward.

The practice manager will be responsible for quality assurance of the pre-birth assessment document.

Following completion of the pre birth assessment, if there is a recommendation for any child protection action, then within one week the group manager needs to quality assure the decision and has responsibility for the decision to proceed with child protection action. (Strategy meeting/section 47/legal planning)

If the decision is for no further action, or step down to early help, then the group manager will need to quality assure this decision and sign it off on frameworki.

If the decision is for child and family plan, then the group manager can take this decision and sign it off on framworki.

## **7) Case Transfer**

If the decision is to issue care proceedings at birth, then a representative from CLA will attend the meeting before proceedings.

There will be agreements made by the practice managers about what role the CLA service can contribute until the matter is before the court. The allocated social worker remains in place until the first ICO Hearing, when the matter will transfer to the CLA service.

A key part of next steps will be ensuring a permanence planning processes takes place and links are made with the Permanency coordinator and the Adoption Services.

If the decision is to proceed to ICPC then the case will remain in FS&P.

If the pre-birth assessment was completed in CAI and the case will transfer at ICPC to FS&P.

If the decision is Pre-proceedings meeting without issuing care proceedings, then an ICPC is to be convened and MBP held by the allocated team. If this is CAI then they need to invite FS&P and the Group Manager from FS&P should chair the Pre-proceedings meeting. The case will transfer after the meeting to FS&P.

If the case was in FS&P and a Pre-proceedings meeting is being convened without issuing care proceedings then the matter will remain in FS&P.

If case is proceeding to child and family plan, the case will remain with the allocated social worker in the service who completed the assessment.



## **Pre-birth Assessment**

**In respect of:**

**Unborn XXXX**

**Due date:**

**Author:**

**XXX**

**Team details**

**Date**

1. Author of this assessment (brief career/academic history)

2. Reason for assessment:

Unborn xx was referred to West Sussex children's Social care on xx/xx/xx when her Mum Ms x was xxxx weeks pregnant.

At this time, the worries were as follows:

*Initial danger statement MASH*

*Initial safety goal from MASH*

*Initial scaling of unborn's future safety at point of referral by professional and reasons*

3. Family Composition (*include all known family and friends networks*):

Name	Dob	Relationship	Address	Safety network person? Y/N

Ethnicity:

Religion:

Legal Status if appropriate:

First Language:

Genogram/ecomap: showing family connections to be pasted into report

4. Professionals currently involved with the family:

Name	Profession	Contact Number	Address

5. Sources of information:

Dates of visits to family members and who was seen

Dates of safety network meetings

Name of professionals who were consulted and when

Names/dates/types of other assessments/interventions by CFIS or other agencies.

Include any cancelled visits/meetings and reasons

6. Ante-Natal Care: Medical and Obstetric History:

When did the booking interview take place

Attendance of appointments

Home birth or hospital birth planned

Any complications or medical concerns re mother or unborn; any genetic inheritance issues

Concealed Pregnancy, wanted pregnancy?

Family Nurse Partnership involved?

7. Brief overview of any previous Children's Services involvement

Chronology must be completed and referred to from children's services records alongside family timeline of events

Dates of any ICPC and outcome

Dates and outcome of any care proceedings in respect any previous children

8. Information gathered section:

*You can place a photo of the parents to be here, as well as their networks if you have them.*

*Start with the parent/carer and family goals and what they would like to see happen.*

*Then divide this section into themes according to the worries which have been identified during the assessment. Each theme should start with a relevant danger statement and safety goal.*

*Refer to the pre-birth assessment written guidance which identifies areas that you should consider exploring during your assessment. However use proportionality and if an area poses no concern then you do not need to refer to it in the final assessment report.*

*If you have photos of the home conditions (if relevant) they should be referred to and added as appendices.*

*For example:*

*Theme 1:*



*Danger statement: "I xxx and Mrs xxx the midwife, are worried because Miss xxx has used heroin 3 times when she was pregnant. We are worried that if she keeps using heroin or other drugs, the baby will be really ill when it is born. Also if Miss x used drugs after the baby is born, that she would be out of it and not notice what the baby needs and he could be left alone, hungry, crying and get cold or dirty, making him very ill or even at risk of death."*

*Safety goal: "Miss xxx has not used drugs for the last three months, and we need this to carry on while she is pregnant so that baby is born well, and Miss xxx will be able to look after him properly. Miss xxx will keep coming to drug testing and testing clean. Miss xxx needs to have a plan for when the baby is born so that if she did go and use drugs, the baby will always be looked after by someone safe who he knows and who loves him, and never be around Miss xxx or other people who are using drugs."*

*For each theme describe:*

*What are the worries currently and historically – include is there anything we don't know or understand?*

*What is working well currently and what has worked well in the past - include what work/interventions have happened to help address any worries?*

*Is there a suitable safety plan in place to address this worry/theme? Who is involved?*

*Is there anything else that needs to happen to help address the worries in each theme?*

*Provide a safety scale for each theme, addressing the question where 0 means the baby will be certain to be harmed when born and 10 means that there is enough safety and this is no longer a worry.*

## 9. Analysis

Overall danger statement summarising the worries.

Overall safety goal for the baby.

Overall safety scale – include everyone's view including family and professionals.

## 10. Recommendations and Conclusions

Is this child at risk of significant harm? If yes, what is the plan to keep this baby safe?

Is there a naturally connected network involved?

Is there a safety plan developed which is being tested and which you are satisfied can keep the baby safe?

Are there any gaps in this assessment?

What is the contingency plan if the baby is unable to remain in the parents' care?

Recommendations for further work, any further assessment and intervention.

Recommendations for next step in process e.g. legal advice/child protection planning etc.

11. Parents/carers and other involved networks views.

Name

Role

Electronic Signature

Date

Quality  
Name

Assured

by

Practice Manager

Date

Appendices:

Safety plan

Words and Pictures

Signs of Safety mapping

Research/references