Multi Agency Practice Guide: Responding to Risk & Need for Unborn Babies, including Concealed Pregnancies

1.0. Introduction

1.1. This practice guidance has been drawn up by multi- agency professionals. Its aim is to ensure that all agencies know what to do and how to exercise safeguarding responsibilities in respect to the risk to and the needs of unborn babies including concealed pregnancies.

1.2. This practice guidance should be read in conjunction with the Wales Safeguarding Procedures

1.3. This practice guidance supports individual agency policies for safeguarding and promoting the welfare of children.

2.0. Definitions and Concealed Pregnancy

2.1. The unborn baby is deemed to be viable post assurances from a dating scan.

2.2. The reasons for a late booking need to be thoroughly explored and recorded. A discussion with the safeguarding lead should be considered.

2.3. It is recognised by maternity services that some women present late in pregnancy or labour if they have not realised they are pregnant. Liaise with Children's Social Services to establish if there are any known concerns.

2.4. A concealed pregnancy is where the mother is aware that she is pregnant, but conceals the pregnancy from family / friends and / or health professionals. The reasons for concealment can be varied, however, should always present as a potential safeguarding concern. Case / Practice Reviews tell us that lack of engagement is a risk factor for potential significant harm.

2.5. A discharge planning meeting should be convened.

2.6. There could be a number of reasons why a pregnant woman decides to conceal a pregnancy including situations of domestic abuse, sexual abuse, religious/cultural stigma, previous intervention with Children's Social Care, victims of modern slavery, and criminal exploitation.

2.7. A Child at Risk Report should be made to Children's Social Care without delay for any identified and concealed pregnancy without a satisfactory explanation. Practitioners can seek support from their designated safeguarding lead. Information should be obtained from the GP and other relevant agencies

The mother should not be discharged home until the outcome of the referral is known.

2.8. A pregnancy is considered to be 'term' once the woman is 37 weeks. Although some pregnancies may reach the Estimated Due Date (EDD) or go beyond that.

3.0. Principles

3.1 This practice guidance is underpinned by the following key principles and is informed by CPRs, SCRs and The Nuffield Health Trust Research *Appendix 7

- That the mother has the right to make a decision whether to continue the pregnancy.
- That the strengths of the family and of individuals should be recognised and incorporated into all assessments.
- That the needs of the unborn baby are paramount.
- That early intervention during a pregnancy is important in order to minimise risks posed to unborn and newborn babies and enable changes to be made.
- That proactive engagement with expectant mothers and fathers contributes to a positive outcome for the unborn baby, parents and family.
- That effective inter-agency working is the foundation for the identification of need, risk assessment and the implementation of planned interventions.

4.0. Recognition of Need and Making Referrals/Reports

It is important that any safeguarding concerns during a pregnancy are reported to corporate safeguarding as soon as they come to the attention of practitioners.

4.1 It is the responsibility of all agencies working with pregnant women to recognise the need for early intervention if there are concerns about any lack of support or the ability of parents or carers to provide safe and effective care for the baby.

4.2 Midwives, health visitors, obstetricians, general practitioners and other health professionals, are well placed to identify safeguarding concerns and the additional needs of pregnant women. Where safeguarding concerns and additional needs are identified, professionals will need to consider the level and nature of appropriate. The Health Pre Birth Assessment should be completed jointly between the midwife and the health visitor at the earliest opportunity following identification of vulnerabilities. The HPBA is a dynamic assessment and should be repeated during the pregnancy into the postnatal period. If a Child at Risk Report is being submitted, the HPBA should be included.

4.3 Practitioners should, if there are any identified risks and/or safeguarding concerns for an unborn baby or if there is any indication of significant harm discuss these with their designated safeguarding lead. The outcome of these discussions should be recorded in line with agency policies.

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<u>Any delay in reporting and referral increases risk and detracts from opportunities for changes to be made.</u>

4.4 There are some circumstances when a Child at Risk Report or a Care and Support referral to Children's Social Care in respect of an unborn baby is strongly indicated. The threshold criteria for Child Protection is reasonable cause to believe that significant harm has occurred or is likely to occur.

4.5 The list is comprehensive and will include numerous situations where the family or individuals fall into a category described. Some of these will include situations where there are no concerns relating to significant harm and therefore any need for child protection. Practitioners should to discuss and agree this with the appropriate corporate lead professional for safeguarding and record the rationale for the decision.

It is important the family and individual's rights to privacy are respected and an unnecessary Child at Risk Report or Referral is not made.

These circumstances are:

- When the pregnant child or young person or other children in the same household are currently, or have previously been, on a Child Protection Register, or a child has suffered significant harm.
- When the father or mother's partner is the parent of a child who has suffered significant harm or is currently, or has previously been on a Child Protection Register, or a child has suffered significant harm.
- When there is a pregnancy to a young woman aged under 14.
- When conception took place before the young person's 13th birthday. Note. A strategy discussion and s47 enquiry will be required.
- When the mother or father or their partner is a child or young person who is currently looked after.
- When the mother and/or father have been previously looked after or are care leavers.
- When the mother or father or their partner has previously had a child removed from their care.
- When domestic abuse has occurred either in the present, or in the previous relationship, of either parent or their partner.
- Where there is substance abuse during pregnancy.
- When there are levels of alcohol and/or substance misuse which seriously impacts on the mother or father or partner's parenting capacity.
- When cognitive functioning or parental learning difficulties seriously impacts on the mother or father or partner's parenting capacity.

- When chronic and disabling mental health seriously impacts on the mother or father or partner's parenting capacity.

- When members of the household have convictions or have been the subject of police investigation for offences, either of a violent or of a sexual nature. This includes situations where a young person made and then withdrew similar allegations.

- When there is a person associated with the household who poses a risk of sexual harm to children.

- When there are concerns that the pregnancy is a result of abuse. I.e. incest, sexual abuse or sexual exploitation etc.

- When a child in the family has died due to unascertained causes.

- When there are concerns that the parent or another adult in the household pose a risk to children and the baby cannot be adequately protected from these.

- When there are maternal risk factors e.g. denial of pregnancy, failed appointments, non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby.

- When parents are street homeless.

- Where the mother has undergone female genital mutilation (FGM), is expecting a female child and there is a risk of FGM taking place.

- Where there are concerns that the mother may be at risk of honour based violence.

Note. If the family are immigrants or asylum seekers gaining information from them may prove difficult or impossible. If so, seek help from other community resources or relevant agencies.

4.6.1. For a pregnant child or woman who is under the age of 18 years or for whom there are concerns then consideration should be given as to whether a referral or report to Children's Social Care is required for them in their own right depending on her circumstances, level of need or vulnerability.

4.6.2. If a decision is reached to refer the unborn baby to Children's Social Care then the Wales Safeguarding Procedures, section 2 (2019) should be followed and a Child at Risk Report completed. All referrals and reports should be made without delay and, whenever known, should always include the estimated date of delivery

4.7. Support plans should be monitored and reviewed (by any service who is working with the expectant mother), including a review of the decision not to refer to Children's Social Care. If significant harm or risk of significant harm is

identified during the period of support a further referral/report should be made to Children's Social Care.

4.8. When a referral/report is made to Children's Social Care under the Wales Safeguarding Procedures the pregnant woman should be informed about the concerns and the referral, **unless in doing so could put the unborn baby, or the pregnant woman, at risk of significant harm.** This may be particularly pertinent in cases of a concealed pregnancy and a potential flight risk.

5.0. Response to Referral/Report to Children Services

5.1 All referrals/reports to Children's Social Care will be managed in accordance with Wales Safeguarding Procedures Section 3 (2019)

5.2. Where there is evidence of concern for the welfare of an unborn baby a proportionate assessment must be undertaken. This proportionate assessment will incorporate views from all the relevant practitioners including:

- Referrer, if appropriate
- Midwife & Health Visitor
- GP
- Obstetrician
- Any specialist services with involvement, for example Adult Mental Health Services (AMHS), Women's Services, Child and Adolescent Mental Health Services (CAMHS), Youth Justice Services, Home Start, Flying Start, Housing, Police, Education &other Family Support Services
- Services involved with other children
- Perinatal mental health service
- Probation
- Substance Misuse Service
- Any other relevant service

5.3. The referrer/ report maker should always be notified in writing of the LA decision following the proportionate assessment. If safeguarding concerns are not identified, the referrer/report maker should also be informed with a view to establishing alternative support. This may include a brief intervention under a Care and Support Plan (CASP) or referral for single agency support as per 4.9 above.

5.4. If the proportionate assessment indicates that the unborn baby is at risk of significant harm, or that once born, the baby would be at risk of significant harm, then a multi-agency strategy meeting should be convened, and Section 47 enquiries commenced following Wales Safeguarding Procedures Section 3(2019).

5.5. Following the conclusion of the Section 47 enquiries, a Children's Social Care Manager will make the decision about future actions taking into account other

agencies involved in the safeguarding process. This may involve a further strategy meeting as per Wales Safeguarding procedures (2019).

5.6. Where there is a concern about the likelihood of significant harm to the unborn baby, and section 47 enquiries are agreed, an ongoing assessment will be undertaken.

6.0. **Pre-birth Assessments**

6.1. A pre-birth assessment is fundamentally an assessment of the risk to the future safety of the unborn baby with a view to making decisions in respect of future planning for the child and the family. Within Appendix 2 is an example of areas to consider in evaluation of risk and strengths. Each LA will have its own model of assessment in this area of practice.

6.2. All pre-birth assessments, at any level of intervention, should consider:

- The pregnant woman, the father and any partner's feelings about the pregnancy
- Family history and 'Adverse Childhood Experiences'
- Personal circumstances and levels of support
- Any specific risks and how these would impact on the unborn baby and new-born baby once born
- If the father is known to the pregnant woman, and she shares his information, then background checks on the father should be made to ascertain any known risks to the pregnant woman and unborn baby
- The time and help that the parents, partners and support networks need in order to contribute their ideas and solutions to assessments to increase the likelihood of a positive outcome for the baby and family.

6.3 The aim of the pre-birth assessment is to consider fundamental questions:

Will the new-born baby be safe in the care of the parents?
Is there a realistic prospect of the parents being able to provide adequate and safe care immediately and throughout childhood?

6.4. In respect of a pre-birth assessment timing is crucial, for family members to contribute to the process and a multi-agency plan and interventions to minimise risk.

6.5. The pre-birth assessment:

- Provides parents with the opportunity to evidence change and to engage with services.
- Enables key agencies to make clear and structured plans for the baby's future.
- Allows support services for the parents to be established.

6.6. Early assessment can help to:

- Ensure that vulnerable parents are offered support as early as possible rather

than when difficulties occur. This is particularly notable when they are expecting multiple births.
- Establish a working partnership with parents prior to the baby's birth
- Assist parents with any problems that may impair their parenting capacity.

6.7. A pre-birth assessment of the pregnant woman and partner should specifically consider:

- A chronology of significant events
- Their experience of parenting and being parented
- Their expectations and preparation for parenting
- Their support networks – both ante-natal and post-natal
- Relevant historic and current information from key agencies with statutory responsibilities for safeguarding
- The circumstances pertaining to removal of any other children born to the pregnant mother, or any partners

The pre-birth assessment will reference the Framework for Assessment. Refer to Appendix 3 on what to consider during the assessment.

6.8. A pre-birth assessment in respect of an unborn child where the pregnancy has been concealed should specifically consider:

- Exploration of the reasons for the concealed pregnancy and any specific issues and / or risks this may represent for the pregnant women and / or unborn child;
- Consideration of the pregnant woman's access to maternity services;
- The pregnant woman's potential not to alert practitioners to the onset of labour and any additional need in respect of accessing obstetric care;
- If concealed from ex-partner, the current partner may be a further risk.

6.9. Consideration of any further specialist assessments regarding the concealment including possible referral to mental health services. There are specific risk management issues associated with pregnant women who have concealed a pregnancy including:

- Any risks to the pregnant woman if the concealed pregnancy is exposed i.e. if it was concealed from ex-partner.
- The issue of a pregnant woman being a flight risk and not accessing maternity services for the birth of the baby which may result in a compromised mother and baby.
- Where there is a local flight risk it is the responsibility of Children's Social Care to request that the safeguarding midwife alerts Welsh hospitals and Welsh Ambulance and if the flight risk is further afield then Children's Social Care should instigate a national alert to other local authorities.

7.0. Planning, Intervening and Review

7.1. When planning for the birth please note whilst there is an EDD it is possible that birth can occur before 37 weeks' gestation. It is recognised that women

may give birth at 37 weeks' gestation or earlier if known to be misusing substances.

7.2. If the pre-birth assessment does not indicate that the baby will be at risk of significant harm when born, but there may be a care and support needs, then planning and provision of services may continue under Section 37 Social Services and Wellbeing Act (2014).

7.3. If the pre-birth assessment indicates that the baby will be at risk of suffering significant harm when born, the Child Protection Processes under Wales Safeguarding Procedures Section 3 must be followed.

7.4. If a pre-birth Child Protection Conference is convened and registration is agreed following birth, the name (baby's mother's name, father's name) and estimated, date of the birth should be entered on the Child Protection Care and Support Plan for the unborn baby and on all electronic records. Ideally a pre-birth Child Protection Conference should take place at around 28 weeks, however they can, and should take place after this if needed.

7.5. The unborn baby's Children Services record should be linked with the mother's record. When the baby is born the Midwife should inform the allocated Social Worker, Emergency Duty Team if out of hours for Children's Social Care records to be updated.

7.6. The Child Protection process including the convening of Core Groups will proceed as Wales Safeguarding Procedures Section3

At birth the baby's name will be entered onto the Child Protection Register.

A Core Group should be held within 10 working days of the baby's birth and a review Child Protection Conference held no later than 3 months after the birth.

Within 10 working days of the conference, at the first core group, a completed Care and Support Plan will be drawn up. The point within the pregnancy is likely to determine the focus of the plan i.e. completion of the pre-birth assessment and the minimisation of risk to the unborn child during the antenatal period, the planning for the immediate safety of the child once delivered: the management of risk during the post-natal period.

Relevant hospital staff and the lead midwife responsible for the mother's care should be involved with the development of the Care and Support Protection Plan. There should be a clear communication pathway to ensure the professionals involved are fully up to date with the plan and Core group meeting dates.

As part of the Care and Support Protection Plan a Multiagency Birth Response Plan should be in place before the women is 34 weeks pregnant. This plan should be agreed either at the Pre Birth Child Protection conference or within the Core Group. The Birth 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

7.7 What to do if the Birth Plan 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 Birth Plan should be held by all agencies responsible for taking forward the Care and Support Plan including, the midwifery unit where it is agreed the baby will be delivered, the community midwife, and the allocated Social Worker.

8.0. Planning and Intervention for a child on the Child Protection Register

8.1. An outline Care and Support Protection Plan will be identified during the pre-birth conference. The Core Group will then be responsible for completing and implementing the plan. The Care and Support Protection Plan will be based on the pre-birth assessment and should include:

- Parenting capacity, parenting skills.
- Any areas of risk and concern.
- What need to change to safeguard the baby and reduce the risk of significant harm
- Support for parents to understand the baby's physical and emotional needs.
- Any other issues identified in the assessment.

8.2. If the child is to be registered at birth, a comprehensive safeguarding pre-birth plan must also be drawn up.

8.3. In the event that the Local Authority plans to remove the baby at birth then a legal planning meeting must be convened.

8.4. All pre-birth Child and Support Protection Plans must be shared with health professionals and the North Wales Emergency Duty Team / Conwy EDT / Gwynedd and Mon EDT.

8.5. In situations where a decision has been made to register an unborn baby at birth and where a pregnant mother moves out of the originating area on a temporary basis, the originating area will alert the receiving area in writing to the Local Authority, setting out the relevant key information and contact details. If the pregnant mother comes to the attention of services in the receiving area, then notification must be sent to the originating area.

8.6. Where a pregnant woman moves into an area on a permanent basis then

transfer- in arrangements will be followed in accordance with Wales Safeguarding Procedures and a transfer-in conference for the unborn will be convened within 15 working days.

8.7. In situations where a decision has been made to register an unborn baby at birth, and the pregnant woman subsequently goes missing or cannot be located by services then a strategy discussion will be held in order to:

- Assess and clarify risk of harm to unborn / pregnant woman.
- Consider a plan for locating the pregnant woman including alerts / notifications needed to be sent to other agencies /areas;
- Agree the plan for responding to the pregnant woman once she is located including potential transfer arrangements;
- Consideration of any legal advice in order to safeguard the unborn baby

https://kentchildcare.proceduresonline.com/chapters/p_alerts.html

The hospital midwives should inform Children's Social Care of the birth of the baby as soon as possible (ideally the allocated Social Worker/social care will be informed once the expectant mother is admitted in established labour).

- It is expected that there is regular liaison between social care and the maternity unit whilst the mother and baby are in hospital.

- Ward staff should keep a record of any concerns that emerge whilst on the ward. This could be important information for child protection planning or evidence needed for care proceedings. Information should be shared directly with the social worker and also with submission of a Child at Risk Report.

- If the baby is to be placed on the child protection register, a Core Group / Pre-Discharge Planning Meeting should be held to draw up a detailed plan prior to the baby's discharge home. This can also be used as a core group meeting.

- It is expected that, where a decision has been made to initiate Care Proceedings following birth, all necessary paperwork is prepared in advance of the birth and submitted ideally by 36 weeks at the latest, given that a pregnancy reaching 37 weeks is considered "term" to prevent any delay. The Social Worker must keep relevant maternity staff updated about the timing of any application to the Courts. The lead named midwife for safeguarding/ maternity safeguarding team 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.

- PLEASE NOTE: The application to court can only be made once the baby is born and is likely to take a few days before the case is heard. If there are immediate child protection concerns prior to the order being granted, then contact the police.

Please note a separate practice guidance/ policy will be developed around Flight Risk.

9.0 Women who chose to birth their baby/babies at Home

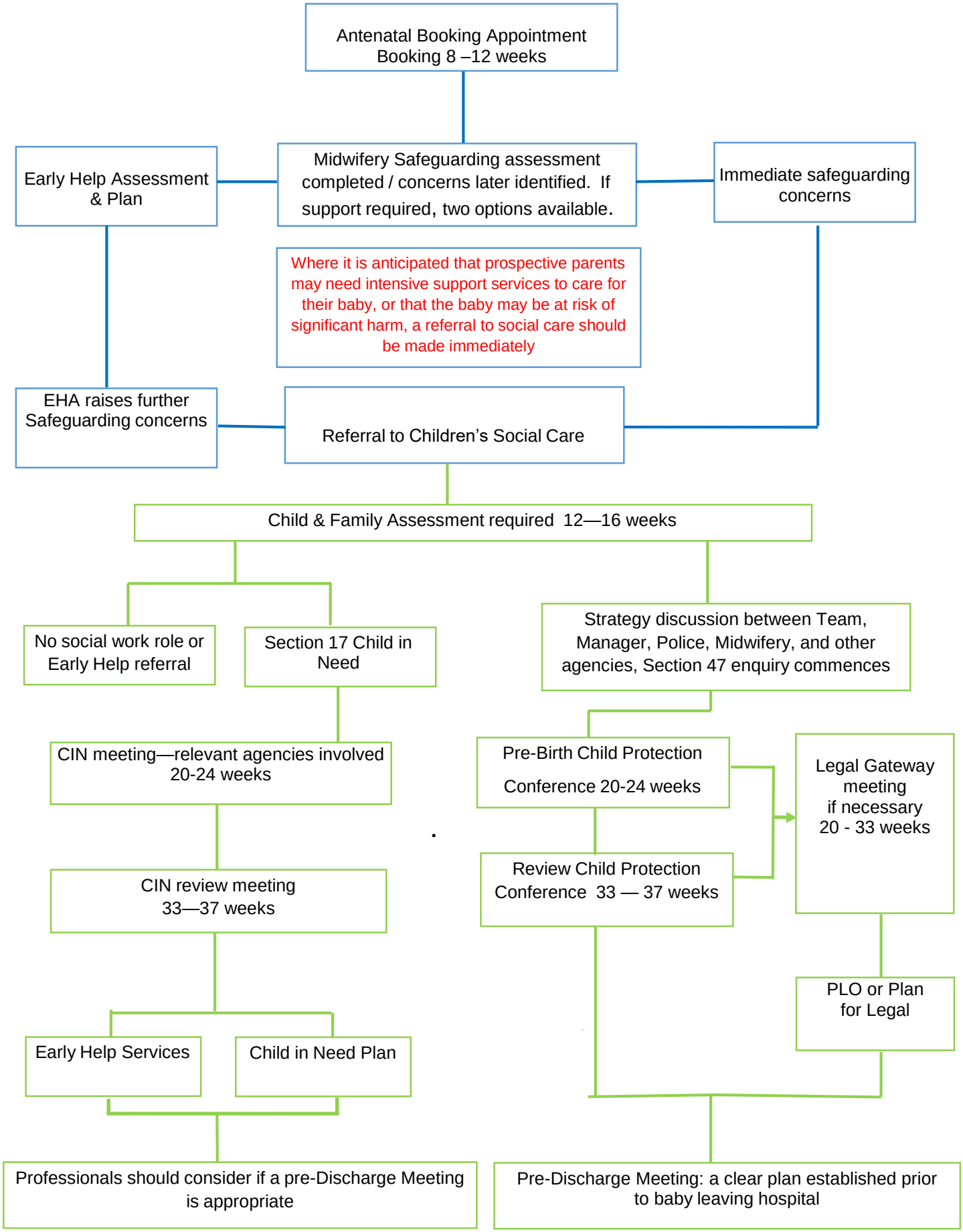
Where possible and where it is safe to do so, midwives will support women in their choice of place of birth for their baby/babies. This could be in hospital, on the labour ward or midwifery led unit (MLU). This could also be in a standalone midwifery led unit or at a home birth.

Safeguarding concerns do not necessarily preclude women from choosing to birth their baby at home or on an MLU, each case will need to be risk assessed at the time.

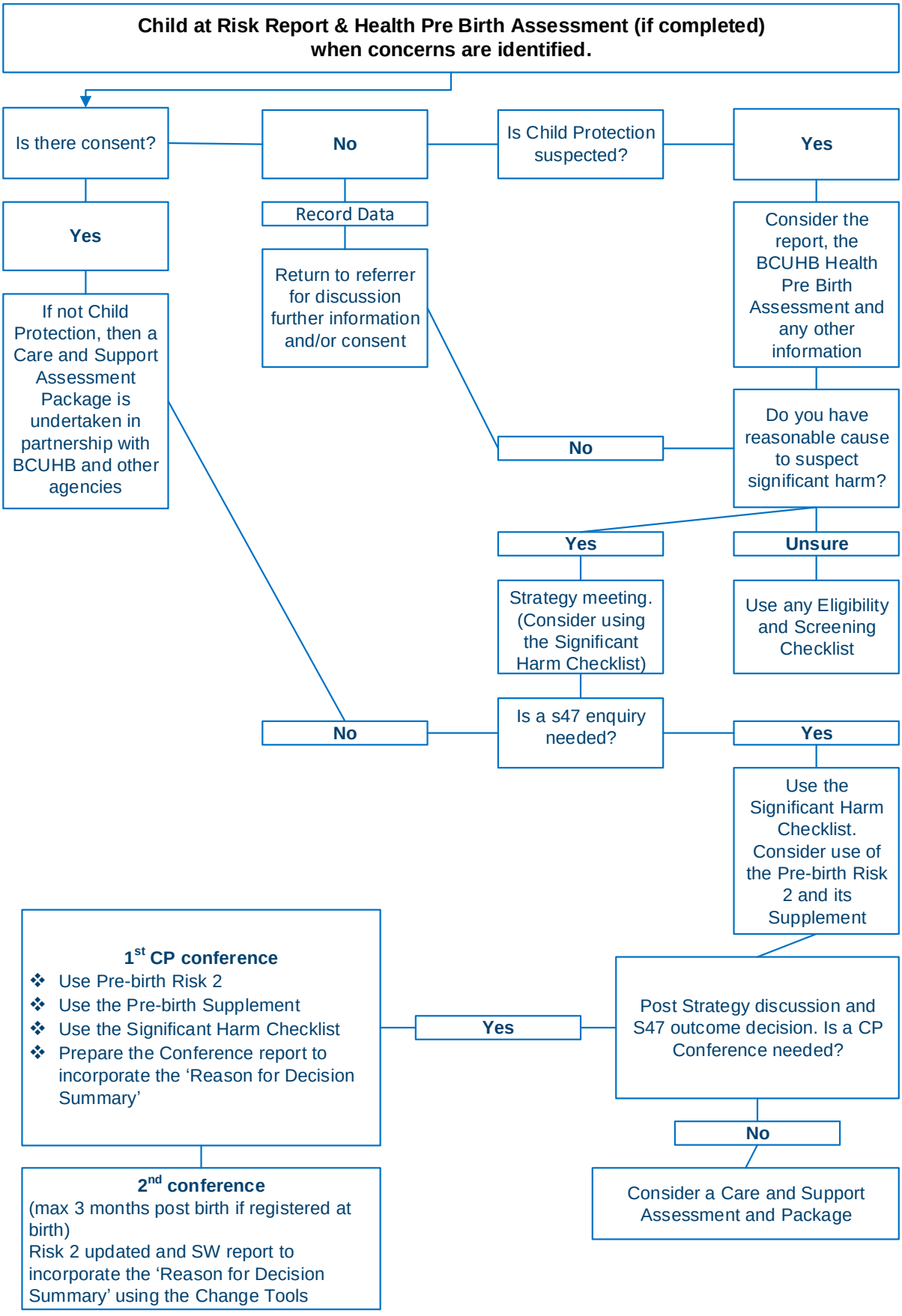
There will be some occasions when home birth is not supported by maternity services, however, women cannot be 'forced' to attend hospital for birth and midwives have a duty to provide midwifery care regardless of the setting. If it is felt that the mother does not have the capacity to make the decision around her place of birth, then this should be escalated to the designated safeguarding leads immediately.

For birth in any location, it is expected that the multiagency team develop a birth plan, in advance of the birth, to ensure that necessary safety issues and eventualities have been planned for. Social services should be notified when the mother goes into labour and as soon as possible following the birth.

Appendix 1 **Multi-Agency Pre-Birth Assessment Flow Chart**



Appendix 2: Children's Services Pre-Birth Assessment and Intervention Specific to LA's using the Child at Risk Model



Appendix 3: Areas to consider within the Pre Birth Assessment

What I need from people who will look after me	
Social History	Childhood ▪ What was it like to be a child in their family home? The nature and quality of family relationships and parenting blueprint. Who was special to them? Who cared for them the most? ▪ Childhood experiences of abandonment, violence, neglect or rejection, or feeling unloved by parents. Were they abused or neglected, if so, who by, for how long? What was the emotional and behavioural consequence for them? ▪ The extent of any parental alcohol and substance misuse and its consequences for them as children and now as parents and their family. ▪ Had there been any referrals to professional agencies? Any periods in local authority care. ▪ Extent of parental separations and family bereavements? ▪ Any issues of "care" and/or "control" conflicts in which the parents' own experiences of adverse parenting left them with unresolved tensions that spilled over into their adult relationships School ▪ Mainstream or special schooling? ▪ Any academic difficulties, behaviour or attainment issues? Statement of special educational needs? ▪ School achievements, aptitude, abilities and qualifications? ▪ Existence of any attendance issues? ▪ Reasons for any changes in schooling, moves or exclusions etc.? Occupational/social/recreational history ▪ Degree of success in establishing adult relationships, social, intimate, employment and the degree of satisfaction and level of responsibility and dependability with these? ▪ Employment history, evidence of any dismissal and extent to which this may indicate social incompetence, problems with authority or substance misuse? ▪ Types of leisure activities/hobbies/clubs etc and extent to which these reflect their social skills and self-image? Criminal history ▪ What is the history, frequency, circumstances, patterns and motivation of the offending behaviour? Number of previous offences? (one of the best predictors of future abuse is the number of previous offences) ▪ Are the offences against people or property, social rule violations e.g. drink driving? ▪ Details of victim; ages, offences and consequences for the adult/child? ▪ Are they entrenched in their behaviour and what does this mean for the expectant baby? Ability to identify and appropriately respond to risks in their lives

Parenting History and Ability	▪ Previous parental experiences i.e. number of children. ▪ History of being responsible for children ▪ CP concerns - and previous assessments? ▪ Care proceedings? Children removed? ▪ Court findings? ▪ Current health status of other children ▪ Family demonstration of feelings ▪ Ability to care for these children? ▪ Impact of another child ▪ Physical? ▪ Emotional? (including self-control); ▪ Intellectual? ▪ Knowledge and understanding re children and child care? ▪ Knowledge and understanding of concerns / this assessment? ▪ Prospective parent is very young ▪ Prospective parent is vulnerable ▪ Prospective parent has communication needs
Attitudes to Previous Interventions where any previous children who have been removed from their care, or where there have been serious concerns about the parenting practices	▪ Do the parent(s) understand and give a clear explanation of the circumstances in which the abuse occurred and how it came into light? ▪ Do they accept responsibility for their role in the abuse? ▪ Do they blame others: blame the child? ▪ Do they acknowledge the seriousness of the abuse? ▪ What was their response to previous any treatment/counselling and/or interventions? ▪ What has changed for each parent? ▪ Any particular characteristics which made the child harder to care for. ▪ It is essential to find out from the parent(s) what problems, if any/they identified in caring for that child.
Non Abusing Parents Ability to Protect	▪ Non-abusing parent's position regarding the abuse/conviction at the time and now? Any change? ▪ Were they aware? What information do they have regarding the abuse and who provided this? ▪ What feelings do they have to the child? E.g. anger, sympathy, blame? ▪ Is the non-abusing partner dependent on the abuser? Is she/he vulnerable? ▪ To what extent do they recognise the existence of future risk to the unborn child. Ability to manage this?
Mental Health Problems	▪ History of the illness – how long: well managed? ▪ Impact on the parent as an individual and their day to day functioning? ▪ Impact on parenting ability ▪ Non-compliance with medication without medical supervision is a cause for concern. ▪ Is the expected child incorporated into any delusional thinking
Substance and Alcohol Misuse	▪ What type of substances is the prospective parent/s dependent upon? ▪ What is the route/amount/duration/pattern of the substance misuse? ▪ The consequences for the baby of the mother's substance misuse

	▪ during pregnancy e.g. withdrawal symptoms, and for the parenting of any other children in the household. ▪ The history of parental substance misuse, current dependency. ▪ Any evidence of being incapacitated/comatose or paranoid/overtly psychotic? ▪ Is the prospective parent engaged with drug and alcohol services? ▪ Motivation to engage with drug and alcohol services? ▪ What is the prospective parent/s understanding of the potential effects of their substance misuse on the unborn and new born child? ▪ Can parental substance misuse be managed compatibly with the demands of a new-born child? ▪ What has been the impact of parental substance misuse been on other children/sibling within the household?
Domestic abuse and other violent behaviours	▪ The nature of violent incidents ▪ Their frequency and severity ▪ Information on what triggers violent incidents. ▪ The non-abusing/non-violent parent's recognition of the potential risks as a result of the history of or current domestic abuse/ violent behaviour ▪ Domestic abuse incidents in the pregnancy ▪ Parent/s may exhibit aggressive behaviour ▪ Cruelty towards animals
Antenatal Care: Medical and Obstetric History. The lead midwife will be able to provide/verify some of the information also	▪ Is the pregnancy wanted or not? Planned or unplanned? The result of sexual assault or control and coercion? ▪ Have they sought appropriate ante-natal care? ▪ Partner support – how involved in the antenatal period ▪ Dietary intake - and related issues ▪ Medicines or drugs - whether or not prescribed - taken before or during pregnancy ▪ Alcohol consumption/Smoking ▪ Previous obstetric history - Miscarriages and terminations ▪ Chronic or acute medical conditions or surgical history ▪ Psychiatric history - especially depression and self-harming ▪ Previous post-natal depression or Postpartum psychosis
Parental Understanding of Expectant Baby's Needs	▪ Expectant parent asking for her unborn child to be adopted ▪ Practical preparation for the baby ▪ Parental Understanding of expectant baby's needs and ability to meet them ▪ Insight into the development of routines and baby's basic needs ▪ To what extent are the parents developing a sense of attachment to their expected baby? ▪ What is the meaning of this child to them individually and as a couple?
How will I grow up and develop	
Antenatal Care: Medical and Obstetric History.	▪ Planned or un planned pregnancy ▪ Needs of the un born/baby prioritised ▪ Any Disability Diagnosed in Utero or in utero concerns ▪ Multiple Pregnancy ▪ Healthy lifestyle ▪ Anticipated complications during pregnancy and/or birth e.g. pre-term delivery with the result of a baby that will require a higher level of care

My wider world **Family and Environmental Factors**	
Relationships – as a couple and their individual relationship history.	▪ Relationship between the parents ▪ How the parents met? ▪ Why they stay together? How their relationship has developed and changed? ▪ Recent separation (acrimonious) ▪ The positive and negative attributes that exist within the relationship? ▪ Role of child in parent's relationship? ▪ Level and appropriateness of any dependency? ▪ Previous Relationships - Extent of disputes and violence in previous relationships? Multiple relationships? ▪ Extent of abuse substance misuse in relationship? ▪ Potential impact of previous problematic adult relationships on couple? ▪ Is the male partner the biological father of the child?
Current Family Structure and Sources of Support	▪ Full details of the immediate and extended family ▪ Family strengths and their potential ability to harness these to produce positive change for the unborn child, as well as the risks that may be prevalent within the household. ▪ Parents range of support networks. ▪ Quality of relationships ▪ Extent to which parents engage with professional agencies? ▪ Community Resources
Circumstances	▪ Housing ▪ Have the family moved home recently or regularly? ▪ Do you have previous addresses? ▪ If the family have moved areas, has relevant information from previous addresses been requested or obtained? ▪ Unemployment / employment? ▪ Debt? ▪ Court Orders? ▪ Social isolation ▪ Criminal Convictions ▪ Cultural considerations, e.g. religious stigma of illegitimate child; honour-based violence which may result if child is dual heritage; ▪ Inappropriate associates; ▪ Uncontrolled or potentially dangerous animals; ▪ Mistreated animals.
Attitude to professional involvement.	▪ Positive and negative use of support / services; ▪ Access to Health Services E.g. ▪ G.P registration, up-to date immunizations, access to education previously - in any context? ▪ Currently - regarding this assessment? ▪ Currently - regarding any other professionals?

Appendix 4: Framework taken from an adaptation by 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; • Drug or alcohol abuse.	• 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.
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;	• Realistic plans; • Exhibit appropriate parenting expectations and plans; • Appropriate expectation of change; • Willingness and ability to work in partnership;

	• 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.	• Willingness to resolve problems and concerns; • Parents co-operating equally.

Appendix 5: The First 1000 Days

The First 1000 Days "All children born in Wales have the best start in life".

The First 1000 Days project in Wrexham is a collaborative multi-partner programme that has representation from Health, Public Health, Local Authority and Third Sector organisations. The programme seeks to achieve the three following outcomes in the first 1000 days of life, from conception to two years of age:

- The best possible outcome for every pregnancy
- Children in Wales achieve their developmental milestones at two years of age
- Children are not exposed to or harmed by multiple adverse childhood experiences (ACEs) in the first 1000 days

All of these are underpinned by a commitment to reducing inequalities between social groups.

This programme has emerged as a priority from the multi-agency Cymru Well Wales initiative (formerly known as United in Improving Health) and seeks to encompass existing improvement projects as well as to stimulate and support other stakeholders to join and to contribute.

The Wrexham project sits under the Public Service Board and is currently focused on the pregnancy phase. Objectives for the project include early booking in with the Midwifery Service, holistic assessment of needs, clear referral pathways and good preventative support.

Wrexham have agreed the following four outcome areas on which to focus its work, with a task and finish group for each:

Group 1: Booking in

- Increase number of women booking in with the midwife as the first point of contact and by 10 weeks

Group 2: Assessments

- Ensuring ACE informed assessments are in place across all agencies (including midwifery) and acted upon in a consistent way if needs / risks are identified at any level
- 100% of pregnant women are assessed by midwifery using an ACE informed assessment

Group 3: Information Sharing

- Improve information sharing across agencies to address/ support family needs

Group 4: Support

- Ensuring clear pathways of support are in place for pregnant women and their families.

Wrexham have a First 1000 Days Project Officer. If you would like any further information relating to the First 1000 Days, please contact on 01978 295376 or email fis@wrexham.gov.uk.

Appendix 6:

Impact of Substance Misuse

Babies are not born addicted even if the mother is, but can suffer distressing withdrawal symptoms due to dependence from what the mother has been taking in pregnancy.

- 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

Substances can have harmful effects on the embryo or foetus at any stage during pregnancy.

In the first trimester the greatest risk 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 behavior.

Substances taken shortly before term can have an adverse effect on labour or the neonate after delivery. Not all damaging effects of intrauterine exposure to substances are obvious at birth as some become evident later in life.

All substances, 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 substances are shown to be conclusively teratogenic, but no substance 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.

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 substance 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 substances

- 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

<u>Risk issues in relation to assessing pregnant women who misuse substances</u>

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

NAS stands for Neonatal Abstinence Syndrome, a withdrawal syndrome resulting from physical dependence developed by the foetus due to the trans placental transmission of substances being used by the mother during pregnancy.

Substance misuse during pregnancy increases the risk of:

- Having a premature or low weight baby
- The baby suffering symptoms of withdrawal from substances 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 substances
- Pregnant women drinking alcohol to excess, risk delivering babies with Foetal Alcohol Syndrome.

<u>Methadone</u>

- Long acting opiate agonist usually given to patients with long history of opiate misuse/ abuse, a variety of sedative type drugs 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
- Methadone is safer for the foetus than illicit substance

- Abrupt withdrawal (detoxification/ reduction) during first trimester should be avoided as associated with increased risk of miscarriage and stillbirth and pre term labour in the third trimester.
- Any reduction in methadone should be under medical advice
- 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 increases in third trimester and the dose may need increasing to prevent withdrawal symptoms developing.

Buprenorphine / Subutex/ Espranor / Buvidal

- Buprenorphine (which is frequently known by its common brand name, Subutex) is a widely used opioid medication considered safe for women during pregnancy
- Buprenorphine produces a less severe neonatal abstinence syndrome than methadone.
- If the pregnant woman is prescribed Buprenorphine prior to pregnancy, she will be able to remain on the prescription following discussion with medical advice.
- Any reduction, detoxification or reduction is the same as the methadone advice.

Cocaine

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

- Placental abruption (placental separation with haemorrhage and foetal hypoxia)
- Intrauterine growth restriction (including reduced brain growth)
- Underdevelopment of organs and/or limbs
- Foetal 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 foetal 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 use tends to have poor health (due to poor nutrition, weight loss, anaemia and mental health problems).

- Amphetamines cause vasoconstriction and hypertension, which may result in foetal hypoxia.
- Potential effects of amphetamine exposure on the foetus during pregnancy include intrauterine growth restriction (IUGR) due to placental insufficiency, foetal

congenital abnormalities including cleft lip and/or palate, cardiac anomalies, limb malformation, smaller head circumference, and foetal death in utero
- Infants born to mothers dependent on amphetamines have an increased risk of premature delivery and low birth weight; these infants should be monitored for feeding difficulties, irritability, agitation, excessive drowsiness and other withdrawal symptoms

Cannabis

- Tetrahydrocannabinol, the main psychoactive component of cannabis, readily crosses the placental barrier.
- Synthetic cannabinoid receptor agonists (SCRAs) such as “spice” are also potent stimulators of the endocannabinoid system, and their safety during pregnancy is unknown
- Evidence is uncertain re harmful effects because it is usually smoked with tobacco which is harmful
- It is linked to low birth weight
- Some observational studies have found an association between cannabis use and a range of adverse obstetric and neonatal outcomes and longer term adverse child neurobehavioral outcomes, but other studies have failed to confirm such an association
- Not known to cause birth defects
- 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
- Could affect brain development in the foetus
- A risk-benefit assessment in terms of risks of untreated psychiatric symptoms against those due to adverse effects of psychotropic medications to the foetus and mother must be considered.

Alcohol

- Department of Health (DOH) and Royal College of Obstetricians and Gynaecologists (RCOG) suggests avoid completely
- There is no conclusive evidence to indicate a safe exposure in pregnancy
- Alcohol damages cells necessary for growth and disrupts connections in the brain
- Brain damage is irreversible

- Binge drinking (5 or more drinks on one sitting) greatly increases a baby's risk of developing alcohol-related damage.
- Drinking moderate amounts of alcohol when pregnant may lead to miscarriage.
- Avoid in first 3 months to reduce the increased risk of miscarriage, low birth weight and premature birth
- Alcohol is a known teratogen, 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 does not 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.

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/behavioral problems)
- Facial abnormalities, including a smooth ridge between the nose and upper lip, a thin upper lip and small eyes.
- Low body weight
- Short height
- Sleep and sucking difficulties
- Small head size
- Vision or hearing problems
- Foetal Alcohol Spectrum Disorder (FASD) is a term used to describe the permanent impacts on the brain and body of individuals prenatally exposed to alcohol during pregnancy resulting in a spectrum of physical, neurological, emotional and behavioral regulation characteristics.
- 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.

Newborn monitoring after delivery

- Monitored for respiratory depression and signs of withdrawal if the mother has been prescribed opioid substitute or used illicit substances / alcohol consumption.
- Signs usually develop 24- 72 hours post-delivery with a delay 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 their babies, especially for skin to skin contact.

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 discloses any illicit substance use, for discussed / reported urgently to Health Care Professional for further support and advice for the mother.

Appendix 7:

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 antivirus 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.

Appendix 8: Executive summary Nuffield Health Trust Research

When there are safeguarding concerns regarding an unborn child, local authorities and related agencies can intervene during pregnancy. Such interventions aim to assess the risk to the infant following birth and mitigate potential issues by providing tailored support to the parent/s. If the local authority determines that the concerns are so great that following birth an infant cannot remain safely in his or her parents' care, action may be taken to remove the baby.

In 2018, the Nuffield Family Justice Observatory (Nuffield FJO) published Born into care, (Broadhurst et al 2018) the first ever national study of newborn babies (under one week old) in the family justice system in England. The study found that in 2007/8, care proceedings were issued with respect to a total of 1,039 newborns (32% of all cases involving infant age under one year). By 2016/17, this number had more than doubled at 2,447 newborns (42% of all infant cases).

Whilst Born into care Wales (Alrouh et al 2019) demonstrated a similar picture in Wales with increasing proportion of infant cases issued close to birth, the incidence rate was even higher and has more than doubled between 2015 and 2018 from 43 to 83 newborns per 10,000 live births

Given the vulnerability of infants and their mothers in the immediate post-natal period, issuing care proceedings at or close to birth is fraught with moral, ethical and legal challenges – and without effective, timely assessment and support during pregnancy, intervention at birth is likely to be poorly planned and can result in instability for the new baby and huge distress for family members. Despite the complexity surrounding this practice, there is scant reference to either pre-birth assessment or removals at birth in national statutory guidance.

This rapid evidence review aims to identify key messages from research concerning birth parents' and professionals' experiences and perspectives of pre-birth assessment and infant removal at, or soon after, birth. It aims to identify and summarise consistent key messages and provide an insight into system-level challenges. A total of 27 papers (published between 1990 and 2018) were included in the final review. The studies were primarily conducted in England and Australia, but also in Canada, USA, Northern Ireland and Scotland. Most were qualitative (derived from focus groups, questionnaires and interviews with professionals and birth parents) and were largely focused on birth mothers in the community, although two studies involved removals at birth from mothers in prison. A substantial proportion of literature is based on the perspectives of birth mothers with drug and alcohol problems.

Key messages across the literature

When birth parent (typically birth mother) perspectives on pre-birth assessment and removal of infants at birth are sought, it results in some difficult messages for policy and frontline practice. However, what is notable from this review is the extent to which professional and family perspectives cohere; studies report similar messages, whether they came from birth mothers or professionals.

Reading across the literature some consistent and important key messages, of immediate relevance for practitioners, policy makers and researchers, were identified:

i. Delayed response and insufficient time for robust pre-birth assessment

A shortened window for assessment – which appears to be due to unborn babies being considered a lower priority than other children – provides insufficient time for parents and professionals to make changes/support change in parenting capacity, promote the health and wellbeing of the unborn child and potentially divert cases from care proceedings.

The review indicates that frontline agencies need to ensure a consistent and earlier response to pregnancy to ensure that mothers and fathers and wider family members are given support at a timely point, which may catalyse change. However, workers may not always possess enough knowledge or access to guidance and tools to support effective early assessment and intervention in pregnancy.

ii. The importance of effective, collaborative relationships

Within the literature, professionals and birth families valued practice predicated on trust, honesty and openness. Birth mothers were sensitive to feelings of being judged by practitioners, and both health professionals and social workers placed significant emphasis on non-judgemental practice in building more positive relationships. Professionals recognised the importance of both collaborative working and effective information sharing.

iii. Psychological impact that state intervention has on birth mothers and babies

The separation of an infant at birth from his or her mother, father and indeed wider family, is an acutely distressing experience for all concerned. The literature also points to the emotional impact that this challenging work has on professionals (felt most acutely by midwives), with studies noting the importance of support and supervision for all staff involved.

iv. Insufficiency of current levels of professional knowledge and guidance

Findings suggest gaps in both professionals' substantive knowledge (relevant to assessment processes) and, in the case of midwives, the mechanisms of child protection processes. Variation in national and local guidance pertaining to pre-birth assessment and intervention following birth contributes to a lack of clarity.

v. Research gaps and next steps

Although it has been possible to derive some key and important messages from the published research, there is an overall sparsity of literature, and some significant gaps to address.

The limited research on birth parents' perspectives is largely focused on experiences of birth mothers (in particular, pregnant women with problems of substance misuse), and there is a paucity of literature on the experience of fathers and extended family members.

There is very little evidence of birth parents' and professionals' experiences *specifically* where an infant is separated from his or her parents at, or near, birth. Regarding birth parents, there are gaps in understanding about what might constitute good practice and the longer-term impacts of state intervention at birth for all family members.

With regards to professional perspectives, the literature is weighted towards midwives and other health professionals, with a smaller number of studies concerning social workers. This is surprising, given the central role played by this group in state intervention during pregnancy and at birth.

Further research is needed to respond to the concerns raised in this review, to ascertain the extent to which shortfalls in practice are widespread, and to identify and develop good practice. An inclusive approach to the development of best practice principles would serve to ensure the voice of families helps shape service intervention in the challenging circumstances of both pre-birth assessment and removal of infants at birth.