



**North Yorkshire and City of
York Safeguarding Children
Partnerships**

**Safeguarding
Unborn Babies –
Pre Birth Guidance**

Practice Guidance

North Yorkshire and City of York Safeguarding Children Partnership

Safeguarding Unborn Babies - Pre Birth Guidance

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1. Aim of Guidance

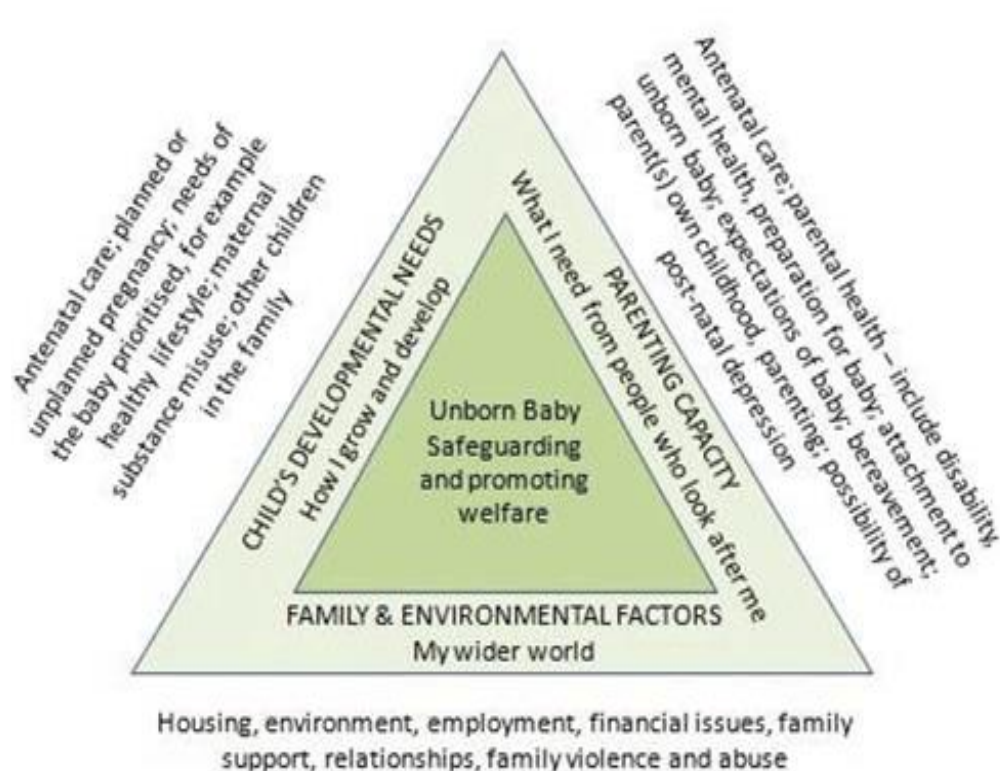
- 1.1 This guidance has been developed in conjunction with North Yorkshire and City of York partner agencies and seeks to assist professionals when considering safeguarding concerns relating to unborn children. It is designed to help all professionals to carefully consider a range of themes and to identify issues that have potential for having a significant negative impact on the safety and wellbeing of unborn babies. Importantly, the guidance aims to support social workers when undertaking an assessment of risk and need.

2. Introduction

- 2.1 The 2016 analysis of serious case reviews (DfE, 2016) found that, as with previous national analyses, the largest proportion of cases were in relation to children under one year of age with nearly half of these (43%) being under three months of age. This has been a pattern in Child Protection since records began to be kept, and seems to relate to 3 factors – physical vulnerability of the infant; its invisibility in the wider community and inability to speak for itself; and the physical and psychological strain it places upon its caregivers. It is critical, therefore, that Local Children’s Safeguarding Partnerships (LSCPs) have robust procedures in place, both to identify the unborn children most at risk and then to effectively manage their welfare and safety at the earliest opportunity.
- 2.2 The nature of safeguarding work dictates that the most successful preventative action can be taken if vulnerable children are identified as early as possible – this includes identifying such children during pregnancy. This early warning system can only operate in a meaningful way if there is an agreed interagency commitment to the importance of this area of safeguarding, and that all professionals work together to assess and manage the response to this high-risk group.

3. Identification of Need and Risk During Pregnancy

3.1 Parents who may require additional support:



- **Parents with LD who may need help to manage caring for a young child** – ‘a learning disability affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently. Around 1.5 million people in the UK have a learning disability.’ (<https://www.nhs.uk/conditions/learning-disabilities/>). The UK legislative framework dictates that parents with learning difficulties have a right to have children and to be supported in bringing them up. However, it is recognised that such parents will face a particular set of problems and challenges, including accessing antenatal care, understanding information about their pregnancy and birth choices or medical information about their baby. Parents may also be anxious about asking for or accepting professional help as they may believe that this will result in their child being removed from their care. Malouf et al (2016) concluded: ‘Mothers who will be subject to a social care assessment of their parenting skills need clear information about the process, their choices and the level of skill they must demonstrate, as well as access to sufficient antenatal and postnatal support...’ If the parents of the unborn child are already accessing support via adult

services the lead worker must be involved in any pre birth assessment. If adult services are not involved this should be explored with the parents and, with consent, a referral could be made for additional support

- **Young and/or unsupported parents** – *'like all parents, young mothers and fathers want to do the best for their children. Whilst a good proportion of young parents manage very well, many young parents' health, education and economic outcomes remain disproportionately poor, affecting the life chances for both them and their children. While every young parent has their own individual story, the risk factors for early pregnancy highlight the vulnerabilities with which some enter parenthood, including family poverty, persistent school absence, slower than expected school attainment and being looked after or a care leaver.'* (Public Health England, 2019). This same report concluded that poor outcomes for the children of young parents can be mitigated by early coordinated and sustained support.
- **Parents who are Looked After or Care Leavers** – some of the key risk factors associated with teenage pregnancy are particularly apposite for young people who are looked after or care leavers. Pregnant teenagers who are looked after/care leavers will need support and guidance to enable them to make informed choices about their future and should be put in contact with relevant health professionals at the earliest opportunity (including specialist teenage pregnancy services where these are available and appropriate). For young people who are looked after by the local authority, the Social Worker will have primary responsibility for ensuring access to services and the coordination and updating of the Care Plan in relation to either or both young parents.
- **Parents with significant physical health problems or disabilities which may make it difficult for them to care for a young child** - there are around 1.7 million disabled parents in the UK, mostly with physical and sensory impairments. A report on a UK study on physically disabled parents' experiences of maternity services reveals that physically disabled people embarking on parenthood face a number of challenges in getting appropriate information and support, including negative attitudes from some health professionals, a lack of knowledge and information available for parents and professionals, as well as poor communication between disabled parents and professionals.
- **Asylum seekers and families where English is not a first language** - there is a five-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared to white women (Knight et al, 2018). There are also significant adverse pregnancy outcomes for babies. Migrants, refugees and asylum seeking women who have recently arrived into the UK bring new challenges for services. The key issues include poor overall health status,

language difficulties as many do not speak English, underlying and possible unrecognised medical conditions and HIV/AIDS and TB.

- **Families who are homeless** - women who are pregnant and homeless constitute a unique group at significant risk of adverse foetal and maternal outcomes. Women often become homeless due to family breakdown, debt, poor mental health and substance misuse problems which add to their vulnerability and those of the unborn infant. Robust collaborative working is needed by all who provide social and healthcare services to homeless pregnant women, to improve the health outcomes for these women and babies.

3.2 Parental behaviours which *may* pose a risk to the child:

- **Domestic abuse:** pregnancy can be both a trigger and risk factor for domestic abuse (DH, 2016) with domestic abuse starting or intensifying in pregnancy. Between 4% and 9% of women are abused during pregnancy and/or after the birth (Taft 2002).

Domestic abuse is associated with an increased risk of miscarriage, still birth and premature birth (NHS 2018). It can also be linked to mental health concerns and substance usage (DH, 2010). Domestic abuse also directly affects the unborn baby: by 18 weeks gestation the unborn baby can hear and by 24-26 weeks gestation the unborn will be startled by very loud noises outside the womb which can cause a stress response in the baby. If a pregnant woman is stressed or scared over a significant period of time, which often occurs where there is domestic abuse, increased levels of the stress hormone, cortisol, will be shared with the unborn baby. Cortisol affects the brain development of the unborn baby and has been associated with mental health concerns later in life as well as affecting the growth of the unborn baby.

- **Current use of drugs or alcohol** - substance misuse by mothers/parents does not on its own automatically indicate that children are at risk of abuse or neglect. However where substance misuse is causing physical, psychological, social, interpersonal, financial and or legal problems, the implications for children and families must be thoroughly assessed. Drug and alcohol misuse during pregnancy, dependent on frequency and severity, can adversely impact the developing foetus, particularly during the first twelve weeks of gestation. Risks include increased risk of miscarriage, likelihood of premature delivery, reduced birthweight and head circumference, and an increased risk of Sudden unexpected death in infancy. The infant exposed to drug or alcohol use during pregnancy may also experience additional long-term cognitive and development problems.
- **Parental mental illness** - during pregnancy and in the year after birth, women can be affected by a range of mental health problems, including anxiety, depression

and postnatal psychotic disorders. These are collectively called perinatal mental illnesses. Perinatal mental illnesses affect at least 10% of women (O'Hara, Swain, 1996) and between a quarter and half of fathers with a partner with a perinatal mental illness are depressed themselves (Goodman 2004). Some women are at an increased risk of experiencing mental illness in the perinatal period, particularly those who have had a previous history of mental illness. A small group of women are known to be at significant risk of developing severe perinatal mental illness. Women who have experienced postpartum psychosis, severe depression in the past or have a diagnosis of Bi-polar disorder have around a 50% chance of becoming unwell in the perinatal period (Oates, M, 2001; Jones, 2019).

Most families where there is perinatal mental illness manage very well and are able to give their children safe and loving care. However, without the right support, perinatal mental illness can have an adverse effect on the baby's brain development and long-term outcomes for the child (Center on the Developing Child at Harvard University 2009). Interactions with caregivers are the most important element of a baby's early experience and help build secure and stable attachments. The nature of this early attachment sets the template for future relationships and can predict a number of physical, social, emotional and cognitive outcomes (Cuthbert et al 2011).

In more serious cases, parental mental illness increases the risk that a baby could be abused or neglected. Babies are particularly at risk if:

- Parents experience psychotic beliefs about the baby
- Parental Perinatal mental illness results in conflict or isolation
- Parental Perinatal mental illness significantly impairs parent's ability to function.

(Manning, Gregoire 2008)

Much of the negative impact that parental perinatal mental health could have on the family and baby's lives can be prevented. The quality of parent's interactions with babies and the development of secure and stable attachment relationships can be improved through effective interventions (Hogg 2013).

The North Yorkshire and York perinatal community mental health team provides a community service to support women who are experiencing mental health difficulties during pregnancy or in the first year after they have had their baby. Please review the link to determine if a referral to this service would be appropriate for the women you are working with.

<https://www.tewv.nhs.uk/services/north-yorkshire-and-york-perinatal-mental-health-service/>

Additionally, practitioners should also consider the potential impact of paternal mental health issues on the safety and wellbeing of the unborn child. Practitioners

are advised to utilise the [North Yorkshire and York PAMIC Tool](#) guidance to support their assessments in terms of need and risk.

- **Maternal ambivalence** - the most recent analysis of Serious Case Reviews (DfE, 2016) recognised that *'maternal ambivalence towards her child (both during and after pregnancy) was highlighted in many reviews as a potential indicator of a child's vulnerability. At its extreme, this may present with a concealed or denied pregnancy. Whilst such cases are rare, other presentations including delayed antenatal booking or uncertainty about keeping the pregnancy are far more common.'* The report concluded that such presentations offer professionals (particularly in primary care and maternity services) opportunities to explore parental concerns and feelings towards the pregnancy and the unborn infant.
- **Denial or concealment of pregnancy** - the concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the unborn infant and the mother. Lack of antenatal care in concealed or denied pregnancies can mean that potential risks to mother and child are not detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy. The potential risks to a child through the concealment of a pregnancy are difficult to predict and are wide-ranging.

While concealment and denial, by their very nature, limit the scope of professional help, better outcomes can be achieved by coordinating an effective multi-agency approach.

- **Surrogacy** - government guidance in respect of surrogacy (2018) advises: *'Altruistic surrogacy is an established and legal way of creating a family in the UK. Surrogacy agreements are not legally enforceable and the IPs (intended parents) need to apply for a parental order after their child is born in order to become the legal parents of the child. The legal framework allows for a surrogate to receive reasonable pregnancy-related expenses from IPs, as assessed by the family court. Surrogacy through commercial means, however, is illegal in the UK (Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to act on a profit-making basis to organise or facilitate surrogacy for another person. Any persons or organisations that organise or facilitate surrogacy must do so on a non-commercial basis.'*

When any professional is made aware of a pregnancy as a result of a surrogacy arrangement they should seek advice from their Designated Officer for Safeguarding Children or the Designated/Named Doctor or Nurse with

responsibility for safeguarding children, to enable them to make the necessary enquiries to satisfy themselves of the legitimacy of the arrangement.

If professionals, following such consultation, are satisfied that the relevant Code of Practice (HFEA, 2017) has been followed, the local authority need not be informed unless there are other concerns being expressed that might indicate that the child may be at risk.

Where the circumstances of the conception and subsequent arrangements for the baby are not clear the parents should be informed of the need for a referral to Children's Social Care to allow for further enquiries to be made.

3.3 **Current or previous history of safeguarding concerns:**

- Previous unexpected death of a child whilst in the care of either parent where abuse or neglect is/was suspected;
- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children;
- Children in the household / family currently subject to a Child Protection Plan or previous child protection concerns;
- Sibling (or a child in the household of either parent) has previously been removed from the household either temporarily or by court order;
- Parent previously suspected of fabricating or inducing illness in a child;
- Families where there is a history of FGM, Honour-based Violence, Forced Marriage or suspected Trafficking.

4. Working with Fathers

- 4.1 It is important that all agencies involved in pre and post birth assessment and support, fully consider the significant role of fathers and wider family members in the care of the baby even if the parents are not living together and where possible involve them in the assessment. This should include the father's attitude towards the pregnancy, the mother and new born child and his thoughts, feelings and expectations about becoming a parent.
- 4.2 Information should also be gathered about fathers and partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified.
- 4.3 A failure to do so may mean that practitioners are not able to accurately assess what mothers and other family members might be saying about the father's role,

the contribution which they may make to the care of the baby and support of the mother, or the risks which they might present to them. Background Police and other checks should be made at an early stage on relevant cases to ascertain any potential risk factors.

- 4.4 Involving fathers in a positive way is important in ensuring a comprehensive assessment can be carried out and any possible risks fully considered.

5. Referrals to Children's Social Care

- 5.1 Practitioners should use this guidance and the local Threshold of Need guidance (click here to access [North Yorkshire's Vulnerability Checklist](#) or click here to access [City of York Threshold Document](#)) to determine if the parents may need support services to care for their baby or that the baby may have suffered, or be likely to suffer, significant harm. Often the presenting issues do not warrant a CSC referral and that the offer of early help is most appropriate way forward. In these circumstances gain consent from the parent (s) and follow the local pathways for early help interventions
- 5.2 Referrals to Children's Social Care should be made early in the pregnancy as soon as concerns have been identified which indicate that the unborn is at risk of significant harm and no later than 16 weeks gestation It may be that concerns are not known until later on in the pregnancy at which point a referral should be made.
- 5.3 Referral at this early stage in the pregnancy will:
- Provide sufficient time for a full and informed assessment;
 - Provide sufficient time to make adequate plans for the baby's protection;
 - Avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time;
 - Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby;
 - Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.
- 5.4 On receipt of the referral, Children's Social Care will make a decision as to how to proceed within one working day.

It is important to note that Statutory Guidance [1] states that:

"Where the local authority is considering proceedings shortly after birth, the timing of the sending of the pre-proceedings letter or letter of issue should take account of the risk of early birth and help to ensure that discussions and assessments are not rushed. Ideally the letter should be sent at or before 24 weeks." (p 19).

- 5.5 Although not all referrals will go on to require legal proceedings, it is important to bear in mind the timescales laid out in the guidance as they will not be met unless referrals are made at an early stage in the pregnancy.

It should also be noted that overall, around 7% of babies are born early and that maternal substance abuse, a major issue for child protection, is associated with premature birth.

Where appropriate, early pre-proceedings meetings provide more opportunity for advice and discussion to influence the parent, and for the parent to influence the local authority's plans. Parents-to-be have more time to demonstrate that they can work with professionals in preparing for the baby, and professionals have more time to assess them and any carers they propose. Pre proceedings meetings should take place before 26 weeks wherever possible.

6. Consent

- 6.1 Concerns should be shared with prospective parent/s and it is good practice to gain consent to refer to LA Children's Social Care. Every effort should be made to work in partnership with parents at this early stage ensuring they are aware of professional concerns and how referral to Children's Social Care will support them. However, if obtaining consent may place the welfare of the unborn child at risk this should be avoided e.g. if there are concerns that the parent/s may move to avoid contact with investigative agencies.

7. Pre-Birth Assessments

- 7.1 A pre-birth assessment should be undertaken on all pre-birth referrals that reach the threshold for Children's Social Care interventions. The assessment should be commenced as early as possible, preferably before 16 weeks. All partner agencies who are involved with either the parents, Unborn Baby or siblings have a duty to contribute towards the pre-birth assessment.
- 7.2 Where appropriate, a strategy meeting / discussion should be held. In the following circumstances a strategy meeting must take place:
- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children
 - A sibling in the household is subject of a child protection plan. If the Unborn Baby has siblings on Child Protection Plan, an Initial Child Protection Conference on the Unborn Baby must be convened. This could, if appropriate, be incorporated into Review Child Protection Conference for the older siblings

- A sibling has previously been removed from the household either temporarily or by court order;
- There are significant domestic abuse issues
- The degree of parental substance misuse is likely to impact significantly on the baby's safety or development
- The degree of parental mental illness / impairment is likely to impact significantly on the baby's safety or development (see [PAMIC tool](#)). This includes where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities.
- There are significant concerns about parental ability to self-care and / or to care for/protect the child e.g. unsupported, young or learning disabled mother. This includes where the expectant mother is not engaging in ante-natal care.
- Any other concern exists that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child;
- A child aged under 13 is found to be pregnant
- Where the expected parent is very young and a dual assessment of their own needs as well as their ability to meet the baby's needs is required. (If the expectant mother is a child/young person, or an open case to social care they must have an allocated Social Worker in their own right)

7.3 Workers should use the Local Children's Social Care – Pre-birth assessment tool when undertaking the pre-birth assessment.

7.4 **Birth Response Plan**

All Unborn Babies subject to a Child Protection Plan must have a written Multi-agency Birth Response Plan before the woman is 34 weeks pregnant. This plan should be agreed at either the child protection conference or within the Core Group.

The Birth Response Plan must include the following elements:

- Planned duration of hospital stay
- Who to notify when baby is born, including EDT
- Contact arrangements for parents, extended family members and significant others

- If supervision is required who is the agreed supervisor
- Details of any pending legal processes
- What to do if the BRP is not followed

The Birth Response Plan should be formed 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 and who will lead this conversation.

Copies of the BRP should be held by all agencies responsible for taking forward the child protection plan including, the midwifery unit where it is agreed the baby will be delivered, the community midwife, the allocated Social Worker and the CSC Emergency Duty Team.

7.5 Pre Discharge Planning Meetings

The 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 BRP. Following the birth and prior to discharge from the maternity unit a Pre Discharge Planning Meeting must be held. This meeting should be convened by the Social Worker in conjunction with the maternity staff.

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

Professionals who should be present:

- Parents (if appropriate)
- Community midwife
- Postnatal Ward Staff
- Social Worker
- Foster carer (where appropriate)
- Wider family(where appropriate)
- A member of the Trust Safeguarding Team
- Health Visitor
- Other agencies may need to be involved should be considered, dependent on the circumstances, such as; School Nurse, Police, Mental Health colleagues, Learning Disability colleagues, GP, LA legal Team and any other key professionals that are in a position to support the safeguarding of the newborn

An agreed multi-agency discharge plan will set 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 agenda for the discharge planning meeting can be found at Appendix 2.

8. Appendix 1: Provision of Maternity Care

Provision of Maternity Care:

Antenatal care is provided once a woman has a positive pregnancy test and is engaging with maternity services. Women have a choice regarding engagement with maternity care and as maternity services are not statutory services this cannot be enforced, however it is a positive indicator that the woman is prioritising the health needs of herself and her baby if engagement does occur. If a woman does not engage with maternity services it is important that any risks relating to the safety of the unborn are highlighted and actioned as appropriate.

Women may not want to engage with antenatal care but attend services for the birth (concealed pregnancy). Women may also choose to only have certain aspects of care (eg Scans) and then wish to have her baby with no medically trained professional present (acknowledge freebirth), women may also choose to not access any care in pregnancy nor have a medically trained professional present at the birth (concealed freebirth). Women may choose to employ a private “doula” (a trained non-medical companion/birth attendant) to support her on her pregnancy journey.

It is good practice that practitioners encourage women to make every effort to engage women in maternity care and highlight the importance and benefits regarding their Unborn Baby’s wellbeing.

If a women chooses to engage with maternity services the midwives will provide care to her and the baby for at least 10 days post birth, but can be up to 28 days post birth. However the midwife may not always be employed by the NHS, as women can choose to employ a private independent midwife.

A booking risk assessment is performed by the midwife ideally between 8-12 weeks gestation. The booking risk assessment will look at medical and social risk factors and an individualised package of care will then be planned based on if any/what risk factors are present.

Frequency of appointments for low risk women (NICE 2019):

For a lady having her first baby (nulliparous or primip)	For a lady who has had a baby before (multiparous/ multip)
Dating scan 10 - 14 weeks	Dating scan 10 - 14 weeks
Screening tests between 11-19 weeks)	Screening tests between 11-19 weeks)
16 weeks	16 weeks
18 - 21 weeks anomaly scan	18 - 21 weeks anomaly scan
24 - 25 weeks	28 weeks
28 weeks	34 weeks
31 weeks	36-37 weeks
34 weeks	38-39 weeks
36-37 weeks	40-41 weeks
38-39 weeks	
40-41 weeks	

Women who are assessed as low risk will have their care facilitated and planned by a midwife. Additional appointments may be planned dependant of any complications or risks. Women who are assessed as high risk will in addition see a consultant obstetrician. All women engaging with NHS Midwifery services will have at least one allocated midwife and information is shared (if consent is gained) with the GP regarding the woman's pregnancy. Information is also shared (if consent is gained) with the health visitor who will also undertake an antenatal appointment.

Women have a choice of where they would like to have their baby. The two options locally are in a hospital or at their home.

"Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option" (Better births, 2016)

After the birth of a baby/babies, postnatal care will be provided to the mother and baby/babies by midwives with the mother's consent. Midwives will then provide postnatal care for a minimum of 10 days post birth but can be provided for up to 28 days post birth after which time care is transferred to the health visitor. If women have their baby/babies in hospital the minimum hospital stay is 6 hours but can be several days dependant on the clinical need. If a woman gives birth to her baby/babies at home then she will not receive any postnatal care in the hospital unless complications occur.

Once a mother and baby/babies are fit for discharge from the hospital, postnatal care will be facilitated in the community.

Following the birth of a baby/babies Health visitors will also visit the family in the community (with consent).

If a woman declines postnatal care for her baby/babies it is important that any risks relating to the safety of the baby/babies are highlighted and actioned as appropriate.

9. Appendix 2: Discharge Planning Meeting Agenda

Discharge Planning Meeting Agenda

1. Introductions and purpose of meeting
2. Professionals attending and apologies
3. Clarify name, DOB, address, ethnicity of child and significant family members including other children
4. Agency updates in relation to pre-birth and post birth considerations during hospital stay
5. Discharge plans will include:
 - When and to whom baby is to be discharged to
 - Reasons why this is the proposed plan
 - Is parental consent required to implement this plan? If not detail how consent will be dispensed with
 - Consideration of the baby's development and whether or not there are specific medical needs which need to be addressed, including how these will be addressed
 - Who will transfer/ transport baby and/or parent/s to proposed address
 - What equipment is required and who will provide this e.g., car seat, clothing, feeding equipment
 - Who and when will parent/s be informed of discharge plan
 - Consider any quality and diversity issues in relation to baby and the family and how these may impact on implementation of plan
 - Contingency plans
6. Consideration of support needs for other siblings, parent/s and significant family members, including how and who will provide this.

7. Where the baby is to be separated from parent/s consider contact arrangements with parents and any siblings following discharge
8. Consider information to be shared or withheld from parent/s and the reasons for this.
9. Arrangements to inform (including who and when)
 - The Community Midwife
 - The Health Visitor
10. Proposed multi-agency visiting arrangements following discharge
11. Dates for review of arrangements

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