



# North Wales Safeguarding Children Board Multi Agency Pre Birth Pathway

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(In light of any changes to All Wales Child Protection Procedures**

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The NWSCB would like to thank Bruce Thornton for allowing the Board to make use the work that he developed with Anglesey County Council in relation to pre-birth assessment. Part of this work is included within this protocol

## Introduction

There is a high proportion of Child Practice Reviews (CPR) in Wales and Serious Case Reviews (SCR) in England that involve children who are under 1 year of age. We have seen in North Wales during 2014-16 that this relates to:

- a) Physical vulnerability of the baby
- b) The baby's invisibility in the wider community and his inability to speak for himself
- c) The physical and psychological strain for caring for a baby in relation to the capacity of the caregivers

The most recent Extended Child Practice Review's (ECPR's) have highlighted to the North Wales Safeguarding Board (NWSCB) that it is critical that agencies have robust procedures in place, both to identify the children more at risk and then to effectively manage their protection.

The most successful preventative action is that which identifies the children at pre-birth. There needs to be a development and adoption of an early warning system, that is based on agencies working together to assess and manage the response to this high risk group.

### 1.1. Purpose of Document

This guidance is designed to better identify those babies most at risk and promote effective sharing of information between agencies. This guidance promotes effective and efficient multi agency working.

This guidance needs to be considered in line with the Regional Information Sharing and Confidentiality Procedure (Appendix 1)

Within this document the procedure relating to pre-birth assessment is clarified and in particular the circumstances in which they should be used.

This document should be read in conjunction with the All Wales Child Protection Procedures and this document should be reviewed when any revisions to relevant parts of the AWCPP is made.

### 1.2 Equality

Each agency will have its own Equality Policy and these policies must be applied to ensure there is no discrimination on the basis of race and ethnicity, disability, age, gender, sexual orientation, religion and belief, Welsh Language or human rights

## 2. Triggers for a Pre-Birth Assessment

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

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

A pre-birth assessment can be completed to answer these questions.

Whether this should be a pre-birth core assessment or a pre-birth risk assessment will depend on the circumstances

This suggests that the pre-birth assessment is primarily concerned with the potential for future care. These questions straddle both the child protection aspect (is the child safe?) and 'good enough parenting' (is there prospect for adequate care?)

In addition to the management of risks or care following birth, there are also 'in utero' considerations.

The function of pre-birth assessment could therefore be to:

- Identify in utero risks that require intervention
- Establish whether the child is at risk of significant harm once born, assessing
  - Will the child be safe when born?
  - Are parent(s) likely to provide adequate care through childhood?
  - Are the parent(s) capable of changing so that the identified risks can be reduced?
  - What are the support needs?

The pre-birth assessment must be of sufficient depth to inform future care planning. It must take into account family strengths as well as the risk factors to ensure that the new born baby receives the necessary level of support to achieve their full potential and be protected from immediate and future harm.

## **2.1 Circumstances in which a Pre-Birth Risk Assessment should be undertaken**

A pre-birth risk assessment should be undertaken:

- Where a child in the family has previously suffered significant harm
- Where a previous child in the family has died due to unascertained causes
- Where a child in the home is on the Child Protection Register or placed at home under Placements with Parents Regulations
- Where a child is likely to suffer significant harm as a result of parenting capacity in relation to:
  - Where the parent(s) has either a severe mental health condition or learning disability or misuses substances which is likely to impact on their ability to parent the child
  - Where there is significant domestic abuse present or escalation during pregnancy?
  - Where one or both parents have convictions or has been the subject of police investigation for offences of either a violent or of a sexual nature
  - Where concerns exist regarding the ability of either parent, to adequately protect the baby from identified risks from the other parent/proposed carer e.g. substance misuse
  - Where alcohol or substance abuse is thought to be affecting the health of the expected baby
- A parent of 18 years old and under with concerns about sexual exploitation, trafficking or abuse
- A parent is suspected of being involved in a forced marriage
- Late booking for maternity care with an inadequate explanation
- Transient and chaotic lifestyle

This list is not exhaustive and there may be other circumstances which may be potentially damaging to a new born baby that will require a pre-birth assessment. The social worker should use his/her professional judgment and discuss with his/her Line Manager during formal supervision.

## **2.2 Rationale for Early Referral**

The rationale for early referral is in order to:

- Enable the early provision of support services, and where possible, the involvement of family and friends in order to provide the safest home environment for the baby
- Provide sufficient time to make adequate plans for the baby's protection
- Ensure adequate time for a full, informed and continuous assessment
- Reduce distress to the parent/s by ensuring that plans are in place as early as possible into the pregnancy
- Enable parents to have more time to contribute their own ideas and solutions and therefore increase the likelihood of being able to successfully parent their child

## **2.3 Sharing Information with the Parents at an Early Stage**

Pre-birth assessments are a source of anxiety not only for parents, who may fear that a decision will be made to remove their child at birth, but also for professionals who may feel that they are not giving parents a chance. Professionals may also be concerned that early discussions and assessment may lead parents to consider terminating the pregnancy. If the professional is worried about this then it should be discussed without delay in supervision and the professional should also sign post the parents to appropriate support and counselling.

However, the Children Act 1989 is clear that there are grounds for intervention if there is a likelihood of significant harm and that the needs of the child (in these situations the unborn child) are paramount.

It is important that the reasons for the assessment are made clear to the parents at the outset and that there is clarity of understanding between professionals as to the purpose of the pre-birth assessment process.

Care must be given to working collaboratively with parents as a means of drawing together a balanced assessment with due consideration of parental strengths and capacity to change as well as areas of concern. However, it is critical that the needs of the unborn child remain at the centre of the assessment as opposed to those of the parent/s. There needs to be good consistent dialogue between professionals, recognition of the strengths and expertise that individual practitioners bring to the process and constant focus that the needs of the unborn child are paramount.

A pre-birth assessment will undoubtedly cause anxiety and fear for parents. Health and Children Service's practitioners should consider the mental wellbeing of the parents and consider referring the parents to Mental Health Services and to seek advice from BCUHB Perinatal Team (established in September 2016) (Appendix 2).

Parents should be reminded of their right to obtain independent legal advice in these circumstances.

## **3. Protecting the Unborn Child in the Womb (In Utero)**

Opportunities for intervention in the past has been considered limited because of health assessments and referrals taking place at certain milestones within the pregnancy. For example, the initial booking in appointment takes place around week 10 and a dating scan at 12 weeks. The next appointment takes place at 16 weeks, with scans usually in weeks

18-20. Health staff consider that a pregnancy is fully 'viable' when capable of survival when born.

In the past, pre-birth health assessments and referrals to children services (where there are concerns) would usually take place later in the pregnancy. Health pre-birth assessments usually took place at around 24 weeks and there was a tendency for children services not to accept referrals until post 24 weeks.

However from September 2016, this will no longer be the practice and BCUHB has introduced a principle that the health pre-birth assessment should be a continuous assessment which commences at around week 12 and in any event as soon as possible following the booking process.

BCUHB will refer to Children's Services as soon as possible after 12 weeks and the referral will include as much information as possible

BCUHB Guidance (Appendix 3) now states that the Health Pre Birth must be completed by week 30 of pregnancy or prior to the Pre Birth Case Conference.

The Health Pre Birth Assessment will be a continuous assessment which will be commenced as early as possible and the assessment **must** be revisited if circumstances or needs change in the latter weeks of the pregnancy.

The Health Pre Birth Assessment is a joint assessment with Maternity and Health Visiting Service but it is led by Maternity Services. When there are concerns in regards to the mother's mental wellbeing, Mental Health Services and the Perinatal Team **must** be contacted for maternal support during and following the assessment process.

#### **4. Referral Pathways and Process Issues**

Well defined processes are in place that drives social work practice. These are outlined in the Assessment Framework and in Child Protection Procedures. These particularly impact on pre-birth.

##### **4.1 Pre-birth Pathway – 'Significant Harm'**

When safeguarding concerns are identified during the initial pregnancy assessment or following review of the Health Pre Birth Assessment, these concerns must be shared with all relevant agencies/ professionals.

Referrals from Health should be received on a Referral Form with relevant information provided by agencies. (This may include the health pre-birth assessment that has been commenced although not completed). Referral decision making is based on an assessment of information available at the time. It may indicate either 'in utero' and/or concern about care once child is born, or both.

Children's Services will return any referral if it is considered that there is not enough information. Referrals should be returned with a request for more information. Referrals can also be returned by Children's Services with a request that a health pre-birth assessment is commenced. Children's Services and Health should agree a timescale for returning the referral. Children's Services should follow up on any referral that has not been returned.

In some cases it is likely that upon receipt of the initial referral the Health Pre Birth Assessment will not have been completed. However the initial referral needs to have enough information for children services to be able to assess risk.

Agencies are reminded of the NWSB Escalation of Concern Protocol (Appendix 4).

## **4.2 Referrals**

A referral is a 'request for service'. Referrals indicate an expectation that social services takes action in response. They usually include an indication of concern.

## **4.3 Open Cases**

If intervention is already taking place with the other children of the family, there will be a care and support plan. This should not stop a referral in relation to the new unborn child. This will ensure that the unborn child's circumstances is not 'lost' within the whole family circumstances.

A pre-birth assessment will inform the change in family circumstance as a new child arrives. If the family is already known and receiving services, the earlier that pre-birth assessments are undertaken, the earlier the current plans for the family can address these new needs that have emerged.

## **4.4 New Cases and Registration**

New cases should be able to include interventions that protect the unborn child 'in utero' and prepares for birth without a dependency on registration. The Child Protection Referral Pathway must not get in the way of making plans.

## **4.5 Assessment**

The assessment should be completed within a maximum of 42 working days, but can be completed before then. Where there are concerns about 'likelihood of significant harm' Child Protection Procedures indicate that the Strategy Discussion must be undertaken within 24 hours of the decision being reached that this is necessary.

In practice, an assessment where there are concerns about significant harm should be concluded without delay, often within 24 hours. These are sometimes called 'Brief Assessments' as they confirm the rationale for undertaking a subsequent Strategy Discussion.

## **4.6 Strategy**

Where there is reasonable cause to suspect significant harm, a Strategy Discussion/ Meeting will take place. The Strategy Discussion may be limited to a single discussion, for example between the Police and Social Services. Alternatively, the Strategy Discussion may decide that a Strategy Meeting should be held. This may include several agencies.

The purpose of the Strategy Discussion (or Meeting) is to decide whether to, and how to, undertake the S47 child protection investigation. This investigation may take place jointly with the Police, or as a single agency investigation by Social Services.

## 4.7 S47 Enquiry

This is an assessment/investigation process and has flexible time scales which should have oversight from managers. The Initial Child Protection Conference should be held within 15 working days of the strategy that made the decision to hold the conference.

## 4.8 Outcome of S47

At the end of the S47 Enquiry, a social services manager will make a decision whether the likelihood of significant harm has been proven and that there is an on-going risk providing a rationale for taking the case to an Initial Child Protection Case Conference.

## 4.9 Assessment of Unborn

The pre-birth assessment should be started by the 20 week stage of the pregnancy. The Social Worker will provide a report for the Conference, informed mainly by the Pre Birth Risk Model. Each Local Authority uses its own assessment.

Authority	Pre-Birth Assessment Model
Gwynedd	Risk 2
Ynys Mon	Risk 2
Conwy	Martin Calder
Denbighshire	Risk 2
Flintshire	Risk 2
Wrexham	Risk 2

It is essential at the start of a pre-birth assessment to conduct the following:

- Read all documents relating to the family including the documents for any siblings subject to proceedings or Child Protection Plan other Local authority case files and reports produced by other professionals. This should include any past legal files and court judgements
- If there is a court judgement, this must form a factual starting point of any assessment
- Compile a Chronology of significant events with coherent histories and accurate recording, following up any missing information if possible
- Take an objective look at the Chronology to see if there are any overall patterns emerging
- Obtain details of all family members/significant adults living in the household including details of any name changes, previous addresses, cautions, convictions, final warnings and other significant relationships
- Establish the date of confinement and the antenatal history relating to the unborn child
- The expectant mothers ante-natal care, medical and obstetric history. This can be completed by the Midwife/Health Professional as part of the pre-birth core assessment but reference to this must be included in the assessment report. The central question is whether there is anything in the medical and obstetric history that seems likely to have a significant negative impact on the child and if so, what?
- Establish details of any previous pregnancies and subsequent births
- Determine professional responsibilities for collating relevant information and supporting the parent(s)
- Prepare and agree a written contract with the person(s) participating in the assessment specifying the dates, times and venues for any assessment sessions as well as the consequences for lack of co-operation
- The pre-birth core assessment is usually conducted by engaging the parent(s) in a number of individual and if more than one person being assessed in joint sessions

- Give consideration to joint and individual assessment sessions, especially if there is potential conflict of interest
- Staff must take notes of the topics discussed and the information provided. Notes of each session should be dated and typed and inserted within the case management system

Other agencies may have completed relevant assessments that children services may wish to consider within the pre-birth. Consideration of all assessment relating to the parent(s) will provide a holistic overall assessment of the parent's capacity to parent a new born child. Such assessments may include:

- Suspected drug/alcohol misuse
- Learning difficulties
- Mental health problems
- Information from the Police (Convictions / Non Convictions)
- Information from Probation and Community Rehabilitation Company
- Chronic or acute medical conditions which may impact on their physical ability to care for a child

The Social Services and Wellbeing Act 2014 provides important principles that underpins the approach to assessing children and their families. These principles should also underpin the approach within the pre-birth assessment process:

- Be child centred
- Be rooted in child development
- Be holistic in approach
- Ensure equality of opportunity
- Involve working with children and their families
- Build on strengths as well as identify difficulties
- Include an inter-agency approach to assessment and the provision of services
- Be a continuous process, not a single event
- Be carried out in parallel with other action and providing services
- Be grounded in evidence based knowledge

#### **4.10 Initial Child Protection Conference**

All Wales Child Protection Protocol (AWCPP) 2008 states that Initial Child Protection Conference for unborn children should take place between week 8 and 16 weeks before estimated date of delivery (EDD). Therefore case conference can take place after week 26 of pregnancy.

The conference may consider the issue of the child's care with the parents and may discuss issues relating to removal of the child from the care of his parents. This is not a decision that conference can make. This discussion should take place through the Local Authority's PLO process.

The child is registered when born and does not have to be reviewed again by the Review Case Conference until 3 months after birth.

When this decision has been made the AWCPP indicate that Core Groups should take place. The nature of the Core Group process will inevitably be different to those taking place after birth. The purpose of the Core Groups will be to develop the Child Protection Plan and to consider a Birth Plan (not in terms of delivery options but rather in relation to who will be allowed on the Ward/Birth Partner/Supervision of Family at the Ward if

relevant/discharge considerations). There should be a Core Group Meeting taking place at the 38 weeks point.

The AWCPP also indicates that this plan should also ensure the Pre Birth Assessment should be completed. This may duplicate the Pre-birth Risk Assessment and cover very similar issues. It may be that the Core is deemed unnecessary.

The different decisions that are implied pre-birth include:

- Referral decision (based on referral information and checks)
- Initial Assessment threshold to convene a Strategy Discussion
- Initial Assessment screening for 'in-utero' risks
- Strategy Discussion threshold to undertake S47 Enquiry
- Outcome of S47 Enquiry to proceed to Case Conference
- Case Conference registration decision
- Child Protection Plan to remove or not at birth
- Pre Birth Core Assessment scope and which agencies should contribute to the assessment

The different assessment phases by SSD that are implied pre-birth include:

- Initial assessment (screening for in utero and significant harm)
- S47 Enquiry
- Case Conference Report
- Pre-birth Assessment (Core Group, informed by the above)

The different intervention options in utero include:

- Prevention – general health information about how to remain healthy in early pregnancy (health agencies/ public health)
- Prevention – targeted general health information for vulnerable groups (e.g. victims of domestic violence, alcohol consumption, drug use, previously on child protection register or children removed) (health agencies/ public health)
- Early intervention by Health agencies – targeted advice and intervention for individuals identified as vulnerable (flagged in health systems, triggered at Booking-in or GP appointments)
- Early intervention by single or joint agencies focussed on prevention e.g. TAF
- Early intervention by Social Care agencies – targeted advice and intervention for individuals already open to Social Care (Children Services) (triggered by awareness of pregnancy or referral from Health)
- Referrals to Social Care – usually by Health agencies, the in utero risks need to be identified in the Initial Assessment (screening) and actions triggered

This would provide an option for a single agency such as Social Services to undertake a 'pre-birth assessment.'

#### **4.11 PLO (Public Law Outline) Process**

If the PLO process has decided to instigate care proceedings upon the child's birth the social worker must inform the lead safeguarding midwife of this decision. The decisions of the PLO process should be recorded on the pregnant mother's records by the Safeguarding Specialist Midwife/Named Midwife who will ensure that the midwives are fully apprised of the plan for the child.

The purpose of the discussion/notification between the social worker and the Safeguarding Specialist Midwife/Named Midwife is to make a detailed plan for the baby's protection and welfare around the time of birth so that all members of the hospital team are aware of the plans.

The discussion/notification with the Safeguarding Specialist Midwife/Named Midwife should address the following:

- How long the baby will stay in hospital (a minimum of 3 days is usually recommended to monitor for withdrawal symptoms for babies born to substance using mothers)
- How long the hospital will keep the mother on the ward
- The arrangements for the immediate protection of the baby if it is considered that there are serious risks posed to the e.g. parental substance misuse; mental health; domestic violence. Consideration should be given to the use of hospital security; informing the Police etc.
- The risk of potential abduction of the baby from the hospital particularly where it is planned to remove the baby at birth
- The plan for contact between mother, father, extended family and the baby whilst in hospital. Consideration to be given to the supervision of contact – for example whether contact supervisors need to be employed
- Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breast feeding
- The plan for the baby upon discharge that will be under the auspices of Care Proceedings, e.g. discharge to parent/extended family members; mother and baby foster placement; foster care, supported accommodation
- Where there are concerns about an unborn of a pregnant woman who intends to have a home birth, the Ambulance Service Lead should be invited to the Birth Planning Meeting
- Contingency plans should also be in place in the event of a sudden change in circumstances
- Hospital staff should be given clear instructions regarding any birth that is likely to occur over a weekend or Bank Holiday
- The Emergency Duty Team should also be notified of the birth and plans for the baby

#### **4.13 Discharge Meeting**

The hospital midwives need to inform the allocated social worker of the birth of the baby and there should be close communication between all agencies around the time of labour and birth. In attendance at the discharge meeting should be the social worker, senior practitioner, midwife, health visitor and members of the core group responsible for the child protection plan and if possible the foster carers if the child is to be placed into local authority care. The discharge meeting will also be recorded as a core group meeting.

In cases where legal action is proposed or where the unborn child has been the subject of a Child Protection Plan, the allocated social worker should visit the hospital on the next working day following the birth. The social worker should meet with the maternity staff prior to meeting with the mother and baby to gather information and consider whether there are any changes needed to the discharge and protection plan. The social worker should keep in daily contact with the ward staff.

If a decision has been made to initiate Care Proceedings in respect of the baby, the child's social worker must keep the hospital up-dated about the timing of any application to the Courts. The lead midwife should be informed immediately of the outcome of any application and placement for the baby. A copy of any orders obtained should be forwarded immediately to the hospital.

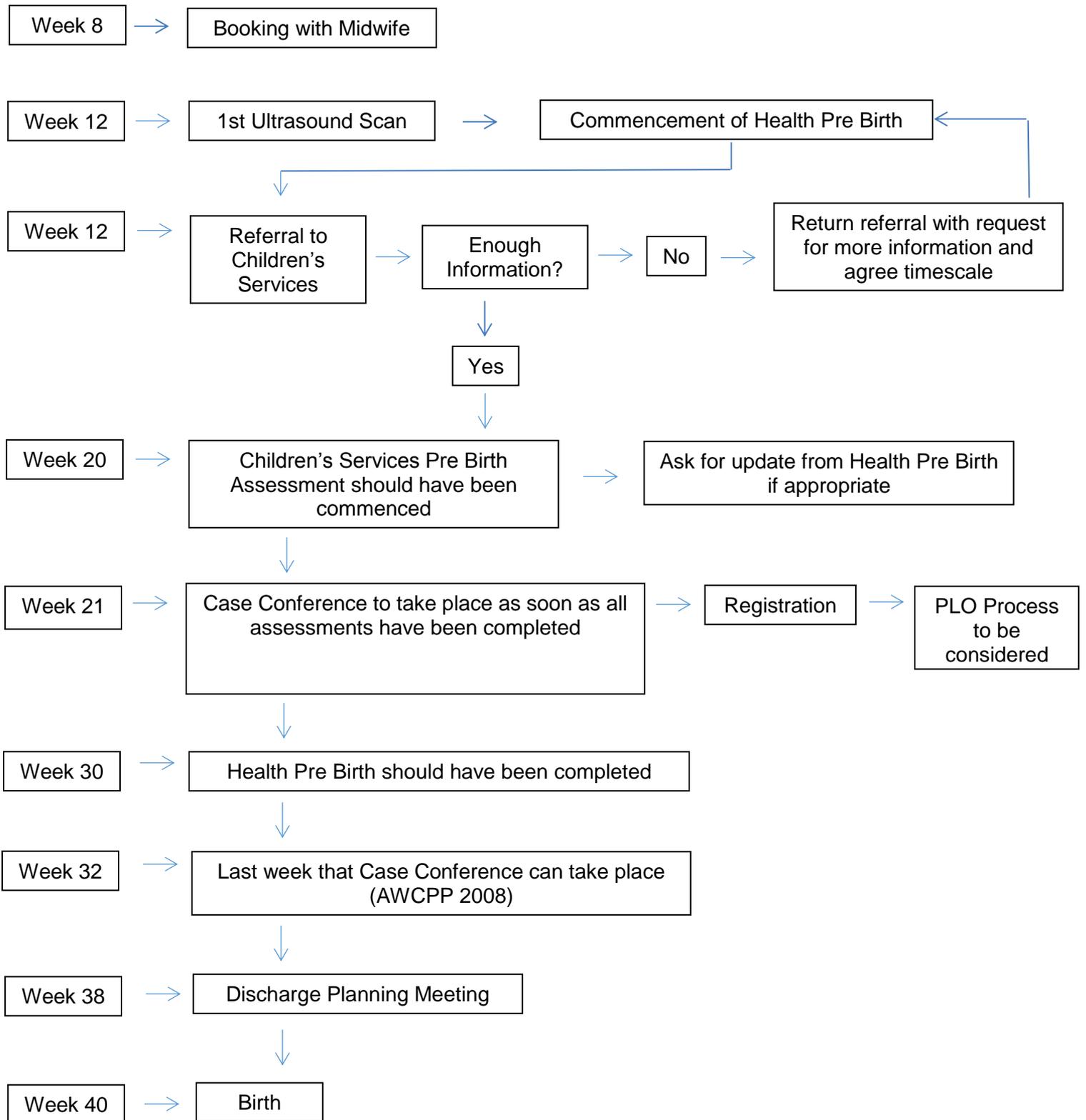
## 5. Glossary of Terms

<b>AWCPP</b>	All Wales Child Protection Procedures
<b>BCUHB</b>	Betsi Cadwaladr University Health Board
<b>CP</b>	Child Protection
<b>CPR</b>	Child Practice Review
<b>CSE</b>	Child Sexual Exploitation
<b>ECPR</b>	Extended Child Practice Review
<b>EDD</b>	Estimated Date of Delivery
<b>LA</b>	Local Authority
<b>NWSCB</b>	North Wales Safeguarding Board
<b>PLO</b>	Public Law Outline
<b>S47</b>	Section 47
<b>SSD</b>	Social Services Department

# Appendices

6.1 Appendix 1

**Flow Chart**



## 6.2 Appendix 2

### **North Wales Inter Agency Information Sharing Protocol for the Assessment of Children in Need and Children in Need of Protection**



North Wales Inter  
Agency Information

## 6.3 Appendix 3

### **Information about BCUHB Perinatal Team and Contact Details**

The team has been developed as a result of consultation with a number of key partners across BCUHB. Recruitment to these posts have not taken place and therefore this team is currently not operating. This document will be updated once appointments have been made.

The team will consist of:

- Part time Psychiatrist x 1
- Part time Psychologist x 1
- Full time Specialist Midwife x 1
- Full time Community Psychiatric Nurse x 3
- Full time Project Support Worker (similar to Health Care Support Worker) x 1
- Part time Administrator x 1

The team will:

- Act as a specialist clinical resource that will enhance and co-ordinate, rather than replace, existing services within BCUHB
- Take referrals across North Wales regarding Perinatal Mental Health from a range of professionals and will act as a source of advice and expertise
- Work jointly in cases that are complex and will work directly with women within in patient settings or the community in severe cases
- Develop a database of cases and queries and will then be able to report corporately on the numbers, activity and outcomes of referrals
- Offer clinical support to other teams
- Offer literature and guidance on various topics within Perinatal Mental Health and will signpost to the small third sector commissioned services who offer low level support and community based groups in North Wales

The contact details of the team are:

- Phone Number: To be confirmed
- Email: To be confirmed

## 6.4 Appendix 4

### Guidance for Completion of Health Pre Birth Assessment by Midwife/Health Visitor Including Referral Form



160722 GUIDANCE  
Completion of Health

## 6.5 Appendix 5

### North Wales Protocol for Resolving Professional Differences of Opinion



North-Wales-protocol-for-resolving-professional-differences-of-opinion

## 6.6 Appendix 6

### Impact of Substance Misuse

Babies are not born addicted even if the mother is, but can suffer distressing withdrawal symptoms.

- **By week 5** brain, spinal cord and heart begin to develop and are at most risk for damage from alcohol, illegal drug use, medications and infections
- **By week 6 to 7** brain forms 5 different areas, some cranial nerves are visible
- **By week 25** the brain is formed
- **By week 27- 30** brain grows rapidly and nervous system has developed enough to control some body functions

Drugs can have harmful effects on the embryo or foetus at any stage during pregnancy. In the first trimester the greatest risk is in 3-11 weeks and can produce congenital malformation (teratogenesis). In second and third trimester they can affect growth or functional development of the foetus or have toxic effects. As the brain develops right up to the end of pregnancy, it is possible exposure at any stage could have a lasting effect on learning and behaviour.

Drugs taken shortly before term can have an adverse effect on labour or the neonate after delivery.

Not all damaging effects of intrauterine exposure to drugs or alcohol are obvious at birth as some become evident later in life.

All drugs should be avoided if possible in the first trimester or taken only if the benefit to the mother is greater than the risk to the foetus. Few drugs are shown to be conclusively teratogenic, but no drug is safe beyond all doubt in early pregnancy. The absence of information on adverse effects does not imply that it is safe. Not all over the counter drugs are safe in pregnancy.

#### **Methadone**

- Long acting opiate agonist usually given to patients with long history of opiate misuse/ abuse, a variety of sedative type drugs and alcohol and people who experience increased anxiety during withdrawal of opiates
- Acute withdrawal of opioids should be avoided in pregnancy due to risk of foetal death

- Methodone is safer for the foetus than illicit drugs
- Abrupt withdrawal (detoxification/ reduction) during first trimester should be avoided as associated with increased risk of miscarriage and still birth and pre term labour in the third trimester. Detoxification / Reduction undertaken gradually during second trimester. Detoxification / Reduction during third trimester not recommended as maternal withdrawal symptoms, even if mild, is associated with foetal distress and risk of neonatal death. Drug metabolism is increased in third trimester and dose may need to be increased to prevent withdrawal symptoms developing. Any reduction in methadone should be under medical advice
- **Newborn** should be monitored for respiratory depression and signs of withdrawal if the mother has been prescribed high doses of opioid substitute. Signs usually develop 24-72 hours post-delivery but could be delayed up to 14 days, so monitoring may be required for a few weeks. Symptoms are high pitched cry, rapid breathing, hungry but ineffective sucking and excessive wakefulness. Rarely severe symptoms such as hypertonicity and convulsions.

### **Breast feeding**

Mothers who are on prescribed drugs should be encouraged to breastfeed in the same way as others mothers. The exceptions to this would be if the mother was:

- HIV Positive – because of risk of transmission
- Using high quantities of stimulant drugs, such as cocaine, ‘crack’ or amphetamines – because of vasoconstriction effects
- Drinking heavily (>8 units/day) or taking large amounts of non-prescribed benzodiazepines – because of sedation effects

Excreted in milk monitor for sedation (high dose has increased risk of sedation and respiratory depression in the new born), inadequate weight gain. If breast feeding mother is found to be using opioid substitute it should be reported urgently to HCP

### **Cocaine**

Cocaine is a powerful vasoconstrictor (restricting blood flow and oxygen to the fetus) and this effect is reported to increase the risk of:

- Placental abruption (placental separation with hemorrhage and fetal hypoxia)
- Intrauterine growth restriction (including reduced brain growth)
- Underdevelopment of organs and/or limbs
- Fetal death in-utero (miscarriage and stillbirth)
- Low birth weight babies
- Pre-term (premature) delivery
- Adverse effects have been largely reported in heavy crack/cocaine users, rather than with ‘recreational’ or occasional users. Cocaine ‘binges’ can potentially cause fetal brain infarcts due to sudden reduced blood flow

### **Amphetamines**

There is no conclusive evidence that amphetamine use directly affects pregnancy outcomes. However, amphetamine sulphate is a powerful CNS stimulant and heavy users tend to have poor health (due to poor nutrition, weight loss, anaemia and mental health problems). Like cocaine, amphetamines cause vasoconstriction and hypertension, which may result in fetal hypoxia.

Withdrawal symptoms in the newborn baby have not been reliably reported with amphetamine use. As with other drugs, in the absence of good data, advice should be to avoid or at least reduce intake during pregnancy.

## **Cannabis**

- Evidence is uncertain re harmful effects because it is usually smoked with tobacco which is harmful
- It is linked to low birth weight
- Not known to cause birth defects but only small number of women studied
- As baby is no longer getting the substance via the placenta, has a withdrawal symptom
- If taken in the weeks leading up to delivery, there is a need to inform midwife as baby with need monitoring

## **Diazepam**

- Risk of neonatal withdrawal symptoms when benzodiazepines are used during pregnancy
- Regular use should be avoided
- High doses taken in late pregnancy or labour may cause neonatal hypothermia, hypotonia and respiratory depression

## **Hypnotics**

- Nitrazepam/Temazepam/Zopiclone – as diazepam above
- Avoid regular use

## **Alcohol**

- Department of Health suggests avoid completely
- There is no conclusive evidence to indicate a safe exposure in pregnancy
- Risk is present once placental flow commences and the foetus is connected to the mother
- Alcohol damages cells necessary for growth and disrupts connections in the brain
- Brain damage is irreversible
- It is thought binge drinking (>5 units at one session) is harmful
- Especially avoid in first 3 months to reduce the increased risk of miscarriage, low birth weight and premature birth
- If a woman must drink it's advised only 1-2 units (1-2 small glasses wine) once or twice a week (RCOG)
- Alcohol is a known teratogen and impairs the development of the foetal nervous system and causes cognitive defects/behaviour problems and poor foetal growth and formation. Severity depends on the amount, gestational age of exposure and co-ingestion of other teratogenic substances. It passes through the placenta to the baby. The baby's liver is one of the last organs to develop and doesn't mature until late pregnancy. The baby cannot process alcohol as efficiently as the mother, stays in its system longer and too much exposure can seriously affect development. (It takes 1 hour for mother to process 1 unit but takes three times as long to pass around foetal system)

## **Foetal Alcohol Syndrome (FAS)**

- This is caused by chronic high alcohol consumption (>5 units/day) and effects include:
  - Pre and post-natal growth retardation
  - Adverse effects on the central nervous system (learning difficulties/behavioural problems) Facial abnormalities

There is also a less severe condition Foetal Alcohol Spectrum Disorder (FASD) reported at lower levels. This is an umbrella term for several diagnoses related to in utero exposure to alcohol at any time during pregnancy. Babies with brain damage may not have classic features but can still be severely affected, and is often undiagnosed or misdiagnosed e.g. Attention Deficit Hyperactivity Disorder (ADHD) or Autism.

ANC regime usually up to 10 appointments for first baby and subsequently about 7 visits should be in place if the mother feels safe to disclose information. First visit should include advice re folic acid/alcohol/smoking etc and mother should be asked about issues such as drugs use/domestic violence/ mental illness/cultural issues if relevant e.g. Female Genital Mutilation

Booking in at 8 - 10 weeks (ideal is 10 weeks). Dating scan takes place around 12 weeks. Some obvious abnormalities can be seen but not all. Some only become evident later in pregnancy. The dating scan confirms viability and number (single/multiple pregnancy), confirms gestational size.

### **Scans are unable to identify brain damage caused by drugs/alcohol**

- 16 week appointment with midwife review/ screening tests and referral for 18 - 20 week anomaly scan
- More frequent visits after 24 weeks. If first baby then seen regularly
- Multiple pregnancies have increased monitoring and referred for consultant led care
- Women with increased risk factors/certain medical conditions will be referred for consultant care

### **Risk issues in relation to assessing pregnant women who misuse substances**

Most drug-using women are of child-bearing age. Substance misuse is often associated with poverty and other social problems, therefore pregnant drug using women may be in poor general health as well as having health problems related to drug use. Use of alcohol and tobacco is also potentially harmful to the baby. Substance misuse during pregnancy increases the risk of:

- Having a premature or low weight baby
- The baby suffering symptoms of withdrawal from drugs used by mother during pregnancy
- The death of the baby before or shortly after birth
- Sudden Infant Death Syndrome
- Physical and neurological damage to the baby before birth, particularly if violence accompanies parental use of drugs or alcohol
- Pregnant women drinking to excess risk delivering babies with Foetal Alcohol Syndrome

## 6.7 Appendix 7

### Suicide in Pregnancy

Suicide during pregnancy and in the postnatal period although uncommon should be considered as an important risk factor.

Data from the UK National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (1997-2012), confirmed that among 4785 women who had died as a result of suicide (between the age of 16-50 years) 98 had died during the perinatal period.

The potential risk factor was the fact the women who died from suicide in the perinatal period were more likely to have received a diagnosis of depression compared with women who died of suicide who were not in the perinatal period and they were less likely to be receiving any active treatment at the time of their death

Notably women who died by suicide in the perinatal period were more likely to have used a method of suicide considered more violent compared with women who died of suicide outside of the perinatal period (hanging or jumping from a height)

### Impact of Blood-Borne Viruses

#### **Hepatitis Viruses**

Hepatitis means inflammation of the liver and can be caused by many irritants, including chemicals, viruses and bacteria, and by other disease processes such as allergic and immunity diseases. There are several types of viral hepatitis, the most common being hepatitis B and C, but hepatitis A can also be caused by injection (the most common cause of hepatitis A is hand to mouth). Individuals injecting any form of drugs are at great risk of also transmitting blood-borne infection and contamination. One of the most serious manifestations of such transmission is the acquisition of blood-borne viruses causing hepatitis. Infection with hepatitis B and hepatitis C may initially be associated with an acute illness, characterised by fevers, nausea, jaundice and abdominal pain. The majority of cases, however, have only a transitory or no illness at all at the time of first infection.

This asymptomatic state may continue for many years and indeed in some cases the virus is cleared from the system without the patient ever having been aware of having had the illness. A significant percentage will, however, proceed to ongoing illness over a period of many years with liver damage culminating in chronic and debilitating liver disease, sometimes cirrhosis in the advanced stages and, in a small minority of cases, liver failure or cancer of the liver.

The presence of current or past viral infection can be detected in most cases by tests for Hepatitis B or Hepatitis C antibodies in the blood. These tests may indicate past infection now resolved or show as a marker of ongoing infection. Additional tests can be carried out when antibodies are present to demonstrate the presence or absence of active infection. The polymerase chain reaction (PCR) test is a highly sensitive technique for measuring the presence or absence of viral genetic material in the blood and a positive PCR test usually indicates the presence of ongoing virus activity.

Monitoring of individuals with positive antibody tests includes measuring antigen tests, another marker of the presence of virus, PCR and clinical symptoms and signs, in order to decide whether or not there is active infection or ongoing disease. It can be derived from this whether or not the patient is likely to remain well, become ill in the future, or represent an infectious risk to drug using partners or sexual partners.

#### **Human Immunodeficiency Virus (HIV)**

Human immunodeficiency virus is similarly associated with an acute infection in a minority (less than 20%) of cases at the time of infection. This may be a mild flu-like illness, a glandular fever-type reaction with sore throats, swollen glands and malaise or a more severe acute illness involving all systems. The majority of individuals, however, acquire the virus with minimum symptoms which often go unnoticed. The virus can be detected by antibody testing a few weeks after initial infection and this antibody positive state is likely to persist indefinitely once acquired. Other tests include the measurement of the white cells specifically attacked by the virus (CD4 or T4 cells). This CD4 count is used as a measure or monitoring tool throughout the course of the infection of the severity of the progression from a normal white count to a depleted or immunologically 'at risk' state in the later stages of the disease. An additional, and perhaps more sensitive test, is the viral load which measures virus activity. This can be particularly useful in monitoring the beneficial effects of antiviral chemotherapy when this is being used.

## **Routes of Transmission**

Hepatitis and HIV are transmitted by infected body fluids, including blood, semen and genital tract secretions and can therefore be passed by injecting drug use, sexual intercourse or from mother to baby around the time of birth. Since HIV can be transmitted by breast-feeding this is not recommended. The vertical transmission rate will depend largely on the mother's viral load at the time of delivery. Consequently, while such interventions have been reported to reduce vertical transmission to <5% overall, individual rates will vary. They will depend on the mother's initial viral load and the efficacy of treatment in reducing this. Thus while various treatment protocols have been used, management should be determined after assessment of the individual. Because effective treatment is available, all pregnant women should be offered an HIV test to enable them to receive care for themselves and management to reduce the risk of vertical transmission. Routine offer of antenatal testing should be available.

As in the case of hepatitis C infection, HIV antibody will be passed from mother to baby in all cases, so all babies born to HIV positive mothers will test antibody positive at birth. Other tests, including testing for presence of virus, are therefore required and can identify infected babies from around 3 months of age.

## **Immunisation**

Immunisation is available for hepatitis A and hepatitis B. Because hepatitis A does not seem to occur very frequently in drug users (although epidemics have been described), no active immunisation is currently recommended. Some authorities recommend that hepatitis A and B vaccines should be given to drug users routinely. Hepatitis B immunisation, however, has been recommended for injecting drug users for many years and is increasingly carried out in substance misuse service clinics and by general practitioners. This is an important and effective way of preventing epidemics in drug using populations, but also in protecting individuals at risk from drug using contacts or from infected sexual partners. Immunisation of children of infected drug users can prevent the onset of active infection and screening of pregnant women during the antenatal period allows this to be predicted and planned. There is no immunisation currently available for hepatitis C or HIV infection.

## **Viral Transmission and Prevention**

Hepatitis B infection is readily transmitted sexually, by injection and at the time of birth. Vertical transmission, as stated, can be prevented or reduced in frequency by the process of screening and active immunisation. Active immunisation of drug users or those at risk of injecting is increasingly likely to prevent infection of drug users and their sexual partners. Infection at birth carries a very high risk of chronic and persistent illness compared to a relatively lower risk when the virus is acquired during adulthood.

The majority of those individuals infected by injecting drug use will therefore be positive for an antibody test for hepatitis B but negative for signs of ongoing or active disease and probably represent little risk to sexual partners. Those with persistent virus infection fall into a number of different categories of infectivity and ongoing damage being done to the liver. This can be detected by an additional range of antigen tests. Hepatitis B vertical transmission probably carries a higher risk of persistent infection than infection in adulthood. Hepatitis C is also easily transmitted by injecting drug use. Transmission by sexual intercourse appears to occur less frequently and the risk of vertical transmission during pregnancy and at the time of delivery is probably less than 10%. The transmission rate may be higher if the mother is also infected with HIV but there is no evidence that the hepatitis C virus is transmitted by breast-feeding and indeed available evidence suggests

that this does not occur. The presence of antibody to hepatitis C does not confer immunity, so those infected in the past who have cleared the virus and are therefore antigen and PCR negative may subsequently become re-infected at the time of re-exposure. It is unclear why hepatitis C seems to be transmitted much less frequently by sexual intercourse than hepatitis B and it is difficult to counsel antibody-positive individuals on whether or not they need to use barrier contraception in the longer term.

HIV is transmitted by all three routes. The risk of transmission by injecting drug use may be less than that for hepatitis B or hepatitis C and the risk of sexual transmission is lower than for hepatitis B but higher than for hepatitis C. The risk of vertical transmission is less than for hepatitis B but greater than for hepatitis C. Unlike hepatitis C, HIV infection is transmitted by breast-feeding. While there is some evidence that in rare cases the virus may be cleared from the body, it is usually regarded as permanently present in all those infected with HIV.

For all three viruses, it may be generally accepted that the risk of infectivity depends on the amount of circulating virus in the system. This can be measured by PCR and viral load tests, and it makes sense to consider that the higher the viral load, the higher the degree of infectivity.

## **Treatments**

Antiviral treatments are available for the treatment of hepatitis C infection and are variably beneficial. Such treatments are not currently available during pregnancy or licensed in young infants. There is little experience in treating children with antiviral drugs. For this reason, routine testing of pregnant women is not recommended, but may be in the future. The transmission of antibody from mother to baby gives rise to a positive test in new-borns of mothers with hepatitis C antibodies but this does not necessarily indicate the presence of virus or active infection so much as the presence of maternal antibodies. The presence of active infection should be sought later in the first year of life. In those with active infection or ongoing illness, the specialist treatment of hepatitis C is increasingly effective. Treatment with Interferon, Ribavirin, or a combination of drugs is complicated and expensive and may require drugs by injection, but can be effective in excluding the virus from the body and possibly effecting long-term cure. This is likely to be increasingly available.

There is now a wide range of treatments, including many antiviral drugs, available for management of HIV infection. These drugs can be given during pregnancy so women already on treatment before they become pregnant can continue their medication throughout pregnancy. Treatment with antivirals will also reduce vertical transmission, therefore women who are not already receiving treatment should be offered treatment during pregnancy. Treatment given to the mother to prevent vertical transmission can be discontinued at delivery if she wishes, but the baby should then receive treatment for the first few weeks of life. Delivery by elective Caesarean section has also been shown to reduce vertical transmission.

## 6.9 Appendix 9

### Impact of Mental Health

Although most parents with psychiatric problems are able to care for their children appropriately research has indicated that child-maltreating parents are often shown to have mental health problems. Non-compliance with medication without medical supervision is a cause for concern

Children are at increased risk of abuse by psychotic parents when incorporated into their delusional thinking (e.g. the baby is trying to punish me for my sins)

Practitioners will obviously seek to obtain a psychiatric assessment in these cases, but practitioners must not be paralysed if that is not forthcoming. It is essential to continue with the assessment based on the behaviour of the parents and not the diagnosis.

## 6.10 Appendix 10

### Late Bookers and Concealed Pregnancy

For the purpose of this Guidance late booking is defined as relating to women who present to maternity services between 15 - 20 weeks.

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

Some indicators are as follows:

- Previous concealed pregnancy
- Previous children removed from care
- Fear that the baby will be removed
- History of substance misuse
- Mental health difficulties
- Learning disability
- Domestic violence
- Previous childhood experience
- Poor relationships with health professionals

NB: This list is not exhaustive

In cases where there are issues of late booking and concealed pregnancy, it is extremely important that careful consideration is given to the reason for the concealment and the risks.

In cases where there are issues of late notifications and concealed pregnancy, it is extremely important that careful consideration is given to the reason for concealment, assessing the potential risks to the child and convening a S47 Strategy Meeting as a matter of urgency.

The Strategy Meeting should take place as soon as possible.

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

- Timescales for completion of an assessment
- Contingency planning
- Whether legal proceedings need to be considered.
- The actions required by services working with expectant parent/s
- The actions required by the nursing team as soon as the baby is born. This includes labour/ delivery suite, post-natal ward staff and the midwifery service and the emergency duty team in the event that the birth takes place outside of normal office hours

Any instructions in relation to invoking an Emergency Protection Order (EPO) at delivery should be communicated to the midwifery manager for the labour/ delivery suite and the Emergency Duty Team

## 6.11 Appendix 11

### **Risk of Fleeing Families**

When there are significant concerns and the whereabouts of a pregnancy mother are not known, children services must inform other agencies and local authorities in accordance with procedures about children who go missing.

If there is concern that a family may flee, then there should be robust document keeping of information relating to vehicles that the family has access to.

## 6.12 Appendix 12

### Young Parents

Levels of teenage pregnancy in Wales is high, with Wales having the highest number of teenage pregnancies in Western Europe.

It is likely that teenagers who become parents experience more educational, health, social and economic difficulties than young people who are not parents. Consequently their children may be exposed to greater social deprivation and disadvantage.

Teenage mothers in leaving care services experience similar difficulties to those faced by all young mothers. However they are less likely to have consistent, positive adult support and more likely to have to move.

Pre Birth Assessment should also be considered if young men are leaving the care system and becoming a father of an unborn child. This should be irrespective of whether the mother herself is or was looked after child.