
# Pre-Birth Assessment, Multi-agency protocol

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# Preamble

## Introduction

Research evidences that young babies are particularly vulnerable to abuse but that robust work carried out in the antenatal period can help minimise harm if there is early assessment, intervention and support.

When agencies are able to anticipate safeguarding risks and vulnerabilities for an unborn baby, such concerns should be addressed through a pre-birth assessment. The aim of this assessment is to make sure that the risks and vulnerabilities are identified as early as possible, to take any action to protect the baby (and any other existing siblings), and to support parents in caring for the baby safely. A common finding in the sample of cases of babies subject to a serious case review was that there had been failings in the pre-birth assessment process and, as a consequence, in the resulting actions[1]

There has been longstanding concern about the relative lack of urgency in relation to pre-birth practice. This seems to extend through all the processes of pre-birth practice – the lack of urgency of professionals making pre-birth referrals, completing pre-birth assessments, putting support plans into place, and convening pre-birth conferences where appropriate

It appears to be inherent in the psychology of pre-birth work that professionals think that they have much more time than they actually have

The essence of pre-birth work has to be the quality of multi-agency involvement and partnership working, together with meaningful engagement and involvement with families. This is always true of safeguarding practice in general, but is particularly relevant in relation to pre-birth work; the family GP, the midwife , the health visitor all have critical roles to play in relation to vulnerable expectant mothers, alongside other statutory agencies and organisations working with family members.

**Purpose:**
The purpose of this guidance is to ensure that a clear system is in place to respond to concerns for the welfare of an unborn child and to maintain clear and regular communication within and between partner agencies.

**Scope:**
This joint protocol applies to all agencies but particularly all Children's Services staff (including social care and education), police, health (including mental health) and relevant Adult Services.

[1] Ofsted (2011) *Ages of concern: learning lessons from serious case reviews: A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

**Definitions:**

Concerns for the welfare of an unborn child include:

- Concerns that the mother's current behaviour, e.g. known mental health concern or substance/alcohol misuse or chaotic behaviour poses a threat to the unborn baby.
- Concerns that the mother may not be able to care for the baby to an acceptable standard, e.g., significant learning difficulty, previous neglect or other children subject of child protection plan or have been removed from parental care.
- Concerns that the behaviour of the father (or any other person including the mother) poses a threat to the unborn baby, e.g. domestic abuse or known allegation or conviction for offences against children under 18 years of age.
- Concerns that the behaviour of the father (or any other person) will impact on the ability of the mother to care for the baby to an acceptable standard.

The presence of one of these factors does not automatically require referral but they highlight the need to consider the known pre-disposing factors to child abuse.

In a situation where the father is the main carer, the same issues could equally apply.

## 1. Introduction

1.1 Pre-birth assessments are a proactive means of analysing the potential risk to a new born baby when there is concern about a pregnant woman, her partner or ex-partner and where relevant, her immediate family.

1.2 The main purpose of a pre-birth assessment is to identify what the risks and potential needs of the unborn child and his/her family may be, whether the parent(s) are capable of changing so that the risks can be reduced and if so, what supports they will need.

1.3 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 to parent their new-born child.

1.4 Research and practice experience suggests that a pre-birth assessment should be undertaken as early in the pregnancy as possible. The anxiety created by undergoing the process can adversely affect the attachment to the unborn child. This, in turn, can aggravate the strain of caring for a new baby. The ideal time to undertake a pre-birth assessment would be in the second trimester.

1.5 The justification for statutory intervention in a family's life is to safeguard and promote the welfare of children. However, in these cases the child is as yet unborn and assessment must attempt to identify the potential risk factors to the baby once born, and to predict whether that child will be safe. This is especially relevant, as research studies have shown that children are most at risk of fatal or severe assaults in the first year of life, usually inflicted by their carers.

1.6 As Brandon et al notes "*Maintaining a focus on the child was specifically mentioned with regard (amongst other things) to keeping the unborn child in mind, especially when services are addressing the parents' needs*"[2]

1.7 This guidance aims to clarify what is meant by pre-birth assessments, their purpose and the circumstances of undertaking them and should be read in conjunction with current SET Child Protection and Safeguarding Procedures (2015)

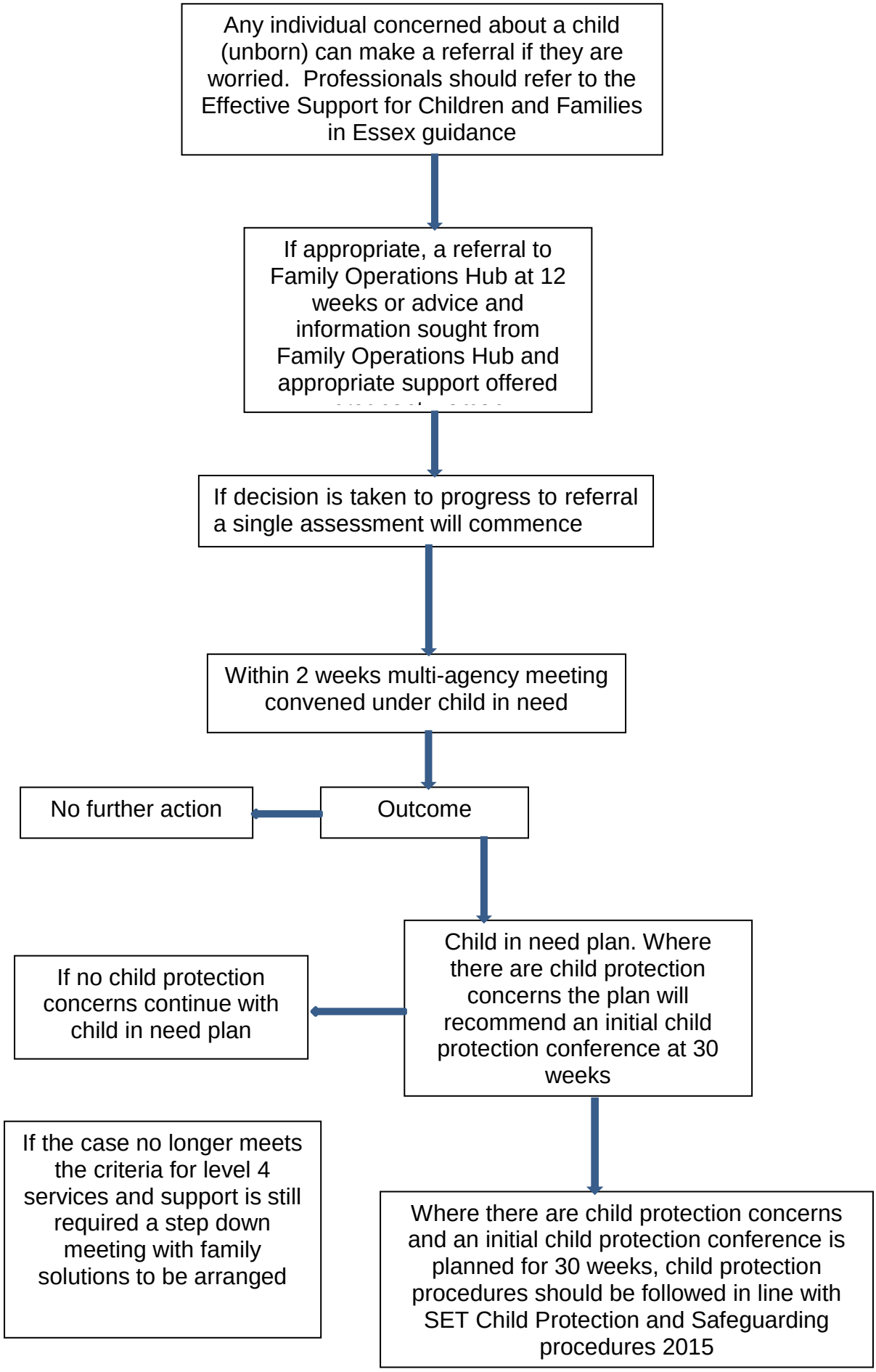
## 2. Raising a Concern about an unborn child

2.1 It is essential that when a professional has a safeguarding concern about an unborn child they gather as much information as is available from within their agency.

2.2 Families should be informed of concerns and any referrals made, unless it is felt that to do so would put a child, unborn baby, or other person at risk of harm.

[2] Brandon et al (2012) *New lessons from serious case reviews: a two year report for 2009-2011*

### 2.3 Raising a safeguarding concern in relation to an unborn child flowchart



## 3 Pre-Birth Assessments

3.1 A pre-birth assessment is essentially an assessment of the risk to the future safety of the unborn child with a view to making informed decisions about the child and family's future.

3.2 Such assessments create ethical dilemmas for practitioners undertaking them. The bond between a mother and child is universally revered and practitioners may be reluctant to intervene, feeling that parents must be "given a chance". 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 unborn) are paramount.

3.3 Working Together (2015) refers directly to unborn children in the guidance for Initial Child Protection Conferences: "*If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth"*. Additionally, an Ofsted report on serious case reviews cited the case of a three-week-old baby, where a pre-birth assessment had not been completed, and if it had, this may have indicated potential risks in the family[3]**.**

3.4 Hart (2009)[4] outlines the advantages of pre-birth assessment as providing an opportunity to:

- **identify and safeguard** the babies possibly most likely to suffer future significant harm;
- ensure that **vulnerable parents** are offered support at the start of their parenting role rather than when difficulties have arisen;
- establish a working **partnership with parents** before the baby is born;
- **assist parents** with any problems that may impair their parenting capacity.

More recent research from Wallbridge (2012) notes:

*A preventative assessment that can more accurately predict risks post-partum should be considered the ultimate in early intervention to assess the level of neglect or ill treatment a newborn infant may be subjected to.*

*However, the reason for conducting a thorough pre-birth assessment is not just to ensure the child's safety, but also to ensure that parents who are vulnerable and/or in difficulties, receive the kind of support and services they require in order to be able to parent effectively*[5]

3.5 However some potential disadvantages are:

- parents may abscond or a mother may not alert health professionals when she has her baby.

[3] Ofsted 2010 *Learning lessons from Serious Case Reviews 2009-2010*
[4] Hart, D 2009 in Horwath, J *the child's world; a comprehensive guide to assessing Children in Need* 2nd edition
[5] Wallbridge, S (2012) Guide to pre-birth assessments

- in some situations , the stress may have an adverse effect on the parents' mental or physical health;
- there may be a risk that a mother could feel pressured into harming herself and the unborn baby or terminating her pregnancy;
- the fear of losing the baby may jeopardise the attachment process between parent and child.

3.6 Hart (2009) 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?

Where there is reason for doubt, a pre-birth assessment is indicated.

3.7 Some parents will be aware of possible problems regarding their forthcoming child and may seek help from various agencies while others may be referred because of concerns identified by others. In the latter case, whilst parents are unlikely to welcome the proposed assessment there is a likelihood that the needs of the child would not be met without such intervention.

3.8 Missed appointments should not only be a cause of concern in relation to ante-natal care, but also in relation to children's education and health, and indicate neglect or parents are struggling. Failing to attend appointments also reduces the opportunities for families to be seen, behaviour monitored and where necessary challenged.

3.9 Pre-birth assessment would be required in the following circumstances:

- A parent or other adult in the household, or regular visitor, has been identified as posing a risk to children (*see SET Procedures Part B, chapter 13, Risk management of known offenders*);
- A sibling or child in the household is subject of a child protection plan;
- A sibling or child has previously been removed from the household either temporarily or by court order;
- There are significant domestic abuse issues (*see SET Procedures Part B, chapter 17, Safeguarding children affected by domestic abuse and violence*);
- The degree of parental substance misuse is likely to impact significantly on the baby's safety or development (see SET Procedures Part B, chapter 41.1, Parents who misuse substances);
- The degree of parental mental illness/impairment is likely to impact significantly on the baby's safety or development (see SET Procedures Part B, chapter 41.2, Parental mental illness);
- There are significant concerns about parental ability to self-care and/or to care for the child e.g. unsupported, young or learning disabled mother; (see SET Procedures Part B, chapter 41.3, Parents with Learning Difficulties)
- Any other concern exists that the baby may be at risk of significant harm including a parent previously suspected of fabricating or inducing illness in a

child (see SET Procedures Part B chapter 19, Fabricated or induced illness) or harming a child;

- A child aged under 13 is found to be pregnant (see SET Procedures Part B, chapter 27, Safeguarding sexually active children and SET Procedures Part B, chapter 24. Safeguarding children from sexual exploitation).
- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent;
- There are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-cooperation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby

Examples might include:

- a young couple, living a chaotic lifestyle with no home base, using drugs and alcohol to excess, refusing ante-natal care;
- a young woman with learning difficulties who is unable to self-care appropriately casting doubt on her ability to care for a vulnerable baby;
- a woman, or couple, with chronic and disabling mental health problems e.g. schizophrenia, affective psychosis, severe substance abuse, personality disorder, obsessive compulsive disorder and eating disorders;
- where there is a high level of domestic abuse;
- when the parents' history suggests that the prospect of the baby being adequately cared for is poor e.g. a history of early abuse, serious violence, of continued substance abuse unresponsive to treatment or serious psychiatric problems;
- when one of the prospective parents is an offender / **or felt to be a risk to a child or** with a conviction for abuse, including sexual abuse, against a child;

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.

**See SET Child Protection and safeguarding Procedures 2015 (Part A 2.6)-add hyperlink**

3.10 Where agencies or individuals anticipate that **prospective parents** may need support services to care for their baby or that the baby may be at risk of significant harm, a referral to Children's Social Care must be made at 12 weeks gestation or as soon as possible after

3.11 In the following circumstances a referral must always be made if:

- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent;
- A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children;
- Children in the household / family currently subject to a child protection plan or previous child protection concerns;

- A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order;
- Where there is knowledge of parental risk factors including mental illness, domestic abuse, substance misuse, learning difficulties;
- Where there are concerns about parental ability to self-care and/or to care for the child e.g. unsupported young or learning disabled mother;
- Where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby;
- Any other concern exists that the baby may be at risk of significant harm.

3.12 In addition to the above as agreed in SET Procedures 2015, the following instances will also require a referral being opened in respect of concerns for an unborn child. It is expected that the allocated social worker in such instances will complete the referral and assessment in discussion with their line manager:

- Young people known to Essex Children's Social Care Teams where the expectant mother is identified as having complex needs;
- Young people in care or open to leaving care teams (see further guidance in 2.12 to 2.19)

**Young people looked after or leaving care**

3.13 Levels of teenage pregnancy in the UK are high in relation to other European countries.

3.14 Teenagers who become parents are known to 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.

3.15 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.

3.16 Pre-birth assessments will also be *considered* when young men looked after or those in leaving care are known to be the father of an unborn child, irrespective of whether the mother herself is, or was looked after.

## 4. The pre-birth assessment and post birth planning

4.1 Pre-birth guidance in Essex considers that the earlier the assessment is undertaken the better the planning around the parents, extended family and the unborn child. This will include early referral to Family Group Conference, and where legal proceedings are considered, fostering to adopt. Therefore a referral at 12 weeks of pregnancy is considered to be good practice, child in need planning can commence with a view to convening an initial child protection conference from 30 weeks of the pregnancy.

4.2 Where there is significant parental history, including current and/or previous child protection concerns relating to other siblings, starting the assessment around 12 weeks of the pregnancy provides an opportunity to both work more closely with parents and to analyse and reflect on the information available

4.3 At the point of starting the assessment, a multi-agency Child in Need Meeting should be held within 2 weeks in order to plan the Pre-Birth Assessment. The views, information and support available from partner agencies should be sought and incorporated into the assessment.

4.4 Additionally, if the ***outcome*** suggests the baby would not be safe with the parents then practitioners are provided with the time and opportunity to make clear and structured plans for the baby's future, and set up support for the parents where necessary.

4.5 The pre-birth assessment will:

- Focus on strengths and concerns about both parents and extended family members,
- Assess the family history of both parents, the fathers of any previous children, and the extended family, previous proceedings and any previous expert reports/assessments including parenting assessments
- Assess concerns about parental mental health, substance misuse or learning disabilities including previous involvement with mental health or substance misuse services
- Assess parents' attitude to new baby and preparedness for its birth
- Build good relationships with the family, especially the expectant mother, using strength based approach, relationship based practice and motivational interviewing and gain an understanding the family systems.
- Consider what support the expectant mother and partner will require and find avenues for this support.
- Seek to engage support from wider family, and may consider Family Group Conference early in the assessment process where necessary, and identify the support needed for the family in order to safely parent the child.

4.6 There is a defined period for completion of the Single Assessment, which is 45 days in total, with a review point at 20 days, it is expected that the majority of these assessments will conclude at 45 days in order for a full and thorough assessment to be completed. **The aim is always to conclude where possible the pre-birth assessment to enable child in need planning to**

**begin by around 27-30 weeks of the pregnancy. A birthing plan will need to be shared with the multi agency professionals prior to the birth.**

4.7 The unborn baby's father **and** mother's current partner (if different) should be included in the assessment.

4.8 If the assessment ***does not*** indicate that the baby will be at risk of significant harm when born but may be a child in need, then the planning and provision of services will continue under s17 of the Children Act 1989.

4.9 If, however the assessment ***does*** indicate that the baby will be at risk of suffering significant harm then a Child Protection Conference will be held at 30 weeks gestation

4.10 The Child Protection conference and any subsequent reviews will proceed as per all other conferences, the first review being held within 4 weeks of the baby's birth or in exceptional circumstances within 3 months with the approval of the responsible Social Work team manager and Child Protection Co-ordinator.

4.11 If the decision is made to proceed with a child protection plan for the unborn child, then the name ("Unborn" mother's name) and the due date of delivery should be entered on all electronic and hard copy records. The baby's record should be linked with the mother's record.

4.11 When the baby is born the midwife should inform the social worker.

4.12 The core group should meet *before* the birth, and also *before* the baby is discharged from hospital. The Core Group record should highlight the:

- Outcome of assessment;
- Pre / post birth plans, including Child Protection Plan;
- Managing non co-operation;
- Removal at birth – if the plan is to remove the baby at birth, plans must be in place to fulfil the statutory requirements relating to Looked After Children and the preparation of foster carers if any post-birth health needs are likely.

4.13 Detailed written plans need to address:

- Who should hospital contact when mother is admitted / in labour / baby delivered?
- Who will give consent for screening?
- What happens if baby is born out of hours?
- What level of contact / care (supervised or not) can the parents have, and who will assume responsibility for supervising care/contact?
- What is the plan in relation to breast-feeding?
- What needs to be in place for baby to go home?
- Where will baby go home to?
- Which professionals need to visit?

- Which day is each person going to visit?
- Does the child need to be seen every day or is it necessary to do an unannounced visit, and what is the contingency plan
- What family support needs to be in place
- What have family members agreed to do?
- Is the family part of the visiting schedule?
- Are the parents aware of the plan & what is their presentation/attitude?
- Possible family arrangements for care of the baby
- Expectations and process for reporting concerns in and out of working hours
- How long the plan is in place for and when it will be reviewed
- What are the arrangements for initiating legal proceedings?
- The intensive support required for mother and baby to live in the community, and any other specialist assessments;

All the information collected from answering the questions above should be written out clearly so expectations/ instructions are known to all parties.

4.14 Legal Planning Meetings will be undertaken by Children's Services Social Care departments when necessary; the recommendations of Legal Planning Meetings will be shared with the Core Group and any other relevant partner agencies as appropriate

4.15 Even when it is agreed that the Local Authority have decided to apply to the Family Court to seek removal of the child at birth, a Child Protection Conference should always be convened.

## 5. Potential Indicators of Risk

### 5.1 Mental Ill Health

5.1.1 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 e.g. depression, history of attempted suicide, schizophrenia etc. Non-compliance with medication *without* medical supervision is a cause for concern.

5.1.2 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".

5.1.3 Practitioners will obviously seek to obtain a psychiatric assessment in these cases but must not become "paralysed" if that is not forthcoming. It is essential to continue the assessment based on the *behaviour* of the parent(s), not the diagnosis, and the potential risk of that behaviour to the new-born child. In addition, where mental health risk factors are identified, ongoing evaluation of risk is essential. There is provision in Essex for the mother and baby to be supported in a mother and baby unit, if assessed as appropriate, and a referral should be made through the safeguarding clinical lead

**(See also SET Procedures 2015 see Part B, chapter 41.2, Parental or carer Mental illness**

## 5.2 Substance and Alcohol Misuse

5.2.1 Experienced practitioners report that most drug/alcohol using women have similar attitudes and motivations to pregnancy as non-drug/alcohol using women and it is important to note that most women with drug/alcohol problems are of childbearing age. However, those with drug/alcohol problems may also have poor general health, housing and financial problems.

5.2.2 Some pregnant drug/alcohol users do not come for antenatal care until late in pregnancy or when they are in labour. There are many reasons why drug/alcohol using women may present late to antenatal services. The local service may not be able to meet their specific needs or it may be perceived to be inaccessible, their drug/alcohol use may place other demands on their time, which often take priority for the user.

5.2.3 Some may feel that it is better not to reveal their drug/alcohol use to antenatal care staff as they fear the attitudes of staff and the possible involvement of statutory services. Also due to the possibility of amenorrhoea caused by the drug/alcohol use, the woman may not know that she is pregnant, or may not be clear about the duration of the pregnancy.

5.2.4 Many of these problems can be overcome if an appropriate service, which meets the needs of drug/alcohol using women, is available, easily accessible and well publicised.

5.2.5 Agencies in the community can play a key role in supporting these women in a range of ways. This includes identifying drug/alcohol use / pregnancy at an early stage, referring on to appropriate help and support, identifying risks, and providing support and advice around pregnancy and/or drug/alcohol use.

5.2.6 Drug or alcohol misuse is not in itself a contra-indication that the parent(s) will be unable to care safely for the baby, but practitioners will need to analyse:

- The pattern of drug use and alcohol misuse;
- Whether it can be managed compatibly with the demands of a new-born child;
- Whether the parent(s) are willing to attend for treatment; and
- 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.

5.2.7 All pregnant women should be asked about their use of prescribed and non-prescribed drugs, both legal and illegal, as part of routine enquiries about general health during pregnancy. Time should be allowed for the exploration of the patient's and the professional's concerns about the risks for both the mother and the child. This needs to be done sensitively so that the woman is not deterred from seeking help, even if she continues to use.

5.2.8 However practitioners should ensure that the woman and her partner are aware of the impact of the following behaviours:

- The use of tobacco, street drugs, alcohol and some over the counter drugs, including the adverse effects of some medicines;
- Chaotic drug/alcohol use; e.g. polydrug use, erratic dosage precipitating withdrawals or intoxication;
- Injecting and sharing of injecting paraphernalia;
- Unprotected sexual activity

**(See also SET Procedures 2015 part B, chapter 41.2 Parental or carer substance misuse)**

## 5.3 Domestic abuse

5.3.1 In a 2004 study examining the prevalence of domestic abuse and its' relationship both to complications in pregnancy and psychological health, the women questioned (on antenatal and postnatal wards) evidenced that around 23% had a lifetime experience of domestic abuse and 3% had experienced violence in the current pregnancy.[6] Further research reports that between four and nine women in every 100 are abused during their pregnancies and/or after the birth of the baby[7].

5.3.2 A recent significant study of over 13,500 women undertaken by Kings College, London's' Institute of Psychiatry[8] noted a strong link was found between antenatal violence and violence post-birth; 71% of women who experienced antenatal domestic violence pregnancy also experienced violence in the postnatal period. Of additional concern is the evidence of child behavioural problems recorded at 42 months of age looking at factors such as hyperactivity, emotion, and conduct problems. Hence, continued exposure to domestic abuse once the child is born can impact on his or her emotional and cognitive development. The extent to which the violent partner also poses a direct physical threat to the child will need to be assessed.

5.3.3 Learning from a recent serious case review clearly notes the vulnerability of children living with domestic abuse:

*"A pattern of domestic abuse and violence, alongside excessive alcohol use by Ms Luczak and her male partners, continued for much of the period of time from November 2006 onwards, and despite interventions by the Police and Children's Social Care, this pattern of behaviour changed little, with the child protection risks to the children in this volatile household not fully perceived or identified"[9].*

5.3.4 Good practice indicates that a current and/or previous history of violence should be carefully evaluated. Detail should be obtained about:

- The nature of violent incidents;

[6] Bacchus, Loraine (2004) "Domestic violence and health" in Midwives Vol.7, no.4, April 2004 cited on Women's Aid site

[7] Taft, Angela (2002) Violence against women in pregnancy and after childbirth: Current knowledge and issues in healthcare responses Australian Domestic and Family Violence Clearinghouse Issues Paper 6 cited on Women's Aid site

[8] Howard, L et al (2011) *Antenatal domestic violence, maternal mental health and subsequent child behaviour: a cohort study*

[9] Coventry LSCB 2013 *Serious Case Review Daniel Pelka Overview Report*

- 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.

However risk is affected by dynamic factors and can therefore change suddenly. Professionals should therefore bear in mind that a piece of information currently not known could raise or lower the threshold of risk for a child.

5.3.5 During the pre-birth assessment increased risk factors may be prevalent for example:-

- Domestic abuse incidents in the pregnancy;
- Parent/s may exhibit aggressive behaviour;
- There may be pregnancy complications that could lead to e.g. pre-term delivery with the result of a baby that will require a higher level of care.

5.3.6 It is essential that there is close liaison with the midwives and obstetricians in relation to these factors. It is also important to examine the history of previous children who have been removed from the parent(s) care. This will indicate if there were particular characteristics which made that 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.

**(See SET Procedures 2015 part B3 section 17 Safeguarding Children Affected by Domestic Abuse and Violence assessing parental capacity.)**

## 5.4 Parents with Learning Disability

5.4.1 For the purposes of these procedures, 'parental learning disability' refers to adults who are, or may become parents/carers for children and who meet the 3 core criteria which describe an individual as 'learning disabled', i.e.:

- **Significant impairment of intellectual functioning**: individuals with an IQ of 69 and below (reference: British Psychological Society and legal system) – this is not a hard and fast rule; overall IQ scores can be subject to interpretation either way for a variety of clinical reasons – interpretations of psychometric test scores are the remit of a chartered psychologist.
- **Significant impairment of adaptive / social functioning**: i.e. how an individual copes with everyday demands of community living; impairment of adaptive / social functioning might be considered to be present if s/he needs assistance with survival (eating, drinking, clothing, hygiene and provision of basic comforts) or with social problem solving and social reasoning.
- **Age of onset before adulthood**: in order for an individual to be considered as 'learning disabled', impairment i.e. of intellectual adaptive / social functioning usually needs to have been present before the age of 18 years.

5.4.2 It is not always clear whether or not a parent/carer has a learning disability, and the following may assist recognition:

- Reference to medical records can offer evidence;
- Reference to educational records (where it is less than 5 years since leaving school) can also provide evidence e.g. Statement of Special Education Needs;
- Personal history involving attendance at special schools;
- Severe difficulties with literacy and/or numeracy;
- Enquiries made of the learning disability register maintained by Adult Social Care;
- A referral to a clinical psychologist.

5.4.3 Learning disabled parents may also experience additional stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care. Such stressors, when combined with parental learning disability, are more likely to lead to concerns about the care of children.

5.4.4 Parents with a learning disability may therefore need positive 'whole family' support to develop sufficient understanding, resources, skills and experience to meet the needs of their child. With effective, sustained support over time adjusted to meet the changing developmental needs of a growing family, learning disabled parents are potentially able to provide good enough care.

5.4.5 It is important to assess the needs and provide support for learning disabled parents as early as possible. To ensure that parents are able to understand what is happening and why, and are able to participate meaningfully, consideration should be given to the involvement of an advocate.

5.4.6 If any professional or agency has any concerns about the capacity of the pregnant woman and her partner to self-care and/or to care for the baby, a referral should be made to Children's Social Care in line with pre-birth procedures.

5.4.7 The GP and midwife must make referrals to the community team for people with learning disabilities for a joint assessment of the pregnant woman's needs, capacity for self-care and to provide adequate care for the baby. Subsequent assessment should be in accordance with pre-birth procedures, but the involvement of the Learning Disability Team is essential.

**(See SET 2015 Procedures Part B section 41.3)**

## 5.5 Concealed Pregnancy

5.5.1 If the pregnancy has been concealed then consideration should be given within the assessment to other potential risk factors

**Appendix 1**

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