BaNES, Swindon and Wiltshire Multi agency Pre-birth Protocol to Safeguard Unborn Babies

Contents

1. Context Page 2
2. Risk Factors Page 3
3. Specific considerations: late booking, concealed /unknown pregnancy; domestic abuse; alcohol and substance misuse; impact of poor mental health; parental learning disability Page 3
4. The importance of working with fathers and male carers Page 6
5. Early Support Page 7
6. The involvement of Children's Social Care Page 7
7. Safeguarding Birth Plan Page 8
8. Discharge Planning Meetings Page 9
9. Resources, research messages and learning from case reviews Page 10

Context

Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention and support. This multi-agency protocol sets out how to identify concerns or risks and respond to concerns for unborn babies. Assessment of risks should include everyone involved in the unborn baby's life or who are relevant to the pregnancy. Understanding the wider network of the unborn baby is critical to understanding the context into which they will be born, including working with the adults who are the parents/carers.

Although Maternity Services have specific responsibilities, all professionals have a role in identifying and assessing families in need of additional support or where there are safeguarding concerns. Where professionals become aware a woman is pregnant, at whatever stage of the pregnancy, and they have concerns for the mother or unborn baby's welfare, or that of siblings, they must not assume that Midwifery or other Health services are aware of the pregnancy, or the concerns held. Each professional should follow their agency's child protection procedures and discuss concerns with their safeguarding lead/named professional for safeguarding. In the absence of a safeguarding lead/named professional for safeguarding a referral should be made directly to Children's Social Care.

This protocol applies to all professionals who have identified any concerns for the unborn baby and provides a robust framework for responding to safeguarding concerns at the earliest opportunity.

Unlike many safeguarding situations, the antenatal period gives a window of opportunity for practitioners to work with families to help them understand what the needs of their newborn will be, the challenges of being a new parent and what they can put in place to be prepared for the birth of their baby both physically and emotionally. It also provides the opportunity for practitioners and families to work together to:

- Form relationships with a focus on the unborn baby
- Understand who the carers might be and the wider family/support network
- Identify risks and vulnerabilities at the earliest stage as well as protective factors and strengths
- Understand the impact of risk to the unborn baby when planning for their future
- Explore and agree safety planning options
- Assess the family's ability to adequately parent and protect the unborn baby and once the baby is born
- Identify if any assessments or referrals are required before birth; for example, an early support/help assessment
- Ensure effective communication, liaison and joint working with adult services that are providing on-going care, treatment and support to a parent
- Plan ongoing interventions and support required for the child and parent(s)
- To work with parents at a key moment where parents are most open to change and supportive interventions which can start in the antenatal period
- Avoid delay for the child where a legal process is likely to be needed such as pre-proceedings

In the vast majority of situations during a pregnancy, there will be no safeguarding concerns. However, in some cases it will be clear that a co-ordinated response is required by agencies to ensure that the appropriate support is in place during the pregnancy to best support and protect the baby before and following birth. It may also be necessary to consider the need for particular arrangements to be in place during and immediately following the baby's birth in order to do so.

When risks have been identified, it is important that practitioners work together to provide appropriate interventions and planning at the earliest opportunity to optimise the outcomes and support for the child and their family.

2. Risk Factors

The following risk factors should alert professionals to be professionally curious, explore concerns that relate to both parents and any other significant care givers, and consider appropriate, proportionate actions.

Where mothers, fathers, partners or any other significant member of the household;

- Are involved in risk activities such as substance misuse, including drugs and alcohol
- Have perinatal/mental illness or support needs that may present a risk to the unborn baby or indicate their needs may not be met
- Are victims or perpetrators of domestic abuse
- Have been identified as presenting a risk, or potential risk, to children, such as having committed a crime against children
- Have a history of violent behaviours
- Are not able to meet the unborn baby's needs e.g. significant learning difficulties and, in some circumstances, severe physical or mental disability
- Are known because of historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care
- Are known because of parental involvement as a child or adult with Children's Social Care
- Are teenage/young parents
- Are living in poor home conditions, homelessness or temporary housing
- Any other circumstances or issues that give rise to concern

The Vulnerability and Protective Factors in Pregnancy to Early Parenthood glossary sets out the factors that may support or prevent the safe development of unborn babies and infants and is a useful tool in assessing whether a family may need additional support, or the unborn baby may be at risk.

3. Specific considerations

Late Booking, concealed/unknown pregnancy

Pregnant women with complex social factors are known to book later on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes (NICE 2010).

A late booking is defined as *presenting for maternity services after 20 weeks of pregnancy* (Wessel, 2002).
A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone; or a woman appears genuinely to not be aware she is pregnant.

Where there is a late booking or a concealed pregnancy the health practitioner should complete an immediate assessment in order to identify which agencies need to be involved and make appropriate referrals. **In the case of a deliberately concealed pregnancy a referral should be made to Children's Social Care.**

The concealment of a pregnancy represents a challenge for professionals in safeguarding the welfare and the wellbeing of the foetus (unborn child) and the mother. There is no national agreed definition of what constitutes a concealed pregnancy; however a coordinated multi-agency approach is required once the fact of a pregnancy has been established; this will also apply to future pregnancies where there has been a previous concealed pregnancy. Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth may be unassisted (no midwife) whereby there might be additional risks to the child and mother's welfare and long-term outcomes.
A concealed pregnancy is when:

- An expectant mother knows she is pregnant but does not tell any professional; or

- An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care; or
- A pregnant woman tells another person or persons, and they conceal the fact from all health agencies.

For the purpose of this guidance the phrase concealed pregnancy is used for both denied and concealed pregnancies. A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases, a woman may be in denial of her pregnancy due to mental illness, substance misuse or as a result of a history of loss of a child or children. A pregnancy will not be considered to be concealed or denied for the purpose of this procedure until it is confirmed to be at least 24 weeks; this is the point of viability.

In some cases, a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability. Concealment may occur as a result of stigma, shame or fear because the pregnancy may be the result of incest, sexual abuse, rape or as part of a violent relationship.
Possible implications:

- Concealment of a pregnancy can lead to a fatal outcome (for both mother and/or child), regardless of the mother's intention;
- Concealment may indicate uncertainty towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity.
- Lack of antenatal care can mean that any potential risks to mother and child may not be detected. It may also lead to inappropriate advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy.
- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected.
- Underlying medical conditions and obstetric problems will not be revealed.
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery.
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth.
- Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently.
- There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community.
- Risks to the unborn baby from prescribed medications.

Domestic Abuse
During pregnancy, domestic violence and abuse can pose a threat to an unborn child as assaults on pregnant women often involve punches or kicks directed at the abdomen, risking injury to both the mother and the foetus. Domestic abuse can also include coercive controlling behaviour and emotional abuse. This may impact on a mother's ability to access appointments or support.

In almost a third of cases, domestic violence and abuse begins or escalates during pregnancy and it is associated with increased rates of miscarriage, premature birth, foetal injury and foetal death. The mother may be prevented from seeking or receiving antenatal care or post-natal care. In addition, if the mother is being abused this can affect her attachment to her child, more so if the pregnancy is a result of rape by her partner.

Young mothers are at greater risk of experiencing domestic abuse especially where there are a range of complicating factors including mental health issues, substance abuse, and a lack of wider support or housing problems. It is often harder for them to ask for help.

Unborn babies and children under the age of 12 months are particularly vulnerable to domestic abuse pre and post birth. Stress hormones, such as cortisol, can have a detrimental effect on an unborn baby. In addition, early

relationships are key and the impact of DA on the mother can influence early attachments and development. See resources below to find out more:

- Impact of domestic abuse on children by developmental level (CAADA Family Interventions Programme)
- The Vulnerability and Protective Factors in Pregnancy to Early Parenthood
- Unicef _ Relationship building resources

Alcohol & Substance Misuse

Use of alcohol, illicit drugs and other psychoactive substances during pregnancy can lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birth weight, prematurity, physical malformations and neurological damage. Dependence on alcohol and other drugs can also severely impair an individual's functioning as a parent, spouse or partner, and instigate and trigger gender-based and domestic violence, thus significantly affecting the physical, mental and emotional development of children.

Pregnancy may be an opportunity for women, their partners and other people living in their household to change their patterns of alcohol and other substance use. All health workers providing care for women with substance use disorders during pregnancy need to understand the complexity of the woman's social, mental and physical problems in order to provide appropriate advice and support throughout pregnancy and the postpartum period. Common risks for drugs, alcohol and tobacco include:

- complications in pregnancy and labour
- maternal death
- miscarriage
- premature birth
- stillbirth
- infant death
- low birth weight
- Sudden Infant Death Syndrome

Where drug or alcohol misuse occurs, this may affect the baby in the following ways:

- withdrawal symptoms in infants
- physical and neurological damage to the baby
- Foetal Alcohol Spectrum Disorder

Women who inject drugs who share injecting equipment risk infection with blood born viruses, which may be passed to the baby. Children born to smokers are more likely to suffer from asthma, chest, inner ear and other infections, and to become a smoker in later life.

Impact of poor mental health in parents

Mental illness during pregnancy, whether anxiety, depression or more severe psychiatric disorders can have a significant negative impact on a mother and her baby. Poor psychological health has been associated with low birth weight, premature birth, perinatal and infant deaths, postnatal depression, as well as longer term behavioural and psychological impacts on the child. It can also impact on attachment: The Vulnerability and Protective Factors in Pregnancy to Early Parenthood. **It is key that a history is taken of both the mother and father's mental health and wider familial mental health, including any other significant adults, as this can be a risk indicator for acute mental health episodes such as puerperal psychosis.**

Maternal antenatal anxiety and/or depression have been shown to predict increased risk for neurodevelopmental disorders in children, and to confer risk for future mental illness. The impact of women's anxiety (and/or depression) during pregnancy has been found to extend into childhood and adolescence, as well as to affect the hypothalamic-pituitary-adrenal (HPA) axis, predicting attention deficit hyperactivity disorder (ADHD) symptoms in 8–9-year-old children. These resources provide advice about supporting mental health in pregnancy and after birth: www.nhs.uk/start4life and About maternal mental health | Maternal Mental Health Alliance.

Parental Learning Disability

Between 30-50% of children whose mothers have a learning disability are at risk of poorer development, compared to children from similar socio-economic groups. They are no more likely to be born with a learning disability, but they are more likely to have developmental delays, lower IQ and behavioural problems. Many parents with a learning disability live under conditions that may contribute to poorer parenting, including poverty, low literacy, poor health, poor mental health, domestic abuse, having grown up in care, and social isolation. Social support (such as living with relatives) can contribute to successful parenting and parents with a learning disability can improve their parenting skills with additional support tailored to their needs. For example, childcare skills can be taught through behavioural modelling, using visual manuals and audiotaped instructions, and using simple behavioural instructions. Parents learn more effectively where they are given praise and feedback, and where complex tasks are broken down into simpler parts.

Parents with a learning disability may be reluctant to ask for support with parenting issues because of fears that this will raise child protection concerns. Many will have already had a previous child removed into care. Some parents will not be eligible for support from adult learning disabilities teams because their learning disability is not severe enough to qualify. Involving an advocate at the earliest opportunity can support them at this time.

For more information:
Supporting parents with learning difficulties or disabilities - Parents with learning difficulties | Early Years in Mind | Anna Freud Centre

Surrogacy

You may become aware of a surrogate pregnancy. A referral to social care should only be made if there are safeguarding risks (see information in Section 2 and Section 6 for more information).

Reasonable adjustments

It is important to consider any reasonable adjustments that may be needed in supporting parents or other significant adults you may be working with. These adjustments may be related to cultural differences, language barriers, disabilities and hard to reach groups etc. For example:

- Use of an interpreter or provision of information in another language
- Understanding of cultural barriers that may exist for them in accessing or engaging with support (this is particularly relevant for hard-to-reach groups such as Gypsy Roma and Traveller communities)
- Understanding and awareness of parenting approaches that may exist within a particular ethnic or cultural community.

4. The importance of working with fathers and male carers

It is important that all agencies involved in pre and post birth assessment and support, fully consider the significant role of fathers with their baby. The national review, The myth of invisible men, identified that "Men are frequently overlooked and are poorly engaged with by universal and specialist services." This can mean that they are not included in appointments or assessments; the result of which is that they can go unsupported and left to feel distanced from the pregnancy. Even more importantly unless fathers are actively engaged with, any risks they may pose may not be understood and they cannot help to mitigate any other risks that may exist in the child's life. Engagement with fathers and supporting them in their role as a parent needs to continue, even if parents are no longer a couple.

Good practice in working with fathers includes:

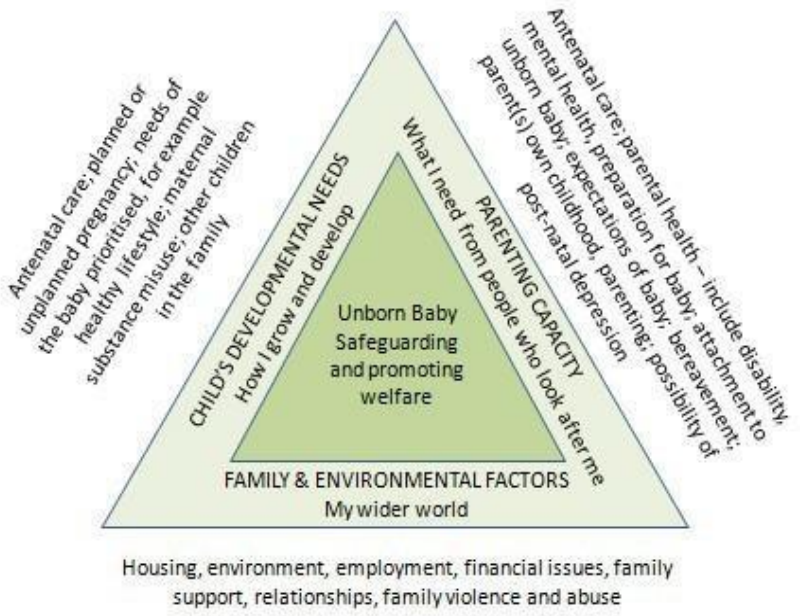
- Involving and engaging with them as early as possible – this also enables key messages to be shared with both parents and continuity of care by both parents, for example in relation to safe sleeping.
- Share helpful resources with fathers such as: Dadpad and Home - ICON Cope (coping with crying).

5. Early Support

It's never too early

Promoting informed choices and resilience pre-conception creates the conditions for families to thrive. The *antenatal* period is a vital stage in child development and in preparation for parenthood.

Identifying need and providing appropriate support as early as possible is key to supporting expectant mothers and their unborn babies. The assessment triangle can help professionals understand the unborn baby's needs, parenting capacity and the family and environment.



Where a professional is concerned that an unborn child or other children in the family may be at risk of or suffering harm, they should seek advice from their manager/lead for safeguarding without delay and together consider whether to consult with or refer to Children's Social Care. In the absence of a safeguarding lead the professional may consult with or refer directly to Children's Social Care.

6. **Involvement of Children's Social Care (CSC)**

Referrals to Children's Social Care about unborn babies should be made early in the pregnancy as soon as concerns or risks have been identified and no later than 18 weeks into the pregnancy, even if mother is stating that they are going to terminate. It may be that concerns are not known until later on in the pregnancy at which point a referral should be made.

Where identified concerns indicate risk of significant harm at any point during the pregnancy an immediate referral should be made to Children's Social Care. Early referral will enable Social Care with other agencies involved to assess the family circumstances and plan any necessary actions and support required in a timely way. This includes whether any actions are required to safeguard the child once born.

In any of the following circumstances a referral to children's social care **must always** be made: -

- Where there is a perinatal mental illness that presents a risk to the unborn baby (not all mental illnesses will pose a risk)
- There has been a previous unexplained death of a child whilst in the care of either parent (please note this does not relate to SUDI cases).

- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children. This may be due to domestic abuse, violence, substance/alcohol abuse, mental health or learning difficulties.
- Children in the household / family currently subject to a child protection plan or previous child protection concerns.
- A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order.
- Where there are serious concerns about parental ability to care for the unborn baby or other children.
- Where there are maternal risk factors e.g. denial of pregnancy, deliberately concealed pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.

- Any other concern exists that indicate the baby may be at risk of harm.
- Previous children having had non-accidental injury/neglect

Outcome of Referral to Children's Social Care

There are a number of possible outcomes from a referral to Children's Social Care:

- It may be that the unborn child is assessed to be in need of support or at risk of harm. In such cases a social worker will undertake an assessment to identify the level of need and risk and the service required to address these to support the child and family.
- Where children's social care assess that the child is at risk of significant harm and the baby's needs and those of their family will be considered within the child protection process. Social Care will complete a Pre-birth Assessment and relevant professionals involved with the family will be asked to contribute.
- MASH may assess that the threshold for their services has not been met however they may signpost the referrer to other appropriate agencies/services. This may include recommending an Early Help/Support Assessment is completed.

If the referrer is of the view that the decision of children's social care leaves the baby at ongoing risk of harm, they must seek advice from their safeguarding lead and use their local processes for escalating or resolving a concern.

If circumstances within the family escalate a new referral should be submitted, detailing the escalation and risk.

7. Safeguarding Birth Plan

Where an unborn baby is subject to child protection planning, it is the responsibility of the Social Worker to develop a detailed safeguarding birth plan at the first core group meeting: this meeting can be used to start planning when a safeguarding plan will be put in place. This will detail the planning for delivery and the immediate post-natal period, including who should be notified upon the birth of the baby. The Safeguarding birth plan should be completed before the mother is 34 weeks pregnant.

It is the responsibility of the Named Midwife for Safeguarding Children to ensure that other health practitioners involved are informed: for example, the obstetrician, neonatologist, GP, Health Visitors (HVs). The social worker is responsible for ensuring all relevant agencies such as Out of Hours Social Care and the police are aware of the detail of the safeguarding birth plan. All professionals will need to be clear about their role and that of others, which should be set out in the safeguarding birth plan. The safeguarding birth plan should include contact numbers and names of professionals involved and the agreed arrangements for where the baby once born is to be discharged to.

The Safeguarding Birth Plan should be shared with parents unless to do so is felt to put the mother or baby at increased risk of harm. Professionals will need to agree how the plan will be shared with parents.

Additional Considerations

- There may be a number of occasions when either the baby and/or mother will need to stay in hospital for a further period, for example where there are medical needs in relation to the baby. In such circumstances professionals will need to assess the baby and mother's needs and risks during this period and how these will be met and managed during this period.

- In situations where the mother has been discharged from the birthing unit/hospital and there are safeguarding concerns for the baby, a multi-agency risk assessment and safety plan may need to be made with the parents about contact with their baby in the hospital setting. This will include whether unsupervised contact between parents, other relatives and the baby is allowed.

- In some cases where a pre-birth risk assessment has been undertaken by Children's Social Care it may conclude that the baby would be at significant risk of harm if they were discharged home to the immediate family following birth. In these circumstances Children's Social Care will consider the best way to safeguard the baby including whether to apply to the courts for an order to remove the baby following birth.

Where the plan is to apply for a court order this will be conveyed to the mother and any other person with parental responsibility by the social worker at the most appropriate time. It is however the decision of the courts whether to grant an order and there should be an alternative agreed care and management plan following discharge of the baby by all partners if this situation arises. The discharge plan will set out where the baby is to be discharged to if not to parental care.

All staff have a safeguarding responsibility to all babies and will ensure that any protective action required within the hospital setting is managed following birth of the baby. These arrangements must be included within the safeguarding birth plan, where the circumstances require, including any protective action that may need to be considered.

Where babies are subject of a Child Protection Plan, they should be delivered within the hospital setting where possible and a Discharge Planning Meeting must take place before the baby leaves.

8. Safeguarding Discharge Planning Meetings

Please also refer to BSW Discharge Planning Policy: discharge of children and young people from a hospital setting.

The safeguarding discharge planning process should be initiated as soon as the mother is admitted/presents for delivery and all Midwives caring for her should have full access to and knowledge of the Safeguarding Birth plan.

It should be noted that there is a difference between a medical discharge planning meeting and a safeguarding discharge planning meeting; medical discharge means a baby is clinically well enough to go home.

- Medical discharge planning meeting – if a baby has complex medical needs there may be a medical discharge planning meeting to make plans for medical follow up once they are ready for discharge from hospital. A safeguarding discharge planning meeting may also be required if there are safeguarding concerns.
- Safeguarding discharge planning meeting – if there are safeguarding concerns a multi-agency discharge plan should be agreed setting out arrangements for the care and safety of the child following discharge from hospital into the community and will include actions, timescales and responsibility for actions.

The Social Worker will ensure that the parents and any support person they choose will be informed when and where the meeting will take place. Depending on the nature of the risk and any information withholding

requirements parent/s may not be invited to participate in the meeting. If this is the case the meeting will need to discuss how and when parents will be informed of the outcome of the meeting.

Where a baby is born prematurely it is reasonable to plan the discharge meeting 7-10 days prior to the earliest likely discharge date. All agencies should aim to agree the baby's discharge as soon as safely and practicably possible.

A new-born baby should not be discharged at weekends or on bank holidays unless there is a consensus that it is safe and reasonable to do so. This should be is documented in the child's medical record and discharge plan.

If a mother is to be separated from her child close to birth due to safeguarding concerns, then this should be managed with sensitivity and compassion. Hope Boxes are being used by some hospitals to minimise trauma in these circumstances. For more advice on best practice: Born into Care: Developing best practice guidelines for when the state intervenes at birth - Nuffield Family Justice Observatory (nuffieldfjo.org.uk).

9. Further resources, research messages and learning from case reviews

Information sharing: advice for practitioners (DfE)

The National Service Framework for Children Young People and Maternity Services (2004) DH: National service framework: children, young people and maternity services - GOV.UK (www.gov.uk)

NICE Quality standards on antenatal care

Welcome to the South West Child Protection Procedures (trixonline.co.uk) - Southwest Child Protection Procedures (SWCPP)

Ockenden Review 2022

Learning from case reviews:
Infants: learning from case reviews | NSPCC Learning – summary of risk factors and learning for improved practice around working with children aged two and under