Pre-Birth Assessment Tool

1. Introduction

This assessment tool is designed to help professionals to carefully consider a range of themes and to tease out issues that have potential for having a significant negative impact on the child.

The word “parent” should be loosely interpreted as appropriate to mean the mother and father, 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://www.russellhouse.co.uk/pdfs/assinchildcare.pdf

Calder provides useful guidance about the timing of a pre birth assessment and advocates that a multi-disciplinary planning meeting should take place at 20 weeks gestation, attended by the identified midwife, the local family centre, the likely health visitor, the parents and the social worker. Ideally the family GP should attend. The task of this meeting is to collate the available relevant family history and determine whether a formal pre-birth risk assessment should be commissioned and what form it should take.

If a Child and Family Assessment identifies any of the following circumstances, a pre-birth risk assessment should be considered.

- Where a previous child/children in the family have been removed because they have suffered harm
- Where a Registered Sex Offender (or someone found by a child protection conference to have abused) has joined a family.
- Where concerns exist about a mother’s ability to protect.
- 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 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 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.

The Local Authority will also be mindful at this early stage of the possibility that legal proceedings may need to be initiated either as a framework around a
parent and baby foster placement or because separation of parent(s) and baby is indicated.

The pre-birth assessment should be completed to a standard that meets the requirements for evidence in Court Proceedings, if necessary, and be signed off as such by the team manager.

**Circumstances indicating a Pre-Birth Assessment:**

- **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 newborn will need to be separated at birth and CSC will be part of the planning (not including a parent’s request for adoption)
- **Always** if either of the prospective parents is a Child Looked After (CLA) or Care leaver
- **Should be considered** if the parents have a child under 8 who was the subject of a CPP within the previous 18 months

2. **Areas to cover:**

2.1 **Name and Expected Date of Delivery:**
e.g. Unborn Baby .......... EDD: 01.01.11

2.2 **Family Structure/Composition:**
Names, addresses, dob, relationships with extended family members. If possible this should include a genogram.

2.3 **Reason for Assessment:**
This should be one of the circumstances set out above

2.4 **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.

2.5 **Ante-Natal Care: Medical and Obstetric History**
This section should be completed by an appropriate Health Professional. 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.
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. Once a pregnancy is confirmed the relevant health professional should consider the circumstances set out above and refer to Children’s Services if relevant.

A booking interview with the community midwife takes place ideally between 8-12 weeks gestation, and if a referral is made at this point, the pre birth assessment should begin as quickly as possible.

The interview 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 Obstetrician and his team. These pregnancies require additional surveillance both pre-birth and in labour. Care is shared between the community midwife, GP and a hospital Consultant and the 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 and community midwife usually takes place during the antenatal period with Health Visitors making contact with the mother in pregnancy. Following the birth of the baby most Health Visitors arrange a primary visit within 21 days of the birth, which coincides well with the handover of care from the midwives.

3. **Assessment of the parent(s) and the potential risk to the child**

This section will usually be completed by the Social Worker – but they will need to draw on help from a range of other professionals regarding some aspects of it.

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, 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 perspective 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’.

Questions 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
- Housing/Finance

3.1 **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?

3.2 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?

3.3 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?

3.4 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.

3.5 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?

3.6 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?

3.7 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.

3.8 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.

3.9 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.

3.10 Support – 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?
3.11 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?

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?

3.12 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?

3.13 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?

3.14 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.
3.15 **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?

3.16 **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?

3.17 **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?

3.18 **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.

3.19 **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.

3.20 **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.
3.21 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

3.22 Planning for the future
   • Realistic and appropriate?

4. Analysis and conclusions

Use should be made of the “Framework for Assessment” The assessment report should address the following issues:

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. What is the risk? Who poses the risk? In what circumstances might this risk exist? Be clear how effective any strengths or mitigating factors are likely to be in reality.
4. Will this risk arise:
   a) Before the baby is born?
   b) At or immediately following the birth?
   c) Whilst still a baby (up to 1 year old)?
   d) 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 the child?
7. How motivated are the parents to make changes?
8. How capable are the parents to make changes? And what is the potential for success?