Guidance for Pre-birth Assessments For Integrated Children's Services

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This guidance should be read in conjunction with the following procedures and guidance:

Kent and Medway Pre-birth Procedures
Relinquished Babies and Children

You may also find the following procedures and guidance useful:

Pre-proceedings, Public Law Outline, Initiation of Court Proceedings Practitioner Handbook
Child Development in the Early Years Programme
Child and Family Assessment
Practice Guidance for Early Help
Undertaking a Parenting Capacity Assessment

Contents

Introduction

Young babies are particularly vulnerable to abuse but robust work at the pre-birth stage, including assessment, intervention, and support, has been evidenced to minimise risk of harm to the baby once born.

The purpose of this guidance is to:

- ensure there is a clear system in place to respond to concerns for the welfare of an unborn child
- give clear guidance about when a Pre-birth Assessment or Pre-birth Risk Assessment is required
- have a clear structure for assessing risk

UK law does not provide legislative rights to an unborn baby. In some circumstances though, agencies or individuals can anticipate a likelihood of significant harm, potential risks, and vulnerabilities with regard to the unborn child. Such concerns should be addressed as early as possible to maximise time for:

- forming professional relationships with family member/s with a focus on the unborn child
- the completion of a full assessment and understanding / identification of risk
- exploring the family's ability to protect the unborn child
- enabling a healthy pregnancy
- early identification of significant relatives or family members who might be able to support or provide primary care
- building multi-agency relationships and networks around the family

A common finding in the sample of cases subject to a serious case review nationally is that there had been failings in the pre-birth assessment process. Key issues include no pre-birth assessment; delayed pre-birth assessments; practitioners being too optimistic; and closing too quickly after the baby's birth (Ofsted, 2011). In addition, there has been an increase in incidents in under one-year olds in 2020/2021, which could partly be related to the Covid-19 pandemic, however, concerns for under ones were already rising prior to this (Ofsted 2021). Therefore, in cases where there is a cause for concern or an identified support need, a Pre-birth Assessment needs to be completed. Whether this is a Pre-Birth Assessment or an in-depth Pre-birth Risk Assessment will need to be determined so the most appropriate service completes the assessment.

It is vital that any pre-birth work is undertaken using trauma informed and relationship-based approaches; using supportive and intensive interventions, with a dynamic assessment of capacity to change. Assessments need to focus on developing the relationship between parents and baby and lead to a clear plan which is shared with the

parents. (This could also include other carers, partners of parent, same sex couples and grandparents, if young parents are living with them).

Delays in initiating a Pre-birth Assessment or Pre-birth Risk Assessment may lead to insufficient time to complete an in-depth assessment and may mean parents have less time to engage and demonstrate capacity to change. This 'late' approach may compound parents' feelings of stigmatisation and will impact on the wider family's ability to be engaged in support and assessment.

Pre-birth work is not only undertaking a holistic and robust assessment but also assessing for support or assessing for intervention. Parents should be educated about parenting and risk. This early work also sets the scene of future work with the family and transparency and respect are important. It is vital that each pregnancy and set of circumstances is assessed in isolation with no bias from previous pregnancies and outcomes.

Challenges of working with parents pre-birth

This is already a highly emotional and anxiety-provoking experience for parents, especially if it is their first child. Assessment pre-birth and post-birth will be difficult due to hormones, sleep deprivation, anxiety, and fear of the outcome of any assessment or intervention. Practitioners should bear this in mind when assessing.

Parents' previous experiences of assessments and possibly care proceedings will have an impact on how they engage with practitioners, how open they are and if they trust the practitioner who is assessing them. Parents may be difficult to engage or seem aggressive as a result, but this should not automatically be seen as non-engagement.

Engaging fathers or absent partners can be difficult and mothers can be evasive about information, blocking access to the father, but this is a vital piece of the puzzle which should not eb overlooked.

When assessing pre-birth we are hypothesising about the future, while considering risk. This can be difficult for practitioners and bias and over-optimism creep in. Evidencing risk, potential harm, and a parent's ability to protect against harm can be difficult and this is when a robust assessment is required.

Pre-birth Assessment or Pre-birth Risk-Assessment

It is important to distinguish between a Pre-birth Assessment and a Pre-birth Risk Assessment and it is essential that those parents in need of support and those in need of intervention, possibly at a legal level, are identified as early as possible.

A Pre-birth Assessment is an assessment to review the history, previous/current relationships, ability to provide for the baby, current living arrangements and any support that may be required before or following the baby's birth. This assessment could take the form of an Early Help Assessment or a Child and Family Assessment. Consent for a Pre-Birth Assessment undertaken at Early Help or Child in Need level would be required. If it is identified that there has been or is likely to be significant harm to the baby, then a Pre-birth Risk Assessment is required, led by a social worker.

A Pre-birth Risk Assessment (normally completed following a Pre-birth Assessment) will collect information about what, if any, action is needed to safeguard the baby, following in-depth analysis of the risk. This needs to be of sufficient depth to inform future care planning and should be completed separately to the Child and Family Assessment using the template (see appendix C and Tri-x).

Social workers should ensure that parents are aware of why an assessment is being undertaken and what is expected of them. Ideally, consent for a Pre-birth Risk Assessment would be gained but if this is not forthcoming, the social worker would need to be clear of the concerns and the potential risks of not co-operating with an assessment. A Pre-birth Risk Assessment may need to proceed with or without consent should the baby be subject to a Child Protection Plan.

The Risk Screening Tool (see Appendix A) can be used at any time to consider the level of risks. This is discussed in more detail later.

Request for Support (referral for Unborn not known previously)

Kent and Medway Pre-birth Procedures state that referrals to the local authority about an unborn child should be made **as soon as concerns have been identified** and ideally, **no later than 18 weeks** into the pregnancy. It may be that concerns are not known until later in the pregnancy or the pregnancy has been concealed, at which point a Request for

Support should be made **immediately**. Where identified concerns indicate risk of significant harm at any point during the pregnancy, a Request for Support should be made to the Front Door Service **immediately**.

If any of the following risk factors have been identified, a Request for Support should be completed immediately and as early in the pregnancy as possible:

- there has been a previous unexpected death of a child whilst in the care of either parent where abuse / neglect is/was suspected
- a parent or other adult in the household, or regular visitor is a person identified as presenting a risk, or potential risk, to children
- children in the household / family currently subjected to a Child Protection Plan
- a sibling (or a child in the household of either parent) has previously been removed by a court order
- there is knowledge that parental risk factors, e.g., domestic abuse, mental health illness or substance misuse may seriously impact on the unborn child's safety or development
- there are concerns about parental ability to self-care and/or to care for the child e.g. unsupported, young, or a disabled parent
- there are maternal risk factors, e.g., denial of pregnancy, late booking of pregnancy, avoidance of antenatal care (failed appointments), non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn child
- concerns that the child is at risk of significant harm, including a parent previously suspected of fabricating or inducing illnesses in a child
- the parent is a child in care to the local authority or considered to be a care leaver
- all pregnant young people under the age of 16 should be referred to the local authority Integrated Children's Services (or the Police) if a risk assessment indicates a risk of sexual exploitation or risk of harm to the child in accordance with the local Working with Sexually Active Young People Procedure and Safeguarding Children and Young People from Sexual Exploitation procedure.
- a child under the age of 13 is pregnant
- in the case of a concealed pregnancy a referral must be made to the local authority Front Door Service

Kent Support Levels Guidance should be used to consider whether a Pre-birth Assessment should be completed. When it is identified a Pre-Birth Assessment is required, the Risk Screening Tool (appendix A) may be used to aid the decision on whether a Pre-birth Assessment or Pre-birth Risk Assessment is required. New referrals for Pre-birth Assessments should be completed by Early Help or Children's Social Work Services (decision to be made by Front Door Service as to which would be most

appropriate). Pre-birth Risk Assessments should be completed by a social worker. A clear rationale explaining the decision should be included in the Analysis and Recommendations by the Front Door Service on the Request for Support and any case notes. If the Screening Tool is used, it should be placed in documents on the child's file.

NB: In those circumstances where there are significant concerns and a Pre-birth Risk Assessment is immediately necessary, a brief Child and Family assessment will need to be completed due to Liberi processes.

Both Pre-birth Assessments and Pre-birth Risk Assessments should be based within a knowledge of child development (pre-birth and post birth).

Pre-birth Assessment

A Pre-birth Assessment will be undertaken on the Early Help Assessment template (EHM) or the Child and Family Assessment template (Liberi), depending on under which service the unborn child is open.

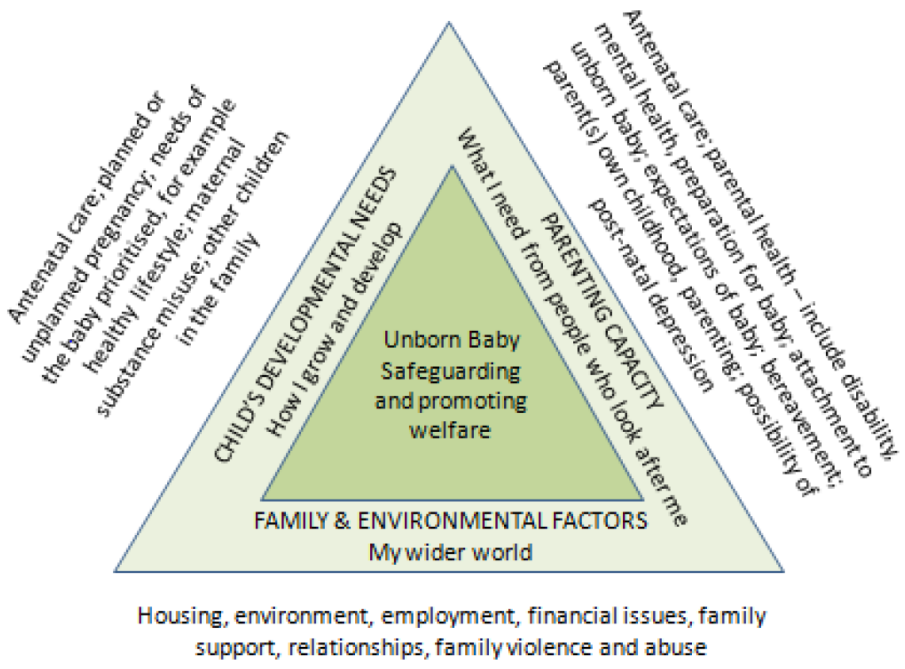
As a minimum the Pre-birth Assessment should include (some guidance in italics), and these headings should be used within the assessment so there is consistency across assessments:

- Current family structure (to include details of the father of the baby) – *father/new partner/same sex partner should be included in the assessment.*
- Baby information - *details regarding the pregnancy, engagement with antenatal services, health of unborn, any other issues which may impact on the health and development of the baby, such as substance misuse.*
- Parents'/partner's views of the pregnancy and attachment to unborn – *planned/unplanned, how do the parents speak about the baby, observations of mother touching bump.*
- Parents' understanding of baby's needs and ability to meet these – *how much do they know about parenting, ability to speak about how they will meet baby's needs, practical preparations, understanding of development, realistic/unrealistic expectations.*
- Family functioning and parental relationship – *length and stability of relationship, likelihood to remain together after birth, subjects likely to cause conflict/domestic abuse (level and frequency), criminal history or violent history, other relevant concerns.*
- Parents' experiences of parenting and being parented – *previous children, previous social care involvement (as children and parents), previous allegations or concerns*

regarding care or abuse of children, parenting style, Adverse Childhood Experiences.

- Circumstances such as housing and practical issues – *housing, employment, finances, home conditions, other stressors.*
- Support networks, now and in the future – *support available from family and friends, services which may be required, courses/support that can be put in place pre-birth and post-birth, parents' willingness to engage in support, views of family members.*
- Strengths and areas of concern.
- Risks – *identified current and possible future risks, possible impact on child. Is a Pre-birth Risk Assessment required?*
- Analysis and recommendation

The assessment triangle below may assist with considering aspects of the assessment specific to pre-birth.



The Pre-Birth Assessment should be completed within the normal timeframe for Early Help Assessments (30 days) or Child and Family Assessments (45 days). Both assessments would need to be quality assured with management oversight within these timescales.

When siblings of an unborn baby are already open to a service and the mother becomes pregnant, the unborn child will be opened, and an assessment will be completed. The level of risk that the siblings are subjected to will inform whether a Pre-birth Assessment

(Early Help Assessment / Child and Family Assessment template) is completed or a Pre-birth Risk Assessment.

Pre-birth Risk Assessment

A Pre-birth Risk Assessment must be undertaken by a social worker. It may be that a Pre-birth Assessment has been undertaken already (Early Help Assessment or Child and Family Assessment) which identified risks and a Pre-birth Risk Assessment is required. In some cases, the risks are significant and identified prior to a Pre-Birth Assessment, in which case, a Pre-Birth Risk Assessment would be completed in place of a Pre-Birth Assessment.

The Pre-birth Risk Assessment should be completed on the Pre-birth Risk Assessment template. It should not be constrained to the 45-day timescale like a C&F assessment but instead, the deadline should be governed by the complexity of the circumstances and the complexity of the multi-agency network. There should be clear management oversight with a rationale and deadline on the child's file to ensure there is no drift in assessing and subsequent actions, including intervention through the Public Law Outline.

The Pre-birth Risk Assessment should include (guidance only in italics):

- Background information - *why the assessment is being undertaken and what led to this point*
- Reasons for the concern - *summary of the known risks/concerns*
- Full history in addition to chronology of key events – including paper files, information from other local authorities and information from other countries, if parents have lived abroad, as well as information from other agencies (*evidence needs to be triangulated, be curious)*
- Current family structure (to include details of the father of the baby) - *father should be included in the assessment*
- Family functioning and parental relationship - *length and stability of relationship, likelihood to remain together after birth, subjects likely to cause conflict/domestic abuse (level and frequency), criminal history or violent history, other relevant concerns*
- Baby information – *details of the pregnancy, engagement with antenatal services, medical and obstetric history, health of unborn, any other issues which may impact on the health and development of the baby, such as substance misuse.*
- Parents' views of the pregnancy and attachment to unborn - *planned/unplanned, how do the parents speak about the baby, observations of mother touching bump*

- Parents' understanding of baby's needs and ability to meet these – *how much do they know about parenting, ability to speak about how they will meet baby's needs, practical preparations, understanding of development, realistic/unrealistic expectations.*
- Parents' experiences of parenting and being parented - *previous children, previous social care involvement (as children and parents), previous allegations or concerns regarding care or abuse of children, parenting style.*
- Previous convictions, cautions and allegations against parents – *relevant incidents to be listed and discussed with parents regarding details and context. What are their views regarding this? What has changed since then?*
- Parents' understanding and views of professionals' previous actions or concerns – *E.g. Previous removals of children/ child protection. Do they acknowledge that intervention was needed, and have they reflected on this?*
- Parents' capacity to make changes (to include willingness to change and ability to change) – *how might the concerns impact on their ability to change? E.g. The impact of their drug use on the ability to change. Consider desire to change vs actual ability.*
- Support networks now and in the future - *support available from family and friends, services which may be required, courses/support that can be put in place pre-birth and post-birth, parents' willingness to engage in support. Consider how risks may impact on support levels.*
- Circumstances such as housing and practical issues - housing, employment, finances, home conditions, other stressors. *Consider risks of future stressors such instability of employment.*
- Strengths – *identify positives of the relationship, parenting support etc and what could help to build the strengths.*
- *Risks identified – list each risk, why it is present, whether it is past/current and consider the likelihood it could be a significant risk in the future.*
- Analysis of risk pre-birth and post-birth – *what is your analysis regarding the level of risk, the likely impact on the child and what, if anything, could mitigate this risk?*
- Recommendations for support/intervention with timescales – *be specific but do not pre-empt any legal discussions such as recommending entering the Public Law Outline before you have held a meeting to discuss this.*

Within the Pre-birth Risk Assessment stage, a multi-agency meeting with parents should be held to give all agencies the opportunity to share information and consider risks. This will not only inform the assessment but inform planning moving forward. The meeting should include consideration to next steps. This may need to be a Strategy Discussion to consider child protection procedures. Ideally, this meeting will be held by 20 weeks and by 28 weeks at the latest to allow sufficient time for child protection or the Public Law Outline to be initiated and completed before the birth.

The vital step when planning any Pre-birth Risk Assessment is to review any previous history. This will entail reading the case files on any children who were removed from the parents' care previously (including information from other local authorities), ensuring searches are done on any new partners in the household and reviewing the parental history if they were known to social care as children, for example, previously looked after children.

It is essential to construct a chronology of key events from the previous history, as repeated serious case reviews point to failures in drawing information together, analysing it and identifying patterns that, when seen together, change the perspective of the case. It is essential to include information from all agencies and, if feasible, for them to contribute to the chronology.

Previous risk is a good indicator of future risk, but changes made by the parent should be considered.

As already stated, a Pre-Birth Risk Assessment should be completed as early as possible but by week 30 at the latest to ensure any intervention and support is actioned.

Timeline

All timelines are suggested. At times, there will be late notifications and the assessment, and any subsequent decisions will be later than we would like ideally.

Task	**Deadline**
Request for Support	No later than week 18 to allow assessment and intervention. High risk or concealed pregnancies should be referred as soon as known
Pre-birth Assessment	As early as possible to inform planning. To be completed within timescales for Early Help Assessment/ Child and Family Assessment
Pre-Birth Risk Assessment	By week 30 Multi-agency meeting with parents to inform assessment and consider risks - no later than 28 weeks, preferably by week 20.
Initial Child Protection Conference	Preferably by week 20 to ensure Child Protection Plan in place and agencies consider risk planning
Review Child Protection Conference	4 – 6 weeks following birth

Pre-birth Plan	By week 36/37 at the very latest (as stated in KSCMP procedures). If significant risks identified and child is subject to Child Protection Plan, at least 6 weeks prior to birth
Legal Planning Meeting	For cases of high risk, the LPM should be held by week 20, and no later than week 30, to allow time for pre-proceedings process prior to birth
Update to Pre-birth Assessment or Pre-birth Risk Assessment	By week 10 following birth
Closure following birth – updating assessment must be completed following birth and before closure	Child MUST remain open to services for a minimum of 12 weeks following birth.

Multi-agency work

As with all assessments, close liaison and working relationships with other agencies is required but specifically with the GP, Midwifery Services and Health Visiting. It is vital all agencies are involved in planning and are aware of any identified risks.

Detailed agency checks involving a discussion with agencies and asking in-depth key questions is essential. This is a joint assessment amongst agencies, and as such, agencies need to share detailed information. For example, information about dates of presentation to services is important but more detailed information such as the parents' emotional presentation, reaction to scans and relationship between parents is important.

Be aware midwives will have a dual focus on the mother and the baby. Close liaison with Midwifery Services is vital and early planning is essential, to ensure parents are getting the same messages from professionals. Planning should consider how a possible removal could be undertaken with minimal distress to the parents, midwifery staff and any patients who may be on the maternity ward.

Any concerns can be escalated through the Safeguarding Lead for Midwifery or escalated through the Kent Safeguarding Children Multi-Agency Partnership procedures.

Engaging fathers

Practice Standards for Child and Family Assessment states *"All significant family members/friends participated in this assessment (**including fathers** who live away from their children) and their views and opinions are recorded in the assessment".*

Father's views are vital when undertaking a holistic assessment at any level. Despite a greater focus on including fathers in our interventions with families, there is a wealth of literature showing they are still the secondary client and sometimes invisible (Phillip et al 2021; Haworth and Sobo-Allen 2020). In a recent study, the Nuffield Foundation found that 20% of care proceedings are initiated without a known/named father.

There are considerations of Parental Responsibility with regard to fathers when working pre-birth and pre-registration of the birth and it is important, they are actively engaged in assessments and interventions. A mother may object to their involvement due to risks to her own safety or unwillingness to include the father in the baby's life, however, a Pre-birth Risk Assessment cannot be thorough or holistic without gaining a father's views. In addition, the wider maternal and paternal family network needs to be engaged early in the process with the view to ensuring support for parent(s) and assessment of alternative carers, if required.

We need to be explicit with mothers about the importance of speaking to the father and including him in the process, while also planning to ensure she would not be put at risk.

Fathers should be seen and spoken to separately to mothers rather than gathering information solely through the mother. They should be treated as separate but equally important to the mother and included in all meetings and processes. Father's history, current circumstances and views should be noted in the assessment. Clearly, if the parents are presenting as a couple and want to parent together, parents should be seen together but also separately. Their capacity to parent together with the mother or alone should be assessed and analysed, together with the father's capacity and willingness to support the mother if they do not wish to be assessed as a sole carer.

The issue of consent from the mother and Parent Responsibility (PR) can be a stumbling block in engaging fathers. Whilst a mother automatically has parental responsibility for her child from birth, a father usually has parental responsibility if he's either:

- married to the child's mother
- listed on the birth certificate (after a certain date, depending on which part of the UK the child was born in)

For a Pre-birth Assessment, consent would need to be gained to engage the father. However, at Pre-birth Risk Assessment level it is vital fathers are engaged due to the possible outcomes of this assessment. In addition, the local authority can engage fathers without consent if the unborn child is subject to a Child Protection Plan.

Potential Indicators of risk

There are a number of vulnerabilities and factors which can increase risk. The analysis of these factors can help to estimate risk and the table in Appendix B offers helpful suggestions of what to look for.

This is not an exhaustive list, but some indicators include:

Mental Ill Health

Although most parents with psychiatric problems can care for their children appropriately, research indicates parents who mistreat their children are often shown to have mental health problems. Non-compliance with medication without medical supervision is a cause for concern. Babies of parents with psychosis or delusional thinking, e.g., 'my baby is trying to punish me', may be more at risk.

Close liaison with mental health professionals is vital. Within the Public Law Outline, a psychiatric assessment may be required.

The Perinatal Mental Health Community Service (formerly MIMHS) specialises in the assessment, diagnosis and short-term treatment of women aged 18 and above who are affected by a moderate to severe mental health illness in the preconception, antenatal and postnatal period.

Mothers who have suffered one of the following will be offered a service.

- previous episodes of post-partum psychosis
- moderate to Severe Postnatal depression or anxiety
- previous or current mental health issues prior to or during pregnancy
- previous birth trauma / PTSD
- strong family history of mental health problems in the perinatal period

For more information and contact details go to the following website:
https://www.kmpt.nhs.uk/information-and-advice/perinatal-mental-health-community-service-pmhcs/

Substance and alcohol misuse problems

All pregnant women should be asked about their use of prescribed and non-prescribed drugs (legal and illegal) during any assessment. Due to their substance and alcohol use and impact on menstruation cycles, mothers with either of these issues may not know they are pregnant. In addition, they may not want to make professionals aware of their pregnancy.

The foetus is highly susceptible to substances due to its inability to filter and process substances in its own body. The impact post-birth on development, behaviour and outcomes as the child grows is well documented but any Pre-birth Assessment should consider the parents' ability to manage a fractious baby or child with behaviour issues should be taken into account.

Drug or alcohol misuse is not in itself a contra-indication that a parent will not be able to care for the baby safely. Factors to consider include:

- The pattern of drug or alcohol misuse and history of use
- Consequence or risk to child
- Parents' willingness to engage in treatment

Part of the role of the practitioner is to educate parents on the impact of drugs and alcohol on the foetus, both biologically and in terms of risks from chaotic lifestyle, drug paraphernalia and drug associates. Early engagement with reduction services is needed to help mitigate risk, as well as consideration to post-birth issues for the baby in pre-birth planning. Practitioners should work alongside substance reduction agencies to educate parents and monitor progress.

Remember the Family Drug and Alcohol Court should be considered for any cases where there is an alcohol or drug issue which is in a legal process.

Learning Disabilities

Learning disabilities are defined as:

"A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence); with a reduced ability to cope independently (impaired social functioning); which started before adulthood, with a lasting effect on development". (Department of Health, Valuing People 2001).

It is not always clear if there is a learning disability, but review of medical records and education records may give an indication. The social workers may feel a Cognitive Assessment is required. Any request for this should be made through the budget holder.

Parents with learning disabilities do not always have problems with parenting but may require additional support. They may have problems accessing antenatal care and have additional stressors such as poverty, poor housing, and social isolation.

It is important the assessment is explained in a way that is appropriate to the parent and support is put in place early. This support may come from extended family and friends or services. Parents with an IQ of under 70 will need a PAMS Assessment (Parent Assessment Manual). Social workers undertaking these assessments should be trained in using the PAMs materials and software.

The parent with Learning Disabilities may be entitled to services within their own right so a referral should be completed to Lifespan Pathway Community Learning Disability Teams (CLDT) or Adult Services, if appropriate.

History of trauma

Parents who suffered previous trauma and adverse childhood experiences are more likely to experience problems parenting their own children and are more likely to be involved in recurrent care proceedings. Therefore, gathering a detailed history for parents is vital.

Unwillingness to accept concerns

If parents cannot acknowledge or accept the local authority's concerns regarding current or future risk or reflect on previous mistakes, they are unlikely to engage in interventions or have the motivation to make changes.

Previous removals of children will inevitably lead to professionals experiencing an acute difficulty of forming a relationship with a parent and this will impact on assessing a current pregnancy.

History of abuse of children

If both parents/partners have abused previously, they will both need to be risk assessed.

A non-abusing parent's ability to recognise risk and protect against it must be assessed. Issues to be assessed include:

- What has changed regarding their view of past abuse?
- Their acceptance of responsibility of any failure to protect or collude with the abuse
- Attitude towards the offence and their view of the associated risk
- Their view of the effects of abuse on the abused children
- Emotional resilience – do they have the emotional tools and resilience to protect the child?

- What has changed and for whom? – is this temporary/permanent, fundamental/ superficial
- Their potential for change
- New partner – history, risks, views on history of partner's children and abuse, how critical these are, and how realistic these are

The abusing parent/partner's assessment should include details and analysis of the following:

- Background, incidences, allegations/convictions – explore fully
- Previous history of parenting
- Attitude towards the offence – do they accept culpability and understand impact on the child? Is there any remorse, insight, or denial? Have they undertaken any work to make changes?
- Current relationship – dynamics, functioning, power balance, level of control.
- Previous relationships
- Current and future – do they live with the non-abusing parent? What are the future plans?
- Willingness to engage with professionals and services

Young parents

Working with young parents can bring its own challenges. Practitioners need to manage all the emotional, hormonal and anxiety factors of engaging parents in assessments, but need to factor in the adolescent brain too. Adolescents struggle with emotional regulation, look for short term gains/instant gratification and can be risk-takers with a motivation for thrills. This coupled with an increasing desire for autonomy and not to be told what to do, as well as pregnancy hormones, can make adolescent mothers difficult to assess. They can easily be labelled aggressive incorrectly, which in turn has a detrimental impact on the Pre-birth Assessment. Processes and the plan will need to be discussed in more detail in clear language and consideration given to how daunting meetings can be for young parents, who are embarking on the adult process of parenting while still developing as a young person.

Pregnant teenagers (under 18s and vulnerable over 18s) have the right to an assessment in their own right, and this should be completed by a different social worker to the one allocated to the unborn. Not all pregnant teenagers will a Pre-Birth Assessment or Pre-birth Risk Assessments. This will depend on the circumstances and age of parents.

13 and under

Children aged 13 and under will require a Pre-birth Risk Assessment but a strategy discussion will also need to be convened as per Kent Procedures and Practice Guidance for Working with Children and Young People who are Sexually Active. Again, the mother will require an assessment in her own right, and this should be completed by a different social worker to the unborn baby and separate to any safeguarding procedures. The social worker for mother and baby should work together to ensure the rights and needs of both are met.

Under 16's

Where it is identified a young person under 16 could be pregnant but is refusing to undertake a pregnancy test or engage with services, a Request for Support will be completed by the professional working with the child. Consent from the parent will be required. Initially, a Pre-birth Assessment should be completed and a further Pre-birth Risk Assessment if significant concerns are identified.

Over 16's

If it is believed the young person is pregnant and concealing the pregnancy, every effort should be made to encourage them to engage with services and undertake a pregnancy test or medical examination. If they refuse, it should be presumed they are pregnant, and a Request for Support should be sent to the Front Door Service. Consent should be gained but if there are safeguarding concerns, a Request for Support should be sent anyway and the Front Door Service will decide what action should be taken and by whom.

Concealed pregnancies

A concealed pregnancy is when someone:

- knows they are pregnant but does not tell anyone
- appears genuinely unaware they are pregnant

Concealment may be due to previous social care involvement with a local authority resulting in the removal of previous children, denial of the pregnancy or genuine lack of capacity or understanding to recognise the pregnancy. It may indicate ambivalence towards the pregnancy; immature coping styles; a tendency to dissociate; or serious mental health illness (e.g., psychosis); all of which are likely to have a significant impact on bonding and parenting capacity.

Where there is strong suspicion, a young person is concealing or denying the pregnancy then it is necessary for agencies share this information, irrespective of whether consent to disclose can be obtained or has been given. In these circumstances the welfare of the unborn child will override the mother's right to confidentiality.

Possible implications for the child arising from the parent's behaviour could be a lack of antenatal care resulting in:

- a lack of monitoring of the health and development of the child during pregnancy and labour, underlying medical conditions, foetal abnormalities, or obstetric problems will not be detected
- a lack of monitoring of the health and development of the expectant parent during pregnancy and labour, underlying medical conditions, or obstetric problems will not be detected

An unassisted delivery can be dangerous for both parent and child, due to complications that can occur during labour and the delivery. Post-natal risks include:

- lack of willingness/ability to consider the child's health needs
- lack of emotional attachment to the child following birth
- poor adaptation and abandonment
- infanticide (the intentional killing of children under the age of 12 months)

All the above highlight the increased safeguarding risks for the unborn child during the neonatal period.

Relinquished babies

The term 'relinquished child' is used to describe a child, usually a baby or at pre-birth stage, whose parents are making the choice of adoption for the child.

For procedures regarding relinquished babies, please see Relinquished Babies and Children as a different assessment process needs to be followed.

Safer sleeping

The sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. Despite substantial reductions in the incidence of sudden unexpected death in infancy (SUDI) in the 1990s, at least 300 infants die suddenly and unexpectedly each year in England and Wales.

Alongside the overall reduction in incidence, however, there has been a steady shift towards these tragedies happening predominantly in families from deprived socio-economic backgrounds. Increasingly, these deaths occur in families whose circumstances put them at risk, not just from SUDI, but of a host of other adverse outcomes. Many of the

recognised risk factors for SUDI overlap with those for child abuse and neglect and this is reflected in the experience of the national Child Safeguarding Practice Review Panel. Of the 568 serious incidents notified to the Panel between June 2018 and August 2019, 40 involved infants who had died suddenly and unexpectedly, making this one of the largest groups of children notified. Sadly, most of these deaths are preventable.

Terminology - You may come across the following two terms which can be described as follows:

Sudden infant death syndrome (SIDS): The sudden death of an infant less than one year old that apparently occurs during normal sleep, which remains unexplained after a thorough investigation, including a complete autopsy, review of the circumstances of death and the clinical history (Krous et al., 2004). There are some cases in which there is no clear cause of death but in which the circumstances do not typically fit the criteria for SIDS. These are cases in which the history, scene or circumstances of death suggest a likelihood of asphyxia but in which positive evidence of such is lacking. Pathologists in the UK often use the term 'unascertained' for such cases, many of which are associated with risk factors such as co-sleeping and bed sharing that might have contributed to the death

Sudden unexpected death in infancy (SUDI): An unexpected death may be defined as the death of a child that was not anticipated as a significant possibility 24 hours before the death, or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death (Fleming et al., 2000). SUDI refers to all unexpected deaths up to one year of age at the point of presentation. As such, it is a descriptive term rather than a diagnosis. At the conclusion of an investigation, they will divide into those for which we have a clear diagnosis, including those related to underlying medical causes, accidents and homicides (explained SUDI), and those for which we do not have a diagnosis (SIDS) (Sidebotham and Fleming, 2007).

Known **risk factors** for SUDI include:

- Unsafe sleeping position
- Unsafe sleeping environment:
  - Co-sleeping in the presence of other risks (including bed sharing)
  - Overwrapping (e.g., head covered, use of pillow or duvets)
  - Soft sleep surfaces (e.g., soft, or second-hand mattress)
- Smoking in pregnancy and/or exposure to second-hand smoke
- Drug and alcohol use (during pregnancy and/or while co-sleeping)
- Poor post-natal care (e.g., late booking and/or poor attendance at appointments)
- Low birth weight of baby and pre-term babies

Other **complicating factors** which may increase risk, or prevent parents/carers from acting on advice include:

- Parental mental ill-heath
- Evidence of neglect, or child abuse
- Domestic abuse

- Social and environmental factors (e.g., deprivation and overcrowding)
- Situation risks (e.g., out-of-routine circumstances such as disrupted routine)
- Parents/carers who have experienced Adverse Childhood Experiences (ACE's)
- Parents/carers who are care leavers
- Young Parents

It is important practitioners discuss safer sleeping with parents during pregnancy, ensure they are aware of risks and discuss how best any identified risks can be mitigated.

Following the assessment (still at pre-birth stage)

The assessment undertaken by Early Help, Children's Social Work Service or Child in Care Service will inform the next steps.

Early Help
The outcome of the assessment undertaken by an Early Help Worker may require ongoing support from Early Help and the relevant pathway would be followed if parents give consent. Alternatively, Open Access may be considered if parents need lower levels of support. If risk of significant harm has been identified in the assessment, the unborn should be stepped across to Children's Social Work Services for a Pre-birth Risk Assessment. If the unborn has siblings, the risk is likely to apply to all the children so they should be stepped across too.

Children's Social Work Services/ Child in Care Service
The Pre-birth Risk Assessment will have identified if there are any risks and what support, or intervention is required. If risk is considered to be at a level that a safeguarding plan is required, a strategy discussion should be convened to consider an Initial Child Protection Conference as early as possible and a Legal Planning Meeting, if there is a possibility the threshold has been met for the Public Law Outline to be initiated.

Child Protection Conferences

The pre-birth Initial Child Protection Conference should take place **by week 20 of pregnancy ideally,** to allow sufficient time for an assessment of parenting ability and the preparation of a pre-birth plan. This meeting must make a detailed pre-birth plan of any actions to be taken and support to be delivered before and immediately following the birth.

Particular care should be taken to ensure representation of relevant agencies including Midwifery Services if the plan involves the possible removal of the child at birth.

Where an unborn child has been identified as requiring a Child Protection Plan at a pre-birth conference, the first review conference should be scheduled to take place within 4 to 6 weeks of the child's birth. This may be extended to 2 months with the written authorisation of the Service Manager if information from a post-natal assessment is crucial for a well-informed review conference.

An early review conference should be considered in the following circumstances:

- where there is a further incident or allegation of significant harm to a child with a child protection plan
- if the child protection plan is failing to protect the child or if there are significant difficulties in carrying out the plan
- where there is a significant change in the circumstances of the child or family not anticipated at the previous conference and with implications for the safety of the child
- where the previous conference was inquorate

Legal Planning Meetings

A Legal Planning Meeting may be required if significant risks are identified; there have been previous removals of children from parents; or if the Public Law Outline procedure is considered to be necessary. A Legal Planning Meeting MUST be held if one of the parents has had a previous child removed or is known to have caused an injury or death of a child.

If the Legal Planning Meeting is held in advance of the birth and time allows, the local authority should initiate the pre-proceedings process to allow for parents to obtain legal advice and representation and for all assessments and work to be undertaken prior to the birth. Ideally, the Legal Planning Meeting should be held by week 20 ideally, to allow plenty of time for legal meetings and reviews to be held and a clear decision to be made about the local authority's plan at birth. This will ensure parents are fully informed prior to the birth and will have legal advice.

In cases of late presentation, concealment or risk of imminent harm post-birth, the local authority could apply for an Emergency Protection Order at birth.

For more information on the Public Law Outline and care proceedings, please read the Pre-proceedings, Public Law Outline, Initiation of Court Proceedings Practitioner Handbook.

Unborn Family Group Conferences (Social Connections Service)

In cases where there is an identified need for support following the birth or where there is identified risk and the Public Law Outline has been initiated, a Family Group Conference should be convened for the parents and wider support network to see what support can be offered to parents. When parents have experienced previous removals of children, there is likely to be mistrust of professionals and there may be a reluctance to consent to a Family Group Conference. In cases like these, all professionals should consider how best to promote this service and engagement with it.

Pre-birth and Proposed Discharge Plan (CSWS and CIC)

It is vital a Pre-birth and Proposed Discharge Plan should be in place at least 6 weeks prior to birth if there are significant risks, the child is subject to a Child Protection Plan, a Pre-birth Risk Assessment is being completed, the pre-proceedings have been initiated, or if the local authority's plan is to issue care proceedings at birth.

The aim of a Pre-birth and Proposed Discharge Plan is to ensure there is a clear and agreed plan for the mother and baby during and following the birth, including the plan for discharge from the hospital or plan for removal.

The Pre-birth and Proposed Discharge Plan should be formulated during a multi-agency meeting. It should be written in partnership with the parent/s and made well in advance of the estimated date of delivery (at the latest 6 weeks prior to birth) unless in exceptional circumstances, i.e., concealed pregnancy.
Suggested attendance to the Pre-birth Planning Meeting:

- parent(s) (mother and father, if safe to do so)
- social worker
- community midwife
- proposed health visitor
- other appropriate agencies (i.e., mental health services, adult services, drug and alcohol support services, interpreting language services)

Pre-birth and Proposed Discharge Plan will include details of local authority involvement and concerns; a risk assessment regarding possible risk to mother, unborn, patients and staff at the hospital; who can/cannot be at the birth (there must be legal grounds for this, e.g. order in place, such as Sexual Offenders Prevention Order, or agreement within Pre-proceedings Meeting); supervision/monitoring required post-birth (this needs to be realistic as hospital staff will be unable to monitor or supervise closely and are not obliged to do so); who should be notified of the birth; local authority's plan at birth including discharge arrangements if appropriate.

The social worker is responsible for completing the Pre-birth and Proposed Discharge Plan and distributing this within 48 hours to the parent(s) and the appropriate safeguarding team at the local hospital trust, who are responsible for sharing the plan with the agreed circulation list. The social worker must upload the plan on Liberi within 24 hours, so it is accessible to any professional accessing Liberi who may need to take action (eg, Out of Hours, Fostering) when necessary.

Post-birth

Not all Pre-birth Assessments will identify any issues and support may be arranged within the community or family network prior to birth. However, when a Pre-birth Assessment has been completed, **the child MUST remain open at least 3 months (12 weeks) post-birth** so that an updating assessment can be completed. This would be completed by whichever team completed the Pre-Birth Assessment (Early Help/CSWS/CIC) unless the child has been transferred to another service. It is not appropriate for a step down from Early Help to Open Access within this 12 week period, although joint working is advised.

When a Pre-birth Risk Assessment is undertaken, an updating assessment MUST be completed post-birth. Due to the level of vulnerability of the baby post-birth, a level of monitoring is required to ensure the risk factors are mitigated or to reassess what support may be required. **The child MUST remain open at least 3 months post-birth CSWS/CIC and be re-assessed by a social worker**.

Permanency planning

When an unborn is subject to the Public Law Outline, a Permanency Planning Meeting should be held during the pre-proceedings process to inform permanency planning, even if a decision has not been made to issue at that stage. A Permanency Planning Meeting should be held prior to issuing care proceedings (see Permanency Planning Guidance).

Use of Supervision/ Management oversight

Working with families pre-birth can be an emotive and stressful area of work for practitioners. In particular, the emotional impact on practitioners of a removal at birth should not be underestimated.

Supervision should be a safe and reflective space to discuss all issues with regard to pre-birth work, including practitioner's views on parents and risk; practitioner's previous experiences and values; possible bias; optimism; engagement of father and any barriers to this; ethical dilemmas; feelings regarding plans for unborn.

The Team Manager/Unit Lead should ensure work starts as early as possible and there is no drift. Pre-birth work should be timely, focused and have clear direction and planning. This requires clear allocation instructions and timescales set at the outset and these are monitored and reviewed regularly. This is particularly important when completing a Pre-birth Risk Assessment, as the timescale may fall outside the statutory timescales for assessments and will not be tracked by PowerBI. Actions from previous supervisions should be reviewed and any drift challenged and recorded.

Following the birth, plans should be reviewed regularly. As already stated, a Pre-birth Assessment and a Pre-birth Risk Assessment **MUST** be updated post-birth and remain open to the service for a minimum of 12 weeks. At every level there should be clear management oversight and rationales for decision-making. After 12 weeks, the level of intervention should be kept under review and alternative levels of intervention considered, if appropriate. Babies must not be closed immediately post-birth as there should be a period of intervention, support, and re-assessment.

Appendix A - Risk screening tool – Pre-birth

This tool should be used as a guide only to whether a Pre-birth Assessment (Early Help Assessment/Child and Family Assessment) or a Pre-Birth Risk Assessment should be completed (click here for template)

Name of Unborn: …… **EDD: ……..**

Pre-birth Assessment		Pre-birth Risk Assessment	
Low/medium risk domestic abuse		Medium/high level risk domestic abuse	
Parental mental health problems (depression/anxiety) or mild learning difficulties		Severe parental mental health problems (diagnosed disorders/suicidal ideation/post-natal depression) or low cognitive functioning (IQ below 70)	
Parents require support		Parent/visitor to home poses a risk to children, including concerns regarding mother's ability to protect	
Substance misuse (low levels – not impairing functioning)		Sibling(s) of unborn subject to Child Protection Plan	
Delayed presentation to antenatal services (not concealed)		Previous removal of a child	
Housing issues		Previous death of a child in care of parent(s)	
In need of services to help promote health and development of baby		Previous concerns regarding Fabricated or Induced Illness by parent(s)	
		Concealed pregnancy	
		Mother who is aged 13 and under	
		Substance misuse where level of drug or level of drug/alcohol use is such as to impact on functioning or likely ability to care for the baby	

Name/role of person completing this form: …… Date completed…….

Appendix B - Risk estimation

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

Factor	Elevated Risk	Lowered Risk
The abusing parent	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	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

	Drug or alcohol abuse	
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

Appendix C- Pre-birth Risk Assessment

Name of Unborn:

Estimated date of delivery:

Social Worker:

Social Worker's details: *Qualification, Social Work England registration, place of work and experience*

Date:

Note: This template is not a definitive list of what should be included but a guide to help in completing a Pre-birth Risk Assessment. Sections can be deleted or added as appropriate.

Reason for Assessment

Include: Brief details of why a detailed Pre-birth Risk Assessment is required and any previous assessments prior to this one e.g. Early Help Assessment, Child and Family Assessment, Cognitive Assessment, etc.

Family Composition

Name	**Relationship to Unborn**	**DOB**	**Address** (*if safe to disclose)*

Genogram

Include: Immediate and wider family.

Consider: It would be helpful to highlight any potential carers. Is there anything regarding family structure/background that seems it will be likely to have significant negative impact on the parents or child?

Sources of Information

Include: Dates and details of any visits or contact with parents or wider family; information from professionals or agencies; number of planned sessions and dates; records/documents reviewed; any other relevant information. Dates and source need to be included.

Consider: Is there any information/evidence that you would have liked to receive but didn't and rationale why.

History of Parents/ Partners

Mother

Father

Partner

Include:

Parents' own experiences as a child and adolescent (positive and negative); previous trauma and adverse childhood experiences; experience of being parented

Previous parenting experience

Previous relationships

Criminal history or violence: history of violence to adults; previous criminal offences, arrests, cautions and convictions

Previous allegations of abuse of a child; previous/current involvement with social care (Children's/Adult Services) including details of any removals or child protection concerns. Obtain records from other local authorities, look at history, obtain court documents within care proceedings, if possible. Review allegation/proceedings; level of allegation; outcome; parents' understanding of this.

Refer to previous records and triangulate evidence given by parents. Obtain information from other local authorities, Police National Computer records and other countries, if applicable.

Previous interventions/services to address any violence or offences.

Consider:

Parents' view of any concerns and willingness to engage in services to address concerns. Parents' views of previous and current professional involvement.

Ante-natal Care, Medical and Obstetric History

In consultation with health professionals, midwifery services and GP.

Include:

Details of pregnancy and engagement with services to date

Health of unborn and any risks which could impact on baby when born or as the child develops (smoking, substances, poor diet)

Health of mother and issues that may cause a risk to Unborn.

Consider:

Issues which could impact on delivery date (e.g., use of substances leading to premature delivery)

Type of delivery and impact of this (e.g., impact of caesarean on mother's ability to care for baby following discharge)

Risks to foetus which could impact on birth and development post-birth

Health issues will impact on level of parenting required or level of hygiene required in the home

Impact of issues such as substance and alcohol misuse, smoking, parental illness.

Impact of any issues on level of attendance at health appointments

Parents' views of known health or developmental issues with foetus or risk of issues due to behaviours during pregnancy

Parents' relationship/ Relationship with partner

Include:

Current status of relationship

Length of relationship and stability

Details of how they met

Strengths of relationship

Domestic abuse / functioning – how often, what level, previous engagement with services to address conflict/domestic abuse.

Expectations of each other e.g., joint/sole parenting

Dependency on each other/one partner support or conflict about each other's views. How do they resolve conflict?

Other factors in the relationship which may impact on their parenting.

Consider:

Impact of the above on stability of relationship. How realistic are parents?

Contingency planning if relationship ends

Risks to child if there are relationship issues now and, in the future,

Current issues likely to affect ability to parent

Consider: Mental health; alcohol/ drug use; learning disability, lifestyle; parent(s)' health; communication issues

Include:

What is the prevalence of this issue?

To what extent does it impact on that parent's ability to function?

How will this impact on the parenting of the baby? To what extent will the pressure of this baby impact the parent's ability to parent?

Mental health – Does the parent have a diagnosis? Is this mild or severe? Are they accessing services and/or medication? Are they and have they always been compliant with prescriptions or therapy? Does the LA need a psychological/psychiatric assessment? – if so, consider this early

Alcohol/ substance misuse – What evidence is available? (tests/observations/hearsay); what interventions/services are in place and what has been the success of this?

Health - Do parents maintain their own health? Is self-neglect an issue?

Learning Disability - What evidence is there of a learning disability? (Cognitive assessment, EHCP, school records)

What support will the parent(s) need?

Understanding of the baby's needs (pre and post birth)

Include:

Attachment to bump; how parent talks about baby (negative labels can denote a lack of attachment; observations of parents' responses to baby in utero (e.g., when baby kicks)

Parents' ability to mentalise with the unborn child, levels of empathy

Views of pregnancy. Planned/unplanned pregnancy. Are parents excited or anxious?

Child's anticipated needs (health, development, disability, possible cognitive difficulties – use knowledge of impact of diet, trauma prior to birth and parents' information to consider this)

Parents' understanding and knowledge of what baby needs to develop emotionally and physically

Support likely to be required to help parents understand and gain knowledge prior to birth

Safer sleeping must be discussed

Consider:

Assessment may need to take a practical form, such as using a doll and making up bottles of milk.

Other professionals, such as Open Access and baby groups may be able to support with assessment.

Triangulate evidence from various source.

How likely is it that the parents will be able to manage the needs of this baby and what are you basing that on?

Ability to protect baby

Include:

Non-abusing parent - what is the view of what the abusing parent/partner has done? Is there resistance to accept the evidence/facts? Would this parent prioritise the baby over their partner?

Abusing parents - Is there any acceptance of responsibility or an understanding of what could have been done differently? What has changed and to what extent? What's the potential for change?

What are the risks if nothing changes?

Consider:

What work/interventions have been done with either parent on accepting the risks and mitigating against them?

NB. Remember that children are at higher risk of abuse from a step-parent. This needs to be factored into assessing risk.

Other circumstances

Include: Employment, finances, housing, home conditions, suitability for baby/child.

Is there anything that can be done pre and post-birth to improve any issues identified?

Consider: Impact on child pre and post birth of any of these issues.

Support

Include: Existing support, wider family, friends, services. What support is available and when? Is this at a level which is sufficient?

Consider: What would be required to mitigate risks and to help parents to care for the baby? What support is needed prior to birth to ensure the health, development, and safety of the unborn?

Analysis

Include: General analysis from your assessment.

Risks identified and mitigation of risk

Explore risks and analyse each one, considering the impact on the child if nothing changes. Is there any support, services or training that can be put in place to mitigate risk? What are parents' views of the risks and what is their willingness to make changes.

Consider factors such as: neglect, physical or mental health, previous criminal behaviour, substance or alcohol misuse, smoking, previous harm to children or involvement with Integrated Children's Services, parents' previous experience during childhood.

How will this impact on the child?

Risk: *name risk*
Analysis of risk:
Impact on child:
Parents' views and willingness to change:
What could mitigate the risk? (support/services/family/changes)
What will happen if nothing changes?

Repeat table with each new risk

Conclusion

Be clear about your conclusion and why.

Plan

What should happen next? What is the plan moving forward?

What level of service/intervention is required? (e.g., Early Help, Child Protection, Public Law Outline). Do not make recommendations for legal action, as this would need to be discussed in a Legal Planning Meeting.

Pre-birth and discharge plan – Is this needed? When will this be completed (in partnership with family and professionals), if there is a specific risk which will need to address in the plan state it here (e.g., sex offender will not be allowed into the hospital)?