

**PRE-BIRTH ASSESSMENT**

**Practice Guidance**

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# Context

This guidance is intended to inform managers and practitioners involved in work with families prior to birth. It is of particular relevance to staff members involved in conducting pre-birth assessments.

It is intended to inform a sustained approach to assessment in which parents are engaged and supported throughout the ante-natal period rather than a ‘stop start’ approach where there are long periods of time where no work is being undertaken. Identifying the needs of and potential risks to the unborn child at the earliest possible stage reduces the likelihood of last minute activity around the time of birth and the consequent distress to the family. This ensures families have a right of representation and can access this accordingly in good time.

The importance of conducting pre-birth assessments has been highlighted by numerous research studies and [Serious Case Reviews](http://www.proceduresonline.com/resources/keywords_online/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.

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 [Adults at Risk](http://trixresources.proceduresonline.com/nat_key/keywords/adult_at_risk.html) and be anxious about the prospective parents losing trust in them.

It is important to undertake the assessment during early pregnancy so that the parents are given the opportunity to show that they can change. If the outcome of the assessment suggests that the baby would not be safe with the parents then there is an opportunity to make clear and structured plans for the baby’s future together with support for the parents.

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.

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 Looked after children’s service, they should be consulted and invited to relevant meetings.

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 new-born 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.

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.

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.

Working with extended families is also crucial to the assessment process and achieving positive outcomes for unborn children. Referrals for a Family Group Conferenceshould be madein any case where there is a possibility that the mother may be unable to meet the needs of the unborn child.

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.

A pre-birth assessment tool is attached to this guidance to help social workers consider the key questions to address when undertaking assessments. It is important to provide an analysis of the likely impact of parental issues on the unborn child rather than just providing a description. For example, the likely impact of parental substance misuse on both the unborn and the new-born child needs to be spelled out explicitly.

This guidance should be read in conjunction with the LSCB procedures.

# Purpose

The main purpose of a pre-birth assessment is to identify:

* What the needs of and risks to the new-born child may be;
* Whether the parent/s are capable of recognising these and working with professionals so that the needs can be met and the risks reduced;
* What supports the parents may need;
* Plans to ensure the needs are meet and risks addressed.

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

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

Where there is reason for doubt about the above a pre-birth assessment is indicated.

# Principles

* Pre-birth assessments should be undertaken within a multi-agency approach;
* Early referrals should be encouraged in order to ensure the following:
  + Sufficient time is allowed in order to undertake a detailed assessment including the preparation of a detailed Chronology;
  + There is sufficient time to make effective care/protection plans;
  + Parents have time to contribute to any assessment and to increase the likelihood of a positive outcome to the assessment;
  + Parents are not being approached in the latter stages of pregnancy which is a stressful time in any event;
  + Support services can be provided in a timely fashion;
  + Late referrals receive the highest level of priority.

# Initial Contact and Referral Stage

A referral should be made to the Duty and Advice Service as soon as the pregnancy is known and there are concerns identified. Research shows that parents are more likely to engage in the pre-birth assessment process at an early stage, therefore where it is anticipated that prospective parents may need intensive support services to care for their baby, or that the baby may be at risk of significant harm a referral to social care should be made immediately.

It should not be an automatic decision to complete a pre-birth assessment in relation to the pregnancies of all care leavers unless there is concern about how that young person may parent their child.

It is important that the expected date of delivery (EDD) is ascertained from the Referrer at the point of referral and recorded onto the electronic social care record (Liquid Logic). If this is not established at the point of referral this will be a priority task for the allocated social worker.

If it is considered that there are insufficient grounds for a [Single Assessment](http://trixresources.proceduresonline.com/nat_key/keywords/assessment.html) to be undertaken, consideration should always be given to signposting the case to other appropriate agencies. This should be discussed with the Advanced Practitioner lead for Pre-birth assessments to ensure critical issues are not overlooked.

The details of the father of the child and/or the male partner of the mother should also be obtained and recorded on Liquid Logic.

# Single Assessment

Pre-birth Single Assessments must be undertaken on all pre-birth referrals where the following factors are present:

* There has been a previous unexplained death of a child whilst in the care of either parent;
* A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children;
* A sibling is the subject of a [Child Protection Plan](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/child_protection_plan.html);
* The parent is a [Looked After](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/looked_after.html) child;
* A sibling has previously been Looked After voluntarily or via a Court Order/ [Police Protection](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/police_protection.html);
* Domestic violence and abuse is known to have occurred;
* The degree of parental substance misuse is likely to have a significant impact on the baby’s safety or development;
* The degree of parental mental illness/impairment is likely to have a significant impact on the baby’s safety or development;
* There are concerns about parental maturity and ability to self-care and look after a child e.g. an unsupported young mother;
* The degree of parental learning disability is likely to have a significant impact on the baby’s safety;
* There are concerns about a parent’s capacity to adequately care for their baby because of the parent’s physical disability;
* A child under 16 is found to be pregnant;
* Concerns that the baby may be subjected to Female Genital Mutilation
* Relinquished babies
* Concealed pregnancy
* Where there are maternal risk factors, e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby, including frequent moves e.g. area to area, hospital to hospital.
* Concerns that the mother and or father of the unborn are at risk from honour based violence.
* Any other concern exists that the baby may be likely to suffer [Significant Harm](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/significant_harm.html) including a parent previously suspected of fabricated or inducing illness in a child.

For all new cases this will be undertaken by the Single Assessment Team. The case will be transferred at the point of a multi-agency meeting. For those cases with siblings already allocated, this will be undertaken by the allocated worker. A pre-birth assessment where the parent is looked after will be undertaken by the Single Assessment Team following a referral made by the Looked after child’s Social Worker.

# Child In Need (CIN)

At the completion of the Single Assessment a decision may be made that parents-to-be should be supported in order that the child’s health and development needs can be met. It should be considered in these circumstances that, without the provision of such services the baby’s health and development (when born) will be impaired (S17 The Children Act 1989).

A CIN plan should be devised and should include all professionals working alongside the family and those who will be working with the baby when born. The plan should be reviewed on a 6 weekly basis to ensure the support is the right support and that it is making a difference.

It is crucial to involve health visitors in the plan. This will be relevant as the pregnancy progresses however the Health Visitor should always be invited to any CIN review meetings prior to the baby’s birth. This is to ensure all those involved have an understanding of the plan and support required.

A referral should be made for a family group conference to consider the family network and the support available.

# Child Protection

Strategy Meetings

It is important that the potential risks to the unborn child are flagged up as early as possible to inform effective planning and in order to gather information at an early stage including relevant Police checks.

If it is evident at the point of referral or the completion of a Single Assessment that there are reasonable grounds to believe that the unborn child may be likely to suffer [Significant Harm](http://trixresources.proceduresonline.com/nat_key/keywords/significant_harm.html), a multi-agency [Strategy Meeting](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/strategy_meeting.html) must be held within 72 hours. Clearly it may become evident at any stage of the assessment that there are grounds to believe a child is likely to suffer Significant Harm, and if so, a Strategy Meeting should be held accordingly. This is particularly urgent where the referral has been received after 24 weeks’ gestation or where there has been an attempt by the mother to conceal the pregnancy Strategy Meetings should not be delayed purely in order to trigger a Child Protection Conference at a later stage.

In cases where previous children have been removed by a Local Authority and continue to be Looked After, the allocated social worker for those children must be invited to the Strategy Meeting in order to provide relevant background information and history.

In cases where [Care Proceedings](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/care_proceedings.html) had been conducted, the Single Assessment team worker should contact the Legal Department to request a copy of the legal file.

The lead Advanced Practitioner for Pre-birth should be invited to attend Strategy Meetings in cases where there have been previous Care Proceedings. Their role will be:

* To advise on areas of assessment;
* To work to ensure that full historical information is made available within 7 days of the Strategy Meeting; and
* To ensure there is no drift and delay in progressing the ongoing assessment and intervention.

Late Bookings and Concealed Pregnancy

For the purposes of this guidance, late booking is defined as relating to women who present to maternity services after 24 weeks of pregnancy.

There are many reasons why women may not engage with ante-natal services or conceal their pregnancy, some of or a combination of which will result in heightened risk to the child.

Some of the indicators of risk and vulnerability are as follows:

* Previous concealed pregnancy;
* Previous children removed from the mother’s care;
* Fear that the baby will be taken away;
* History of substance misuse;
* Mental health difficulties;
* Learning disability;
* Domestic violence and abuse and interpersonal relationship problems;
* Previous childhood experiences/poor parenting/sexual abuse;
* Poor relationships with health professionals/ not registering with a GP.

In cases where there are issues of late booking and concealed pregnancy, it is extremely important that careful consideration is given to the reason for concealment, assessing the potential risks to the child and convening a Strategy Meeting as a matter of urgency.

Any plan arising from a Strategy Meeting should decide on the following:

* Timescales for completion of an assessment;
* Contingency planning;
* Whether the [Public Law Outline](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/public_law_outline.html) process should be commenced - see [Initiating Care Proceedings Procedure](http://southwark.proceduresonline.com/chapters/p_init_care_proc.htm).

The allocated social worker must contact the Midwifery Service and set up an immediate home visit within 3 working days to meet with the pregnant woman. Any home visit should set out clear expectations of engagement under a written parental agreement.

Parental Non-Engagement

There are many reasons why expectant mothers may fail to engage with the assessment, some of which relate to the factors outlined above. For example, a parent suffering from mental health problems may be reluctant to attend appointments or be compliant with medication. It is extremely important that parental non-engagement does not become the reason for delaying the assessment and making multi-agency plans and contingency plans for the birth of the baby.

Pre-birth Child Protection Conferences

If it is decided that a pre-birth Child Protection Conference should be held it should take place as early as is practical and **never later** than 10 weeks before the due date of delivery, so as to allow as much time as possible for planning support to the baby and family. Where there is a known likelihood of a premature birth, the Conference should be held earlier. N.B. Drug using pregnant women are more likely to give birth prematurely, therefore early conferencing in such cases is vital.

If the unborn baby has siblings subject to a Child Protection Plan, a pre- birth conference must be convened separately to ensure the needs of the baby are given specific consideration.

A referral should be made for a family group conference to consider the family network and the support available.

Child Protection Plan

If a decision is made that the baby needs to be the subject of a [Child Protection Plan](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/child_protection_plan.html), the plan must be outlined to commence prior to the birth of the baby.

The [Core Group](http://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/core_group.html) must be identified and should meet prior to the birth to agree the plans for the birth and plans for the baby’s discharge home after a hospital birth.

If the mother goes missing at any point – child protection procedures should be followed and notifications sent to other Local Authorities.

Once the child is born, he or she should not be discharged from hospital until a pre-discharge meeting chaired by a Team Manager from social care has been arranged and everyone involved is aware of the plan. (See section 9.Pre- birth discharge planning meeting**)**

Pre-birth Review Child Protection Conference.

The first Review Conference should take place within 4 weeks of the child’s birth or within three months of the date of the Pre-birth Conference whichever is sooner.

# Public Law Outline

It is critical that planning takes place early and that all assessments and support identified is commissioned/undertaken before the baby is born. This ensures that a clear plan can be made for the baby and this plan is made robust as a result of evidence based assessments. Where the concerns are so significant that it is considered the baby will be at risk of harm once born, a legal planning meeting should be convened.

The legal planning meeting may decide that the case needs to be managed within pre-proceedings and clear timescales will then be set. The case will be tracked to ensure assessments are undertaken in a timely way. If this is agreed, 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 preferably avoid initiating Care Proceedings.

The responsible Team Manager will chair a pre-proceedings meeting which will be held with parents and their legal representatives (these may need to be separate meetings with each parent having their own legal representation depending upon their circumstance). The purpose of this meeting is to set out clear expectations and actions required and the timescales for completion.

The Pre-proceedings meeting has a set agenda and this should be followed. The TM will be responsible for ensuring that the meeting is recorded accurately. The minutes of this meeting should be recorded on the child’s file within Liquid Logic.

In cases where there is a recommendation to initiate Care Proceedings at birth, cases should be booked into the weekly Legal Planning Meeting following the completion of the pre-proceedings process and at the earliest possible date prior to the birth. The [Single Assessment](http://trixresources.proceduresonline.com/nat_key/keywords/assessment.html) and full Chronology must be available at the Legal Planning Meeting.

In the case of late referrals meeting the threshold for legal planning, the Service Manager can be requested to convene an emergency Legal Planning Meeting rather than waiting until the next weekly Legal Planning Meeting. This should be an emergency and necessary and as an exception as all steps must be taken to book onto the panel.

# Pre- birth discharge planning meeting

If the decision of the Legal Planning Meeting is that the unborn baby should be the subject of Care Proceedings, a Birth Planning Meeting must take place at the hospital. This is a professionals meeting which should be chaired by a Team Manager.

The decisions of this meeting should be recorded on the child’s record and a copy provided to those attending including acute (LRI or LGH) maternity services so they can be placed on the patient’s records.

The purpose of the meeting is to make a detailed plan for the baby’s protection and welfare around the time of birth so that all members of the hospital team are aware of the plans.

The agenda for this meeting should address the following:

* How long the baby will stay in hospital (a minimum of 7 days is usually recommended to monitor for withdrawal symptoms for babies born to substance using mothers);
* 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 to the e.g. parental substance misuse; mental;
* Health; domestic violence and abuse. Consideration should be given to the use of hospital security; informing the Police etc.;
* 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 being taken by the mother which is 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;
* Where there are concerns about an unborn of a pregnant woman who intends to have a home birth, the Ambulance Service Lead should be invited to the Birth Planning Meeting;
* Contingency plans should also be in place in the event of a sudden change in circumstances;
* Hospital staff should be given clear instructions regarding any birth that is likely to occur over a weekend or Bank Holiday;
* The Duty and Advice Out of Hours Service should also be notified of the birth and plans for the baby.

# Birth and discharge of a new-born baby

The hospital midwives should be advised that they need to inform the allocated social worker of the birth of the baby and there should be close communication between all agencies around the time of labour and birth.

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://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/lead_social_worker.html) should visit the hospital on the next working day following the birth. The Lead Social Worker should meet with the maternity staff and the mother, father and baby to gather information and consider whether there are any changes needed to the discharge and protection plan. The Social Worker should keep in daily contact with the ward staff and visit the baby and the parents on the ward regularly to meet with the parents. This may need to be daily depending upon the circumstances and should be agreed with the Team Manager.

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://www.proceduresonline.com/resources/keywords_online/nat_key/keywords/core_group.html) should meet within 7 days of the baby’s birth.

If a decision has been made to initiate Care Proceedings in respect of the baby, the Social Worker must keep the hospital up-dated about the timing of any application to the Courts. The lead midwife should be informed immediately of the outcome of any application and placement for the baby.

# Appendix 1: The Pre-Birth Assessment Tool

*This 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'.*

Family Structure

Names, addresses, ages etc. Extended family and potential support should be included. Nationality, religion, race and culture should be explored within this.

Ante-Natal Care: Medical and Obstetric History

General Guidance

Antenatal care begins as soon as the pregnancy has been confirmed and midwives continue care in the postnatal period for at least 10 days following birth. A booking interview with the community midwife takes place ideally between 8-12 weeks gestation. This is usually in the woman's home or at the GP's surgery. It is at this interview that the midwife is able to assist women in their choices for childbirth and ensure they are informed of all the options available to them.

Women are given choices in early pregnancy of lead professional and place of birth:

Midwife-led care (MLC) means the midwife is the lead professional. All antenatal care would be conducted in the community and is often shared with the General Practitioner (GP). Women would have the choice of giving birth in the hospital under MLC or at home with midwives in attendance.

GP led care is less frequently offered and again all antenatal care is conducted in the community and is shared between GP and community midwife. The place of birth is rarely at home with the GP in attendance so most GP births occur in a low-risk hospital environment.

Consultant led care is offered to women who have recognised health risk factors or who choose to see the consultant team. These pregnancies require additional surveillance both pre-birth and in labour. Care is shared between the community midwife, GP and a hospital consultant team consisting of midwives and doctors specialising in care of high risk pregnancy. Delivery of the baby will take place in the hospital.

The booking interview is a time of collection of information and an opportunity for the midwife and mother to plan her care in pregnancy. It is an ideal time for the midwife to assess health and social needs of families and to consider packages of care and support suitable for individual needs.

Antenatal appointments are arranged to suit the individual clinical needs of the mothers and the initial choices may change if complications of pregnancy arise. A collaborative approach between all health professionals is encouraged with direct midwife referral to obstetrician being available at all times.

In the case of home births all postnatal care is provided in the home by the community midwife. For births in hospital - with either the midwife, GP or obstetrician as the lead professional - initial postnatal care is provided by midwives and support staff on the maternity wards. Hospital stays are getting shorter with many women going home within a few hours of birth but generally 12-48 hours are the more normal lengths of stay. On transfer home care is undertaken by the community midwife for at least 10 days following the birth. Care can be extended to up to 28 days if a particular clinical or social need is identified. Liaison between the Health Visitor attached to the GP's surgery and community midwife usually takes place during the antenatal period with some Health Visitors making contact with the mother in pregnancy. Following the birth of the baby most Health Visitors arrange a primary visit at 10 days postnatal, which coincides well with the handover of care from the midwives.

Assessment of Parents and potential risks to Child

Pregnancy can create special circumstances/influences for both parents, which need to be accommodated and understood by all professionals who come into contact with these families. Pregnancy will have a major impact on some people's lives and will affect both behaviour and relationships. Pregnant women's health and their responses to external factors often change in pregnancy - and the physiological, emotional and social influences that both cause and are affected by these changes can have a direct impact on their behaviour and health and how they manage in key relationships.

Particular care should be taken when assessing risks to babies whose parents are themselves children. Attention should be given to a) evaluating the quality and quantity of support that will be available within the family (and extended family), b) the needs of the parent(s) and how these will be met) the context and circumstances in which the baby was conceived, and d) the wishes and feelings of the child who is to be a parent.

Relationships

The following should be considered

* History of relationships of adults
* Current status
* Positives and negatives
* Any notion or evidence of violence?
* Who will be main carer for the baby?
* What are the expectations of the parents re 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

Consider:

* Physical
* Emotional (including self control);
* Intellectual
* Knowledge and understanding re children and child care
* Knowledge and understanding of concerns / this assessment

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

Behaviour

Is there;

* Violence to partner?
* Violence to others?
* Violence to any child?
* Drug/alcohol misuse? *If drugs or alcohol are a significant issue, more detailed assessment should be sought from professionals with relevant expertise.*
* 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?

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

* Chaotic?
* Health risks / insanitary / dangerous?
* Over-crowded?

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

* 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

* Convictions re offences against children?
* CP Registration?
* 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?

If 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 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?

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?

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?

It may be appropriate to consult with Health professionals re this section.

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?

It will usually be appropriate to consult with relevant Health professionals re this section

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?

It will usually be appropriate to consult with other professionals re this section.

Planning for the future

* Realistic and appropriate?

1. Concerns identified;
2. Strengths or mitigating factors identified;
3. 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;
4. Will this risk arise:
   1. Before the baby is born?
   2. At or immediately following the birth?
   3. Whilst still a baby (up to 1 year old)?
   4. 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.
5. What changes should ideally be made to optimise well-being of child?  
   If there is a risk of significant harm to the child.
6. What changes must be made to ensure safety and an acceptable level of care for child?
7. How motivated are the parent's to make changes?
8. How capable are the parent's to make changes? And what is the potential for success?

| **Factor** | **Elevated Risk** | **Lowered Risk** |
| --- | --- | --- |
| **The abusing parent** | * Negative childhood experiences, inc. abuse in childhood; denial of past abuse; * Violence abuse of others; * Abuse and/or neglect of previous child; * Parental separation from previous children; * No clear explanation * No full 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; * Lack of interest or concern for the child. | * Positive childhood; * Recognition and change in previous violent pattern; * Acknowledges seriousness and 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 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. |
| **Non-abusing parent** | * 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 issues (marital partnership and the wider family)** | * Relationship disharmony/instability; * Poor impulse control; * Mental health problems; * Violent or deviant network, involving kin, friends and associates (including drugs, paedophile or criminal networks); * Lack of support for primary carer /unsupportive of each other; * Not working together; * No commitment to equality in parenting; * Isolated environment; * Ostracised by the community; * No relative or friends available; * Family violence (e.g. Spouse); * Frequent relationship breakdown/multiple relationships; * Drug or alcohol abuse. | * Supportive spouse/partner; * Supportive of each other; * Stable, or violent; * 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. | * Easy baby; * Acceptance of difference. |
| **Parent-baby relationships** | * Unrealistic expectations; * Concerning perception of baby's needs; * Inability to prioritise baby's needs above own; * Foetal abuse or neglect, including alcohol or drug abuse; * No ante-natal care; * Concealed pregnancy; * Unwanted pregnancy identified disability (non-acceptance); * Unattached to 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; * Co-operation with antenatal care; * Sought early medical care; * Appropriate and regular ante-natal care; * Accepted/planned pregnancy; * Attachment to unborn foetus; * Treatment of addiction; * Acceptance of difference-gender/disability; * Parents agree about parenting. |
| **Social** | * Poverty; * Inadequate housing; * No support network; * Delinquent area. |  |
| **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; * Only one parent co-operating. | * 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. |