Pre-Birth Assessments

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1. Introduction

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| 1.1 | Some prospective parents may need additional support during the pregnancy and for the care of their baby or in some circumstances it may be anticipated that the baby yet to be born is likely be at risk of [**Significant Harm**](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html). |
| 1.2 | For those involved with pregnant women, irrespective of age, there is a need to be mindful of safeguarding issues, including a pregnancy as a result of sexual abuse, domestic violence or if there are concerns about the parents / potential carers ability to look after the new baby/babies.  1.3 A pre-birth assessment should be considered:   * + where a previous child/children in the family have been removed because they have suffered harm;   + where a person is assessed as posing a risk to children due to their offending behaviour (or someone found by a child protection conference to have abused children) has joined a family.   + where concerns exist about a parent’s ability to protect the baby from suffering significant harm at the hands of someone in the immediate or extended family.   + where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health difficulties or learning disabilities.   + where alcohol or substance abuse is thought to be affecting the health of the expected baby, and is likely to impact on the parents’ ability to meet the needs of the child once born is one concern amongst others   + where the expected parent is very young and a dual assessment of their own needs as well as their ability to meet the baby’s needs is required.   + where one the parent to be is a Child Looked After (CLA) or is a Care Leaver. Importantly, this should include both prospective parents not simply the expectant mother;   + when the pregnancy is denied or concealed;   1.4 Circumstances indicating a Pre-Birth Assessment is required:   * + Always if a previous child/young person has died unexpectedly in the care of the parents and the cause of death is a result of anything other than ‘natural causes’;   + Always if a previous child has been removed via Care Proceedings due to abuse or neglect or other Risk of Significant Harm or if they have a current child who is the subject of Care Proceedings or within a PLO process;   + Always if the parents have a child living with them who is currently the subject of a Child Protection Plan;   + Always if there is a current Sec 47 investigation on the unborn that is likely to lead to an Initial Child Protection Conference or Child in Need Plan;   + Always if for any reason (in addition to the above) it is possible that the mother and new-born will need to be separated at birth and Children Services will be part of the planning (not including a parent’s request for adoption);   1.5 If a decision is made not to undertake a pre-birth assessment then this should be clearly recorded an all agencies files. |

## 2. Early Information

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| 2.1 | Most pregnancies are identified within the first 3 months and during the booking interview with the midwife the following information is collected:   * Name; * Age/Date of birth; * Address; * Next of Kin; * Marital Status; * Details of the unborn baby’s father; * Partner Support; * Family structure and support; * Occupation; * Ethnic origin; * Planned/unplanned pregnancy; * Feelings about being pregnant; * Diet; * Medicines or drugs taken before and during pregnancy; * Alcohol/cigarette consumption; * Previous obstetric history including: * Number of children, date of births of children, names, current health status; * Do the children live in the household; * Same partner as previous children; * Any history of mental health issues; * Family health history; * Domestic Violence and Abuse; * Substance misuse; * Evidence or risk of Female Genital Mutilation; * Any concerns around factitious or induced illness of other primary family members. |
| 2.2 | This information builds into a full medical and social history and when all the data is assimilated, the midwife not only will be able to assist the women in making informed choices about the care she receives, advise on the suitability of her choices but will be able to consider if there are any concerns for the unborn child. Equally other professionals involved with either parent may also be concerned when aware of a pregnancy and must not assume that they are known to midwifery services and therefore undertake their own assessment of risk. |

## 3. Sharing Concerns

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| 3.1 | Where agencies or individuals anticipate that prospective parents may need support services to care for their baby they should clarify as far as possible, working with the family to undertaken an Early Help Assessment (EHA), to consider family strengths; their concerns in terms of how the parent's circumstances and/or behaviours that may impact on the baby and what risks are predicted. This could result in the EHA author calling a multi-agency meeting to help identify a multi-agency support for the baby and family. This should take place as soon as possible but preferably not later than 18 weeks. |
| 3.2 | If the EHA author is concerned that the unborn baby may be at risk of Significant Harm, a referral to Children's Social Care must be made. This will then be considered for a Child and Family [**Assessment**](http://trixresources.proceduresonline.com/nat_key/keywords/assessment.html). Once open to Medway Children's Social Care the support to the unborn baby and family should be planned and monitored by a multi-agency plan, which may be a Child in Need or a Child Protection Plan as appropriate. |
| 3.3 | A multi-agency meeting and/or referral should be made at the earliest opportunity in order to:   * Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth; * Enable the parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome to assessments; * Avoid initial approaches to the parents in the last stages of pregnancy, at what is already an emotionally charged time; * Provide sufficient time for a full and informed assessment; * Provide sufficient time to make adequate plans for the baby's protection. |
| 3.4 | Concerns should be shared with prospective parent(s) and consent obtained to refer to Children's Social Care UNLESS in doing so the unborn/sibling will be at an increased risk of significant harm. In those cases, practitioners should liaise with named / designated professional for safeguarding for advice and support. |
| 3.5 | If an urgent response is required due to a concealed pregnancy or denied pregnancy a strategy meeting is required. |

## 4. Assessment

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| 4.1 | A pre-birth Assessment should take place when there is evidence to indicate the unborn child is suffering harm or may be at risk of Significant Harm. |
| 4.2 | Consideration needs to be given seriously as to when during the pregnancy the child protection procedures are invoked to ensure the appropriate support and monitoring can be put in place sufficiently early to enable appropriate preventative action in cases such as:   * The mother is identified as at risk of sexual exploitation; * The complex needs of the mother are putting the foetus at risk of harm e.g.: misuse of alcohol and/or other substances, particularly where there has been no response to interventions or engagement in specialist treatment services. (Alcohol or substance misuse may be identified by relevant local screening tools identifying the potential harm to the foetus as well as the potential harm to the mother, third party information, observed presentation of intoxication, smelling of alcohol, or signs of withdrawal); * Planning protection for after the birth - if it is assessed that there is a need to provide particular support services or a change of living accommodation when the child is born. |
| 4.3 | The longer the time available for such a period of assessment the more thorough and comprehensive such an assessment can be. |
| 4.4 | The Pre-birth Assessment should whenever possible be completed within 25 days and recorded on the social work assessment template. It will commence as early as possible when a viable pregnancy is identified. At this point a decision is to be made whether an [**Initial Child Protection Conference**](http://trixresources.proceduresonline.com/nat_key/keywords/init_chi_prot_conf.html) is appropriate, or a Legal Planning Meeting needs to be convened to consider initiating Public Law Outline prior to birth and/or initiating proceedings at birth (see [**Section 7, Public Law Outline**](https://greatermanchesterscb.proceduresonline.com/chapters/p_pre_birth_assess.html#plo)). |
| 4.5 | There may be unusual circumstances when an assessment may be required to be undertaken expediently, e.g. a pre-conception assessment is requested; e.g. IVF, or if a pregnancy has been concealed, or denied.  In summary the Assessment should identify:   * Risk factors – what are we worried about; * Strengths in the family environment – what is working well; * Factors likely to change, reasons for this and timescales; * What needs to happen next to increase safety for the unborn child and mitigate against harm and risk of harm. |
| 4.6 | The assessment must make recommendations regarding the need, or not, for a pre-birth Child Protection Conference. The assessment should also make a recommendation about the need, or not, for a pre-birth Legal Gateway Panel. |
| 4.7 | When there are features of neglect in a case the Graded Care Profile must be used in order to create a base line assessment for future assessment.  4.8 The assessment report should address the following issues:   * What are we worried about? * What is working well? * Is there a risk of significant harm for this baby? It is crucial to clarify the nature of any risk - of what? From whom? In what circumstances? etc - and to be clear how effective any strengths or mitigating factors are likely to be in reality; * Will this risk arise: * Before the baby is born? * At or immediately following the birth? * Whilst still a baby (up to 1 year old)? * As a toddler? or pre-school? or as an older child? * If there is a risk that the child's needs may not be appropriately met, what needs to happen next? What changes should ideally be made to optimise well-being of child? What changes must be made to ensure safety and an acceptable level of care for child? * How motivated are the parent's to make changes? * How capable are the parent's to make changes? And what is the potential for success? |
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### Pre-birth ‘Good Practice Steps’

4.9 In a High Court judgment (Nottingham City Council v LW & Ors [2016] EWHC 11(Fam) (19 February 2016)) Keehan J set out the fundamental good practice steps with respect to public law proceedings regarding pre-birth and newly born children and particularly where Children’s Services are aware at a relatively early stage of the pregnancy. These are:

a) The birth plan should have been rigorously adhered to by all social work practitioners and managers and by the local authority's legal department;

b) A risk assessment of the mother and the father should have been commenced immediately upon the social workers being made aware of the mother's pregnancy. The assessment should have been completed at least 4 weeks before the mother's expected date for delivery. The assessment should then have been updated to take account of relevant events immediately pre and post delivery which could potentially affect the initial conclusions on risk and care planning for the unborn child;

c) The assessment should have been disclosed, forthwith upon initial completion, to the parents and, if instructed, to their solicitors to give them an opportunity, if necessary, to challenge the assessment of risk and the proposed care plan;

d) The social work team should have provided all relevant documentation, necessary for the legal department to issue care proceedings and the application for an interim care order, no less than 7 days before the expected date of delivery. The legal department must issue the application on the day of birth and, in any event, no later than 24 hours after birth (or as the case may be, the date on which the local authority is notified of the birth);

e) Immediately upon issue, if not before, the local authority's solicitors should have served the applications and supporting documents on the parents and, if instructed, upon their respective solicitors.

f) Immediately upon issue, the local authority should have sought from the court an initial hearing date, on the best time estimate that its solicitors could have provided.

## 5. Pre-Birth Conference

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| 5.1 | On occasion there will be sufficient concerns about the future risks to an unborn child to warrant the convening of a Child Protection Conference to consider the need for the baby to be the subject of an inter-agency [**Child Protection Plan**](http://trixresources.proceduresonline.com/nat_key/keywords/child_protection_plan.html). |
| 5.2 | This decision will normally follow on from a pre-birth risk assessment. This conference should have exactly the same status as any Initial Child Protection Conference. |
| 5.3 | A pre-birth conference must be held:   * When a pre-birth assessment gives rise to concerns that an unborn child may be at risk of [**Significant Harm**](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html); * Where a previous child has died or been seriously injured or been removed from parent(s) as a result of Significant Harm; * Following assessment where a child is to be born into a family or household which already have children subject to a Child Protection Plan; * Following assessment where a person known to pose a risk to children resides in the household or is known to be a regular visitor.   Other risk factors which must be considered are:   * The impact of parental risk factors such as mental ill health, learning disabilities, alcohol and/or substance misuse and domestic violence and abuse, as well as non-attendance, lack of engagement or recurring lapses, evidence of superficial compliance, or persistently not recognising the impact of parental risk factors on child’s needs and potential consequences; * A mother under sixteen about whom there are concerns regarding her ability to care for herself and/or to care for the child. |
| 5.4 | All agencies involved with pregnant women should consider the need for an early referral to the local Children's Social Care team so that assessments are undertaken, and family support services provided as early as possible in the pregnancy. |

## 6. Timings of Conference

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| 6.1 | The pre-birth conference should be convened in time to pool and share information and identify an inter-agency Child Protection Plan where necessary. The timing of the conference should consider the expected date of delivery. Ideally the pre-birth conference should take place as soon as possible after 24 weeks. An earlier conference should be considered for multiple births or pregnancies where there are complications likely to result in early delivery. An earlier conference should be considered for multiple births or pregnancies where there are complications likely to result in early delivery. |
| 6.2 | If a decision is made that the unborn child will be made the subject of a Child Protection Plan, the main cause for concern should determine the category of the Child Protection Plan. The [**Core Group**](http://trixresources.proceduresonline.com/nat_key/keywords/core_group.html) must be established at the initial conference and meet prior to the birth and certainly prior to the baby's return home after a hospital birth. The first Child Protection Review Conference will take place within three months of the pre-birth conference or within one month of the birth whichever is the sooner. |
| 6.3 | The Safeguarding Midwife will record the pre-birth conference decision and expected date of delivery as part of the plan prior to the birth. |
| 6.4 | If it is not possible to hold a Child Protection Conference before the birth of a baby who is considered at risk of Significant Harm, contact should be made with the relevant Children's Social Care team for immediate action to protect the child, and consideration should be given to them convening an Initial Child Protection Case Conference at the earliest opportunity. |

## 7. Public Law Outline

7.1 In cases where it has been agreed at Legal Gateway Panel that work should be undertaken under the [Public Law Outline](http://trixresources.proceduresonline.com/nat_key/keywords/public_law_outline.html) framework, there should be as little delay as possible in sending out Letters before Proceedings and holding Pre Proceedings meetings. This is in order to avoid such approaches to the pregnant woman in the late stages of pregnancy and to work with the family to explore all options in order to avoid, where possible, initiating [Care Proceedings](http://trixresources.proceduresonline.com/nat_key/keywords/care_proceedings.html). There is also an opportunity to commission specialist assessments at this stage.

7.2 In cases where there is a recommendation to initiate Care Proceedings at birth, cases should be booked into the Legal Gateway Panel at the earliest possible date prior to the birth. The Child and Family Assessment and full Chronology must be available at the Legal Gateway Panel and a referral for a [Family Group Conference](http://trixresources.proceduresonline.com/nat_key/keywords/family_group_conference.html) will have been completed prior to the Legal Gateway Panel.

7.3 In the case of late referrals meeting the threshold for Legal Gateway Panel, the social worker and team manager can request an emergency Legal Planning discussion rather than waiting until the next available date for a Legal Gateway Panel.

## 8. Birth Planning Meeting

8.1 If the decision of the Legal Gateway Panel is that the unborn baby should be the subject of Care Proceedings, a Pre-Birth Planning Meeting should take place, ideally at the hospital.

8.2 The purpose of the Pre-Birth Planning Meeting is for professionals to be clear about their roles and responsibilities and to agree a multi-agency plan to safeguard the baby once born.

8.3 The social worker with case responsibility will attend this meeting.

8.4 Consideration should be given to the expected date of delivery and other ongoing investigations when planning the timing of the meeting. The decisions of this meeting should be recorded on the patient’s records by the lead midwife in consultation with the named midwife for safeguarding, who will ensure that the midwives are fully appraised of the plan for the child.

8.5 The agenda for this meeting should address the following:

* How long the baby will stay in hospital. If a baby is showing signs of withdrawal then their length of stay will depend on the clinical need of the baby;
* How long the hospital will keep the mother on the ward;
* The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed from parental alcohol consumption, substance misuse; mental ill health and/or; domestic violence. Consideration should be given to the use of hospital security; informing the Police;
* The risk of potential abduction of the baby from the hospital particularly where it is planned to remove the baby at birth;
* The plan for contact between mother, father, extended family and the baby whilst in hospital. Consideration to be given to the supervision of contact – for example whether contact supervisors need to be employed;
* Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication or drugs being taken by the mother which are contraindicated in relation to breastfeeding;
* The plan for the baby upon discharge that will be under the auspices of Care Proceedings, e.g. discharge to parent/extended family members; mother and baby foster placement; foster care, supported accommodation;
* Contingency plans should also be in place in the event of a sudden change in circumstances;
* Who to contact should the baby be born out of hours;
* The Children’s Out of Hours Service should also be notified of the pre-birth and plans for the baby.

## 9. Birth and Discharge of a Newborn Baby

9.1 The hospital midwives should inform Medway Children’s Social Care of the birth of the baby as soon as possible (ideally the allocated Social Worker will be informed once the expectant mother is admitted in established labour).

9.2 In cases where legal action is proposed or where the unborn child has been the subject of a Child Protection Plan, the allocated [**Social Worker**](http://trixresources.proceduresonline.com/nat_key/keywords/lead_social_worker.html) should visit the hospital as soon as practicable following the birth. The Social Worker should meet with relevant maternity staff prior to meeting with the mother and baby to gather information and consider whether there are any changes needed to the discharge and protection plan. The midwife with access to the health records should record a brief note of the Social Worker’s visit on the child’s medical notes, which should include the time, key points of the discussion, agreements and social work contact details. The Social Worker should visit the baby and parents on the ward in accordance with the agreed child protection plan and pre-birth plan.

9.3 Ward staff should keep a daily record of any visitors to the child and details of any concerns that emerge whilst on the ward. This could be important information for child protection planning or evidence needed for care proceedings.

9.4 If the baby is the subject of a Child Protection Plan, a Core Group discharge meeting should be held to draw up a detailed plan prior to the baby’s discharge home. If this is not possible, the [**Core Group**](http://trixresources.proceduresonline.com/nat_key/keywords/core_group.html) should meet within 7 days of the baby’s birth.

9.5 If a decision has been made to initiate Care Proceedings in respect of the baby, the Social Worker must keep relevant maternity staff updated about the timing of any application to the Courts. The lead midwife and named safeguarding nurse or designated doctor should be informed immediately of the outcome of any application and placement for the baby. A copy of any Orders obtained should be forwarded immediately to the hospital if they are not being discharged that same day. PLEASE NOTE: The application to court can only be made once the baby is born. If there are immediate child protection concerns prior to the order being granted then contact the Police.

## 10. Pregnancy of Young People in Care

10.1 When it is established that a young person in care or a supported care leaver is pregnant, the referrer must ring for a consultation with Medway Single Point of Access. A decision can then be reached about the assessment process between both the referring team and the Medway Single Point of Access.

10.2 It should not be an automatic decision to complete a pre-birth assessment in relation to the pregnancies of all care leavers unless the thresholds are met as outlined above.

10.3 If the [**Section 47**](http://trixresources.proceduresonline.com/nat_key/keywords/sec_47_enq.html) threshold is met and a [**Strategy Meeting**](http://trixresources.proceduresonline.com/nat_key/keywords/strategy_meeting.html) convened, relevant staff from 16+ Leaving Care or Children in Care teams should be included.

10.4 If the young person’s placement is out of borough Medway Children Services must refer the case of the unborn baby to the relevant Local Authority.

10.5 In any event, the Strategy Meeting will consider risk/need in the context of the young person being pregnant and plans will be agreed accordingly.

## 11. Allocation and Case Transfer

11.1 The Single Point of Access will be responsible for the initial screening of all pre-birth cases referred. A decision about allocation will be made within 24 hours of receipt of the referral.

11.2 Cases where siblings of unborn children are already open to Medway Children Services or in Care Proceedings the unborn child will continue to be allocated within those teams with the exception of the 16+ Leaving Care Teams. In cases where the court proceedings have concluded, the pre-birth assessment will be referred to the Team that managed these proceedings if they fall within a 3-month period. Outside of the 3-month timescale the case will be allocated within the Assessment teams.

## 12. General Guidelines for Conducting Pre-Birth Assessments

12.1 The importance of conducting pre-birth assessments has been highlighted by numerous research studies and [Serious Case Reviews](http://trixresources.proceduresonline.com/nat_key/keywords/serious_case_review.html) which have shown that children are most at risk of fatal and severe assaults in the first year of life, usually inflicted by their carers.

12.2 Pre-Birth Assessment is a sensitive and complex area of work. Parents may feel anxious about their child being removed from them at birth. Referring professionals may be reluctant to refer vulnerable adults and be anxious about the prospective parents losing trust in them.

12.3 It is important to undertake the assessment during early pregnancy so that the parents are given the opportunity to demonstrate the capacity to change. If the outcome of the assessment suggests that parenting capacity is affected in a negative way there is an opportunity to make clear and structured plans for the baby’s future, together with support for the parents.

12.4 Social Workers undertaking the assessments should have access to appropriate resources, liaison with key professionals and undertaking joint assessment visits.

12.5 It is important that social workers do not conduct assessments in isolation. Working closely with relevant professionals such as midwives and health visitors is essential. Liaising with relevant substance misuse, mental health and learning disability professionals is also crucial. The liaison mental health worker will also offer advice on cases with a mental health component and become involved in liaison with mental health professionals.

12.6 The importance of compiling a full chronology and family history is particularly important in assessing the risks and likely outcome for the child. Where there have been previous children in the family removed, the previous Court documents such as copies of Final Court Judgements and assessment reports should be accessed at an early stage. If there have been Social Workers involved from the Children’s Social Care Services, they should be consulted and invited to relevant meetings.

12.7 Workers should try to compile a clear history from the parents about their own previous experiences in order to find out whether they have any unresolved conflicts, for example that may impact on their parenting of the child. It is important to find out their feelings towards the newborn baby and the meaning that the child may have for them. For example, the pregnancy may have coincided with a major crisis in the parent’s life, which will affect their feelings towards the child.

12.8 It is also important to find out the parents’ views about any previous children who have been removed from their care and whether they have demonstrated sufficient insight and capacity to change in this respect.

12.9 It is crucial to seek information about fathers/partners whilst conducting assessments and involve them in the process. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

12.10 Working with extended families is also crucial to the assessment process and achieving positive outcomes for unborn children. [**Family Group Conferences**](http://trixresources.proceduresonline.com/nat_key/keywords/family_group_conference.html) must be always convened in any cases where there is a possibility that the mother may be unable to meet the needs of the unborn child.

12.11 Family Group Conferences can enable the families to be brought together to make alternative plans for the care of the child thus avoiding the need for Care Proceedings in some cases. Parallel assessment of alternative family carers can prevent delays in Care Planning for the child.

**13. 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' and blended with the Sings of Safety approach to risk assessment

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| **When assessing** | **What are we worried about?** | **What is working well?** |
| Parents assessed previously as causing harm or posing a risk of harm to children | * Negative childhood experiences, inclusive of abuse in childhood; denial of past abuse; * Violence and/or abuse of others; * Abuse and/or neglect of previous child; * Parental separation from previous children; * No clear explanation for previous harm caused to children and adults; * No understanding of abuse situation; * No acceptance of responsibility for the abuse; * Antenatal/post-natal neglect; * Age: very young/immature; * Mental disorders or illness; * Learning difficulties; * Non-compliance with medical advice; * Lack of interest or concern for the child. | * Positive childhood; * Recognition and change in previous violent patterns of behaviour; * Acknowledges seriousness and takes responsibility without deflection of blame onto others; * Full understanding and clear explanation of the circumstances in which the abuse occurred; * Maturity; * Willingness and demonstrated capacity and ability for change; * Presence of another safe non-abusing parent; * Compliance with advice from professionals; * Abuse of previous child accepted and addressed in treatment (past/present); * Expresses concern and interest about the effects of the abuse on the child. |
| New parents and/or partners of parents assessed previously as causing harm or posing a risk of harm to children | * No acceptance of responsibility for the abuse by their partner; * Blaming others or the child. | * Accepts the risk posed by their partner and expresses a willingness to protect; * Accepts the seriousness of the risk and the consequences of failing to protect; * Willingness to resolve problems and concerns. |
| Family dynamics (couple relationship and the wider family) | * Relationship disharmony/instability; * Poor impulse control; * Mental health problems; * Violent network engaged or suspected to engage in criminal activity involving kin, friends and associates (including drugs dealing, exploitation of others); * Lack of support for primary carer /unsupportive of each other; * Not working together; * No commitment to equality in parenting; * Isolated environment; * Rejected by the community; * No relative or friends available; * Family violence; * Frequent relationship breakdown/multiple relationships; * Drug or alcohol abuse. | * Supportive spouse/partner; * Protective and supportive extended family; * Optimistic outlook by family and friends; * Equality in relationship; * Commitment to equality in parenting. |
| Expected child | * Special or expected needs; * Perceived as different; * Stressful gender issues. | * Healthy baby; * Acceptance of difference or expected needs. |
| Parent-baby relationships | * Unrealistic expectations; * Concerning perception of baby's needs; * Difficulty to prioritise baby's needs above own; * Foetal abuse or neglect, including exposing unborn baby to alcohol or drug abuse; * No ante-natal care; * Concealed pregnancy; * Unwanted pregnancy identified disability (non-acceptance); * Have not formed a relationship with the foetus; * Gender issues which cause stress; * Differences between parents towards unborn child; * Rigid views of parenting. | * Realistic expectations; * Perception of unborn child normal; * Appropriate preparation; * Understanding or awareness of baby's needs; * Unborn baby's needs prioritised; * Sought early medical care; * Appropriate and regular ante-natal care; * Accepted/planned pregnancy; * Has formed a relationship with the unborn foetus; * Treatment of addiction; * Acceptance of difference-gender/disability; * Parents agree about parenting. |
| Social context | * Poverty; * Inadequate housing; * No support network; | * Sufficient financial means to prepare for the baby: * Adequate housing; * Extended family and friends that are willing and able to offer help |
| Future plans | * Unrealistic plans; * No plans; * Exhibit inappropriate parenting plans; * Uncertainty or resistance to change; * No recognition of changes needed in lifestyle; * No recognition of a problem or a need to change; * Refuse to co-operate; * Disinterested and resistant. | * Realistic plans; * Exhibit appropriate parenting expectations and plans; * Appropriate expectation of change; * Willingness and ability to work in partnership; * Willingness to resolve problems and concerns; * Parents co-operating equally. |
| Where are we on a scale of 0 to 10, where 10 means there is enough safety for Medway Children Services to close the case and 0 means it is certain that the baby will have to be removed from the parent/s’ care at birth?  0 10 | | |