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PRE-BIRTH ASSESSMENT IN SOCIAL WORK

ANN VERA HODSON

A thesis submitted to the University of Huddersfield in partial fulfilment of the requirements for
the degree of Doctor of Philosophy

The University of Huddersfield

August 2011

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The name of the LA from which data gathering was conducted has been withheld.

Abstract

The Children Act 1989 imposes a duty on Local Authorities in England to 'safeguard and promote the welfare of children' and to 'promote the upbringing of children by their families' wherever possible. If, during pregnancy, concerns are identified that suggest the child may be at risk of harm a referral may be made to the Local Authority for a pre-birth assessment. When completing a pre-birth assessment social workers and other professionals are often involved in the process of collecting and analysing information, which will ultimately be used as a basis for planning and decision-making and can have life long consequences for the family. Removing a baby at birth brings with it an inevitable impact on the process of attachment and bonding, as well as the impact of subjecting a family to court proceedings and all of the emotions that entails. However, allowing a baby to be discharged from hospital to a family who are unable to provide appropriate care and protection or do not have the necessary support in place to assist them may result in irreparable harm to, or even the death of the baby.

Sitting within the context of general child and family social work assessment, pre-birth assessment has received a very limited amount of specific research attention. This thesis comprises a report on the outcomes of my own research, which was exploratory in nature, and details the findings from a mixed methods study of relevant legal and procedural frameworks in England, Local Safeguarding Children Board procedures and a case study of pre-birth social work assessment practice in one Local Authority.

The findings were that pre-birth assessment is a complex process guided by a national and local procedural framework which does not recognise the unique status of the unborn child. Having evolved from a historical perspective based on protecting live children, the procedural guidance is contradictory as it does not acknowledge that an unborn child has no legal status and a pregnant woman maintains rights over her own body. The case study also revealed that social workers in the host LA were practising in an environment of managerial systems which aimed to improve accountability and yet the very systems designed to ensure children did not fall through the '*safety net*' of professional support were, ironically, prompting systems which made practice in (and research into) pre-birth social work assessment a challenge. A narrow forensic approach to pre-birth assessment was found to have developed, with the documentary process of completing pre-birth Initial and Core Assessments (as defined by the Department of Health (2003) documentation) becoming split from the process of actually 'doing' a social work pre-birth assessment.

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Dedications and Acknowledgements

I dedicate this thesis to my husband Jim. Thank you for the financial support which allowed me to give up full time social work practice and pursue my ambition to complete a PhD. Most of all, thank you for the emotional support, particularly during the final write-up stages when I know I have not always been easy to live with!

I wish to acknowledge the support of my supervisors, Professor Helen Masson, Professor Nigel Parton and Professor Ruth Deery. Their knowledge and advice has been invaluable and their supportive but academically challenging approach to supervision and feedback has made an enormous contribution to my early career development as a researcher. In particular, I wish to acknowledge Professor Helen Masson for her unerring support; from my first approaching her for advice about the PhD to the feedback on the final drafts of the thesis she has been professional, approachable and inspirational. Helen, there are no words that express my gratitude, thank you.

In memory of my dad, Albert Cope, I know he would have been proud of what I have achieved.

List of abbreviations

CA – Core Assessment

CAF – Common Assessment Framework

DH – Department of Health

EDB – Electronic Database

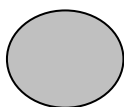
IA – Initial Assessment

ICS – Integrated Children’s System

LA – Local Authority

LSCB – Local Safeguarding Children Board

Genogram Key



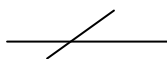
- Female



- Male



- Relationship



- Severed relationship

Chapter 1

Introduction, Aim and Research Questions

1. 1 Early interest in pre-birth assessment

As a social work practitioner I spent nine years in child protection work in a statutory setting, initially as a front line social worker and, for the last 5 years, as a manager. During the nine years I was involved in the pre-birth assessment and planning process and felt enormous responsibility attached to my involvement in decisions about whether a mother and baby should be separated at birth or not.

There were two cases from my practice that originally sparked my interest. One involved a teenager who was in the care of the Local Authority (LA), had no support from her family and was pregnant following a rape. This was my first ever experience of pre-birth assessment and concluded with the baby being removed shortly after the birth. I cannot begin to understand how this teenager must have felt, 'being assessed' and then losing her baby as well as having to endure the court process without any support from her family. The second case that sparked my interest involved a mother who, at my first involvement with her, had had her child removed from her care and the LA were pursuing a plan for adoption. I was appointed as manager to the team as the case was drawing to a close and so I took over management responsibility for the social worker at the point when the final court hearing was due to take place. Taking over at such a late stage I did not review the whole file and history but accepted my predecessor's decisions and actions. The court agreed with the LA plan for the baby to be adopted and I did not think a great deal more about this until a referral, two years later, from a midwife informing the LA of the woman's pregnancy. By now the original social worker had left the team and a new social worker took over the case. Based on almost identical information, the second social worker concluded there was a good chance the mother could, with the support of her family, actually care for her baby. Following the birth a support plan was put in place. The baby thrived in her mother's care and by the time she was 18 months old we were able to end LA involvement. I question to this day whether the decision for the first child had actually been the best one.

How information is gathered and interpreted by social workers has a direct impact on assessment outcomes and getting it 'wrong' can have lifelong implications for children and their families. Removing a baby at birth brings with it an inevitable impact on the process of attachment and bonding, as well as the impact of subjecting a family to court proceedings and

all of the emotions that entails. However, allowing a baby to be discharged from hospital to a family who are unable to provide appropriate care and protection may result in irreparable harm to, or even the death of the baby. The constant balance and tension between what is 'right' for the baby and the consequences of getting it 'wrong' in pre-birth assessment always interested me as a social worker and manager but it appeared that this aspect of practice had not received significant research attention. This is not to suggest that pre-birth assessment is any different to other forms of assessment in terms of the potential implications of the decisions made, indeed the tensions around decisions are the same for any child of any age. However, there are some particular ethical and moral implications pertinent to pre-birth assessment relating primarily to the unborn child having no legal rights, and therefore no status of personhood, and also to a woman's rights and choices. By undertaking this PhD I hoped to begin to explore some of the key issues specifically pertinent to assessing unborn children.

1.2 Research aim and questions

The research started with the broad aim of studying pre-birth assessment and supervision and the process of PhD progression monitoring was invaluable in the process of narrowing this down to something that was manageable and that reflected my personal interests. One of the first steps in formulating my research aim was to actually consider the definition of a pre-birth assessment. At first sight this may seem quite simple, namely all assessments that take place before the baby is born. However, the problem with such a wide definition is that it incorporates all kinds of assessments undertaken by any number of professionals. For example, the midwife providing obstetric care, the teacher supporting a pregnant teenager, and the prison official allocating places on a mother and baby unit are all involved in some form of pre-birth assessment. My social work practice had been in the area of working with children in need as defined by the Children Act 1989 and so, to reflect my experience, I decided to focus on assessments carried out using the *Framework for the Assessment of Children in Need and Their Families* (Department of Health 2000).

My early literature searches confirmed that pre-birth assessment was an area that had received minimal research interest and so it seemed appropriate to conduct an exploratory study into front line social work practice. The research aim was therefore set as:

To explore what is currently known about pre-birth assessment within the context of Local Authority social work practice.

As regards the boundaries of the study I assumed there may be differences in legislation and guidance across the nations of the United Kingdom that may impact, subtly or significantly, on

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pre-birth assessment. So, in order to ensure the study had focus and clarity, I decided to look only at social work practice in England, with a longer-term aim (post PhD) to consider practice elsewhere in nations covered by other legislative frameworks and guidance.

In order to achieve the overall aim of the research and to provide structure to the process of literature searching, data gathering and analysis the following research questions were devised:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

ii) What are Local Authority processes in relation to pre-birth assessment?

iii) What are social workers' views about pre-birth assessment?

iv) How do social workers approach the task of pre-birth assessment?

The above four questions, devised in the early stages of my research deliberations provide the basis for the literature searches, data gathering and analysis.

1.3 Doing research in a shifting context

During the eighteen months of data collection there were several developments that impacted on social work practice in England most significantly in relation to the media and political fallout from the tragic death of baby Peter Connolly in August 2007. There was also media coverage of the cases of Fran Lyon, a young pregnant woman who claimed Northumberland Children's Services intended to remove her baby at birth and who fled Britain to prevent this happening. Thus, although due consideration was given to that which was knowable at the outset, many other developments had to be responded to during the course of the fieldwork and subsequent analysis. Throughout the thesis the impact of these developments are discussed and so here, by way of introduction, a time line of events and how they related to the research process as a whole is provided below.

Wider social and political picture	Research stage
<p>April 2007</p> <p>The introduction of the Integrated Children's System in England (full implementation in the host LA, where the fieldwork was conducted, was on 1st April 2008)</p> <p>September 2007</p> <p>Fran Lyon case on the national television news, in newspapers and the subject of a 30 minute television programme</p>	<p>Initial stages of planning</p>
<p>11th November 2008</p> <p>Jason Owen and Steven Barker found guilty of causing the death of Peter Connelly.</p>	<p>12th May 2008</p> <p>Ethical approval from the University of Huddersfield to proceed with the research</p> <p>8th July 2008</p> <p>Ethical approval from the host agency to proceed</p> <p>1st October 2008</p> <p>Start of data gathering in host LA</p> <p>↓ Data gathering in host LA</p>
<p>20th November 2008</p> <p>Ed Balls Secretary of State, Department for Children, Schools and Families makes a statement that Lord Laming had been asked to provide an urgent report on the state of services to protect children.</p>	<p>↓</p>
<p>12th March 2009</p> <p>Lord Laming publishes his report (HM Government 2009)</p>	<p>↓</p>
<p>May 2009 the government publishes 'The protection of children in England: action plan. The government's response to Lord Laming' (DfCSF 2009) and sets up the Social Work taskforce, leading to various significant reports.</p>	<p>↓</p> <p>31st December 2009</p> <p>End of approval date for access to EDB and data gathering in host LA</p>

Figure 1 – Timeline of National Events and the research process

Figure 1 highlights some of the factors which I had to take into account and consider their possible impact on the research as a whole. The death of Peter Connelly, in particular, had a significant impact on social work as a whole and I was engaged in the process of data gathering throughout the height of the media coverage and government responses. From a research perspective these were interesting times as I observed the immediate impact of the news coverage on social work practitioners and the LA, followed by further LA actions implemented in response to government pronouncements and decisions.

1.4 The Layout of the Thesis

Chapter Two of the thesis provides an historical overview of the current context of statutory social work practice. The chapter then moves on to explore the literature relevant to the assessment of children, and more specifically to pre-birth assessment. The purpose of this chapter is to provide some context to my research by outlining the framework of understanding from which I developed my thoughts and research approach.

Chapter Three provides an explanation of the methodological approach adopted by looking at my journey from first-hand experience of conducting pre-birth assessments through to the process of designing the research. With reference to the research questions detailed above, Chapter Three also lays out the structure to the research process as a whole and how I planned to address each of the research questions.

The main body of the thesis is then dedicated to presenting the results and analysis of the various data gathered. Chapter Four provides an analysis of the data gathered in the first stage of the research which addressed research question *i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?* Looking firstly at the legal framework, the chapter outlines the law contained in the Children Acts 1989 and 2004 and how legislation, which aims to safeguard children and promote their welfare, relates to unborn children. The exploration is then widened by considering aspects of law, such as that relating to in-vitro fertilisation treatment, and legal rulings and case law that have relevance to the unborn child. The chapter also considers the policy context of *Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children* (HM Government 2006), hereon referred to as *Working Together* in the thesis and *The Framework for the Assessment of Children in Need and Their Families* (DH 2000), hereon, throughout the thesis, referred to as the *Assessment Framework*, with specific reference as to how both publications relate to unborn children.

It is important to note that since completing the research *Working Together* (HM Government 2006) has been updated and replaced with the 2010 version of the guidance with the same title. The 2010 guidance has no additional information with regard to pre-birth assessment but, as the data collected for the research was gathered during the period when the 2006 version was current, then this version is referred to throughout the thesis.

In Chapter Five the findings from the documentary analysis of Local Area Safeguarding Procedures are detailed. This chapter particularly addresses research questions *i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?* and *ii) What are Local Authority processes in relation to pre-birth assessment?* Looking at the national picture the chapter offers an exploration as to how the national legal and procedural framework (the subject of Chapter Four) has been translated into local procedural guidance for use by front line practitioners involved in the process of pre-birth assessment.

The thesis then moves on to look at the data gathered from one LA in England and addresses research questions *ii) What are Local Authority processes in relation to pre-birth assessment?*, *iii) What are social workers' views about pre-birth assessment?* and *iv) How do social workers approach the task of pre-birth assessment?* Chapter Six provides a reflexive account of the experience of being in the host LA and working as a researcher. The purpose of this chapter is to explain the LA team structures and to provide context to how the pre-planned research design translated into the actual process of data gathering in action.

In Chapter Seven the findings from a six-month audit of all pre-birth referrals made to the host LA are presented. Chapter Eight builds on this by summarising the findings from case file analysis and interviews with case-holding social workers of a small sample of cases selected from the audit cases. In the final results chapter, Chapter Nine, the themes drawn from interviews with social workers which explored their general approach to the task of pre-birth assessment are detailed.

Chapter Ten provides an analysis of the key findings from data collection and links these back to the literature review. Drawing on each of the previous chapters, the purpose of this chapter is to identify the links between the legal and procedural framework, the literature and the findings from the data gathered nationally and in the host LA.

Finally, chapter 11 provides a reflection of my research journey outlining the process of transition from social work practitioner to researcher. Chapter 11 also provides a conclusion to the Thesis by summarising the key findings and looking at the next steps in pre-birth assessment research.

Chapter 2

Pre-Birth Assessment In Social Work: Setting the Scene and Review of the Assessment Literature

2.1 Introduction

The assessment of children and their families is a recognised and fundamental area of social work practice and is the subject of ongoing research and policy development. I begin this chapter by providing a very brief outline of some of the historical circumstances that have contributed to the development of current social work practice with children and families. My aim is not to provide a comprehensive account of the historical development of child welfare and safeguarding work; such a task would be highly complex and well beyond the remit of my thesis. However, the historical backdrop provides some insight into the influences and socio-political developments that have contributed to my understanding of working with children in need and in need of protection and the emergence of assessment practice as an aspect of the social worker's role. This, therefore, provides the context within which I began my research and undertook the review of existing literature.

The chapter then moves on to consider literature relevant to my research, firstly looking at the wider body of literature relevant to the assessment of children in need and their families, and then onto considering the more specific pre-birth assessment literature.

2.2 The historical development of child and family social work in England

...consideration of social work's history suggests that it is a contingent activity, conditioned by and dependent upon the context from which it emerges and in which it engages. (Harris, 2008. p 662)

Social workers employed by LAs to ensure children in need are identified and safeguarded do so within agency settings that have evolved over time and must constantly respond to a wide range of influences, not least of which is public accountability. Writers such as Ferguson (2004), Jackson (2000), Parton (2006 and 2007), Payne (2005) and Webb (2007) all provide historical accounts of the development of social work and safeguarding children and, in doing so, link the development of practice to the socio-political pressures and demands through time.

Interwoven with the development of social work is the development of the process of assessment and outlining the historical perspective provides a backdrop to understand the development of assessment activity.

By tracing current assessment processes back to the early development of the social work role it can be seen how the focus on the child and children's welfare has emerged. It can also be seen how social and political ideology relating to safeguarding children and assessing needs has, at the core, notions of identifying, or predicting, the 'risk of harm'. Back in the 1800s the process of industrialisation created a socio-political imperative for children to grow into healthy and productive members of the workforce in order to serve the ongoing development and wealth of the economy. From Victorian times we can trace how universal services, such as education and child health provision, developed to support children's ultimate engagement in the industrialised society. Alongside universal services the more directed services, such as social work, emerged to ensure standards of childcare (as socially and legally defined) were maintained. With increased scrutiny into the private lives of families came an awareness of how some children were being treated, which in turn provoked moves toward charity and state intervention (Ferguson 2004; Webb 2007).

'The New York Society for the Prevention of Cruelty to Children' (NYSPCC) developed in 1875 and was the model for *'The National Society for the Prevention of Cruelty to Children'* (NSPCC) in England (Parton 2007; Ferguson 2004). The NYSPCC was founded following the work of social reformists who brought before the courts the case of a young girl abused by her parents. At the time there was an absence of specific childcare legislation and so the reformists used animal cruelty laws, ultimately succeeding in removing the child from her family (Ferguson 2004). During the latter part of the 19th century the English courts were also beginning to deal with cases of child cruelty, albeit in the absence of formal legislation to protect children. The use of the court arena and the work of charitable organisations in the home environment highlighted to the middle classes concern about child cruelty and neglect amongst the poorer classes. As a result the NSPCC was founded in 1889 and became the principal agency in the development of child protection policy and procedures (Parton 2007; Ferguson 2004).

The creation of the welfare state in the 1940s marked a new era of optimism and a fundamental shift in social attitudes toward state provision (see Ferguson, 2004; Parker 1995; Parton 2007; Fraser 2009). Of notable relevance for pre-birth assessment were the changes in attitudes surrounding pregnancy and childbirth. Advances in medical knowledge and the development of technologies such as X-rays and ultrasound resulted in awareness of the fetus and the importance of maternal health and well-being in ensuring a healthy baby (Kent 2000). The provision of maternity services under the National Health Service increased access whilst

also moving pregnancy and childbirth into the arena of state welfare provision and public interest. It must, however, be noted that, although there was growing awareness of the impact of maternal health on the development and well-being of the unborn child, this was not then linked to the other developing area of medical awareness on the subject of child abuse.

Alongside welfare provision and the development of maternity services, the work of Kempe and colleagues in the 1960s had an impact on public awareness of child protection (Parton 2006). As Parton (2006) comments there was a shift from a criminal perspective on child protection to one where abuse could be diagnosed and then treated. The medical language of diagnosis and treatment permeated through the work of Kempe who wrote:

The diagnosis of battering must be considered in all trauma to small children.
(Kempe 1971 p33)

Kempe and his colleagues considered the characteristics of the parents as important, stating that parents likely to harm children were 'impulsive, self centred, hypersensitive, and quick to react with poorly controlled aggression' (Kempe *et al.*, 1962). Shifting the emphasis toward the detection and 'treatment' of child abuse rather than adopting a punishment route began to dominate the work of the NSPCC and influenced policy makers (Parton 2006). However, the death of Maria Colwell in 1973 at the hands of her step-father prompted a public enquiry and a subsequent shift in emphasis with regard to the state's role in protecting children.

Maria Colwell had been removed from her family at only a few months old but was then returned to her family when she was five years old. Despite being regularly visited by social workers from the Local Authority and the NSPCC Maria's death was not prevented (see Parton 2006 and Munro 2008 for more in-depth accounts of Maria's story and its political implications). The enquiry report, published in 1974, was critical of social workers, NSPCC inspectors and the lack of inter-agency systems for dealing with child abuse (Parton 2006). Emphasis was placed on developing effective procedures and securing inter-agency co-operation (Parker 1995) yet in a study of child abuse enquiries between 1974 and 1994 Munro found:

Twenty-five percent of the reports were not critical of anyone; the deaths were considered unpredictable given the contemporary level of knowledge about the child abuse. Many of these reports applauded the quality of practice. Social workers, who often bear the brunt of critical press reporting, were exonerated or, indeed, praised in 42% of the reports. (Munro 1998 p784)

Notwithstanding Munro's findings, the media often held that the professionals were to blame for the failures rather than parents, resulting in on-going strengthening of procedures and a move toward more controlling aspects of social work (Munro 2008). However, in 1987 news broke of child protection practice in Cleveland which resulted in over 100 children being kept,

using legal powers, in hospital on suspicion of sexual abuse (Frost and Parton 2009). In contrast to other child abuse enquiries, Cleveland involved the possible over-reaction of professionals, acting against parents' wishes and invading the privacy of family life. Government and policy makers were therefore in a position of having to strike a fine balance between protecting children and also, at the same time, protecting families from over intrusive state interference (Frost and Parton 2009).

Thus policy and procedures to protect children evolved within the context of research, the pioneering views of Kempe and his colleagues, various child death enquiries and media coverage. However, whilst there was a growing medical awareness of the fetus and recognition of the well-being of the mother, social work assessment practices seemingly evolve without any links to unborn children.

2.3 The development of assessment as an explicit process in social work practice

Although there was an emphasis on developing effective procedures in the face of media and public scrutiny, assessment as an explicit process was not necessarily high on the agenda for discussion. Whilst assessment has been an inherent task within social work since the 1800s, as an explicit process it has a much shorter history. Gray (2002) pinpoints the Children Act 1948 as a period when the term 'assessment' became part of the statutory language although only in relation to children in the care system. In 1981, following a wide-ranging review of assessment by a government working party, the following definition of assessment was offered:

A continuous process whereby problems are identified and appropriate responses decided upon. (Department of Health and Social Security 1981 p2. cited in Gray 2002 p170).

A definition is only part of the story and government inspection reports and investigations following child deaths have repeatedly identified the lack of a structured assessment process as a contributory factor to children not being protected (see Horwath 2010). In response, '*Protecting Children. A Guide for Social Workers Undertaking a Comprehensive Assessment*' (Department of Health 1988), was introduced. Popularly known as the '*Orange Book*' it provided a guide for completing assessments for children where there were concerns of a child protection nature but was not regarded as a guide for assessing children in need. Even with the focus on assessment under the remit of child protection a number of difficulties remained and the Department of Health (1995) studies found that families found assessment and investigation a distressing experience. In 1997 the Social Services Inspectorate found:

Assessments were not usually carried out on new referrals, even of a basic kind. As a result staff did not sufficiently understand the needs of the families with whom they were working. (Department of Health 1997, 10.7)

Social Service Department policies indicate little expectation that assessments would be undertaken. (Department of Health 1997, 10.8)

Where assessments were undertaken, they were poorly co-ordinated, lacked structure, and had poor content. (Department of Health 1997, 10.11)

To address the identified problems, and in response to the government agenda for improving the life chances of the most vulnerable children, the development of a national assessment framework was announced in 1998 (Horwath 2001 and Horwath 2010). The Labour government introduced the five-year '*Quality Protects*' programme and a key element of the programme was the development of a national framework for the assessment of children and their families. Emphasis was placed on improved and timely assessments that ensured the referral and assessment processes differentiated between levels and types of need (Horwath 2001 and Horwath 2010). The resultant *Assessment Framework* (Department of Health 2000) reflected the government focus on early intervention in order to prevent long-term problems and was based on the principle of professionals working together in partnership with families (Cleaver *et al*, 2004).

During the implementation process of the *Assessment Framework* (DH,2000) news broke of the death of Victoria Climbié on the 25th February 2000. On the 12th January 2001 Victoria's great aunt Marie-Therese Kouao and Carl John Manning were convicted of her murder and a public enquiry was ordered to consider why this eight-year-old girl had died, despite being known to a range of agencies and professionals. In the subsequent inquiry by Lord Laming emphasis was placed on systemic failures across agencies responsible for protecting children (Cm, 5730, 2003). The recommendations from the enquiry related to greater accountability of agencies and strengthening of interagency recording procedures, as well as increased management of front line professionals (Cm 5730, 2003 and Corby 2006). Further legislation and guidance followed in the form of the Children Act 2004 and another edition of '*Working Together*' (HM Government 2006). Plans were made to improve electronic systems to ensure children could not fall through the safety net of professional involvement and the construction of the Integrated Children's System (ICS) began in 2000 (Cleaver *et al* 2008). Designed to provide an electronic record of professional involvement, assessment, decision making and review from first point of contact to case closure the ICS became operational in LAs in Wales on the 31st December 2006 and in LAs in England on the 1st January 2007 (Cleaver *et al*,2008).

Although the ICS provides an electronic system of recording professional involvement it is the process of assessment that is significant in terms of the approach to identifying children in need of support and/or protection. Set against a backdrop of procedures that sought to 'protect' children, developments in the late 1990s and 2000s actually saw a shift in emphasis toward holistic assessment and the safeguarding of all children, rather than only those children thought to be at risk. The *Assessment Framework* (DH 2000) marked the move toward more holistic assessment and early intervention to ensure prevention of longer-term problems for families (Horwath 2001; Horwath 2010; Cleaver *et al* 2004). However, as indicated earlier, the procedures and guidance surrounding assessment evolved within the context of live children, and whilst this is not to suggest pre-birth assessment was ignored, the lack of research and literature indicates only limited attention could have been paid to the unique circumstances of unborn children and pregnant mothers.

2.4 Pre-birth child development: A developing area of knowledge.

As noted earlier in this chapter, the development of the Welfare State resulted in changes in attitudes surrounding pregnancy and child birth along with increased awareness of the fetus. Growing medical knowledge has brought about greater understanding of the importance of maternal health in promoting the health of the baby (Kent 2000) although understanding about the interlinked needs of mother and fetus has not, as yet, impacted significantly on attitudes toward child protection work. Whilst it is now widely accepted that all forms of abuse have an impact on post birth child development, over recent years there has been increased evidence that, for example, maternal drug and alcohol use during pregnancy can also have significant developmental consequences for the child (Ward and Glaser 2010). However, the extent to which any one particular issue associated with drug use can be pinpointed is a subject to debate.

The physiological development of the fetus and the impact of maternal substance use became world news in the 1960s when German paediatricians and geneticists began to identify that certain types of birth deformities were directly linked to Thalidomide, an anticonvulsant drug prescribed during pregnancy (Thalidomide Trust, accessed online Nov 11). In the 1970s Jones and Smith (1973) and Jones *et al* (1973) coined the term fetal alcohol syndrome and began to delineate the impact maternal use of alcohol during pregnancy could have on fetal development, highlighting the lifelong physical consequences for the child. These early studies considered developmental abnormalities brought about by exposure of the fetus to particular substances, a theme which has persisted in more recent studies which have attempted to identify the impact of drugs such as cocaine and opiates (Moe and Slinning 2002). However, as Moe and Slinning (2002) comment, the actual impact on the unborn child of drugs such as

cocaine and opiates is less clear as pre-natal drug exposure is often associated with other factors such as poor nutrition, poverty, stress, domestic violence, chaotic lifestyles and polysubstance use. Hence, claims that drug exposure during pregnancy has long term effects on child development are difficult to substantiate given the complexity of factors influencing early childhood development (Moe and Slinning 2002). In relation to pre-birth assessment, what this body of work highlights is that an understanding of substance use and the impact on the unborn child is significant but forms only part of the picture. What is of equal, if not greater, importance is early understanding and prediction of the impact of a wide range of post-birth factors which will or might influence the child's long term well-being.

In this context, developing knowledge surrounding fetal and early childhood brain development has much to add when considering the importance and underpinning knowledge base for pre-birth assessment where there are concerns for the long term wellbeing of the child. Growing medical knowledge of fetal development has also seen a greater understanding of brain development in the importance of the early stages of life on the long term health and wellbeing of children. Brain cells, known as neurons, grow before birth and, although some neurons continue to develop into adulthood, what babies have at birth is primarily what they have to work with as they develop (Shore, 1997). During the sixth to 18th week after conception the neurons are produced which, during the early weeks of gestation, develop points of communication known as synapses (Belsky and de Haan 2011). Belsky and de Haan considered parenting and children's brain development pre and post-birth and whilst they recognised research has tended to focus on maltreatment and not on 'normal' parenting they stated:

Unless one believes in magic, it is difficult to conclude on the basis of evidence available that parenting does not affect the developing brain in terms of either structure or function – or both. (Belsky and de Haan 2011 p 409).

Likewise, Ward and Glaser (2010) comment:

Certain pathways in the developing brain expect and await input signals before they 'wire' permanently. Serious psychological and emotional neglect, and failure of environmental stimulation during sensitive periods of development of these pathways, may lead to the lack of development of certain functions which may not be remediable later. (p165)

Belsky and de Haan (2011) regard brain structure and functions as 'chiselled' by parenting and that, although the brain is substantially shaped by genetic processes, interaction with the environment also impacts significantly. Pre-birth assessment must, therefore, focus on both the impact of, for example, the substance use by the mother on the fetus and on the likelihood

that post-birth care giving responses will be appropriate for physical and neurological development.

One area of post-birth context which has immense significance for pre-birth assessment is the importance of attachment for young babies and factors which may impact on a mother's ability to provide consistent care. Huth-Bocks *et al* (2004) undertook a study of two hundred and six women between the ages of 18 and 40, interviewing them during the last trimester of pregnancy and one year post-birth. Their findings were that mother's pre-natal representations of their baby and social support were significant in predicting infant-mother attachment patterns. Strathearn (2011) considered hormonal and chemical changes experienced by women during and after pregnancy and found that depletion of Oxytocin and Dopamine could occur in response to drug addiction, stress and post-natal depression. If untreated (medically and socially) the depletion of these chemicals could result in mothers not recognising their babies' emotional needs, in turn resulting in child neglect. Whilst the research by Huth-Bocks *et al* (2004) and Strathearn (2011) focus on the mother, Fahlberg (1991) and Ward *et al* (2006) have considered the importance of secure attachment for babies removed from their families at or shortly after birth highlighting the importance of secure and consistent foster placements in order to ensure good attachment behaviour in later life. What this whole body of research adds up to is recognition that not only should pre-birth assessment consider the impact of maternal actions on the fetus during pregnancy but also the importance of identifying the potential attachment patterns which may impact on brain and emotional development in the very early stages of life.

Recent findings from serious case reviews in England between April 2007 and March 2011 have highlighted shortcomings in the timeliness of pre-birth assessment and that there is a need for improved assessment and support for parenting capacity (Ofstead 2011). However, the question of what constitutes timely can be approached in various ways – for example, from the optimum point during gestation to safeguard the developing fetus or from the perspective of early enough in pregnancy to enable the mother and family to make changes. As has been indicated above, the human brain begins to develop at six weeks' gestation and is susceptible to the impact of substances such as alcohol. Nathaniels (1992) suggested the use of alcohol or tobacco may increase if women face added stress factors during pregnancy which in turn will increase health risks to the fetus. It seems reasonable to assume that when social workers are involved in coordinating an assessment to establish if a family poses a risk to a child this process will be a stressful experience, not least for the mother who may be (either in reality or based on her own perception) facing having a child removed from her at birth. Timely assessment from the perspective of fetal development would, therefore, need to draw on the growing knowledge and understanding of early brain development in order to minimise

the physiological impact on the unborn child while, at the same time, recognise the potentially negative impact on a mother's sense of well-being arising from professional intervention which, in turn, may increase fetal risk.

When considering timely from the perspective of providing optimum time change much can be drawn from literature relevant to the field of midwifery and maternal empowerment. Cahill (2001) considered the historical development of obstetric care and suggested that women's power during pregnancy and childbirth had been limited as a result of a patriarchal model of care provision which regarded women as passive in the process of childbirth. Since Cahill's seminal work the issue of maternal empowerment has been central to midwifery practice and as Leap (2009) comments, a number of midwifery professional colleges in western countries now have a core philosophy that affirms women's rights. In relation to pregnant women and involvement in choices about medical interventions to safeguard their own and their baby's health, Portela and Santarelli (2003) considered the impact of empowerment. What Portela and Santarelli recognised was that providing pregnant women and their families with the opportunity to explore information relevant to their individual medical situation enabled them to engage in exploration of appropriate solutions. Service user empowerment is an established feature of social work intervention and assessment and yet no literature or research has emerged which specifically considers how pre-birth assessment may support women in making lifestyle changes which may ultimately reduce the risk of harm to their baby.

In English law the unborn baby has no rights (this is discussed in greater detail in Chapter 4) but, from a developmental perspective, this distinction is not entirely helpful. At birth the supply of nutrients via the placenta ends and the baby's body begins to function totally independently of the mother. However, as scientific knowledge of pre-natal development has grown it has become evident that physiological development occurs along a continuum from the point of conception and is not something which simply begins at birth. Pre-birth assessment is, therefore, important within the context of child protection and promoting children's wellbeing in that early intervention pre-birth can support the process of maternal change as well as identify those children likely to be in need of intervention and support at birth.

2.5 A Review of assessment literature

Literature relevant to social work assessment is wide reaching and can be seen as a continuum ranging from the generic basis, approaches and techniques (the 'how to' assess) through to quite specific and focussed literature. Although there is a wide base to the assessment literature there is a relatively small sector specific to pre-birth assessment and, whilst I had a

notion of this prior to beginning the PhD, the process of searching for relevant literature highlighted this.

In order to begin the process of reviewing the literature I took the advice of my supervisors and entered into a wide-ranging search of numerous resources including the library, electronic databases and the Internet. With hindsight, my early searching was not particularly systematic but at that stage was no less useful because it allowed me to 'detach' myself from some of the key texts I clung to and relied upon in practice and I began to look at the wider context of assessment. Significantly, this stage also helped in the formulation of ideas that subsequently helped generate the research aim and questions.

Early searching helped identify how assessment literature is interlinked and interconnected with numerous other disciplines such as psychology, sociology and social policy. It also helped identify how choosing any one approach would have a significant impact on the research direction, methods and analysis as a whole. As interesting (and enjoyable) as this stage was, I then had to begin sorting out what would ultimately be the focus of the research and literature review. In doing so I made endless lists and entered into a process of mapping out and drawing figurative plans to outline areas of interest, interconnections, omissions and thoughts (to name but a few). Figure 2 provides an example of one figurative plan.

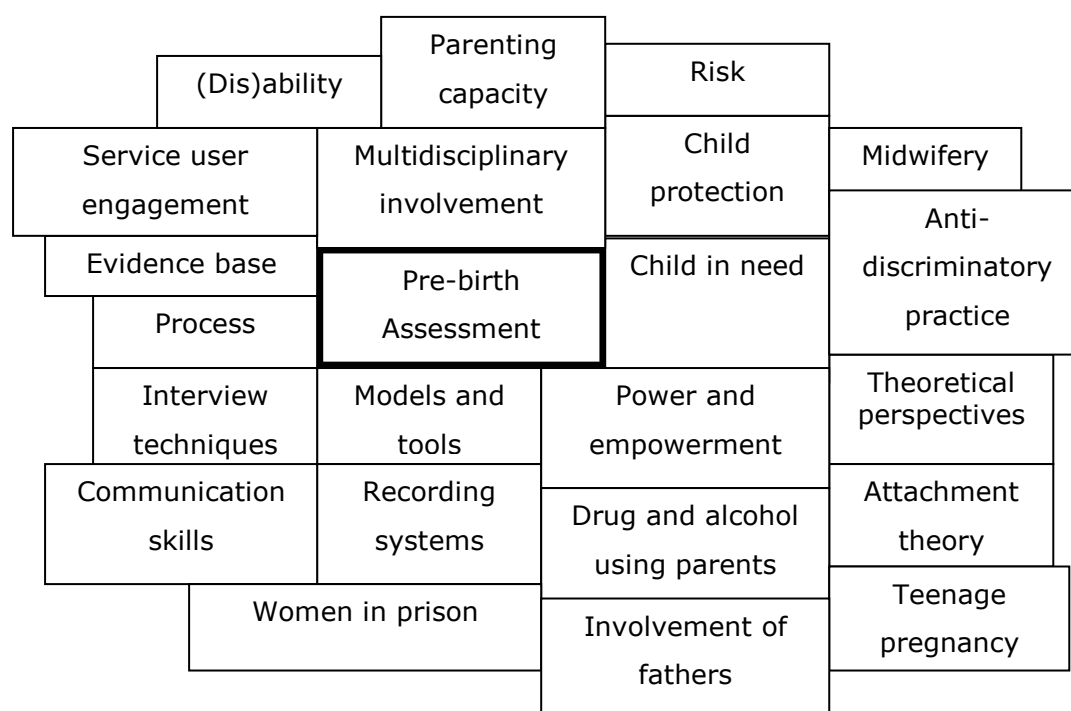


Figure 2

Figurative plan (example)

This process of mapping out highlighted key areas of interest that linked back to my practice experience of actually conducting assessments. I therefore chose to focus the literature review on assessments within the context of working with children in need and was aware that, even by opting to leave out many other relevant areas of literature, there would still be a vast body of work to draw upon. Having a focus enabled a more systematic search for literature to be undertaken. I initially began by searching the university library, the electronic library catalogue and electronic databases of journal articles using the broad search terms of 'social work' 'assessment' 'safeguarding children' and 'assessment frameworks'. These searches produced a wealth of research that was then narrowed down by selective reading of the abstracts to highlight those that appeared to be of greatest relevance. In conjunction with the searches for assessment literature I also undertook a more specific search for literature about pre-birth assessment. I will discuss the search process in more detail later in this chapter but what was most interesting at this stage was that whilst searches produced a wide body of literature relevant to the assessment of children, there was a very small body of literature relevant to pre-birth assessment.

2.5.1 Generic Assessment Literature: a starting point for social work assessments

The generic literature on assessment is aimed at social work practitioners involved in all aspects of practice and with all service user groups. What this body of literature provides is

discussion of some of the key elements of assessment practice and identifies some of the issues, approaches and models that underpin work with service users.

Milner and O'Byrne (2009), now in its third edition, consider issues such as power and anti-oppressive practice as well as the theoretical paradigms from which assessments may be approached. Parker and Bradley (2003) provide an overview aimed at student social workers to enable skill development for practice and, as such, focus on the general 'how to' aspects of assessment. Similarly, Beckett (2010) also aims at student social workers and uses case studies to highlight some key issues such as assessing need, judgement and risk.

The nature of the content of this generic literature, suggests there are certain key themes and ideas that 'should' form part of basic professional social work training and knowledge base, not least of which are promoting anti-oppressive practice and the empowerment of service users. In particular, the more generic literature highlights the inherent power imbalance between assessor and those being assessed, as well as the impact assessment has on decision making, planning and resource allocation, all within the context of an array of complex law, policy and procedures. Deconstructing the process of assessment highlights its complexity and so the generic literature does not attempt to detail the specifics of assessment work across different areas of practice. Instead, it highlights the vulnerability of service users and the importance of assessment practice that meets the needs of both the service user and agency. Thus it is perhaps not surprising that another set of literature has emerged which considers assessment from a range of theoretical perspectives and with reference to specific assessment issues and service user groups.

2.5.2 Research and literature focusing on assessment work with children and families.

As an explicit aspect of children and family social work practice assessment has a relatively short history and therefore the related body of research has an equally short history. Gough (1993) commented that the comprehensive 'Orange Book' assessment was an area of child protection intervention that received little research attention. Similarly, Holland (2004) suggested that whilst there was criticism of the 'Orange Book' this was most often based on theory or practice experience rather than research. However, whilst there may have been limited research attention focussed on the 'Orange Book' itself, this is not to suggest there was no research on assessment at all.

During the 1990s there was a growing body of literature and research that looked at social work approaches to assessment. White (1997), although not looking specifically at safeguarding children, argued that ethnographic research and social work assessment share

characteristics in relation to their methods of data gathering and analysis, but where social work assessment differs is that it forms the foundation of action. White concluded by suggesting that assessments should be rigorous and useful and should accept that it is not possible to form a simple assessment of reality when working with the complexity of human relations. Approaching the issue of complexity from a different angle, but arriving at a similar conclusion, Katz (1997) offered a critique of the 'Orange Book' guidance and found that whilst it provided a structure for assessment framework some practitioners were using it as a checklist, which was not the intended approach. Holland (2000) looked at 16 assessments undertaken using the 'Orange Book' guidance and found there was a high reliance upon verbal interactions and that major areas of evidence in the assessment centred on social workers' perceptions of service users' personalities and their levels of co-operation. In turn, Holland suggested that parents who conformed to a social worker's expectations were more likely to form a positive relationship with the social worker and that the relationship was central to the outcome of the assessment.

At the same time, research was also undertaken which considered the impact of social work interventions on families. The Department of Health (1995) studies found that investigations into child protection cases often had traumatic effects on the families subject to assessment and investigation. In one of the studies, Thoburn et al (1995) highlighted that child protection assessments focussed on risk rather than considering the child's needs as a whole and so it is perhaps not surprising that another study (Farmer and Owen 1995) found the process of assessment and investigation provoked anxiety for parents and children. Moreover, if risk was not found, this often led to no service at all being offered to families in which there were, nevertheless, children in need. As a result of these and other studies the late 1990s saw a shift toward a more holistic approach and consideration of children in need as well as children at risk.

As outlined earlier in this chapter, the development of a national assessment framework was announced in England in 1998 and emphasis was placed on timely assessment that distinguished between levels and types of need. The subsequent introduction of the *Assessment Framework (DH 2000)* marked a new era in assessment practice and generated a new field of research interest. Holland (2004) identified that research into assessment systems had often been retrospective and commented that, as with the 'Orange Book' in England, assessment systems in the United States were often introduced with no research into their effectiveness. The *Assessment Framework (DH 2000)* was somewhat different in this respect as it did attract research at the pilot stages of implementation.

Platt (2001) described a small-scale evaluation of the introduction of the Initial Assessment Process that forms part of the *Assessment Framework* (DH 2000). The evaluation involved quantitative examination of 47 cases from which a sample of 10 cases was selected and qualitative interviews with the social worker and main carer/parent were undertaken. The evaluation found that:

At the point of first contact, there was a sense that, for some families, a social worker knocking on the door was bad enough, irrespective of whether they were investigating alleged abuse or offering an assessment of the children's needs. (Platt, 2001, p139)

The evaluation also found, however, that there was scope for what Platt described as 'cautious optimism' about the more holistic and needs focussed assessment approach. Similarly, Corby *et al* (2002) interviewed 34 sets of parents and found that:

If used with skill and sensitivity, the framework helped create conditions which in some parents changed their attitude to social workers, as well as to their own strengths and difficulties as carers. (Corby *et al*, 2002, p13)

However, Platt (2001) also highlighted that the new Framework was being introduced at a time of a growing recruitment crisis in social work and the changes envisaged by government could not be dealt with without due consideration to management and resource issues in front line practice. Cleaver and Walker (2004) described a two-year study conducted in 24 English councils to evaluate the implementation of the *Assessment Framework* (DH 2000). Split into two phases the research looked in phase one at how councils implemented the Framework and in phase two at the impact. As with Platt's evaluation, Cleaver and Walker's research also commented on the major difficulties of recruitment and retention of social work staff along with organisational change and poor information technology facing most Local Authorities. At a practice level, however, Cleaver and Walker found the *Assessment Framework* (DH 2000) provided a foundation for strengthening the assessment process. Notably, parents said they had been involved and consulted, at all stages, about the assessment process.

The implementation of the *Assessment Framework* (DH 2000) brought with it guidance and specific assessment documentation and tools to assist social workers. Focussing on children's needs the documentation was split into age ranges to reflect the differing needs of children from birth to 18 with pre-birth being linked into the assessment documents relevant to children up to the age of one year. In addition to the guidance '*The Child's World. Assessing Children in Need*' (Horwath, ed, 2001) was published and contained chapters looking at some of the key research and practice issues relevant to the assessment of children in need. The second edition of '*The Child's World*' was published in 2010 to reflect updated research and

development and, as will be discussed later in this chapter, the 2001 and 2010 editions both contain a chapter specifically relating to pre-birth assessment.

Tools and guidance are only part of the picture when it comes to assessment and, as identified earlier, the complex nature of assessment cannot be understated. Most significantly the subjective nature of assessment cannot be ignored. Thus Horwath (2005) identified that whilst a pre-defined framework may serve to encourage consideration of certain factors, the social workers own subjectivity and the role of the team within which they practice will also influence their interaction with the child, family and other professionals. Horwath (2007) identified the influence personal, professional, and organisational factors may have on assessment and suggests that when using assessment frameworks and tools consideration should also be given to the 'practitioner's domain' (Horwath 2007 p 1299). Echoing Holland's findings (2004) discussed earlier, Platt (2007) highlighted how the social worker's perception of parental co-operation had a direct impact on judgements about the future. Platt (2007) considered the interaction between parents and social workers and found that the extent to which a social worker understood the family's situation affected the degree of co-operation the parents showed.

Yet, whilst the subjective nature of assessment is recognised in the research, it is somewhat at odds with political rhetoric and policy direction that place increasing emphasis on formal (and computerised) record keeping and standardisation of practice. As highlighted earlier in this chapter, the death of Victoria Climbié became national news during the period of time when the *Assessment Framework (DH 2000)* was being implemented. It can be argued that Lord Laming's enquiry (Cm 5730) and subsequent legislation and guidance have all served to promote the importance of formal process and prescribed record keeping. However, attempts to create such systems have the potential to neglect the complexity and subjectivity of social work.

In considering policy in Australia and a similar push there towards developing standardised (risk) assessment practice, Goddard *et al* (1999) commented on child protection assessment as follows:

It is complex, overwhelming, multi-disciplinary and multi-dimensional. Ethical, moral and emotional issues abound. In spite of this complexity, or perhaps because of it, we continually seek to discover simple solutions. (Goddard *et al*, 1999, p 254)

Stressing that thorough assessment is to be welcomed Goddard *et al*. commented that attempting to create tools that specify the areas workers should focus on might actually serve to increase the danger of poor assessment. The rationale for this assertion was that, as form

filling becomes routine, skill and discretion give way to reliance on categorising similarities in behaviour as opposed to understanding an individual family and its circumstances. The views of Goddard *et al* (1999) have interesting resonance with more recent research in England by Crisp *et al* (2007) who compared four different assessment frameworks, including the *Assessment Framework* (DH 2000). They found that implicit within the frameworks considered was an assumption that the assessors were skilled and able to articulate their reasoning and actions. However, if used by inexperienced practitioners or used as a mechanistic checklist the assessment tool's potential to contribute to effective practice was significantly limited and so the need for training and supervisory support was important.

Broadhurst *et al* (2009) specifically considered the Initial Assessment stage from the *Assessment Framework* (DH 2000). Undertaking a multi-site ethnographic study of five Local Authorities in England and Wales which looked at the practice in 15 social work duty and assessment teams, Broadhurst *et al* produced some concerning data in relation to the impact of standardised assessment documents. Their research highlighted how performance management in the public sector and the Integrated Children's System (ICS) constrained workers to follow certain steps in a formally defined model of the assessment process. Whilst the performance management mechanisms were initially designed to enhance rather than inhibit assessment practice Broadhurst *et al* found workers were prompted to gather information in a systematic way but the computerised systems, when used in busy teams, meant the pressure to maintain the workflow overtook the demands of supporting families. The findings were that teams devised deflection strategies to assist with the management of the volume of referrals such as sending the referral back to the referrer to ask for more information or responding to domestic violence referrals with a standard letter. Whilst the research identified that in some circumstances such responses may be appropriate, the volume and workflow pressures resulted in professionals responding without reflecting on the potential impact of their responses (Broadhurst *et al* 2009).

The assessment literature highlights the complexity of the task as well as the importance of ensuring practitioners are skilled, not only in how they work with families but also in how they make use of the assessment tools available to them. Horwath (2007) highlighted the importance of recognising that assessment is a technical process that draws on research, theory and experience as well as a process that draws on the practitioner's feelings and values. The development of tools to assist practitioners is a significant development but it is important to note the development has occurred in regard to assessing parents and children. Barlow and Scott (2010) examined research findings in relation to the use of initial and core assessments and concluded that the importance of pregnancy and early years in terms of later

wellbeing was little recognised and with this I now move to consider the literature specific to pre-birth assessment.

2.6 A review of the specific pre-birth assessment literature

Whilst there is a wide body of literature relating to assessment in social work there is a very limited body of literature relevant to pre-birth assessment in social work. When in practice as a social worker and manager I frequently made use of two books each containing a chapter on pre-birth assessment, these being: *'Assessment Prior to Birth'* (Hart 2001) and *'Unborn Children: A Framework for Assessment and Intervention'* (Calder 2003). These two chapters 'served me well' but I could not help thinking that there must be much more out there and it was only by virtue of not having had time to search that I had not located them. My subsequent literature review highlighted that my reliance on two chapters as a social work practitioner was not due to my lack of searching skills but as a direct result of there being a gap in the literature.

2.6.1 The process of searching specifically for pre-birth assessment literature

As identified earlier in this chapter, the initial stages of the literature review involved a wide ranging search of all areas I felt relevant and interesting. The wide ranging review did not generate any specific pre-birth assessment references and so I then began by looking at the reference lists of Hart (2001) and Calder (2003). This revealed that whilst both Hart and Calder drew on a range of literature relevant to assessment a publication *'Pre-birth Risk Assessment in Child Protection'* (Corner, 1997) was the only reference (common to both authors) that was of specific relevance. Searching the reference list of Calder's chapter (2003) highlighted several journal articles, also by Calder, looking at various aspects of assessment and by accessing them and again, searching their reference lists, was able to track down a journal article entitled *'Toward a Framework for Conducting Pre-Birth Risk Assessments'* Calder (2000). When I accessed the article, however, I found much similarity between Calder (2000) and Calder (2003). Searching the reference list in the chapter by Hart (2001) highlighted a journal article by Barker (1997), which, although not specifically about pre-birth assessment, raised legal and procedural issues relating to child protection procedures and unborn children.

Faced with only four references specifically dealing with pre-birth assessment and one reference relevant to pre-birth child protection procedures, I then began detailed library searches in order to uncover further sources. Using the Metalib search facility for data bases 'ebrary' 'Electronic Journals Service (EBSCO)' and 'Social Services Abstracts' I initially began

searching using the key words '*prebirth assessment*' which brought up numerous references. However, the references identified in the searches related to assessments linked to health (health of both the mother and the fetus) rather than relating to assessments undertaken by social workers involved in assessing children in need and their families. Adding the key word '*welfare*' to the search narrowed this down to 2 references but for these references the search had highlighted the word '*birth*' and, when accessed, both references in fact related to the physical welfare of the child at birth in relation to health needs.

Manipulating the search fields by hyphenating '*pre-birth*' resulted in no references being identified. Widening the search of other databases available on Metalib, searching the University of Huddersfield's electronic library catalogue and using key words *unborn, social work, risk, child in need, child protection and safeguarding* resulted in references linked to pre-natal health, assessment in general (post birth) and safeguarding and child protection (post birth). However, I was unable to locate any other literature specific to pre-birth assessment as it relates to the context of my study.

The only additional piece of research-based literature specifically related to pre-birth assessment was found during the final stages of my thesis when, in the process of revisiting the literature, I accessed the second edition of '*The Child's World*' (Horwath 2010) which contained Hart's (2010) revised chapter on '*Assessment Before Birth*' in which Hart refers to her unpublished PhD thesis entitled '*The Contested Subject: Child Protection Assessment Before Birth*' (2003, unpublished). This was the first time I was aware of Hart's thesis and so it was read after I had completed my data gathering and much of my analysis.

With the exception of Hart (2001 and 2010), who provided some guidance on applying the Assessment Framework (DH 2000) to unborn children, the literature found did not directly reflect the legal and procedural guidance relevant to practice today. The changes in political context, the enquiry into the death of Victoria Climbié (Cm 5730, 2003), the introduction of the Children Act 2004 and of *Working Together* (DH 2006) have all impacted on practice in child care services since. It must, therefore, be remembered that whilst the literature specific to pre-birth assessment has relevance in terms of some of the issues raised, in general, it reflects a different socio-political context of social work intervention.

2.6.2 The research base of the pre-birth assessment literature

Not all of the pre-birth assessment literature is based on the findings from empirical research. Calder (2000 and 2003) described a pre-birth assessment framework, devised by a multi-agency working group in Salford, which will be described shortly, but did not indicate whether

this was devised as a result of research. Barker (1997) drew on research and statistics relevant to child protection in order to explore legal, policy and practice issues but he did not conduct his own research specifically about unborn children. Corner (1997) and Hart (2003, unpublished thesis), on the other hand, were based on small-scale studies that employed different research methods and focussed on pre-birth assessment where professionals had identified risks to the unborn child.

Corner (1997) undertook a study using both qualitative and quantitative methods of data collection and looked specifically at pre-birth risk assessments. In his research, Corner conducted a small-scale survey of five NSPCC projects and explored pre-birth risk assessment practice and compared the differences between pre and post-birth assessments. He looked at data generated from a total 11 pre-birth risk assessments and from these selected one family to interview about the assessment experience. He also interviewed the professionals who had attended the child protection review conference at which the family's circumstances had been discussed. This piece of research is the only research, to date, that seeks a parental perspective of pre-birth assessment.

Corner concluded his research account by noting several themes and issues which have specific relevance to child protection practice (as opposed to working with children in need), not least of which is the need for a model of pre-birth risk assessment that helps guide practitioners in making complex decisions. Calder does then go on to provide a pre-birth assessment model that highlights factors to consider (see figure 3 for the categories Calder highlights) but stresses the importance of using the model as a guide and not applying it rigidly. Another key theme identified by Corner was the importance of establishing a working relationship with parents that was based on mutual respect and trust. Corner suggests pre-birth assessment should be undertaken in the early stages of pregnancy to enable parents to show those involved in the child protection plan that they have changed as well as providing the opportunity to demonstrate they have formed an attachment with the baby. In cases where the assessment results in a plan to remove the baby then early assessment can also allow time for professionals to develop support plans for the baby and undertake grief work with the parents.

In a similar vein to Corner (1997), Hart (2003, unpublished thesis) looked specifically at pre-birth assessment in relation to child protection, collecting data from a sample of all children under the age of one year who were the subject of a pre-birth child protection conference in one department over the period 1st April 1993 to 31st March 1994. 31 cases met Hart's research criteria although, for reasons of consent and access, 26 of these cases only were finally selected for a documentary analysis of case files and child protection conference

reports. Hart's data collection efforts pre-dated the introduction of the *Framework for the Assessment of Children in Need and Their Families* (DH 2000) and so the assessments she considered had been completed using '*Protecting Children. A Guide for Social Workers Undertaking a Comprehensive Assessment*' (Department of Health 1988), the '*orange book*'. Hart found pre-birth assessments to be tentative in nature, with a tendency to postpone decision making until after the child was born, despite the vulnerabilities of the babies. Like Corner (1997), Hart commented on the complexities of conducting a pre-birth assessment both in relation to engaging with the parents as well as analysing the information gathered, and she also linked this to lack of clear procedural pre-birth guidance:

This study demonstrates that pre-birth assessment would be a daunting task for practitioners in any circumstances but the challenge is compounded by lack of a clear mandate. (Hart 2003, P189 unpublished thesis)

2.6.3 Pre-birth assessment literature and what it says about the rights of the mother

The pre-birth assessment literature as a whole had several key themes in common, not least of which is the important issue surrounding the rights of the mother and the lack of rights of the unborn child.

Hart (2001) identified the overarching rights of the mother and made the following statement:

A pregnant woman is not a human incubator, but retains autonomy over her own body and as a consequence that of her baby' (Hart 2001, p237).

Similarly Corner (1997) pointed out:

In pre-birth risk assessment practice the primary user is the unborn child. This poses considerable ethical problems, particularly as the expectant parents are involuntary service users participating in a process which it is assumed they would much prefer to avoid. (Corner, 1997 p16)

Whilst Corner's statement is not only about maternal rights but more about parents having the option not to take part in a pre-birth assessment both of the above quotes identify a key issue in relation to the difference between pre and post birth assessment, namely that maternal rights cannot be ignored. Barker (1997) took this discussion a stage further in relation to the rights of the father:

Whilst a mother has some rights over the foetus, in law, it would appear that the father, whether married or not to the mother, has no rights over the foetus. (Barker 1997, p222)

Barker pointed out that what this equates to in practice is that whilst authorities may choose to involve the putative father in actions concerning the unborn child the father does not have any right to be consulted, even if married to the mother.

The rights of the mother not to be treated as '*a human incubator*' can also be seen in relation to debate about the stage at which a pre-birth assessment might be undertaken. Calder (2000 and 2003), like Corner (1997) highlighted the importance of conducting an assessment in the early stages of pregnancy as this affords parents the opportunity to implement changes to ultimately support the child. However, Calder (2000 and 2003) also commented on the potential outcome of intervention in the very early stages of pregnancy:

However, there do remain powerful ethical arguments against early intervention, not least of which centres on the possible impact of such interventions on the considerations by the mother about seeking a termination of the pregnancy (Calder, 2003 p362)

Barker (1997) also pointed out the possibility of a mother choosing a termination as a result of early intervention but stopped short of developing this argument in relation to the impact on the father.

2.6.4 Pre-birth assessment literature and guidance models

Calder (2000 and 2003), Corner (1997) and Hart (2001 and 2010) all provided practice suggestions in relation to completing pre-birth assessments. These suggestions focused on ensuring a wide range of information was gathered in relation to the child and on the use of assessment tools or models to assist in this process. Corner's research (1997) considered pre-birth risk assessments only in circumstances when one or more of the parents had committed abuse of a previous child and he produced, therefore, a risk-based model of intervention. Calder (2000 and 2003) described a holistic framework devised by an inter-agency working group in Salford that offered practical pointers to issues to consider when conducting a pre-birth assessment. Hart (2001 and 2010) considered the use of the *Assessment Framework* (DH 2000) in relation to pre-birth assessment, identifying particular factors for professionals to consider such as the family history and characteristics of the parents. In doing so Hart highlighted that '*by definition pre-birth assessment is triggered by the characteristics of the parents*' (Hart 2010, p230). This is perhaps somewhat different to post-birth assessment which may also be triggered by observations of the child and actions or omissions in the care of a child which may impact negatively on the child's physical care and emotional well-being.

The assessment models discussed by Corner (1997), Calder (2000 and 2003) and Hart (2001 and 2010) are compared in figure 3. In comparing the three pre-birth assessment models it is

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possible to see that all three highlight family history as especially important. Calder and Corner's models also differed from the *Framework for the Assessment of Children in Need and Their Families* (DH 2000) as they identified 'plans for the future' as something to specifically consider. Whilst Hart (2001 and 2010) identified how to make use of the *Assessment Framework* (DH 2000) and highlighted the importance of engagement with parents and multi-agency working. All three authors indicated that material take up of antenatal care was an important indicator of future care for the baby, although take up of antenatal care is not explicit in the domains of *Assessment Framework* (DH 2000).

Analysis of the three models and their 'usefulness' from a practice perspective could be debated further but it is worth reiterating that these models were based on research into pre-birth assessment in an era pre-dating the *Assessment Framework* (DH,2000). On the other hand, whilst the *Assessment Framework* (DH 2000) was informed by research, policy and practice (see Horwath 2010) this research focussed on children and did not take into account some of the unique issues pertinent to assessing unborn children, or perhaps more specifically, pregnant women.

Pre-Birth Risk Assessment in Child Protection Corner 1997	Unborn Children: A Framework for Assessment and Intervention Calder 2000 and 2003	The Framework For The Assessment of Children in Need and Their Families Department of Health 2000 as it relates to pre-birth assessment discussed in Hart (2001 and 2010)
<p>1) Previous abuse</p> <ul style="list-style-type: none"> • The category and level of abuse • The explanation of the abuse • The acceptance of responsibility • The parents' views of the abuse • The parents' concern/understanding for the abused child <p>2) The unborn child</p> <ul style="list-style-type: none"> • The parent's individual/separate view of the unborn child • Ante-natal care • Plans for the future <p>3) The parental relationship and family support</p> <ul style="list-style-type: none"> • Parental relationship and their individual physical, intellectual and emotional abilities. • The effect of the baby on the parental relationship • The parents' co-operation with professionals • Extended family support and understanding 	<ol style="list-style-type: none"> 1) Definition of the problem 2) Antenatal care 3) Full social history 4) Current family structure, extended family and potential support The parental relationship 5) Family functioning and strengths 6) Previous abuse and convictions 7) Family attitudes towards previous action/ professional involvement and ability to engage them in current intervention process. 8) Assessment of non-abusing parent's ability to protect 9) Understanding of expected baby's needs and ability to meet them 10) Future Plans 11) Alcohol or drug using parents and anticipated health problems 12) Measuring family's potential for, and motivation to, change 13) Determining the way forward 	<p>1) Parenting capacity</p> <ul style="list-style-type: none"> • Ensuring Safety • Emotional Warmth • Stimulation • Guidance and Boundaries • Stability <p>2) Family and environmental factors</p> <ul style="list-style-type: none"> • Family History and Functioning • Wider Family • Housing • Employment • Income • Family's Social Integration • Community Resources <p>3) Child's developmental needs</p> <ul style="list-style-type: none"> • Health • Education • Emotional and Behavioural Development • Identity • Family and Social Relationships • Social Presentation • Selfcare Skills

Figure 3 – A comparison of three pre-birth assessment models

2.7 Conclusion

What this chapter has highlighted is how history has shaped practice in assessment work with children and families today. Practice, which focussed initially on child protection, has been shaped by policy and responses to professional interventions that have, at times, been condemned as not preventing child deaths and, at others, has been regarded as over intrusive. In turn this has resulted in the current practice context and a procedural framework that seeks to encompass the wider concept of working with children in need and early intervention. Although assessment has been an implicit aspect of professional intervention when working within the realm of both child protection and children in need, it is an aspect of intervention that has received much more explicit research attention in more recent years.

Despite the relatively short history of research into assessment there is now a reasonable body of research and literature upon which to draw. The chapter has focussed on literature that looks at the assessment of children in need as well as then focussing specifically on pre-birth assessment. What this has demonstrated is that any assessment relevant to children in need is complex and requires practitioners to have a comprehensive skill and knowledge base. Even when assessment tools and frameworks are available less tangible factors such as team dynamics, the relationship between the professional and the parent and professional perceptions will all serve to influence the assessment process and outcomes. These factors are potentially further compounded in the process of pre-birth assessment as maternal rights mean there is no clear mandate for intervention. Assessment processes have evolved within the context of a focus on children and, apart from two small-scale research projects undertaken by Corner (1997) and Hart (2002 unpublished) there has been no consideration of the applicability of the existing processes to the unborn child.

Chapter 3

Methodological Issues: Research Planning and Design

3.1 Introduction

Working as a social worker and then team manager for a Local Authority (LA) had equipped me with first-hand experience of conducting and supervising pre-birth assessments. It was this experience that sparked my research interest and prompted me to undertake my full time PhD research. This chapter outlines the methodological journey from my original interest through the process of designing the research to the final research design.

In the early stages the research design took place alongside the literature review and early reading about the legal and procedural framework and this reading and my practice knowledge of the assessment of children shaped the initial design. What became apparent as I developed my knowledge base and began the research process was that some of my original ideas were not totally practical in research practice. This chapter will, therefore, also indicate some of the problems encountered along the way and hence the revisions made.

3.2 The research aim and questions

The research began with a very broad aim of studying pre-birth assessments and so it was important to refine a wide area of interest down into a clear research aim. There were several stages in the process of refining the original research proposal, the first of which involved clarifying what aspect of pre-birth assessment I wanted to consider.

As indicated in Chapter 2, the early stages of the literature review played an important role in the development of the research as a whole by allowing me the opportunity to broaden my thinking which, in turn, facilitated consideration of the more specific aspects of pre-birth assessment. Interlinked with the literature review was the process of supervision, which enabled discussion and prompted my early writing, particularly in relation to thinking about the definition of pre-birth assessment. It became apparent that, in its widest definition, the term 'pre-birth assessment' could include absolutely any assessment of a pregnant woman, as such it could encompass the activity of health professionals in the maternity services, prison officers

allocating places in mother and baby units and education staff providing academic support to pregnant teenagers (to name but a few). From my practice experience, the literature review and supervision it became apparent that what I was particularly interested in was those situations where someone had felt it necessary to make a referral to a LA children's service department. In particular I was interested in the process and how social workers approached pre-birth assessment. For the purpose of the research, I arrived at a working definition of pre-birth assessment as:

The assessment activity social workers undertake following a referral to a Local Authority children's services department about an unborn child.

My early exploration of the topic also highlighted that pre-birth assessment is a subject area that had received very limited attention and the preliminary literature search revealed only four directly relevant references, Calder (2000 and 2003) Corner (1997) and Hart (2001). Given the gap in the literature it seemed appropriate to conduct an exploratory study because, as Robson states, the purpose of an exploratory study is to '*find out what is happening, particularly in little understood situations*' (Robson 2002, p 59). My intention was to conduct research that would form a base line of understanding about how LA social work staff approached pre-birth assessment. The overall aim of the study was therefore set as:

To explore what is currently known about pre-birth assessment within the context of Local Authority social work practice.

Having identified the overall aim for the study more specific research questions were devised. In writing about quantitative research Neuman (1997) points out that a narrowly defined question is needed before designing a research project whilst Rugg and Petre (2007) identify that research is about answering questions but that, as a starting point, you need to have an answerable question. In relation to qualitative research Flick (2004) states that a decisive factor in the research design, and subsequent success or failure, is formulation of the research question(s). Given the importance of the research question(s), time was spent considering what I actually wanted to ask (and answer) and also in ensuring my questions met the criteria for good research questions, that is, being '*clear*', '*specific*', '*answerable*', '*interconnected*' and '*substantively relevant*' (Robson 2002, P59). However, the process of devising the questions was not as linear as this chapter might suggest. The actual process was interlinked with the process of working out the research aim and undertaking the preliminary review of the literature. Devising the research questions involved a great deal of thinking and re-thinking to ensure they reflected the research aim and, after much supervisory discussion, the following questions were formulated:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

ii) What are Local Authority processes in relation to pre-birth assessment?

iii) What are social workers' views about pre-birth assessment?

iv) How do social workers approach the task of pre-birth assessment?

The research questions were devised to capture both the national and local context and were intended to ensure my research was 'do-able' and had an interconnectedness that would underpin the ultimate validity of the study. In setting the overall aim and research questions, it was not my intention to offer, for example, comparisons of pre and post birth assessment work, nor to consider what constituted 'good' practice. Whilst these are areas of interest (and may form the basis of future study), what I planned to undertake was an exploratory study to begin to understand what comprises pre-birth assessment work by social workers in a largely un-researched area.

3.3 Theoretical and methodological underpinning

I approached this study with the assumption (politically and professionally derived) that state intervention is 'necessary' in some families' lives and that professionals can identify the point at which a child is, or is not, in 'need' of support or intervention. In my practice and for the purpose of this research the notion of 'in need' is defined by the Children Act 1989 section 17 as:

- a) He is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
 - b) His health or development is likely to be significantly impaired, or further impaired, without the provision of for him of such services; or
 - c) He is disabled
- (Children Act 1989, s17(10))

My overall personal 'theoretical bias' is toward constructionism and therefore I regard notions and terminology surrounding 'children in need' as socially constructed. As Burr (2003) suggests, there are numerous constructions of the world, each of which will result in different action. Lock and Strong (2010) in their explanation of social constructionism write:

'Social Constructionism'. This is the claim that we are not just individually encapsulated information processors, but are inherently social beings who go through a remarkable process of becoming enculturated adults and experience the world in all its glories and disappointments: simply put, we are humans who are constructed through our inherent immersion in a shared experiential world with other people. (Lock and Strong, 2010. p5)

From a constructionist stance I therefore approached the study from a perception that policy, procedures, team dynamics and individual attitudes would all impact on the process of assessment by shaping how front line social workers constructed notions of 'child in need'. The initial stages of the literature review had also begun to identify that variable factors such as team dynamics and personal perceptions could impact on assessment outcomes and decisions ultimately shaping the assessment process as a whole (Holland 2000; Horwath, 2005 and 2007). However, I did not choose to undertake the study from a purely constructionist perspective as I felt this would, potentially, have taken my research into a theoretical paradigm which explored the social construction of the fetus, childhood, and motherhood rather than the process of assessment. Instead I chose to approach the study from the perspective of street level bureaucracy.

3.3.1 Street level bureaucracy

In his writing on American society in the 1970s, Lipsky (1980) described public service workers who, as part of their role, meet directly with the public in the process of delivering services as '*street-level bureaucrats*'. Occupying a critical position in the delivery of front line services Lipsky stated:

Although they are normally regarded as low-level employees, the actions of most public service workers actually constitutes the services "delivered" by government. Moreover, when taken together the individual decisions of these workers become, or add up to, agency policy. (Lipsky, 1980 p3).

Thinking about the research aim and questions as a whole, the point at which a legal, policy or procedural document was actually implemented by a social worker seemed central to the notion of what a pre-birth assessment was. Social workers' decisions becoming, or adding up to the agency policy, had resonance with my practice experience of managing pre-birth assessments without ever feeling there was 'sufficient' guidance to assist in the task.

As I began to undertake the literature review, the notion of street level bureaucracy also seemed relevant in relation to issues such as professional culture and social work decision-making. Given that the literature review had identified that pre-birth assessment, particularly within the context of the *Assessment Framework* (DH 2000), represented a gap in the body of

knowledge and research into assessment practice I began to wonder about the professional knowledge base upon which social workers were approaching their practice.

In relation to public employees and street level bureaucracy Hjörne *et al.* (2010) comment:

They meet the citizens face-to-face as a routine part of their job, and they participate in institutional decision making and what services to provide and how to respond to the issue. Because of these face-to-face routines, street-level workers are the only actors who have access to both institutional rules and procedures and to the clients' experiences, needs and demands. (Hjörne *et al.* 2010 p303).

Having access to information about the unborn child and the family and then implementing plans within the context of national and agency policy and procedure, I thought it interesting that social workers were engaged in this process without, apparently, any significant research base with which to underpin their actions. For example, in thinking about my practice experience, I was aware of the assessment time frames of seven working days for an initial assessment and 35 working days for a more in depth core assessment as imposed by the *Assessment Framework* (DH 2000). I was also aware of the implementation of the Integrated Children's System as a means of ensuring accountability and managerial processes focused on performance indicators. This led me to question how the imposition of time frames that sought to ensure timely assessment of children in need could be applied pre-birth. In particular how did they 'fit' with the nine-month duration of a pregnancy that may not end on the actual given expected date of delivery?

Westell *et al* (2009) reviewed the debate surrounding regulatory practice introduced by government and the potential for regulation to reduce the ability of street level bureaucrats to act autonomously. Wastell *et al* (2009) identified that, on the one hand, more rules and guidelines may generate more need for interpretation but, on the other hand they may control employees to such an extent that they lose the benefits of professional autonomy. Whilst the purpose of my study was not to consider the degree of autonomy experienced by social workers undertaking pre-birth assessment, the impact of autonomy was a factor that could not be ignored by virtue of the significance I felt it had. As Lipsky (1980) points out, discretion is a main characteristic of street level bureaucrats' jobs because they often work in situations that are too complicated to reduce to simple explanations and/or solutions. As the review of the literature had identified, pre-birth assessment, as in other social work assessment work, is complex activity and so social workers are required to use discretion as they function at the interface between the procedural world and practice realities. This, in turn, places them in the position of having to make potentially life-changing decisions about a mother and her baby by interpreting information from a range of sources and applying this information within a procedurally-led framework of assessment. To paraphrase Lipsky (1980) I was interested to

explore the actions of social workers in delivering pre-birth assessments to service users and how these added up, in effect, to agency policy.

3.4 Research methods

Thinking about social work practice within the theoretical framework of street level bureaucracy strongly influenced the methodological approach adopted in the research. Given that the study was to be exploratory in nature I adopted a research strategy that allowed for flexibility. In an exploratory study a flexible design allows for adapting the approach in response to the data collected and making changes if necessary (Robson 2002). It also allows for the use of quantitative and qualitative methods, which, as Denscombe (2007) suggests, can lead to the development of a fuller picture and increased opportunity for triangulation of the data. Had I chosen to adopt a purely constructionist perspective, triangulation would have been an issue to debate, perhaps in some depth, as Gibbs (2007) points out that a constructionist perspective suggests triangulation of data is not possible because each piece of research is its own interpretation. However, notwithstanding my sympathy toward constructionist perspectives, the research was approached from a Lipskyan perspective which meant that data triangulation could add value to my research efforts. As Peräkylä (2004) highlights, validity and reliability are important in order to ensure the study has credibility, therefore by considering pre-birth assessment from more than one viewpoint I sought to increase the opportunity for triangulation and in turn, increase the possibility of demonstrating the value of the findings.

In the same way the development of the research questions was not a linear process, deciding on the methods was equally not simple and straightforward. The process of making the final choice of research methods was totally interwoven with consideration of factors such as views and ideas emerging from the literature review, my practice experience, my previous masters' level research experience, my chosen theoretical perspective and constraints of time and resources. Thus, thinking about ways of addressing the research aim and questions, and bearing in mind all these factors, three kinds of research methods were eventually employed: documentary analysis of a range of public and agency documents, an audit of all pre-birth assessments in one LA area and in-depth analysis of a sample of pre-birth assessment cases in the same LA, including semi-structured interviews with the case-holding social workers.

3.4.1 Quantitative and qualitative data

Both quantitative and qualitative data were collected in the process of the research, with some stages involving the collection of more quantitative data than others. However, there was no specific phase of the research that was either purely quantitative or purely qualitative. As Blanaves and Caputi (2001) argue, the 'seal' between qualitative and quantitative methods is not a watertight one; in other words, it is not always possible to make a very clear-cut distinction between them.

The quantitative methods used in this study were relatively simple in that they involved measuring, for example, the space devoted to a discussion of pre-birth assessment work in various documents and the numbers of pre-birth assessment referrals in a six-month audit. Computerised methods of data collection and analysis were not needed, given the volume of material to be reviewed, instead relatively straightforward data collection tools (described shortly) were devised, with results being presented with the aid of simple descriptive statistics.

However, when the content of documents were explored, when the kinds and characteristics of pre-birth assessment referrals were distilled and when particular cases were analysed in depth and social workers interviewed much more qualitative data were collected. At one stage it was hoped that even the small sample of pre-birth assessment cases might lend themselves to some more standardised analysis but, for reasons which will be outlined, this proved not to be possible.

3.4.2 Documentary analysis

The definition of a document is extremely wide reaching and can include almost anything such as diaries, memos, books, pictures and so on (McCulloch 2004). Documentary analysis, therefore, can include consideration of any form of document and can be approached from numerous different angles drawing on a range of analytical perspectives and techniques. Examples such as linguistic analysis, discourse analysis and audit are all applicable approaches in conducting documentary analysis (Morgan 2000) but the fundamental aim is an understanding of the document's purpose, content and structure.

Documents are not static, one-dimensional objects. They are inherently linked to the purpose of their production and, as Prior states:

... the birth and life of documents rests on the foundations of a collective rather than an individual action. (Prior 2003. P 10).

Not only is the purpose of the production important but the importance, meaning and significance of a document is inherently linked to the rationale behind the production of the document and its subsequent use (Prior 2003). Flick (2009) suggests documents should always be regarded as a means of communication and it is important for the researcher to ask who produced the document, for what purpose and for whom. Prior (2004) suggests that often documents are used in research because of the content they contain, which is of course a valid use, but they can provide much more. Documents are dynamic objects and the manner in which they are created, used, manipulated are all 'qualities' worthy of analysis (Prior, 2004).

The documents used in my research can be broadly defined as national documents, local authority area documents and case specific documents. The differentiation is significant because their rationale, use and the information they communicate all impact on the process of pre-birth assessment. National documents are produced by government departments for use by all agencies and individuals in England working with children. Local documents are designed for use by agencies and professionals in a given area and as such may reflect particular needs of the local population. Case specific documents are produced to provide a record of what has happened during the course of agency intervention in an individual family's life.

Based again on my practice experience, I had anticipated being able to access some, if not all, of the national and local documents online. As McCulloch (2004) points out, online access is an efficient method for a researcher to access documents in terms of saving time. This proved to be the case and, in terms of my research methods, they also provided the opportunity to consider qualitative aspects of the documents as well as the quantifiable aspects.

Documents form an integral part of assessment practice and the documents relevant to my research have an interconnectedness, which makes it difficult to consider one without considering the others. May writes:

There are a wide variety of documentary sources at our disposal for social research. Documents, as the sedimentations of social practices, have the potential to inform and structure decisions which people make on a daily and longer term basis; they also constitute particular readings of social events. (May 1997, p 157)

In my research area, laws and national guidance are closely linked to local guidance that, in turn, is linked to front line practice with individuals. Documents are available for use at each stage of the process of pre-birth assessment with local guidance aiming to inform and structure decisions and providing a 'reading' of national perspectives for assessing children. By looking at the various tiers of guidance, starting with national guidance, documents provide

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the opportunity to explore where pre-birth assessment fits into the English legislative, procedural and practice framework (research question i) and the guidance given in relation to LA processes (research question ii).

At a case specific level, work with individuals is often recorded in files that are a product of the practical need to keep a record of what happened, when and what decisions were made and interventions delivered. Case files may contain any number of documents but what is recorded will be shaped by national and local guidance and also by variable factors such as professional approaches, practitioner skill levels, custom and practice and organisational constraints (for example time, access to computers and staffing levels). Documentary analysis of case files would provide, therefore, the opportunity to also consider social workers' approaches to pre-birth assessment (research question iv).

Another reason for choosing documentary analysis is that it provides the opportunity to explore what happens in practice in an unobtrusive manner, rather than just have this information presented from the perspective of the person or agency who has produced the document. When considering the implementation of policy and procedures as well as how social workers approach pre-birth assessment documentary analysis provides a specific advantage. As Robson states:

Instead of directly observing, or interviewing, or asking someone to fill in a questionnaire for the purpose of our enquiry, we are dealing with something produced for some other purpose. (Robson, 2002, p349)

Combining documentary analysis of national documents through to case specific documents allows for researcher observation of how the documents and guidance fit within the national legislative and procedural framework and then to observe how they are then used in practice. Assessment documents, for example can be analysed both in terms of the wider national guidance but also in terms of what, and how often, information is then recorded. How many assessments are undertaken and the content of the assessment documents can be used to explore how they shape and inform the planning and decision making process for individual families. From a Lipskyan perspective they can also be analysed in relation to what they show about how social workers interpret and shape the delivery and evolution of pre-birth assessment policy and practice.

3.4.3 Audit of pre-birth assessment referrals over a six month period

Based on my existing knowledge from practice as a social work manager (and therefore responsible for collating my team's statistics in relation to child protection and assessment

activity) I was aware that national data was not being gathered in relation to pre-birth assessment work in terms of, for example, numbers and kinds of referrals and outcomes. Thus, it seemed to me essential for the purposes of my research aim and questions, to develop such a picture by collecting quantitative and qualitative data about pre-birth assessments referrals over a given period, in one LA.

Such studies can provide a very useful although limited (in terms of depth of data) overview of an activity about which little is known. I expected that such research would provide an illuminating context to my subsequent work to analyse a small sample of cases in more depth and would be an essential aid in selecting as representative range of such cases as possible.

3.4.4 Semi-structured interviews

The primary reason for choosing interviews as a medium for gathering data was to ensure those responsible for leading and completing pre-birth assessments were given the opportunity to talk about what they did, why and how. Interviews yield rich insights into people's experiences, opinions, aspirations, attitudes and feelings (May 1997) and, for the purpose of my research, provided another dimension to data.

Semi-structured interviews utilise techniques from both structured and focussed methods of interviewing (May 1997). The semi-structured interview has pre-determined questions but the question order and phrasing can be changed based upon the interviewer's perception of what seems more appropriate (Robson 2002). Perhaps reflecting my own inexperience as a researcher, the prospect of having some pre-determined questions around which to 'organise' the interview felt comfortable. I have considerable experience of conducting a range of different types of interviews, from job interviews to assisting the police in interviewing child victims of crimes. However, I felt very conscious of having limited experience of research interviewing and felt adopting a semi-structured approach would assist me as the researcher and therefore help ensure quality and focussed data were gathered.

Alongside my own 'trust' in semi-structured interviews as a method was the potential such an approach provided for obtaining in-depth information and data. The semi-structured interview allows the interviewer to probe beyond the answer and allows the interviewee to answer more on their own terms (May 1997). This was important both because I had some existing knowledge regarding the subject but this was based purely on my own experience and therefore I wanted to probe further into the views and experience of others, to add another dimension to the data analysis.

As Rubin and Rubin (2005) suggest, interviews provide the opportunity to understand experiences and reconstruct events the researcher did not participate in. The use of interviews would, therefore, allow the person who had completed the assessment to 'fill in the gaps' of what happened and tell the story of the case as they remembered it and interacted with it. Scourfield (2001) comments that social workers, in their professional practice, rely heavily on verbal exchange in the process of gathering information from their clients. Scourfield also suggests the social workers' familiarity with the process of interviewing assists the research process and helps make them a relatively easy professional group to interview.

Familiarity with the process of interviewing presents as helpful on the one hand, however it is also important to consider the context of the interview and the impact upon people's responses. Wilson and Sapsford (2006) comment upon the importance of considering power relations between the researcher and the interviewee and the impact this may have on the research data. In the early planning stages this was a significant consideration, particularly as I had previously worked for the host agency as a manager. When considering which research methods best suited the research questions I also gave consideration to which methods would also generate the most useful data. In relation to selecting semi-structured interviews as a method of data collection, mitigating against the impact of a power imbalance was achieved by giving careful consideration to ethical issues and also ensuring that those I interviewed recognised my role as a researcher first and foremost.

3.5 The research design and the rationale behind it

At the start of the research I was aware that the *Assessment Framework* (DH 2000) was the guidance used for pre-birth assessment. I had my own experience of undertaking and supervising pre-birth assessments and had begun the process of the literature review. Therefore, based on my formative knowledge I had developed an expectation of a case's 'typical' trajectory from the point of referral and through the various stages of assessment. My research design was therefore, structured around these expectations and was split into three distinct, but overlapping, phases looking at both national and local context and practice. At a national level, law, policy and procedural guidance provide a framework for front line practice and therefore understanding the national level context of pre-birth assessment seemed a logical place to begin.

3.5.1 Phase 1: The national context

Phase 1 of the research linked primarily to the research question:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

As a starting point I organised my research design around the national procedural framework consisting of:

- 1) The Children Act 1989
- 2) The Children Act 2004
- 3) *Working Together* (HM Government 2006)
- 4) *The Assessment Framework* (DH, 2000)

These documents provided the framework and guidance and I considered them in relation to the following questions:

- 1) What do they actually say about pre-birth assessment?
- 2) How does what they say relate to the process of conducting pre-birth assessment?

The findings from considering the national framework documents from this perspective then provided the basis for looking at procedures and guidance at the LA level.

3.5.2 Phase 2: Local Authority context

At the LA level, Local Safeguarding Children Boards (LSCBs) become significant bodies, so the second phase linked primarily to the second research question:

ii) What are Local Authority processes in relation to pre-birth assessment?

LSCB procedures can be seen as providing the interface between national level law and guidance and day-to-day front line practice. LSCBs were established on a statutory basis by the Children Act 2004 and *Working Together* (HM Government 2006) details their functions, a key function being to devise procedures and guidelines for all agencies and individuals working with children in a given local authority area. This includes procedures for the actions to be taken where there are concerns for the safety or welfare of children and:

Setting out thresholds for referrals to children's social care of children who may be in need, and processes for robust multi-agency assessment of children in need (HM Government 2006, 3.19)

LSCBs are required to be made up of key local agencies working in partnership with the purpose of ensuring a common understanding, more efficient joint working and effective use of local resources. There is, therefore, potential for each LSCB to devise procedures based on national guidance but with a degree of uniqueness to reflect local need, local budgetary constraints, the views of LSCB partners and the service users they represent. This potential for uniqueness provided the rationale for conducting a documentary analysis of all LSCB procedures in England rather than selecting just a few.

3.5.3 Phase 3: A case study of one LA

The third phase involved a case study of one LA children's services department looking at front line procedures and practice surrounding pre-birth assessment. This phase specifically addressed the questions:

ii) What are Local Authority processes in relation to pre-birth assessment?

iii) What are social workers' views about pre-birth assessment?

iv) How do social workers approach the task of pre-birth assessment?

The framework within which front line social workers approach pre-birth assessment is shaped by law and national guidance as well as by LSCB procedures. Therefore, this phase of the study had connectedness with the first and second phases by exploring how legislation and national and local procedural guidance and policy were translated into front line practice.

A case study approach was chosen because it provides a research strategy that allows a contemporary phenomenon to be studied in the real life context (Yin 2004). Yin comments that a case study approach is particularly useful for research that asks 'how' questions in situations where the boundary between context and phenomenon is not always very clear. Drawing on ideas about street level bureaucracy highlighted for me the rather unclear boundary between the agency context, set within a national framework of laws, procedures and guidance, and 'front line' practice where social workers deliver the actual practice of pre-birth assessment work. It therefore seemed appropriate that a case study approach would allow exploration of the boundary between the agency context and social work practice and place emphasis on the 'how' part of research question iv) *'How do social workers approach the task of pre-birth assessment?'*

Another significant factor in choosing to undertake a case study in one LA was to add a multi-agency dynamic to the research. I was aware that guidance contained in *Working Together* (HM Government, 2006) and *The Assessment Framework* (DH 2000) outlines the LA responsibility to co-ordinate assessments of children in need. This co-ordinating role puts social workers in the centre of a web of multi-agency networks, and holding the key responsibility for pooling information about the child relevant to each individual case. Consequently, this provides the potential to explore the nature of information shared with social workers and how this ultimately shapes the assessment and decision making process.

With regard to ensuring a study of one LA would provide enough data for a study of this size I relied heavily on my practice experience. The Department for Children, Schools and Families (DCSF) (2007) produced national statistics relevant to children's services work but none of the statistics is broken down by the age of the child. It is, therefore, impossible to have an accurate picture of the scale of pre-birth assessment activity in England. From my practice experience I could estimate how many pre-birth assessments my team undertook and, from discussion with managerial colleagues (from my own and other LAs) it seemed that the numbers my team dealt with were fairly typical. Based on my approximations I felt reasonably confident that a study of one LA would generate sufficient numbers of pre-birth assessments to provide data, particularly given the mixed methods approach and the opportunity to consider each assessment from a number of perspectives. On the other hand, I recognised that limiting the study to one LA meant the findings of the research could not be generalised to all English Local Authorities because, were the research to be repeated in another LA, there may be different findings for a host of reasons. However, as a lone researcher, expanding the study to encompass more than one LA, would have required more time and resources than were available to me. I also felt that by looking at the legal and procedural context applicable to the whole of England a case study in one LA would provide the opportunity to take an in-depth analysis appropriate for a PhD and provide the platform for future research.

In order to consider what happens to referrals, the case study of one LA was approached via three stages consisting of:

- 1) An audit of all pre-birth referrals made to the LA within a designated time period;
- 2) In-depth study of a small sample of case files;
- 3) Interviews with social workers who had been involved with the cases subject to detailed study.

The first stage consisting of the audit had the purpose of gathering largely quantitative data about the numbers of referrals and assessments and to track the case trajectory from point of

referral, through the decision making process to the birth of the child. A six-month time frame was chosen as I anticipated sufficient referrals would be made during this period of time and also six-months fitted with the overall time plan of the thesis.

With regard to the second stage and the in-depth study of a sample of cases I planned to select 10 cases to look at in more depth. These 10 cases were to be selected from cases identified in the six-month audit and were to be cases which social workers and managers in the LA had identified as requiring an in-depth assessment. The aim was to look in greater detail at the process of assessment from referral to the birth of the baby. I therefore began by brainstorming, based on my knowledge of child care law and practice experience, what I thought would be the possible outcomes from the pre-birth assessment process and categorised them as follows:

- 1) An emergency application to protect the child at birth either by using the police powers of protection under section 43(7) of the Children Act 1989 ,or an application by the LA to court for an Emergency Protection Order under section 44 of the Children Act 1989.
- 2) A planned application to court at birth under section 31 of the Children Act 1989 for an Interim Care Order
- 3) A planned application to court at birth under section 31 of the Children Act 1989 for an Interim Supervision Order
- 4) An investigation under section 47 of the Children Act 1989 followed by a pre-birth child protection conference and a decision for a safeguarding plan in place prior to birth
- 5) Child defined as in need under section 17 of the Children Act 1989 and a package of support provided in agreement with the mother but no intervention as identified in points 1-4 above.

I anticipated selecting two case examples from above five possible outcomes and therefore arrived at the figure of 10 cases. Based on my experience of the type and volume of information that may be on a child's case file I anticipated 10 cases would be a manageable number to physically look at as well as providing a representative sample of cases.

In selecting the cases I wanted to ensure I was able to interview the social worker with case responsibility at the point of birth (or case closure if this was prior to birth). My rationale for this was that I anticipated the case-holding social worker would also be the social worker who had conducted the pre-birth assessment. I therefore hoped to be able to read the case file

and all documents contained within it and then capture both the social worker's views about the assessment and hence obtain an additional dimension to my documentary analysis.

3.6 Devising the data collection tools

A series of three data collection tools and an interview schedule were devised which linked to the three research phases as identified above. Phase one of the research which considered '*The National Context*' did not require the use of a specific data tool but this stage did provide the basis for designing the data collection tools needed for phases two and three. Reading the key documents related to phase one highlighted procedural process that shape practice and by summarising their content and developing categories from it I engaged in a process referred to by Mayring (2002) as inductive category formation.

Phase 2 '*The Local Authority Context*', involving looking at LSCB procedures was the first point at which a data collection tool was used. In devising tool 1, the '*Analysis of Safeguarding Procedures*' (appendix 1) I considered the structure and content of *Working Together* (HM Government, 2006) because this document forms the basis of LSCB procedures. I followed a process of identifying the information contained in *Working Together* (HM Government, 2006) which specifically related to unborn children and then developed categories and headings which related to this information.

For phase three '*A Case Study of One LA*' I devised two data tools and an interview schedule. Data tool 2, the '*Case Audit Record*' (appendix 2) was based on the *Assessment Framework* (DH 2000) and the *Integrated Children's System Exemplars Referral and Information Record* (DH 2003) (see appendix 7 for a copy of this exemplar). The *Assessment Framework* (DH 2000) provided the structure and identified key stages in the process of assessment and decision making whilst the *Integrated Children's System Exemplars Referral and Information Record* (DH 2003) identified the information to be gathered at the point of referral. For each pre-birth case referred to the LA I would have a '*Case Audit Record*' which could be used to capture a range of quantitative data particularly in relation to the numbers of pre-birth referrals and assessments. The tool also allowed for quantitative and qualitative data gathering in relation to the reasons for referral and family information.

Also for phase three I devised the '*In Depth Cases*' data tool 3 (see appendix 3) which I envisaged could be used to add additional information about the selected case, brief details of which would already be recorded on the '*Case Audit Record*' (data tool 2 appendix 2). My intention was that the headings on data tool 3 would provide structure for my reading and data gathering from the individual case files and ultimately provide a means of organising

information for analysis. However, when I actually began the process of reading case files, it quickly became apparent that the complexity of the files and the nature of the information contained within them did not lend itself to a pre-determined data collection tool. I therefore abandoned the use of this tool in favour of approaching each case file individually and recorded my findings in note form to reflect the differing case file order and content.

Finally I devised the *Interview Schedule* (Data tool four, appendix 4). My plan was to conduct the interview after completing the case file audit and in-depth study of the case files. Therefore the purpose of the interview schedule was to identify pre-determined questions that related to all four research questions. In devising the tool I did not organise the question sequence to coincide with my approach of looking, firstly, at the national legal and procedural framework and then moving on to a more case specific focus. Instead I considered it important to ensure the interviewee felt comfortable and therefore willing to enter into the process of being interviewed. I therefore began by using general questions about the social worker and their experience and this was designed to ease them into the interview process and feel comfortable to talk openly. The interview then (question 3 onwards) moves into more focussed pre-birth assessment questions with question 4 to 7 being specifically about the in-depth case selected from the audit. The case focussed questions were designed to explore the social worker's perception of the case in recognition that there may be similarities or differences in how the information appeared in the case file. Questions 8 to onward relate to pre-birth assessment in more general terms and were designed to explore social workers' perceptions of the national and local frameworks.

3.7 Ethical issues

It is important to note that I had previously worked in the agency where the research was ultimately undertaken. This brought with it advantages and disadvantages as well as several ethical issues that arose throughout the research process. However, underpinning any specific ethical issues relevant to my having prior knowledge of the agency, was the wider ethical consideration of the research as a whole. As Silverman (2010) points out, there are many ethical issues which need considering particularly when researching vulnerable groups. From the outset of planning the research I was mindful of the *Research Governance Framework for Health and Social Care* (DH 2005) as well as my own professional social work ethics and values. The basis of all my ethical consideration was:

The dignity, rights, safety and well-being of participants must be the primary consideration in any research study. (DH 2005. 2.21)

This links very closely with my social work professional *Code of Practice* (GSCC 2004) in particular in relation to protecting and respecting service users' rights and upholding public trust. As a researcher and as a registered social worker, therefore, I set out to ensure my research was ethically sound.

Flick (2009) identifies that ethical issues arise at all stages of research. While agreeing with this view, Guillemin and Gillam (2004) identify two distinct phases of ethics in empirical research. Firstly 'procedural ethics' which involves the process of seeking approval from ethics committees and, secondly, 'ethics in practice' which are the ethical issues arising in the process of undertaking the research. It is relation to these two phases that I will outline my ethical approach by first looking at the factors which were considered during the procedural stages of obtaining approval and then looking at the ethical issues which arose in the process of undertaking the research.

3.7.1 The procedural stage

The procedural stage involved two formal processes of obtaining ethics approval; firstly from the university ethics committee and then from the Data Protection and Research Governance (DPRG) team in the host agency. During this process several ethical issues were identified and strategies put in place to ensure the research adhered to the ethical guidelines.

The process of obtaining university approval was clearly outlined in guidance but finding out how to get ethical approval from the LA was more problematic. As I had been employed by the host agency prior to undertaking the PhD, I was able to make use of my professional contacts and find out who would be likely to be able to offer help and advice on the approval process. I was also able to make some preliminary approaches to the agency and find out how receptive they may be to the research. Preliminary discussions with the host LA involved e-mail correspondence and face-to-face discussion with senior managers and staff in the DPRG. Although I had worked in the agency previously, and was respected by my social work colleagues, the 'gate keepers' in relation to ethical approval did not know me. The preliminary discussions allowed the key staff involved in approval process to get to know me and a little about my research interest over and above anything I could convey in the formal documentation associated with ethical approval. It also provided an opportunity for me to seek guidance on the approval process and to avoid unnecessary delay in the formal approval stages.

Not all of the research process required formal ethical approval. Phases one and two of the research related to analysis of documents accessible to any member of the public and so data

collection was not constrained by the need to obtain ethical approval. By contrast, all the phase three work in the LA raised considerable ethical issues particularly in relation to confidentiality. In order to protect the identity of the LA, social work staff and the service users I was clear from the outset that I would use pseudonyms and omit any information from the final thesis which might enable identification. Maintaining confidentiality also required storing sensitive data safely and so I set up systems to store electronic data using passwords and to store paper based data in locked filing cabinets at the university and the host LA. I also planned to transcribe the interviews myself and ensure tape recordings were deleted immediately after transcription.

A key decision in devising the research was ethical considerations surrounding involvement of families and, for a number of reasons, I ultimately chose not to interview mothers (or other family members) directly. My foremost reason related to my social work experience of pre-birth assessment and having experienced removing a child from a mother shortly after birth. As a result I was well aware of how traumatic and difficult this area of practice can be for mothers and the wider family (as well as the professionals involved). I therefore decided not to undertake research that involved interviewing mothers and families who had recently been the subject of a pre-birth assessment. This was not because I thought their views were not valid or relevant, but because I was conscious of the risk that the research may cause them additional upset or trauma. Without access to resources that would allow for families to receive additional support (possibly in the form of counselling), if the research did cause upset, I did not feel comfortable taking the risk of adding to a family's trauma.

I was also conscious of my skills and levels of confidence as a researcher. Whilst I had experience of gathering information and conducting interviews in my role as a social worker, as a researcher I was a relative novice. Consequently, I felt it would have been unethical to engage in a process of research where the boundaries between social work and research practice might become blurred. I acknowledged that, for me, there was some risk that I might fall back into a social work-related process of re-assessing a case rather than taking objective more detached researcher stance and recognised this would be unethical and potentially damaging for the family.

Having identified that I did not want to engage in research that directly involved interviewing parents, I then considered the ethical issues in relation to interviewing social workers. I did not anticipate causing undue distress to social workers but recognised that the process of asking them to 'tell their story' in an interview situation might prompt reflections on practice which might actually cause them to question their practice. In turn, there was a risk I may uncover information about social workers' practice that potentially placed children at risk of

harm. In order to address these issues I met with a senior manager in the LA who assured me that social workers' access to counselling via occupational health (offered as part of their terms of employment) could also be accessed in the event of a research interview causing them distress. I also ensured that the senior management team recognised my role was not to undertake a practice audit on their behalf and that, when looking at case files and interviewing social workers, I would not be reporting back on any issues of practice. The only exception to this would be if I encountered any issues of a child protection nature when, as per my professional code of social work ethics, I would follow the procedures of the host LA.

Having given consideration to the ethical issues and familiarised myself with the formal process I made my formal application to the university ethics committee which was approved on the 7th May 2008 (see appendix 5 for the list of documents submitted as part of this process). Once this approval was granted I immediately began the ethical approval process with the host LA by submitting the same collection of documents and the additional DPRG research application form. Unfortunately, despite my preliminary discussions, the approval by the host LA did not go as smoothly as anticipated because of office moves within the host LA. When I eventually tracked people down, ironically my approval application had been lost in the office moves and so I had to re-submit everything again. The host LA finally approved the research on the 6th August 2008.

3.7.2 Ethics in Practice

Whilst ethical approval to proceed with a piece of research may be granted this does not mean that there are no further ethical issues to negotiate. Activating and interpreting that approval in the context of the actual day-to-day process of conducting the research is another matter. Thus, for example, two situations emerged which serve to highlight the complexity of ethics in practice, the first relating to case file access and the second relating to informed consent.

During the process of application the DPRG stipulated that prior to looking at the ten in-depth cases I needed to seek parental consent to access the case file. At the time of approval this had a degree of logic as I would be looking at assessments, case notes and information from other agencies and parents had a right to know who was looking at this highly personal information and why. However, this requirement was based on the assumption that the six-month initial audit of referrals using the LA electronic database was a self-contained activity, pre-dating the selection of a small sample of cases involving in-depth assessment work. From the audit it was anticipated I would identify cases that had proceeded to a full assessment which I wanted to look at in more depth, then seek consent from parents and then look at the paper case file that contained the in-depth information. However, what this did not take into

account was the LA's decision to adopt a 'paperless office' approach and to transfer all the paper based case files onto the electronic system. Thus, as soon as I entered the database, I did, in fact, have access to all the in-depth 'case file' information, as well as all the initial referral information. In practice it was impossible to make a simple distinction between the referrals for audit and the more in-depth case material and so I entered into consultation with a senior manager about how to proceed. We agreed that to seek consent from all parents who had been subject to a pre-birth referral would be impossible and potentially cause undue distress to the families involved. So it was agreed that the cases which were eventually selected to form part of the in-depth study could only be included in the research if parents gave consent. This subtle difference in the ethical approval meant that I could actually read case files without parents giving consent but could not then use the information which extended beyond the data tool two 'Case Audit Record' unless parental consent to do so was granted.

The issue of informed consent arose in one of the in-depth cases and highlighted its complexity:

Informed consent entails giving as much information as possible about the research so that prospective participants can make an informed decision on their possible involvement. Typically this information should be provided in written form and signed off by the research subject. (Economic and Social Research Council 2005 pp 23)

One of the cases used in the in-depth study involved an unaccompanied asylum seeking pregnant teenager who was in the care of the LA whose first language was not English. This case raised several ethical issues, relating to a child in care being able to consent, not having a parent who could consent (or withhold consent) on their behalf and also to the impact of a language difference. With regard to tackling the issue of age and consent the social worker and the team manager both regarded this young person to be of sufficient age and level of understanding to make decisions about her life. However, as she was in the care of the LA, they had a duty of care and therefore would act as 'corporate parents' and ensure she had the appropriate information and support to make decisions. It was, therefore, arranged that I would meet with this young person along with an interpreter, the social worker and anyone else the young person felt appropriate. It transpired the young person trusted the interpreter and (via university funding to pay the interpreter) I had the relevant consent forms and research information translated and sent out in advance of the meeting. When we actually met the interpreter spoke with me about the research and relayed this information to the young person and asked questions of me on her behalf. It was evident from the questions and discussion that the young person was both interested and understood the research and therefore was able to sign the consent forms.

3.8 Negotiating access to the front-line

Closely allied with ethical approval but a distinct and somewhat different process was the process of negotiating access to the agency documentation and staff. On the one hand, I required physical access to the case files and, on the other, I needed social work staff to agree to be interviewed. Although I had worked for the LA before, there had been a wide scale reorganisation of front line services, which resulted in significant staff turnover and system changes. I therefore began the process of negotiating access from a position of thinking I knew what to do but quickly discovered I did not.

A key aspect of negotiating access involved front line staff knowing what I was doing and why because, without their co-operation, I was unable to physically access the case files. The reorganisation of front line services had resulted in a high staff turnover and many staff did not even know me, let alone know what my research was about. I therefore arranged to attend a managers' meeting and several team meetings in order to introduce myself and to explain my research. This proved to be a valuable starting point as I was able to explain to large groups of people at once who I was and also to ensure people were familiar with me before they found me in their office, using a computer to look at their work. The reorganisation of services had also left many of the staff who had been employed by the LA for a while feeling quite vulnerable and so I was able to assure them that my reasons for reading case files was purely for my research and not as part of an audit process for sinister management purposes.

Having engaged in the process of informing front line staff about my research I embarked on, what transpired to be, the exceptionally difficult process of negotiating access to the electronic database. Initially I envisaged only being given access to data relevant to my research and that electronic case files would only be accessible with a relevant password. However, the electronic database did not allow for such refined access. Moreover the database had five levels of access, as per figure 4 and passwords were linked to the level of access to be granted. The IT department accepted that I had legitimate access to the computer system as a researcher but my name was already recorded in the system from my employment with the agency as a team manager. From an IT perspective, my previous employment caused a recurring problem throughout the research and at times hampered me enormously in data gathering.

Level	Staff group	Access
1	IT staff administrators	<ul style="list-style-type: none"> • System configuration and system management • Access to all aspects of the system
2	Senior Managers	<ul style="list-style-type: none"> • Access to read and input data on individual case records for all adults and children referred to the LA • Access to all team caseloads and ability to allocate cases, electronically action decisions and close cases • Access performance indicators for adults and children's services • Ability to perform audits, generate statistics from case records and review performance indicators
3	Team Managers	<ul style="list-style-type: none"> • Access to read and input data on individual case records for all children referred to the LA • Access to their own team case loads and ability to allocate cases, electronically action decisions and close cases on own team only • Access to performance indicators for their own team
4	Social Workers & Team office administrators	<ul style="list-style-type: none"> • Access to read and input data on individual case records for all children referred to LA • Ability to electronically request managers to make decisions such as sign off assessments and close cases
5	CAFCASS officers & Complaints officers	<ul style="list-style-type: none"> • Limited 'read only' access to case file for child in question • No access to child protection reports or court documents unless specific approval granted in advance of reading the file

Figure 4 Levels of Access to Computerised Database

Setting my password as a team manager meant I did not have access to some of the audit functions that allowed comprehensive searches of the database. When I discussed with the IT department that I was no longer employed by the LA and I was now a researcher this resulted in my access level being reduced to five and, in effect, I then could not access any data on referrals and could not access any files without obtaining individual permission from the manager for each file in question. I eventually found a member of the IT team who was a social worker and therefore understood exactly what I was requesting and why. However, it

became apparent that it was impossible to set a password that would allow read only access to the system and access to all children's referrals. It was finally agreed I would have full senior manager level access but that I must agree not to make any amendments to the case records.

A further problem arose due to the data protection systems of the LA. The IT team keep a record of all staff no longer employed and, on a monthly basis, check the electronic systems to ensure the passwords of ex-employees are deleted. Although it was possible to have my researcher access granted for a specified time period (and on several occasions I was told this had been done) staff in the IT department continued to regard me as an ex-employee and so, throughout the research period, this resulted in my password being totally deleted from the system on a monthly basis. This was frustrating because getting the password re-set required 24-hours' notice before the system would accept the new password and then the password was invariably re-set to team manager level necessitating phone calls and explanations to have it re-set. After several months I was on first name terms with many of the IT team and the process of re-setting passwords became smoother but still caused significant delay in obtaining data.

3.9 Conclusion

Research is not a static activity and throughout the study various revisions to the research design had to be made in response to challenges presented in the process of data gathering. However, as outlined at the start of this chapter, time spent working out the overall aim of the research and devising research questions proved invaluable during the course of the research journey as a means of helping me remain focussed. Moreover, the overall aim and specific research questions were sufficiently open ended to allow me to develop ideas and follow lines of enquiry and interest that arose during the process of data gathering. This was particularly useful when I began to encounter problems in data gathering as indicated above.

In summary, in order to pursue my overall aim and my specific research questions, the research design involved three phases of research and a variety of data collection methods, all with the view of trying to explore pre-birth social work assessments, to understand how they are constructed and undertaken. Specifically, it was planned that data collection would comprise:

Phase 1 – Documentary analysis of English national documents relevant to assessing children in need;

Phase 2 – Documentary analysis of Local Safeguarding Children Board procedures in England;

Phase 3 – A case study of one LA comprising of three elements, an audit of pre-birth referrals made to one LA over a six-month period, detailed documentary analysis of 10 cases selected for in-depth analysis and semi-structured interviews with the social workers with case responsibility for the 10 selected cases.

The theoretical perspective of street level bureaucracy provided a useful framework from which to explore pre-birth assessment.

Chapter 4

Pre-Birth Assessment: Relevant Law, Guidance and Procedures

4.1 Introduction

As was outlined in Chapter 2, safeguarding children as we know it today has evolved for over a century in response to many factors including child death enquiries and research. Surrounding pre-birth assessment practice is a complex framework of legislation and guidance which has evolved in relation to social and political ideology and which front line practitioners (street level bureaucrats) are required to interpret and apply.

This chapter outlines the results from an exploration of the research during phase 1 which looked at primarily at the research question:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

I begin this chapter by focussing on the law starting with the Children Acts 1989 and 2004 which form the basis of safeguarding interventions today. In Chapter 2 I referred to Corner (1997) Calder (2000), and Hart (2001) who identified the important issue of the legal rights of the mother and the lack of legal rights of the unborn child. With this in mind, this chapter also considers the law surrounding the unborn child and maternal rights.

Having considered the legal framework the chapter then looks at the procedural framework with particular reference to *Working Together* (HM Government 2006) and the *Assessment Framework* (DH,2000). In doing so I will consider what they actually say about pre-birth assessment which will then be used (in this chapter and subsequent chapters) to explore how what the guidance says relates to the process of conducting a pre-birth assessment. Finally this chapter provides a brief overview of the Common Assessment Framework and the Integrated Children's System. The purpose of the overview is to provide context for subsequent chapters (particularly Chapters 7, 8 and 9) where the impact of procedures and guidance contained within the Common Assessment Framework and the Integrated Children's System had direct impact on pre-birth assessment practice.

4.2 Relevant Law

When considering children's needs the Children Acts 1989 and 2004 are the key pieces of legislation in England. Both Children Acts shape front line practice with children and families particularly in relation to the definition of a child in need and outlining actions to be taken where there are child protection concerns. I will, therefore, begin by providing an overview of the two. However, there are other aspects of law that have relevance to the unborn child, in particular the Human Fertilisation and Embryology Acts (HFEA) of 1990 and 2008 which set out the law in relation to abortion, human fertilisation and scientific use of embryos, which will be considered.

4.2.1 The Children Acts 1989 and 2004

The Children Act 1989 was, and still is, a significant piece of legislation in the history and development of child protection. Prior to the development of the Children Act 1989 a series of child death enquiries raised questions about why professionals had not intervened, these were followed by the Cleveland enquiry raising questions about professionals over reacting. Concern and disquiet about the practice of health and child welfare professionals gave government a mandate for legislative reform. With the central principles being based on negotiation and working in partnership with parents, the Children Act 1989 sought to strike a balance between supporting families and child protection (Frost and Parton 2009). Drawing on research emphasis was placed on actively providing services to children in need rather than focussing only on child protection, with the definition of need encompassing health, development and disability (Frost and Parton 2009).

The Children Act 1989 is based on the principle that the welfare of the child is the paramount consideration and so professionals working with children are required to ensure any action is taken in the child's best interest. Part III section 17 of the Act is important because it sets out the principles defining children in need and the related duties for Local Authorities (LA). The definition of a child in need is:

- a) he is unlikely to achieve or maintain, or have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this part
- b) his health or development is likely to be significantly impaired, or further impaired without this provision for him of such services; or
- c) he is disabled. (Children Act 1989 S17 (10))

The key duty is to safeguard and promote the welfare of children in need and, whenever it is safe to do so, promote the upbringing of children with their families. In carrying out its specific duties to children in need, LAs are required to support families either by providing services in kind or, in exceptional circumstances, providing cash to a family. There is considerable discretion in how services can be provided and the process of deciding which children and families receive support will involve some form of assessment. The assessment process forms part of the gate-keeping process for allocating finite services and resources but it can also provide a thorough understanding of a child's circumstances and needs. As such assessment forms the basis of a programme of support appropriate to the child's individual needs.

Part V of the Children Act 1989 relates to the protection of children and section 47 specifically relates to the duty to investigate where there is reasonable cause to suspect a child is suffering, or is likely to suffer, significant harm. In cases where significant harm is suspected the LA must make any enquires they consider necessary to decide if they need to take further action to safeguard or protect the child's welfare. Section 47 of the Children Act 1989 carries with it great responsibility and power in relation to assessment as it enables social workers to access highly confidential information (sometimes even without the person who the information is about giving permission for it to be shared and on some occasions even without their knowledge).

The more recent Children Act 2004 does not change the Children Act 1989 but focuses on the more administrative functions of safeguarding and promoting the welfare of children. The Children Act 2004 sets out the importance of clear lines of accountability and improved joint working between all agencies involved in providing services for children. It also places a duty on LAs to make arrangements through which key agencies should work together and co-operate in order to promote the well-being of all children (HM Government 2004). A key mechanism for achieving co-operation is the Local Safeguarding Children Boards (LSCB), introduced by the Children Act 2004 to replace the non-statutory Area Child Protection Committees. Prior to the introduction of the LSCB, Local Area Child Protection Committees maintained the register of all children deemed to be at risk of harm and set out procedures (under section 47 of the Children Act 1989) for the protection of children. By contrast, the statutory LSCB extends beyond child protection and incorporates what action should be taken to support children in need (as defined by section 17 of the Children Act 1989), hence the much wider context of safeguarding children. Whilst not providing front line services, the LSCBs comprise of senior representatives of agencies with responsibility for children. The LSCB have the authority to pool budgets and resources and commit childcare agencies to following agreed practices and policy (HM Government 2006).

What exists therefore, is legislation that has at the core the principle of working in partnership as well as the needs of the child being paramount. The Children Act 1989 provides a legal definition of a child in need and a legal duty to investigate where significant harm is suspected or has occurred. These legal duties are supported by the Children Act 2004 which enshrines the principles of agency co-operation and commitment to safeguard the needs of all children. However, these laws do not make any reference to pre-birth assessment and intervention because, in English law, there is no status of personhood until the point of birth. Whilst they provide the principles by which intervention by LAs and professionals working with children are guided the Children Acts 1989 and 2004 are not actually applicable until the point of birth.

4.2.2 The 'unborn child' and maternal rights

As indicated in the introduction, throughout the thesis I use the phrase 'unborn child' and I chose to do so because it is the terminology that appears in key policy documents referred to later in this chapter. However, from a legal perspective an 'unborn child' is something of an oxymoron with the terms gamete, embryo and fetus applying pre-birth and the status of 'child' only being applied actually at birth. The Human Fertilisation and Embryology Acts of 1990 and 2008 provide the definitions of gamete, embryo and fetus and these definitions provide the basis for policy relating to what procedures can be undertaken at various stages of development.

From the point of conception the human form goes through various stages of development and knowledge about gametes and embryos and the physiological transition from embryo to fetus has had impact on social and legal perspectives. Embryos can now be created by means beyond natural conception, with eggs being fertilised outside of the mother's body (Brinsden, 2004) and cloning techniques even removing the need for sperm and egg (see Vöney, and . Wolfrum, R. 2004 (eds) for discussions about the ethical and scientific debates surrounding human cloning). There is also the enhanced medical knowledge and technology that has resulted in the ability to keep extremely premature babies alive which in turn has impacted on the point at which a fetus is regarded as 'viable'. Scientific developments open the door to significant theological debate surrounding the existence of the human soul, the point at which human life actually begins and the morality of abortion (Thompson 2004).

The 'abortion debate' is an area that highlights the issue of the unborn child's 'right' to life and the mother's rights of choice. Opposition to abortion tends toward the premise that the fetus is a person from the moment of conception whereas support for abortion tends toward the rights of women to make choices about what happens to their bodies (Thomson 2004).

Whatever moral stance is taken, legislation surrounding abortion is clear that in England, a woman has the right to seek a termination of her pregnancy. The Human Embryo and Fertilisation Act 1990 amended the Abortion Act 1967 and reduced the time limit for termination of pregnancy to 24 weeks, a time frame which reflects the stage at which a fetus is regarded as viable. It is significant to note that the time limit relates to viability and not to any greater or lesser rights of the mother over her body. The principles of the law are quite clear that a woman maintains the rights over her own body throughout her pregnancy.

The right to choose is enshrined within medical law where a mother has the right to refuse medical treatment even if doing so would cause harm to the unborn child. In England a key legal landmark case that highlights maternal rights involved Ms S who appealed against an enforced caesarean operation. Ms S first presented to the medical services at 36 weeks of pregnancy and was diagnosed with pre-eclampsia. She was advised that she and her unborn child were in real danger but, although accepting the dangers, she refused medical treatment. She was subsequently assessed and then detained under the Mental Health Act 1983 following which the hospital made an ex parte application to the courts to allow a caesarean operation. The courts granted the application although at the time the court had been wrongly advised that Ms S was unable to consent and had been in labour for several hours. The Judicial Review of the case (England and Wales High Court (Administrative Court) Decisions 7th May, 1998) ruled in favour of Ms S and criticised the actions of the hospital and their legal advisors. Whilst this case can be regarded as quite extreme the principle it clearly highlights is the importance of maternal choice.

The complex nature of the 'relationship' between a pregnant woman and her unborn child is further highlighted by a case considered in 1994 in the House of Lords. The case involved a situation where a pregnant woman was stabbed, resulting in a premature labour. Although she gave birth to a child who actually survived for 121 days the child ultimately died as a direct result of the stabbing. The Court of Appeal had concluded that the fetus should be treated as an integral part of the mother in much the same way as any other part of her body and as such could not be considered 'murdered' if she survived. However, the House of Lords rejected this view:

There was, of course, an intimate bond between the foetus and the mother, created by the total dependence of the foetus on the protective physical environment furnished by the mother, and on the supply by the mother of the physical linkage between them of the nutrients, oxygen and other substances essential to foetal life and development. The emotional bond between the mother and her unborn child was also of a very special kind. But the relationship was one of bond, not of identity. The mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects. The mother's leg was a part of the mother, the foetus was not. ... I would therefore, reject the reasoning which

assumes that since (in the eyes of English law) the foetus does not have attributes which make it a "person" it must be an adjunct of the mother. Eschewing all religious and political debate I would say that the foetus is neither. It is a unique organism. To apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead. (UK House of Lords Decisions 1994. no page number)

What can be seen is that there is a complex relationship between the pregnant woman and her unborn child, or fetus. On the one hand maternal choice is paramount but there is also the recognition in the above quote that the fetus is a 'unique organism' and is not just a part of a woman's body.

Scott (2000) considers maternal responsibility toward the unborn child in relation to the law of torts and in doing so adds another dimension to the concept of the unborn child's rights. Scott outlines that in the process of medical intervention during pregnancy and childbirth practitioners can cause injury that may result in physical harm to or death of the fetus. To deal with such situations the law regards injuries sustained in vitro to actually be sustained at the point of birth. This issue is somewhat complex in that, whilst the fetus is in the womb, any injury or harm sustained as a result of negligent medical practice cannot be acted upon. However, at the point of birth, the child achieves the status of personhood and therefore has rights with regard to claims for medical negligence (see Scott 2000 for a comprehensive description and analysis of this principle). However, this principle does not apply in law if a pregnant woman acts in a way that harms her child in vitro. Therefore, women who choose to drink excessive alcohol, take drugs or engage in any other activity which may cause physical harm during pregnancy are not held accountable if their baby experiences trauma or physical harm at birth as a result of the mother's actions. The issue of maternal choices and the impact on the unborn child, particularly in relation to fetal development, is addressed in Chapters 10 and 11.

4.2.3 The Law and pre-birth assessment

In considering the Children Acts 1989 and 2004 and the laws surrounding unborn children and maternal rights it emerges that pre-birth assessment does not fit within the remit of either. Even in the most serious of situations where there is a plan to remove a baby at birth (or shortly after), the Children Act 1989 is not actually applicable until the moment of birth and the status of personhood applies. However, this is not to say that there is not a requirement to conduct a pre-birth assessment. Indeed, the serious nature of cases where an application is made to court at birth the requirement for high quality pre-birth assessment cannot be underestimated. As the Honourable Mr Justice Munby declared:

At the risk of unnecessary repetition I emphasise that the removal of a child from his mother at or shortly after birth is a draconian and extremely harsh measure which demands extraordinarily compelling justification. The fullest possible information must be given to the court. The evidence in support of the application for such an order must be full, detailed, precise and compelling. Unarticulated generalities will not suffice. The sources of hearsay evidence must be identified. Expression of opinion must be supported by detailed evidence and properly articulated reasoning. (England and Wales High Court (Administrative Court) Decisions 15th April 2003, point 44.ii)

In ensuring full information is available, professionals are required to work in partnership with the pregnant mother and the wider family but are without any redress to the law in cases where families do not wish to co-operate. No matter how serious the concerns for the unborn child, the same principles that allow a mother to refuse medical intervention, apply to refusing to take part in an assessment.

Section 7 of the Local Authority Social Services Act 1970 requires LAs to act under the general guidance of the Secretary of State and so any guidance issued under this Act must be complied with, unless there are exceptional circumstances that justify not doing so. The statutory guidance (discussed later in this chapter) contained in *Working Together* (HM Government 2006) and the *Assessment Framework* (DH 2000) is issued under s7 of the Local Authority Social Services Act 1970 and therefore must be complied with. Any reference to pre-birth assessment within the above mentioned guidance therefore provides the rationale for the LA undertaking pre-birth assessments and allows for the 'fullest possible' (England and Wales High Court (Administrative Court) Decisions 15th April 2003, point 44.ii) information being gathered.

Returning again to the Human Fertilisation and Embryology Acts of 1990 and 2008 and the issue of pre-birth assessment, the law has been taken a step further to include the prospect of pre-conception assessment. Since the early research by Patrick Steptoe and Robert Edwards into IVF and the birth of the first 'test tube baby', Louise Brown, in 1978 there has been ongoing scientific development and ethical debates surrounding artificial methods of conception. In 1971 Edwards and Sharpe (cited in Brindsen 2009) wrote about the need for research into IVF to be conducted under strict ethical guidance and in 1990 the United Kingdom became the first country to impose strict regulations on reproductive technology (Brindsen 2009). One area of regulation is the responsibility to consider the future of the child even before conception:

A woman shall not be provided with treatment services unless account has been taken of the welfare of the child who may be born as a result of the treatment (including the need of that child for a father), and of any other child who may be

affected by the birth. (Human Fertilisation and Embryology Act 1990, Section 31 (5))

Guidance to fertility clinics suggested that in the course of considering the welfare principle they should focus on the likelihood of significant harm but with a general presumption in favour of providing treatment (DH 2006). However, *The House of Commons Science and Technology Committee* were opposed to the welfare assessment on the grounds that people able to conceive naturally were not subject to such checks (DH 2006).

In 2004 the *Human Fertilisation and Embryology Authority* (HFEA) launched a process of consultation on the welfare of the child principle and in November 2005 produced a report on the findings entitled '*Tomorrow's Children*' (HFEA 2005). Whilst this report indicated some opposition to the welfare principle, on the whole, the report concluded that in the field of assisted conception third parties have some responsibilities relating to the child to be born (HFEA 2005). The HFEA decided that fertility centres should consider factors that may pose a risk to the potential child (or any existing children) and in doing so should focus on the following:

- Any aspect of the patient's past or current circumstances which means that either the child born or any existing child of the family are likely to face serious physical or psychological harm or neglect. Such aspects might include:
 - a) previous convictions relating to harming children
 - b) child protection measures taken regarding existing children; or
 - c) serious violence or discord within the family environment,
- Any aspect of the patient's past or current circumstances which is likely to lead to an inability to care for the child to be born or which is already seriously impairing the care of any existing child of the family. Such aspects might include:
 - a) mental or physical conditions; or
 - b) drug or alcohol abuse

(HFEA 2005, Page 8)

The government also remained in support of fertility centres considering the welfare of the potential child. However, they government did remove the requirement that there was a 'need' for a father (DH 2006).

The involvement of a 'third party' in the creation of human life is the trigger to the guidance on the welfare principle as applied to IVF and as such is not in exactly the same realm as professionals conducting pre-birth assessments under statutory guidance issued under Section 7 of the Local Authority Social Services Act 1970. However, what it does do is highlight further

the complexity of law that relates to the unborn child. Exploration of the law has identified that the term unborn baby does not exist legally and that women have rights over their own body, but even then it is not quite that simple. As with all law, guidance is offered which builds on the law and therefore it is to the guidance surrounding safeguarding and assessing children in need I now turn.

4.3 Working Together To Safeguard Children

The Children Acts 1989 and 2004 provide the legal framework, which was then built upon in *Working Together* (HM Government 2006). *Working Together* provides statutory and non-statutory practice guidance for all agencies and individuals working with children. Part 1 (statutory guidance issued under the s7 of the Local Authority Social Services Act 1970) focuses on specific roles and responsibilities, actions and procedures whereas Part 2 (non-statutory practice guidance) focuses on research and inspection and their potential implications for practice. Within both the statutory and non-statutory sections of this substantial 239 page document there were a very limited number of specific references to unborn children, the details of which will be made clear but, firstly, it is important to outline the general duties of agencies and individuals that are pertinent to assessment of any child.

As indicated, the Children Act 2004 established Local Safeguarding Children Boards (LSCB), which replaced the previous non-statutory Area Child Protection Committees. Membership of the LSCB is made up of senior managers from key agencies and the voluntary sector, therefore providing management level commitment to safeguarding and promoting the welfare of children. A key statutory mechanism for agreeing how organisations in each local area will co-operate, the LSCB has responsibility to plan future resources and the power to pool budgets where necessary. *Working Together* (HM Government, 2006) set out the scope of the LSCB as follows:

The scope of the LSCB role falls into three categories: firstly, they will engage in activities that safeguard all children and aim to identify and prevent maltreatment, or impairment of health or development, and ensure that children are growing up in circumstances consistent with safe and effective care; secondly, they will lead and co-ordinate proactive work that aims to target particular groups; and thirdly they will lead and co-ordinate arrangements for responsive work to protect children who are suffering, or at risk of suffering, significant harm. (HM Government, 2006, p13).

All three categories of scope, in theory, apply to work relevant to pre-birth assessments, both in preventing the need for them at all, through the provision of services and education, for example, which would promote the welfare of all children (category 1) and by focusing on groups where one might expect there to be particular concerns, for example, in the case of

pregnant school-aged children (category 2). It is in relation to the third aspect of their scope, however, that pre-birth assessment processes are typically located within the context of the historical development of working with children and families as outlined in Chapter 2.

LSCBs are given a specific responsibility for producing the Safeguarding Children Procedures relevant to each LA in England (discussed in more detail in Chapter 5) and co-ordinating multi-agency child protection conferences for cases where an investigation under section 47 of the Children Act 1989 has found significant concerns about a child's welfare. The purpose of a child protection conference is to bring together family members and professionals most involved with the family and then to analyse information and make judgements about the likelihood of the child suffering significant harm in the future.

Pre-2007, the outcome of a Child Protection Conference could be that the child's name was placed on a Child Protection Register that listed all children in the LA where there was a child protection plan. However, from the 1st January 2007, the system of the LA maintaining the child protection register was replaced with a requirement to have information technology capable of producing a list of children in the area considered to be at risk of significant harm and for whom there was a safeguarding plan. This created a subtle, but important, change of emphasis, which is highly relevant to unborn children. The confusion with regard to whether or not an unborn child's name could be placed on the child protection register pre-birth or whether it would only become eligible at birth (a dilemma discussed in Barker 1997) was removed. Instead, the emphasis became one of developing multi-agency plans which all agencies who made up the LSCB were statutorily responsible for working with to ensure the safeguarding of the child in question.

In relation to safeguarding and promoting the welfare of children *Working Together* (HM Government, 2006) was clear about the importance of basing safeguarding plans on the findings from assessment as well as having a multi-agency approach to assessment. However, whilst there was a shared responsibility each agency also had specific duties to ensure children achieve their optimum potential. Relevant to assessment the LA duties included:

LAs, with the help of other organisations as appropriate, also have a duty to make enquiries if they have reason to suspect that a child in their area is suffering, or likely to suffer, significant harm, to enable them to decide whether they should take any action to safeguard or promote the child's welfare. (HM Government, 2006, 2.16)

Where a child is at risk of significant harm, children's social care staff are responsible for co-ordinating an assessment of the child's needs, of the parents' capacity to keep the child safe and promote his or her welfare, and of the wider family circumstances. (HM Government, 2006, 2.17)

The duty of LA social care staff to co-ordinate an assessment meant that social workers held (and still hold) a pivotal role in the process, in terms of their approach to gathering, sharing and analysing information.

In setting the context of safeguarding and promoting the welfare of children and understanding the nature of harm the guidance offered a definition of abuse and neglect as follows:

Abuse and neglect are forms of maltreatment of a child. Somebody may abuse or neglect a child by inflicting harm, or by failing to act to prevent harm. (HM Government 2006, 1.29)

Abuse was further defined as i) physical abuse, which may involve hitting or other forms of physical harm ii) emotional abuse, which is persistent emotional maltreatment causing adverse effects on emotional development and iii) sexual abuse, which involves forcing or enticing a child to take part in sexual activities including looking at images, being involved in the production of images or encouraging children to behave in sexually inappropriate ways (HM Government 2006). Whilst abuse definitions relate to children, neglect was also defined and it was here that the first reference to unborn children appeared in the guidance:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:

- provide adequate food, clothing and shelter (including exclusion from home or abandonment)
- protect a child from physical and emotional harm or danger
- ensure adequate supervision (including the use of inadequate care givers)
- ensure access to appropriate medical care or treatment.

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs. (HM Government 2006, 1.33)

Wright and Walker (2007) summarised that substance use impacts on the unborn child either as a direct result of the drug itself or as a result of poor fetal growth or premature delivery and that the use of tobacco during pregnancy is likely to result in lower birth weights. As discussed in Chapter 2, the increased awareness of the importance of maternal health had a direct impact on the provision of maternity services (Kent 2000). It is therefore probable that increased awareness of the impact of substance use (including the use of tobacco and alcohol) may also impact on the procedural approach to pre-birth assessment.

The next reference to the unborn child in *Working Together* (HM Government, 2006) was not until Chapter 5 'Managing Individual Cases' which started on page 73 and which, firstly, set out the principles underpinning work to safeguard and promote the welfare of children. These principles were identified as being '*child centred*', '*rooted*' in '*child development*', '*focussed on outcomes for children*' and '*holistic in approach*' (HM Government 2006, p 99). In the whole of this chapter there was just one line that referred to the unborn child but this sentence was very important in terms of its message:

The procedures and timescales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child. (HM Government 2006, 5.14)

Therefore, if anyone believed a child, including an unborn child, might be suffering, or be at risk of suffering, significant harm they should make a referral to the LA children's services department. The LA would then have a responsibility to clarify with the referrer the nature of concerns, how and why concerns had arisen and what the needs of the family were (HM Government 2006 5.13). At this point key time scales would come into play, the first of which was to decide, within one working day, what action should be taken. Following initial assessment chapter 5 of *Working Together* (HM Government, 2006: 5.44 & 5.45) identified that a child might be defined as in need, in which case consideration should be given to what services (if any) were appropriate. However the majority of chapter 5 then went on to outline in considerable detail and in prescriptive tone the processes that should be followed in cases where a child was thought to be at risk of significant harm.

The procedure to be followed where a child is thought to be at risk of significant harm first required a strategy discussion involving the LA children's social care staff, the police and other bodies as appropriate. The purpose of this was to co-ordinate information and plan courses of action. Once a decision had been taken to follow the procedures under Section 47 of the Children Act 1989 the LA social worker would begin the process of completing an assessment which might, in turn, lead to a decision to hold a child protection conference. In relation to unborn children there was specific reference to core assessment and child protection conferencing as follows:

Where a core assessment under s47 of the Children Act 1989 gives rise to concerns that an unborn child may be at future risk of significant harm, LA children's social care may decide to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and proceed in the same way, as other initial child protection conferences, including decisions about child protection plan. Child protection review conferences should also proceed in the same way. Involvement of midwifery services is vital in such cases. (HM Government 2006, 5.140)

This paragraph was significant for a number of reasons. Firstly by giving a pre-birth child protection conference the same status as other child protection conferences it identified the importance of pre-birth planning. Secondly, it identified the notion of applying the principles of child protection law before birth by indicating that an assessment could be conducted under section 47 of the Children Act 1989.

In many ways the 'devil is in the detail' with regard to the statutory guidance as it relates to unborn children. There are several points at which the professional would have to opt not to apply the principle contained in paragraph 5.14 of *Working Together* (HM Government, 2006) about procedures and timescales that apply to children also applying to unborn children. A notable example would be the procedures relevant to immediate protection:

Where there is risk to the life of a child or likelihood of serious immediate harm, an agency with statutory child protection powers **should act quickly to secure the immediate safety of the child** [guidance emphasis in bold]. (HM Government 2006, 5.49)

Application of this section could potentially allow intervention to prevent abortion or legitimise intervention with pregnant women refusing medical treatment. The issue of opting not to apply the principle in paragraph 5.14 is highlighted by two further references to unborn children found in the non-statutory guidance. Chapter 9 looked at lessons from research and inspection and made reference to situations that might constitute harm to an unborn child. The first of these was about domestic violence:

It can pose a threat to the unborn child, because assaults on pregnant women frequently involve punches or kicks directed at the abdomen, risking injury to the mother and foetus. (HM Government 2006, 9.15)

The second reference in the non-statutory section of the guidance was in relation to drug and alcohol misuse:

Maternal substance misuse in pregnancy can have serious effects on the health and development of an unborn child, often because of the mother's poor nutrition and lifestyle. Newborn babies may experience withdrawal symptoms that may interfere with the baby's attachment to their parents or caregivers.' (HM Government 2006, 9.18).

Applying statutory powers to secure the immediate safety of the unborn child in the above situations would potentially require professionals to over-ride the principle of maternal choice; maternal choice to remain in a relationship even if there is domestic violence, and maternal choice to use any substances in pregnancy. On the other hand, acting quickly to secure the safety of the unborn child may also involve provision of services and resources such as access to a safe place for the pregnant woman to live or food to prevent the impact of poor nutrition.

As a whole *Working Together* (HM Government 2006) provided some framework for professionals working with pregnant women and their families in that it identified that what applies to a child also applies to an unborn child. However, the anomalies and ambiguities this creates in relation to the legal rights of the mother and the lack of rights of the unborn child were not explained, explored or addressed within either the statutory requirements or non-statutory practice guidance making up the document.

4.4 Assessment Frameworks and their relevance to Assessing Unborn Children

As identified above, there is a legislative requirement for professionals to undertake assessments and statutory guidance that indicates (albeit without total clarity) that unborn children should be subject to the same procedures as all children. When it comes to the actual process of conducting assessments in England all professionals work within a framework devised to provide consistency in how information about children and families is gathered and recorded.

The *Assessment Framework* (DH 2000) and the '*Common Assessment Framework*' (CAF) (Children's Workforce Development Council, 2009) draw on research about children's needs and what is considered to be best assessment practice. Both are based on a conceptual framework which is designed to assist in the process of systematically gathering and analysing the individual needs of the child. Often represented as a triangle (figure 5), the child is at the centre of the assessment surrounded by the three inter-related domains of '*parenting capacity, child's developmental needs and family and environmental factors*'. Although based on similar principles, the *Assessment Framework* and the CAF fulfil different purposes, the former being designed for the use by professionals involved in assessing children in need or at risk of significant harm under Sections 17 or 47 of the Children Act 1989 and the latter providing a means of early identification and assessment of children's needs. Based on their respective dates of publication I will now look at the two assessments before considering the *Integrated Children's System*, which although not an assessment tool, is a key mechanism for monitoring the assessment and decision making process.



Figure 5 – Assessment Framework (DH 2000) Assessment Domains Triangle

4.4.1 Framework for the Assessment of Children in Need and their Families (DH 2000)

The *Assessment Framework* is issued under section 7 of the Local Authority Social Services Act 1970 and should be complied with unless there are exceptional circumstances which indicate otherwise. In terms of approach and context the guidance reflects the principles contained within the United Nations Convention on the Rights of the Child (ratified by the UK government in 1991) and the Human Rights Act 1989 and is informed by the requirements of the Children Act 1989 (DH 2000). The policy context during the development and publication was one in which the government were 'committed to ending child poverty, tackling social exclusion and promoting the welfare of children' (DH 2000 p(x)).

Not designed to provide step-by step assessment procedures to follow, the view was that the *Assessment Framework* should be adapted and used to suit the individual needs and circumstances of each child and family being assessed (DH 2000). However, in an attempt to ensure assessments did not continue over a prolonged period without analysis being made the guidance introduced a series of timescales for assessment and decision making which relate to Referral, Initial Assessment (IA) and Core Assessment (CA). (See appendix 6 for Maximum Timescales diagram). In 2003, as part of the introduction of the Integrated Children System (discussed later in this chapter) a series of exemplar forms were introduced which outlined the type of information which either should be gathered during the process of referral, IA and CA or could be gathered to inform the process of assessment.

When a referral is made to the LA information is recorded on the '*Referral and Information Record*', (see appendix 7 for a copy of the Department of Health 2003 exemplar) and the first stage of analysis and decision-making begins:

There is an expectation that within one working day of a referral being received or new information coming to or from within a social services department about an open case, there will be a decision about what response is required. A referral is defined as a request for services to be provided by the social services department. The response may include no action, but that is in itself a decision and should be made promptly and recorded. (DH 2000, 3.8)

The '*Referral and Information Record*' guides information gathering with the focus being on basic details, such as name, date of birth/expected date of delivery and address and a summary of the reason (see appendix 8 for the Department of Health 2003 IA exemplar). The IA should be completed within a maximum of seven working days and is defined as '*a brief assessment of each child referred to children's services with a request for services to be provided*' (DH, 2000, 3.9). The IA is a tool for recording salient information and to assist in determining if a CA is necessary (DH, 2000 3.12). During the IA stage interviews may take place with the family but there is a requirement for the child to be seen:

As part of any Initial Assessment, the child should be seen. This includes observation and talking with the child in an age appropriate manner. (DH 2000, 3.10).

An assessment cannot be made without seeing the child, however young and whatever the circumstances. (DH 2000, 3.42)

There is no mention with regard to what should happen in the case of an IA on an unborn child and the exemplar IA form issued in 2003 as part of the Integrated Children System (ICS) does not guide the assessor toward any specific information pertinent to conducting a pre-birth assessment. There is a requirement, however, for the assessor to analyse the information gathered and to decide if the child is defined as a child in need or at risk of significant harm under sections 17 or 47 of the Children Act 1989. The ICS exemplar form categories the possible actions following the IA as follows:

- Initiate a strategy discussion
- Immediate legal action to protect the child
- Core Assessment
- Provide accommodation (including respite care)
- Provide short term services
- Commission specialist assessment

- Referral to other agency (ies)
- No further action

(DH 2003 Initial Assessment Record page 6, see appendix 8)

The assessor is required to tick the boxes corresponding to the above decisions but there is no requirement for the assessor to record the reason(s) for their decision. There is space on the IA form for the child and the parent or carer to add their comments to the assessment and a set of boxes to tick to indicate if the assessment has been shared with them and if they have been given a copy of the assessment. The decision to initiate a strategy discussion relates to the procedures to follow in cases where there are concerns a child may be suffering significant harm (as defined by the Children Act 1989 s47) and if, following the strategy discussion, the plan is to complete an assessment under section 47 of the Children Act 1989 then a CA will be initiated and used as the tool for information gathering.

A CA is deemed to have commenced at the point at which the IA ends or the decision of a strategy discussion is to initiate enquires under section 47 of the Children Act 1989 (DOH 2000 3.11) and is defined as:

... an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parent or caregivers to respond appropriately to those needs within the wider family and community context. (DH 2000, 3.11)

A CA should be completed within a maximum of 35 working days and whilst led by a social worker it should involve other agencies and other professionals who can either contribute specialist knowledge or who have specific information about the child and family. Chapter 5 of *The Assessment Framework* (DH 2000) outlines the roles and responsibilities in inter-agency assessment and highlights the importance of ensuring optimal outcomes for children as well as avoiding duplication of services. Midwives, along with nurses, health visitors and school nurses, are identified amongst the groups of professionals who may contribute to an assessment, the guidance stating that:

The midwife and health visitor are uniquely placed to identify risk factors for a child during pregnancy, birth and the child's early care. (DH 2000, 5.24)

There is no other reference to midwives or assessment of the unborn child in the *Assessment Framework* guidance published in 2000, however, the exemplar CA document, issued in 2003, does incorporate questions pertinent to a pre-birth assessment.

The CA record was split into age bands and, for the youngest age band, originally covered birth to two years (NSPCC *et al*, 2000). This was a direct reflection of the Action and Assessment Record which were used to monitor progress and needs for children Looked After by the LA (DH 2000). However, the equivalent age band on the *Integrated Children's System* exemplar forms (DH 2003) (in use during the course of my research and the subject of discussion from herein) is pre-birth to one year (see Department of Health 2003 exemplar, appendix 9). The first part of the 24 page ICS exemplar CA document covers basic details and a summary of the reasons for undertaking the assessment. For the assessment of the unborn child there are twenty questions, organised over two pages of A4 which can be broadly categorised as relating to maternal health, pregnancy and pre-natal development, maternal use of drugs or alcohol, expectant parents' preparation for the baby and any history of child protection or court involvement with previous children. The exemplar then directs the assessor to move from page six to page fifteen, the section of the assessment relating to parental attributes, family and environmental factors and the summaries and analysis of the information gathered.

The ICS exemplar also breaks down the possible responses into similar categories to the IA although the decision to complete a CA is removed from the list and the decision to provide services under S17 of the Children Act 1989 for a child in need is added. Unlike the IA, there is also the option in the CA for 'other', therefore indicating the assessor is not constrained merely by the tick boxes and decisions available on the form.

The *Assessment Framework* (DH 2000) has become a fundamental part of policy and practice frameworks in children's services (Rose 2010). In the early stages of implementation of the *Assessment Framework* a government commissioned study found there was more transparency and accountability in working relationships with families and a more focussed approach to assessment (Horwath 2010). However, since implementation there have also been further developments, including the introduction of the CAF (Children's Workforce Development Council 2009) with an emphasis on early intervention and prevention and the ICS (DH, 2003), designed to improve efficiency and standardise how information is recorded (Cleaver *et al* 2008; Horwath 2010).

4.4.2 The Common Assessment Framework (CAF)

The CAF is designed as a tool to aid early intervention and co-ordination of services and support for children in need. The CAF is not designed for use in cases where there are concerns about a child who may be suffering, or may be at risk of suffering significant harm; in such cases the LSCB procedures must be followed (Children's Workforce Development Council, 2009) and children assessed using the *Assessment Framework* (DH 2000).

The aim of the CAF is to help identify needs at an earlier stage so practitioners can assist in meeting those needs. A 'lead professional' takes responsibility for coordinating information and acts as a central point of contact for families where there may be several professionals or agencies involved in providing support. The CAF is designed to provide a common assessment tool for use by all practitioners in all agencies working with children and provides a structure for multi-agency assessment, provision of services and review. The guidance issued to practitioners outlines circumstances when the CAF may be used and, with regard to pre-birth assessment, states:

The CAF can be used to assess the needs of unborn babies, infants, children or young people. (Children's Workforce Development Council, 2009. 2.3)

With its focus on individual needs and strengths (Children's Workforce Development Council 2009) the CAF's emphasis is on ensuring the multi-agency support network meets the identified needs of the child and builds on a family's strengths. Organised around a standard form that can be stored electronically and accessed by other professionals, the ideology is that families should not have to repeat the same information over and over to different agencies and practitioners can access information that is recorded using a common language and format. Research by White et al (2008) found the CAF constrained professional practice because of the focus on categorisation and description. Alongside this the institutional context within which the forms were being used placed requirements upon the author to present information in certain ways. In relation to referral it was found:

... completing the CAF for the purpose of referral to another agency placed particular requirements upon the author to present information in a manner designed to engage their interest and resources. (White et al, 2008. p16).

The purpose here is not to analyse the use and completion of the CAF but, for now at least, to highlight how information gathered and recorded during the CAF stage of intervention can have a direct impact on what happens next with regard to assessment. In particular, the *Assessment Framework* (DH 2000) guidance identifies that prior to referral there is likely to have been previous involvement:

Prior to social services departments becoming involved with a child and family a number of other agencies and community based groups may have had contact with the family. For some children assessments will have already been carried out for purposes other than determining whether they are a child in need. (DH 2000, 3.2)

In such cases the information may have been gathered following the CAF process.

4.4.3 The Integrated Children's System (ICS)

The ICS has been a key feature of the government's agenda for change in England and has been under construction since 2000 (Cleaver *et al.*, 2008). Shaw *et al* (2009) commented on the government's intention for ICS to be central to statutory childcare practice and therefore applicable to all children in need in England. Operational in LAs in England since 1st January 2007 and Wales since 31st December 2006, the ICS provides an electronic record of professional involvement, assessment, decision making and review from first point of contact to case closure (Cleaver *et al.*, 2008).

The Green Paper *Every Child Matters* (Cm 5860, 2003) led directly to the passing of the Children Act 2004 (there being no associated White Paper) and brought in a range of reforms relating to the e-government agenda particularly relating to information sharing between professionals. The ICS not only relates to children in need and those considered to be at risk of significant harm but also forms part of the wider remit of ensuring children achieve their optimum potential. Part of the process of ensuring children achieve their potential and that information technology enhances professional practice has been the development of processes that seek to ensure information is shared across agencies.

The Children Act 2004 (part 2 s12) underpins the requirement for LA children's services to establish and operate databases relevant to interagency co-operation to improve the welfare of children and the arrangements to safeguard children. Whilst there is no one national computer system there are requirement for systems to be ICS compatible and systems are required to contain information in a manner which has commonality across all LAs in England. They are also to be organised around a set of exemplar forms that set out what should be recorded at different stages of social work intervention (Shaw *et al*, 2009). The '*Referral and Information Record*' (appendix 7), the '*Initial Assessment Record*' (appendix 8) and the '*Core Assessment Record*' (appendix 9) form part of the battery of exemplar documents that were in operation during the data gathering stages of my research.

ICS is now regarded as unhelpful in that it creates a 'micro-control of workflow' which, in turn, results in social workers spending time engaged in repetitive form filling and reducing the time available to engage with children and families (DfE 2011). However, in commissioning Munro to undertake a review of frontline child protection services the current government has outlined their commitment to reducing bureaucracy whilst maintaining accountability. Clearly there will be ongoing change and reform but, during the period of my research the ICS was in the early stages of implementation and will be a focus of discussion in subsequent chapters of this thesis.

4.5 Conclusion

This chapter has served to outline the legal, procedural and policy context of pre-birth assessment. In doing so the chapter has considered the legal framework of the Children Acts 1989 and 2004 and the statutory guidance contained in *Working Together* (HM Government 2006) as well as the *Assessment Framework* (DH 2000). Explanation has also been given relating to the CAF and ICS systems which were in operation during the data gathering process of this thesis.

What is evident is that laws designed to safeguard children do not apply pre-birth as the unborn child does not have any legal rights. Despite this *Working Together* (HM Government 2006) indicates that procedures applicable for children are also applicable for unborn children. Alongside the lack of legal status of the unborn child, scientific development has opened the door to debate surrounding what scientists can and cannot do to human eggs and furthered the moral debate surrounding the morality of abortion. In response the Human Fertilisation and Embryology Acts of 1990 and 2008 were developed to provide guidance and case law has highlighted that pregnant women have autonomy over their own body. In response to the question what does the law say about pre-birth assessment what is evident is that there are two aspects to the law. Firstly, the aspect that considers child protection, safeguarding and children in need. Secondly, the aspect that considers the fetus.

What emerges is a confusing picture and one which places professionals involved in pre-birth assessments in a difficult situation of being directed by statutory guidance to treat the unborn child the same as any other but with a wider legal framework which supports totally the rights of the mother. From a Lipskyan perspective, street level bureaucrats are left grappling with the same issue debated by the House of Lords when they concluded that an unborn child is a 'unique organism' and that to 'apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead' (UK House of Lords Decisions 1994. no page number). In later chapters I will look at how social workers actually approach pre-birth assessment and, in so doing, will consider how, on a day-to-day basis they interpret the confusing framework. However, in the first instance I will consider Local Safeguarding Children Board procedures in order to build on research question one 'Where does pre-birth assessment fit in the English legislative, procedural and practice framework?' which has been considered in this chapter.

Chapter 5

Phase 2 results: Exploring Local Safeguarding Children Board Guidance

5.1 Introduction

Documentary analysis of Local Safeguarding Children Board (LSCB) guidance was undertaken as phase 2 of my research with the purpose of considering the research questions:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

ii) What are Local Authority processes in relation to pre-birth assessment?

In this chapter I will briefly outline the context to LSCB procedures and then explain the rationale for wanting to access all such procedures in England. The chapter then focuses on the findings from my analysis before summarising the emergent themes. As discussed in Chapter 3, in order to structure my data collection recording and to assist in the analysis a data collection tool was devised (see Appendix 1). This tool was based on the information contained in *Working Together* (HM Government 2006) and my research aims and questions. The presentation of the findings are therefore, also structured around the data tool.

5.2 The context of Local Safeguarding Children Board procedures

As indicated in previous chapters, children's services have been shaped by history, social perceptions and policy development. Historically, under the remit of Area Child Protection Committees, LAs produced detailed procedures which outlined what should happen if a child was abused or thought to be at risk of abuse (Frost and Parton 2009). Where there were deemed to be significant concerns for a child their name could be placed on the child protection register. Whilst there was emphasis on agencies working together, social workers took the lead role in gathering and coordinating the information held by other agencies and LAs were regarded as the lead agency.

In 1993 the term safeguarding began to appear in relation to concerns about children in public care (Frost and Parton 2009) and on the 1st April 2006 the term came into widespread use

when the statutory Local Area Safeguarding Children Boards (LSCBs) replaced the non-statutory Area Child Protection Committees. Policy initiatives under the Labour Government's *Every Child Matters Change For Children Programme* (HM Government 2004) and the enquiry by Lord Laming into the death of Victoria Climbié (Cm 5730, 2003) helped create a shift in emphasis from child protection to the much wider remit of assessment and provision of services for all children in need.

The Children Act 2004 introduced statutory changes in the administrative functions surrounding children's services that encompassed the much wider remit of early intervention and working with all children in need (in need as defined by the Children Act 1989). LAs were given the task of establishing LSCBs with a membership that represented local services and local needs. *Working Together* provided clear policy guidance that LSCB members must hold strategic responsibility in the agency they represented and so be able to commit their organisation to practice and policy decisions surrounding local services for children (HM Government 2006). What this shift encompassed was recognition that multi-agency co-operation should span all levels within children's services organisations and that effective service provision may also require pooled budgets and co-ordinated services.

Chapter 3 of *Working Together* (2006) set out the role of the LSCB, highlighting the particular focus on the 'staying safe' outcome identified in the five *Every Child Matters* outcomes (HM Government 2004). Whilst LSCBs do not directly provide front line services the Children Act 2004 set out the core objectives as:

- to co-ordinate what is done by each person or body represented on the Board for the purpose of safeguarding and promoting the welfare of children in the area of the authority
 - to ensure the effectiveness of what is done by each such person or body for that purpose
- (Children Act 2004 s14(1))

Working Together (2006) guidance provided further details of what was required of LSCBs in the fulfilment of their core objectives which includes:

(a) Developing policies and procedures for safeguarding and promoting the welfare of children in the area of the authority, including policies and procedures in relation to the following:

(i) The action to be taken where there are concerns about a child's safety or welfare including the thresholds for intervention.

(HM Government, 2006, 3.18)

The policy and procedural function of the LSCBs was the focus of my documentary analysis of LSCB procedures in England. Having conducted a documentary analysis of *Working Together* (HM Government 2006) I anticipated that LSCB would include some reference to pre-birth assessment that, at the very least, replicated that in the statutory guidance. I did, however, anticipate the LSCB procedures would perhaps say more and, in relation to pre-birth assessment reflect the *National Service Framework for Children, Young People and Maternity Services Core Standards* (DH 2004) which set out the government's commitment to a 10-year plan to improve the health of children and young people. In particular the plan identified the key role midwifery services play in the early identification of children's needs, which would be central to safeguarding unborn children.

5.3 Rationale for the 100% Sample of LSCB Procedures

The geography and demography of England is quite diverse with some parts of England being predominantly rural whilst others are predominantly urban. Some areas have particular features which may have an impact on professional practice in safeguarding children, for example, having an army base which would involve working with families who move around the country in response to army postings or having a woman's prison which houses a mother and baby unit. Although the Children Act 2004 lists agencies that should make up the LSCB membership, there is also scope to allow for some differences in membership in response to local needs and demography. To ensure the documentary analysis captured the potentially wide variations that might be in existence, all LSCB procedures in England were accessed.

The first stage of the data gathering process was to establish the name and location of each LSCB in England. The Department for Children, Schools and Family published on its web pages a list of Children's Services Authorities and therefore, my first step was to download the list for 28th February 2008 (DFCS 2008), which was then used as the basis for accessing LSCB procedures.

Data for the documentary analysis of LSCB procedures were gathered online between the 1st and 30th April 2008 for all procedures apart from those of Nottingham LSCB. Nottingham's procedures were not available online in April 2008 but they had become available online by June 2008 and so were accessed slightly later than the others.

In April 2008 there were 151 children's services authorities listed in England. Of these the following areas were linked into one administrative area, for LSCB purposes, resulting in a total of 144 LSCB areas.

- City of London linked to Hackney
- Isles of Scilly linked to Cornwall
- Leicestershire linked to Leicester
- Middlesbrough linked to South Tees
- Poole linked to Bournemouth
- Redcar and Cleveland linked to South Tees
- Rutland linked to Leicester

In addition to combining for administrative purposes, several LSCB areas had also joined forces with other (usually geographically close) LSCBs when it came to devising shared procedural guidance. Thus, in April 2008, the 144 LSCB areas in England were actually covered by a total of 73 sets of procedural guidance.

All of the LSCBs in England had a web page dedicated to safeguarding children and which outlined the LSCB function and remit and provided links to relevant documents including the safeguarding procedures. All of the LSCBs produced procedural guidance in either a PDF or word-based document or as a web page based system. Each set of procedures were searched by reading the subject index pages looking for any reference to unborn children. I also searched the sections of the procedures that related to assessment and child protection conferences even if where unborn children were not specifically referred to in the index. My rationale was to search in sections of the LSCB procedures which may relate to, or replicate, sections of *Working Together* (HM Government 2006) that made specific reference to unborn children.

As indicated already Appendix 1 '*Analysis of Safeguarding Procedures*' was used to structure and record the data collection.

5.4 Results

The findings below are presented in four sections which roughly correspond with the 8 questions listed in Appendix 1 although, because it was found that some of the questions overlapped to an extent, some sections address more than one question at a time.

5.4.1 Section 1: The extent to which pre-birth assessment is addressed

Q1 Is pre-birth assessment addressed in the procedures?

Q2 If yes how much space is allocated to it?

Q3 Is paragraph 5.14 of Working Together (HM Government, 2006) reflected in the procedures?

Q4 How far does the guidance reflect paragraph 5.140 of Working Together (HM Government, 2006)?

Paragraph 5.14 of *Working Together* states:

Procedures and timescales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child. (HM Government 2008, 5.14)

Paragraph 5.140 states:

Where a core assessment under s47 of the Children Act 1989 gives rise to concerns that an unborn child may be at future risk of harm, LA children's social care may decide to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and proceed in the same way as other initial child protection conferences, including decisions about a child protection plan. Child protection review conferences should also proceed in the same way. The involvement of midwifery services is vital in such cases. (HM Government 2008, 5.140)

Of the 73 sets of procedural guidance 66 (90%) contained, at the very least, a reference that indicated the procedures applied to unborn children. The depth of reference varied from a direct quote of paragraph 5.14 and 5.140, a paraphrase of paragraphs 5.14 and 5.140 or a direct web link to *Working Together* (HM Government 2006).

I was unable to find any reference to unborn children, pre-birth assessment or pre-birth safeguarding conferences or a web link to *Working Together* (HM Government 2006) in seven sets of procedural guidance (10%).

With regard to the data tool question 2, the amount of space allocated, I had originally expected that I would be able to quantify a) the number of pages in each set of procedures and b) the number of pages allocated to pre-birth assessment. However, it was not possible to make like-for-like comparisons across the sets of procedures because there was little consistency in the formatting and presentation of the procedures and many differences in the content and extent of additional information that was provided. In the end, therefore, I decided to distinguish between:

- Those sets of procedures that did not go beyond the guidance contained in *Working Together* (HM Government, 2006);
- Those that did offer additional guidance.

Out of the 66 sets of procedures that addressed pre-birth assessments at all, 42 sets of procedures (64% of the 66 sets) contained information that was additional to that contained in *Working Together* paragraphs 5.14 and 5.140 (HM Government 2006).

The following extract is an example of information I regarded as modest additional guidance:

Pre-birth core assessments may be carried out following a referral from a professional who is concerned that prospective parents may need support to care for their baby, without which they may not be able to provide for the baby's well-being and welfare, or where there are concerns the baby may be at risk of significant harm.

The referral will usually result in an initial assessment being completed followed by a planning meeting to agree which agencies need to contribute to the core assessment and identify what specific areas of knowledge about the family they may have. It should also clarify what support can be made available, by which agency, after the birth.

Pre-birth assessments should identify any potential risk to the baby which may suggest a need for immediate action to protect the child after birth. In circumstances where a pre-birth conference has taken place and a child protection plan put in place a 'review conference' must be held prior to the baby's discharge, even if that discharge is to a 'place of safety'.

(Wigan Safeguarding Children procedures accessed online April 08)

On the other hand, five LSCBs provided guidance that spanned between six to 19 A4 pages. The type of information covered in these procedures included guidance on early identification and assessment, levels of risk and pre-birth strategy or planning meetings. With regard to early identification the type of information covered included:

Women who are pregnant may present initially via a number of different professionals, for example GP, hospital antenatal services, community midwife services, health visitor or housing officer. Additionally, other health professionals may become aware of a pregnancy prior to a formal referral to the obstetric/midwifery services. It is important that all professionals are aware of assessment needs and of other routes of referral in order to facilitate care and intervention.

(Bracknell Forrest Safeguarding Children Procedures accessed online April 08)

All professionals working with families need to be alert to the factors that may indicate a potential risk to the child either before or after birth. It is vital that assessments are started early and that information is shared so that the child and family have the necessary support and best start to family life thereby minimising the need for child protection intervention. (South West Safeguarding Children Procedures accessed online April 08)

The procedures which attempted to categorise levels of risk categorised 'low level' as identified early in pregnancy (8-12 weeks) but did not specify what 'low level' may be. The procedures stated that discussion should be held between the midwifery services and children services to establish if additional support would be appropriate. In relation to 'medium' and 'high' levels of concern the following statements were made:

Medium/high level concern exist when there is reason to believe that an unborn baby may be a child in need, or in need of protection, and is unlikely to achieve and maintain a reasonable standard of health and development without high level intervention from a number of services. (Bracknell Forrest Safeguarding Children Procedures accessed online April 08)

This [medium /high] level of concern relates to when there are concerns that an unborn baby may be 'in need' (section 17) or 'in need of protection' (section 47) which means that their basic physical and/or psychological need will not be met and is likely to impair the child's health or development. (South West Safeguarding Children Procedures accessed online April 08)

Although there was some recognition of varying levels of concern or categories of risk there were no explanations or examples of what may constitute 'reasonable' standards of health and development. In the second example there was also an assumption that anyone reading the procedures knew the differences between the sections of the Children Act 1989 to which reference was made.

Information regarding pre-birth strategy or planning meetings included comments such as:

This discussion should be in the form of a meeting chaired by a Children's social care line manager and involve:

- Community midwife
- Maternity services manager
- G.P
- Health Visitor
- Police
- Social Worker
- Other professionals as appropriate, eg. obstetricians, mental health services, probation
- Where required by a legal advisor

The purpose of the meeting is the same as that of other strategy discussion and should determine:

- Particular requirements of the pre-birth core assessment
- Whether a S.47 enquiry is to be initiated
- Role and responsibilities of agencies in the assessment
- Role and responsibility of agencies to provide support before and after the birth

(Sussex Safeguarding Children Procedures accessed online April 08)

In the above example the circumstances when a strategy discussion/meeting should be held would be any situation that may constitute 'significant harm' and required a referral being made to the LA children's services department. It seems interesting that a meeting which brought together the group of professionals identified in the above quote would be held prior to a core assessment being undertaken as the resource implication would be quite significant and may not be proportionate to the 'significant concern'. For example, a significant concern for a child could involve parents who were willing to co-operate with a support package but who had physical, mental or learning difficulties which necessitated additional support being provided. Notably, the above list of people to be invited to the meeting did not include the parent(s), family members or voluntary agencies.

The above procedures were not alone in holding a planning meeting prior to the assessment process:

An initial multi-disciplinary planning meeting is to be held to plan the pre-birth assessment. A pre-birth assessment must be based on a robust assessment model, such as that given in Section Two.

The meeting, to be convened by Children's Social Care, is to be held during the 19th or 20th week of pregnancy.

Agencies/professionals who should be invited include:

- Children's Social Care Team Manager and Social Worker
- Identified Midwife
- The likely Health Visitor
- The family GP
- A representative of any local family centre or equivalent, where appropriate.
- Any other professional involved with the family.

Relevant information held by the Police and by the Named Nurse/Senior Nurse for Child Protection should be obtained.

Parents should throughout be involved in planning as far as possible.

A date should be set for a further multi-disciplinary planning meeting (which is to take the form of a child protection strategy meeting if the assessment outcome indicates the baby is likely to be at risk of significant harm).

(North Yorkshire Safeguarding Children Procedures accessed online April 08)

Whilst the above quote does make it clear that parental involvement should occur there appeared to be no procedural guidance to direct professionals to invite them to the meeting.

Interestingly, 12 sets of procedures were based on the same web based system called 'Tri-X'. Although the 12 LSCBs were from around England and represented different demographic factors and local needs, in relation to unborn children, the procedures were exactly the same. In each of these 12 sets of procedures additional reference to unborn children was only made in relation to safeguarding conferences, comprising one and a half A4 pages of information focussed only on the timing and administrative process of such conferences. There was therefore, emphasis on child protection as opposed to working with children in need.

5.4.2 Section 2: Distinctions between pre and post-birth assessment

Q 5 Is distinction made between pre-birth and post-birth assessment?

Some sets of procedures did attempt to address distinctions between pre-birth and post-birth assessment. These distinctions were related to, firstly, helping to clarify the reasons why a pre-birth referral might be made and, secondly, to the process of assessment itself. These are discussed in turn.

Reasons for a pre-birth referral

17 sets of procedures (26% of the 66 sets of procedures making reference to unborn children) made reference to the reasons why a pre-birth referral may be appropriate. The type of information ranged from paragraphs of information of varying lengths through to lists of information. An example of information provided in paragraph format was taken from Durham LSCB procedures that stated:

Where an agency 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 Safeguarding and Specialist Services must be made after 20 weeks gestation unless the mother is known to abuse substances or where there are serious concerns for the unborn baby.

Where the concerns centre around a category of parenting behaviour, e.g. substance misuse, the referrer must make clear how this is likely to impact on the baby and what risks are predicted.

(Durham Safeguarding Children Procedures Accessed online April 2008)

An example of information provide in list format was taken from Hampshire LSCB procedures:

- 1) There has been a previous or unexpected or unexplained death of a child whilst in the care of either parent
- 2) A parent or other adult in the household is a person identified as presenting a risk to children
- 3) Children in the household / family currently subject to a child protection plan or previous child protection concerns
- 4) A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order.
- 5) Where there is a knowledge of parental risk factors including mental illness, domestic violence, substance misuse, learning difficulties
- 6) Where there are concerns about parental ability to self care and/or care for the child e.g. unsupported or young learning disabled mother
- 7) 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
- 8) Any other concern exists that the baby may be at risk of significant harm

(Hampshire Safeguarding Procedures accessed online April 08)

As can be seen from the two examples above there were varying degrees of information provided to front line professionals on when to make a referral to the LA.

Pre-birth versus post birth assessment

13 sets of procedures (20% of the 66 sets of procedures making reference to unborn children) made specific reference to doing a pre-birth assessment. 10 of these 13 sets of procedures provided reasons for undertaking either a pre-birth initial or a core assessment but offered no guidance on how to approach the assessment. Three sets of procedures made reference to Calder (2003); one of the three contained a one paragraph quoted from Calder's publication, the other two contained information based on Calder's model of pre-birth assessment.

Northumberland LSCB contained information about when and how to conduct pre-birth assessment and was one of the procedures that made specific reference to Calder (2003). It is, perhaps, worth noting that Northumberland County Council had been involved with a pre-birth case that had received media attention in late 2007. Fran Lyon alleged that Northumberland social workers had held a pre-birth child protection conference and planned to

remove her baby from her at birth. Fran Lyon went public on the matter and the Sunday Telegraph reported:

Under the plan, a doctor will hand the newborn to a social worker, provided there are no medical complications. Social Services' request for an emergency protection order – these are usually granted – will be heard in secret in the family court at Hexam magistrates on the same day. (Harrison 26th August 2007)

The Chair of Northumberland LSCB, in response, issued a press release and stated:

Due to legal reasons we are unable to discuss the detail of individual cases and unfortunately it does mean that only one side is being heard. (Doughty 27th November 2007)

Northumberland LSCB's guidance on pre-birth assessment was the most in depth of all of the procedures I accessed in April 2008, which may, in some part, be a response to media attention given to this case in 2007.

5.4.3 Section 3: Legal status of the fetus and maternal rights

Q 6 Is the legal status of a fetus addressed?

Q 7 Is there any guidance regarding a pregnant woman's right to autonomy over her own body?

Of the procedures that contained additional information 3 sets of procedures (just 4% out of the total sample of 73 sets of procedures) made specific reference to the unborn child having no specific rights in law. For example, the Isle of Wight procedures stated:

UK law does not afford legislative rights to an unborn baby. In some circumstances though, agencies or individuals are able to anticipate a likelihood of significant harm with regard to the as yet unborn baby.

(Isle of Wight, Hampshire, Portsmouth and Southampton LSCB procedures accessed online 5th April 2008).

Put another way, apart from these 3 sets of procedures, the 63 sets that contained basic or additional information seemed to have assumed that procedures applicable to a child could be readily applied to the unborn child. None of the procedures made any reference to the rights of a mother to retain autonomy over her own body either with reference to her right to refuse medical treatment or to refuse to take part in the assessment process.

5.4.4 Section 4: Timescales

Q 8 Is there any guidance regarding the timescales for intervention pre-birth?

The procedures containing information pertinent to timescales had information that related either to the timescale for referral or the timing of the child protection conference. Where timescales were mentioned, this ranged from a statement such as, '*as soon as concerns are recognised*' (Derbyshire LSCB procedures Accessed April 2008) through to specific timescales.

In total, 27 sets of procedures (41% of those making any reference at all to unborn children) had a specific timescale for referral or the child protection conference. Two sets of procedures made specific reference to the timescale for referral. Durham (quoted above in relation to additional information) set a timescale for a referral as 20 weeks' gestation but did not set a timescale for the child protection conference. Similarly North Yorkshire stated:

Referrals about unborn babies should be made by the 18th week of the pregnancy, unless it has not been possible to meet this timescale, for example, because the pregnancy has been concealed.

(North Yorkshire LSCB procedures accessed online April 08)

Durham and North Yorkshire LSCB procedures both indicated that the reasons for early referral were to provide sufficient time to conduct full and informed assessments, to enable parents to contribute to the process and increase the chances of a positive outcome to the assessment and (or) make plans for the baby's protection where necessary.

The remaining 25 sets of procedures focussed on the timescale for the child protection conference. Fourteen sets of the procedures set the time scale for a child protection conference to be held at 12 weeks before the expected date of delivery (or expressed this as 28 weeks' gestation). Nine sets of procedures gave a time scale of 8 to 10 weeks before the expected date of delivery (30 to 32 weeks' gestation). One set of procedures gave the time scale of 6 to 12 weeks before the expected date of delivery (the 28th to 34th week of gestation). One set of procedures set the time scale as before 28 weeks' gestation.

When a rationale was offered for the time scale, this related to allowing time for assessment and planning: For example Warrington LSCB stated:

Wherever possible the pre-birth child protection conference should be held before 28 weeks' gestation to provide sufficient time for an appropriate plan and assessment to be made. (Warrington LSCB procedures Accessed online April 08)

In relation to timescales one set of procedures did mention the '*foetus*':

Child protection concerns for an unborn child should be referred immediately to Children's Social Care for an Initial Assessment in the usual way. Whilst a Core Assessment of the need of the unborn child may be initiated where a Child Protection Conference is deemed necessary, this will not be convened until the foetus is 24 weeks, the accepted legal definition of a viable foetus. (Hull LSCB procedures accessed online April 08)

In all of the procedures the timescale for the safeguarding conference related to procedural issues and allowing time for professionals to conduct assessments and implement plans. There were no procedures that indicated that the time scale for the conference should reflect the mother's needs or that a conference should be delayed in the event of maternal ill health.

5.5. Other notable information contained in the LSCB procedures

In addition to the findings that related to the questions set out in Appendix 5, the data collection tool, two other interesting aspects were referred to in the sets of procedures that are addressed below.

Information sharing with parents

Common to all of the procedures were comments on working in partnership and sharing information with parents. One set of procedures made specific reference to the potential impact of information sharing on the unborn child:

Wherever possible, the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to Children's Social Care, unless this action may place the unborn child at risk, for example, through termination of the pregnancy or the parent(s) possibly making their whereabouts unknown. (North Yorkshire LSCB procedures)

Whilst the issue of not knowing the parents' whereabouts carries somewhat obvious issues of potential risk both to the mother and the unborn child if services and support cannot be provided, North Yorkshire procedures offered no guidance on what action to take should this happen.

The issue of termination of pregnancy constituting a risk to the unborn child is an interesting one. In identifying termination of the pregnancy as action that may place an unborn child at

risk there is an implicit assumption that mothers should not have the right to choose abortion in cases where Children's Social Care intervention occurs. The North Yorkshire procedures did not explore the issue of sharing concerns and the termination of pregnancy further, therefore leaving something of an 'ethical gap' for professionals working with women in the early stages of pregnancy. If, for example, a social worker or health professional were anti-abortion would they read the procedures as a legitimate rationale for denying a pregnant woman the option of choosing termination rather than risk having her child removed at birth. Conversely, could social workers or health professionals who were pro-abortion influence a pregnant woman's choice and therefore deny her right to services that might produce desired change. There are whole layers of ethical dilemmas spreading from these two positions relating to the abortion debate as a whole but possibly also to the quite uncomfortable debate that could be had surrounding the financial savings that could be made with abortion as an alternative to children being removed from their families!

Pregnancy and children looked after

Bristol LSCB procedures were the only set of procedures to contain a section on working with teenagers who were in LA care and who had become pregnant. The guidance offered outlined how there might be difficulties in being able to make an accurate assessment of a teenager's parenting capacity. The procedures stated that the social worker and team manager should consider if a separate social worker, specifically to assess the needs of the unborn child, should be allocated. In cases where the teenager's social worker could complete the pre-birth assessment a separate referral on the unborn baby should still be created. If, however, a different social worker were needed then referral to another team was recommended in order to ensure objectivity. The procedures referred to a teenager who had become pregnant and did not indicate if a teenage father would require assessment or support.

5.6 The LSCB procedures covering the host agency

The LSCB procedures that covered the host agency in which the phase 3 fieldwork took place were accessed as part of this phase 2 documentary analysis stage and, therefore, general findings from them are incorporated in the above results. With regard to their actual content, the LSCB procedures covering the host LA area contained a reference to the procedures relating to pre-birth assessment in the format of a web link to the two paragraphs contained in *Working Together* (HM Government 2006). During my time based in the host LA gathering data I checked the procedures several times but no additional information was added with regard to pre-birth assessment.

The host agency's LSCB derived procedures were an example of a LSCB which had joined forces with other geographically close LSCBs in relation to the production of procedures which reflected local need. The procedures were in electronic format and could only be accessed from a computer that had access to the Internet. The LSCB had issued information in the form of emails, letters and visits by staff from the safeguarding unit to teams and departments to all agencies about the use of the electronic procedures. This guidance explained how to search the electronic procedures and outlined the importance of discarding any previous paper based procedures as these would not continue to be updated and would not, therefore, reflect the up-to-date electronic guidance.

During my time spent in the host LA administration staff and professionals from other agencies advised me that the electronic procedures caused some agencies and individuals particular difficulties. One area of difficulty related to concerns that not everyone who may need to access the procedures had the level of computer literacy needed to search the system. However, a more significant concern related to physical access to the Internet in the working environment. The electronic procedures covered a wide geographical area which contained several prisons and hospitals. I was advised prison staff had limited access to the Internet as a result of the high security levels and hospital staff did not always have access to a computer in their work setting, or if they did the computer was used for patient records and linked to hospital systems only. There had been discussion with regard to supplying procedures in a paper format or on a CD, however, the LSCB had decided against this on the basis of not being able to update procedures. During the time I gathered data from the host LA I was not aware of a resolution to this difficulty.

5.7 Conclusion

The documentary analysis of LSCB procedures began with an expectation that there would, at the very least, be a replication of the content contained in *Working Together* (HM Government 2006). However, I also expected that the LSCB procedures would say more about pre-birth assessment and intervention, partly because of the need to reflect local demography.

In 2008, when I accessed the procedures, LSCBs were relatively newly established, having replaced the former Area Child Protection Committees two years previously. The documentary analysis indicated that some LSCBs had joined forces in the process of producing guidance, resulting in the 144 LSCBs being covered by 73 sets of procedural guidance. With regard to Questions 1, 2, 3 and 4 on the data tool, (which relate to the extent to which pre-birth assessment is mentioned) I found that the majority of procedures at least made some

reference to unborn children with only 7 (10%) of the total 73 sets of procedures making no reference at all. 66 (90%) of the procedures indicated that they applied to unborn children but the extent to which comment was made varied and focus was predominantly on procedural issues such as when and how to make referrals and time scales for child protection conferences. A direct quantifiable comparison of the amount of space allocated in each set of procedures to unborn children was not possible due to the differing formats of the information. However, I was able to identify variations that ranged from a direct quote of paragraphs 5.14 and 5.140 of *Working Together* (HM Government 2006) to one set of procedures which contained 19 A4 pages of relevant information. What emerged in the procedures that did provide additional information was that the language of well-being and working with need permeated the procedures. This was in line with the legal framework of the Children Acts 1989 and 2004 which embody notions of working in partnership with parents and procedures which focus on health and wellbeing and not simply on child protection.

With regard to the distinction between pre and post-birth assessment (Question 5 on the data tool) I found 17 sets of procedures (26% of the 66 sets of procedures making reference to unborn children) made reference to why a pre-birth referral to a LA may be appropriate. With regard to actual assessment following referral, 13 sets of procedures (20% of the 66 sets of procedures making reference to unborn children) made reference to the process of pre-birth assessment with three of these making reference to Calder's (2003) model (see Chapter 2 for an outline of this model). It was interesting to note that Northumberland who, following their involvement with Fran Lyon became the subject of media attention, was one of the LSCBs who offered additional guidance on pre-birth assessment.

In relation to Questions 6 and 7 of the data tool (looking the lack of legal status of the feuts and the rights of the pregnant woman) what was noteworthy was that where any reference was made to any form of pre-birth assessment or intervention the terminology used was 'unborn child' or 'unborn baby' rather than fetus. As indicated in Chapter 4, *Working Together* (HM Government 2006) used the term 'unborn child' and so the terminology used in the LSCB procedures may be a direct result of the national guidance, however it may also be because those writing local procedures have not given thought to the terminology. As indicated in Chapter 4, the legal and procedural basis for pre-birth assessment contains several ambiguities with the unborn child having no legal status whilst *Working Together* (HM Government 2006) contains explicit statements that procedures that applied to a child could be readily applied to the unborn child (paragraphs 5.14 and 5.140). The documentary analysis demonstrated that this perhaps inappropriate certainty at a national level had been translated, and in some cases built on, at LSCB level. In the process of attempting to add clarity by adding to the statutory guidance it was evident that pre-birth assessment guidance was

evolving without consideration of the ethical, moral or practical considerations linked to the unique relationship between a pregnant woman and her unborn child.

The final question on the data tool related to timescales and here it was found that 27 sets of procedures (41% of those making any reference at all to unborn children) had a specific timescale for referral or the child protection conference. Focus was on procedural issues surrounding timescale with only Durham and North Yorkshire making reference the impact early assessment may have on the family. North Yorkshire's procedures are particularly interesting in that they venture into the ethical grounds surrounding the lack of legal status of the child and the rights of the mother and comment that information available to professionals should not be shared with the pregnant woman if doing so may result in the termination of the pregnancy. In doing so North Yorkshire's procedures highlight how LSCBs, when attempting to add clarity without consideration of the legal issues identified in Chapter 4, can serve to potentially contravene maternal rights.

In conclusion, the documentary analysis has highlighted that, the majority of procedures at the very least follow the guidance contained in *Working Together* (HM Government 2006). However, where this guidance was built upon with additional guidance the LSCBs tended to focus on procedure and build on the anomalies inherent within the legal and statutory guidance framework. The language of promoting the well-being of unborn children was present but how to achieve this within the context of maternal rights was not considered within any of the LSCB guidance.

Having looked at pre-birth assessment work from something of a contextual, macro-level in phases 1 and 2 of the research, my focus turned to pursuing a more in-depth extended case study of policy and practice in one LA, phase 3 of the research design. However, before presenting the results of that phase, in chapter 6, a reflective account is provided of my experience of being in the host agency and how aspects of its organisation and other developments impacted on my fieldwork.

Chapter 6

Phase 3: Fieldwork in the Host LA – setting the scene

6.1 Introduction

Before presenting the phase 3 results in chapters 7, 8 and 9, it is important to outline the process of doing the fieldwork in the host LA as it both generated data and shaped how the data was gathered. The main purpose of this chapter is, therefore, to explain how children and family social work services were organised in the host LA and how information about families was managed and stored. The information in this chapter is drawn from information on the LA web pages (and therefore available to the public), procedural documents, my observations whilst accessing the electronic data base (EDB) and my experience of, in a research capacity, working with the electronic case files.

In the early stages of the research I had not anticipated undertaking any form of ethnographic research. Yet when I began reviewing the early stages of fieldwork in the host LA, it quickly became apparent that a great deal of data was being generated which was highly relevant. In particular there was data which was directly relevant to research question ii) what are Local Authority processes in relation to pre-birth assessment? In this chapter I will therefore, outline how the LA organised their children and family services relevant to assessment work and then I will consider the impact of the LA's methods of case recording and monitoring. The chapter will then move on to consider the wider social and political issues which had a direct impact on social work practice during the course of the phase 3 data gathering period.

6.2 The ethnographic elements of the research process

The data gathering process was undertaken in line with phase 3 of the research design set out in Chapter 3 and as such was not a piece of ethnographic research, however the process of observation had some elements of ethnography by virtue of spending time in offices accessing the case files. When planning the research, I did not consider the rich seam of data that would arise purely by virtue of actually being in the social work offices and asking questions about where and how information was stored on the computer systems. Accessing the computers for data took a considerable amount of time and as I did not have a specific desk to work from I spent many hours sitting in different offices in different team bases around the LA district. This time provided numerous opportunities to discuss the systems in place (particularly in

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relation to the paperless office environment (discussed later in this chapter), observe social workers' actual approaches to their work and engage in a range of conversations about pre-birth assessment.

In order not to breach my ethical approval I categorised data which was broadly ethnographic into three groups:

- information relevant to case recording systems and therefore not about service users;
- information about pre-birth assessment practice in general; and
- information which related to confidential case files.

In order to ensure I did not breach my ethical approval I was conscious that any conversations about specific cases could not be used as data as I did not have parental consent to use the information. However, with regard to all other information, I had approval from the LA to proceed with the research, to access the electronic systems and to interview front line staff. In addition staff in all of the offices had been given written and verbal information about my research. I also made a point of reminding people that I was conducting research when they began talking about general issues and also gave them the option of not saying anything. When working in the team offices staff, on the whole, showed an interest in my research and frequently spoke about their experiences of pre-birth assessment. As a 'rule of thumb' I used the principle that if a member of the public heard the information would it breach agency or client confidentiality. In situations where the answer was 'yes' information was either not used in the research or the formal process of obtaining written consent to take part in the research was followed.

Whilst the general conversation about pre-birth assessment practice generated some data the most significant seam of information related to the case recording systems and the general pressures staff felt they were under in the process of maintaining them. This was very interesting as in the initial stages of the research it had not occurred to me that the methods of case recording and creating the pre-birth files would constitute potential data and findings in their own right. However, as will be seen throughout this and the next two chapters, the computerised data recording systems had a significant impact on both my research and the practice of staff engaged in pre-birth assessments.

With regard to the computerised systems I spent considerable time accessing help and support from administration teams and the Information Technology staff. I was also required to take part in a half day training course for all new social work staff who had to use the Electronic Database (EDB) as part of their work. An understanding of the systems was essential to accessing data but also turned out to be essential to understanding how social workers

approached pre-birth assessment (research question iv). Without the training, time spent in the team offices and discussions with staff I would have had no understanding of the demands placed upon social workers as a direct result of the EDB. Equally I would have had no insight into other areas of pressure associated with the team roles and responsibilities, staff shortages and case loads, all of which I will now outline.

6.3 Team roles and responsibilities in the host LA

The host LA covered a geographical area of 350 square kilometres with a population of approximately 320,000 living in city, town, urban and rural communities. Following the decline of 'traditional' heavy industries in some areas other areas had seen economic improvement as a result of regeneration schemes and links to the local motorway network. The impact of the changing nature of employment had resulted in areas of economic affluence but local council planning policy had identified that 30% of the local population lived in the most deprived areas in England (LA web pages. Full reference withheld for reasons of maintaining agency confidentiality).

The LA's children's services social work teams were based in offices around the district and were organised around a model of intervention which distinguished emergency and duty intervention, longer term family support and child protection and long term looked after children's teams as follows:

6.3.1 Access point: Duty and emergency cover

Access point was the first point of contact for advice, screening and access to all social care services. A generic service available 24 hours a day, 7 days a week, the team also provided the out of hours' emergency social work services for the LA social care departments. The team was based in one office and was made up of social workers, managers and administrators and, apart from the administration staff, everyone working in the team was a qualified social worker. During the period of my fieldwork, the Access Point team comprised staff with a range of practice experience with some staff being newly qualified, some experienced in adult work, Approved Social Workers (an ASW is an experienced social worker who has undertaken additional training and is approved by the LA, in accordance with the Mental Health Act 1983, to undertake specific duties) and some experienced in children and families' work. Due to the demands placed on the service of the 24-hour cover, the volume of referrals for adult and children's services and staffing levels it was not always the case that a social worker with children and family experience dealt with referrals about children.

The Access Point was the only area of the LA services that required social workers to cover both adult and children's work. From the Access point teams referrals were passed to adult teams or the children's teams described below.

6.3.2 Initial Assessment Teams

There were three Initial Assessment Teams based in one office covering the whole of the LA. Their role was to deal with all requests for Initial Assessments (IA) on cases that were new to the LA or had no current active involvement from a longer term team. Each team had a manager, social workers and family workers (the job title 'family worker' related to staff across Children's Services who held no formal social work qualification but had child care experience or vocational qualifications relevant to working with children) with an administration team serving all three Initial Assessment Teams. In addition to undertaking assessments the Initial Assessment Team social workers also provided short-term support and interventions for up to a maximum of six-weeks. Any cases requiring longer-term intervention would be passed onto the Family Support or Looked After Children Teams. The Initial Assessment Team social workers might also be involved in preparing the most serious and urgent cases for court or child protection conference.

Both social workers and family workers were involved in undertaking IAs and there was no clear delineation of work, the only exception being child protection investigations as defined by s47 of the Children Act 1989. If a case was defined as such from the outset a social worker would take the lead in the assessment process, although staff reported it was not always possible to know a case was of this type until the worker actually went to visit the family. It was, therefore, an implicit expectation that family workers would be able to recognise and either obtain support from a social worker or deal with child protection situations alone on their allocated caseload.

6.3.3 Family Support Teams

There were five Family Support Teams based in two separate office locations. The teams covered the whole of the district and although some efforts were made to allocate work on the basis of geography (to reduce social workers travel time) cases were normally allocated according to the capacity of teams to accept new work. Each Family Support Team consisted of a manager, social workers and family workers with two separate administration teams (one at each office location) providing office support.

The Family Support Teams' remit consisted of work covering children in need (as defined by the Children Act 1989 s17), children subject to a Safeguarding (child protection) plan and

procedures and cases where the LA had made an application to the court for an order. Social workers would therefore be involved in a wide range of work including direct work with children and families, assessment, devising and managing support packages, report writing and attending meetings, child protection conferences and court. In cases where there were ongoing court proceedings Family Support Team social workers would also be responsible for the Looked After Child procedures (such as placement reviews) and be involved in the long term planning for children placed for adoption.

Although the majority of the Family Support work was planned, staff also had to be able to respond to emergency situations as they undertook all child protection investigations on cases that were already known to the LA (this involved cases being dealt with by the Family Support Teams, Looked After Children Teams and other Support Teams).

There were significant staffing shortages and this meant that the Family Support Teams were holding cases which were not actually allocated to a social worker. The unallocated cases consisted of children in need as well as some cases where children had been discussed at a child protection conference and were now subject to a safeguarding plan. A team manager advised me that each Family Support Team would have at least two cases (a case was defined as one family and not one child in this discussion) that had a safeguarding plan in place and at least 10 child in need cases unallocated. In order to deal with the child protection investigations and to manage the unallocated cases the Family Support Teams had initiated a form of duty system to ensure there were always at least two social workers in the office and available to deal with emergency situations which arose.

The family workers were, primarily, involved in managing and supervising contact with families for children who were subject to on-going legal proceedings and who were placed in foster care. Although located within a team, family workers worked across teams in an attempt to ensure all court directed contact was covered. Court directed contact took up a significant amount of time for family workers, due to the sheer volume of contact sessions and the travel involved in collecting children from foster placements and transporting them to the contact centres. Family workers also assisted social workers with complex cases and assessments and also held a small caseload of children in need (as defined by s17 of the Children Act 1989).

Cases would remain within the remit of the Family Support Teams until the child was no longer regarded as a child in need and the case could be closed, or a long term plan for the child to remain in foster care had been agreed (either at court or by voluntary agreement with the family) and the case could be passed to the Looked After Children Teams, or the child had been placed for adoption and the final adoption order had been made.

6.3.4 Looked After Children Teams

There were three Looked After Children (LAC) teams based in one office. Each team was made up of a team manager, social workers and family workers. The team worked with all children who had a long term plan to remain in the care of the LA. The team also worked with young asylum seekers under the age of 18 who were either in residential care or living independently with financial support from the LA. There was no clear distinction between the work of social workers and family workers although social workers would be more likely to hold the more complex cases and cases where children were in secure accommodation. Family workers would hold the more settled long term placements and children with disability living in residential placements or foster care.

6.3.5 Support Teams

There several support teams at various locations across the district providing services to children pre-birth to 18. There were LA Family Centres that provided rooms that could be booked by the above-mentioned teams for contact or direct work with families. The Family Centre managers were all social work qualified and some centres also had at least one other member of the team who had a social work qualification. However, the most of the staff in the Family teams held a nursery assistant qualification or were unqualified but had early years' child care experience.

The Family Centre teams drew work from the LA teams identified above, from midwives and health visitors in the LA area, from schools and directly from members of the public. The centres also ran groups such as 'Parent and Toddler', 'Play Skills', and 'Baby Massage' and families could attend on a 'drop-in' basis without the need for a formal referral.

In relation to pre-birth work the Family Centre teams provided practical skills training for parents and midwives and health visitors also ran sessions in the centres alongside the Family Centre staff. Due to the development of Children's Centres (linked to schools) in the LA area there was an increasing overlap of services and, at the time of the fieldwork, the Family Centres' futures were unclear.

The Family Centres focussed on work with children under the age of nine with an Additional Support Team working with children over the age of nine. The Additional Support Team consisted of social workers, youth workers and family workers. The team provided short-term interventions (lasting up to six weeks) with parents or children over the age of nine that included one-to-one direct work as well as group activities. Their main remit was to address

issues related to anti-social behaviour, drug use and sexual activity. Whilst not directly involved with pre-birth assessment the team would work with teenagers who had become (or were at risk of becoming) pregnant.

6.3.6 My observation of the team structures

During the data gathering process I spent time in all of the above teams apart from the Additional Support Team. In each of the teams I observed different pressures brought about by the differing demands of the aspect of the service each team was charged with providing. Without exception, staff in the teams spoke of feeling under pressure, partly as a result of the issues discussed in the remainder of this chapter, but also as a direct result of the team structures.

Staff reported 'bottle-necks' in the system as cases transferred from one team to another. With regard to the transfer from the Access Point to the Initial Assessment Team, this bottleneck had been dealt with for cases that required an urgent response as part of a child protection investigation by social work staff in the Access Team passing cases directly to social workers in the Initial Assessment teams, thus circumventing the management decision-making process at the point of actual transfer. Managers were aware of this and recognised that experienced social workers were able to identify and begin work on child protection cases without immediate direction from a team manager. Whilst this was a deviation from the ICS case management systems the need to protect children in the first instance was regarded as more important and so managers were amenable to completing the stages of case signing and processing after the event. However, for cases which were not of an immediate child protection nature, it could take at least a day to transfer a case from one manager to another and then might be a few days before such cases were allocated, as a process of 'sifting' the most concerning cases and giving them priority allocation occurred.

The most significant bottleneck occurred at the transfer point between the Initial Assessment Teams and the Family Support Teams. This seemed to be partly caused by the respective nature of the work of the two kinds of the teams, with the short-term nature of IA work and the longer-term work involvement of the family support work creating a disparity in the case turnover rates of each team. Therefore more cases were transferring from the Initial Assessment Teams to the Family Support Teams than were being closed or were being transferred from the Family Support Teams to the LAC Teams. This caused significant difficulties between staff in the Initial Assessment and Family Support Teams, difficulties which were compounded by them never actually meeting each other on a face to face basis. Staff in the Initial Assessment Teams complained that work transferred over was often quickly closed

by the Family Support Teams, resulting in repeat referrals. Family Support Team staff complained that IAs did not contain sufficient information upon which to make an assessment of the need for longer term intervention and so time was then spent re-assessing the case. Family Support Team staff also raised suspicions that Initial Assessment social workers took some cases to a child protection conference and 'weighted' information toward the need for a safeguarding plan just to prevent cases being closed when they were transferred.

Whether the Family Support Team social workers' concerns were founded or not, there were certainly unallocated cases sitting in the Family Support Teams. Staff spoke of the unallocated cases impacting negatively on staff morale and team managers spoke of their anxiety of not being able to manage the volume of work within their teams. Without question, the social workers and front line managers in the Access Point, Initial Assessment and Family Support Teams all felt the splitting of the assessment process had been 'a step too far' and that combining the Initial Assessment team and Family Support functions would alleviate some of the difficulties.

6.4 The Electronic Database (EDB)

All staff in the above teams maintained records and information about families on the Electronic Database (EDB). Maintaining some information in an electronic format was not new to the LA, however, on the 1st April 2008, the LA switched to all case records being electronic and began the process of creating paperless offices. The EDB had a significant impact on how staff were managing case records and also on how I gathered data and therefore it is important to provide an overview of the system as a whole.

6.4.1 The Theory behind the EDB

The host LA having decided to move to a completely paperless office system that was also compliant with the Integrated Children's System (ICS), in the six-month period before I began data gathering on the 1st October 2008, all paper files had been scanned and converted into electronic files. Once scanned, all documentation was shredded and so 'traditional' paper case files no longer existed.

One of the advantages of the EDB was that it was instantly accessible by staff (who had authority to access it) regardless of the staff member's physical location. There were many advantages to holding all of the information in one electronically virtual place so that information was not dotted around the LA in various offices and filing cabinets. Staff in the Access Point team receiving new information or undertaking emergency out of hours work

could access the same file as the case-holding social worker, allowing them to have the most up to date information to work with. Similarly, staff in other LA teams such as support teams who provided parenting programmes, fostering and adoption team social workers involved in placement finding and family workers involved in arranging or supervising contact had access to the same body of information as everyone else. Managers, senior managers and legal advisors also had access to the system thus enabling decisions and plans to be updated on the system on an ongoing basis.

The range and type of information that could be stored electronically was extensive and diverse. Aside from the more obvious reports and case notes other information and data such as photographs, drawings, letters and faxes were stored on the system. Each morning administration staff would open post sent to their teams and then scan information such as letters, reports from outside agencies and photographs (including family photographs sent to children in LA care as well as copies of forensic photographs taken by the police in criminal investigations) and then upload them onto the relevant child's file. Once scanned the original paper based documents were then shredded.

In theory, from the perspective of the case-holding social worker, all LA staff working with the family updated the same case file and this should have assisted the social worker in building a picture of what is happening. Not having to catch up with other staff by phone, email or letter and not having different teams making up different paper files should ensure the case-holding social worker was fully aware of all aspects of intervention with the family on a day-by-day basis.

The electronic case record was also seen as assisting in the review and case audit responsibilities of managers and the investigative functions of the LSCB (set out in *Working Together* HM Government 2006 Chapter 8). The audit functions of managers involved ensuring that case files were kept up-to-date and that information was there to allow an understanding of what was happening to, or for, a child and family. The Serious Case Review functions of the LSCB involved seeking to establish if lessons could be learnt in situations where child was seriously injured or killed and/or where there were concerns about inter-agency working to protect children from harm. Whilst the review and investigative systems were only applied in a very limited number of cases they were nonetheless very significant. Having one file, containing all of the information relevant to the child, could enable a comprehensive review of a situation without the need for a 'paper chase' and complicated processes involved in compiling the chronology of events.

6.4.2 Disadvantages of a Computer Based System

Whilst there were advantages to the EDB, reliance upon computers comes with several down sides. Firstly there was the obvious issue with any computerised system, lack of access to information when the system crashes. When I raised this originally with the IT staff I was advised this was not a significant problem as any system failures could be quickly rectified. However, staff in the teams held quite a different view and many complained that it regularly crashed or was slow and it was irrelevant if the system was 'only' down for 10 minutes if during that 10 minutes they were trying to deal with a family in crisis or were trying to share information with other agencies in a child protection investigation.

Another area of difficulty related to computer literacy. In the host LA many of the more recently qualified social workers were computer literate but some of the more experienced social workers found using the system a challenge. When I spoke with staff about this, it seemed to be less about actually accessing information, indeed many staff said the system was not complicated and required little more than the ability to use the arrow keys and mouse to read information. The difficulty seemed to relate to the high level of typing and data input skills needed to keep the system up-to-date. Many staff complained they now spent much longer writing up case notes and completing reports than they had in the past and that reading information on a computer screen was not as easy as reading paper files.

The most notable of the complaints made by several staff in the teams was one period in time when the 'delete' and 'save' functions on the EDB had been inadvertently transposed, resulting in documents being lost into an un-retrievable abyss. In relation to a pre-birth assessment written just days before the baby was due one member of staff said:

When I pressed the save button the form just disappeared from the screen. I just thought it had saved and closed it so I went to open it again...but it wasn't there. So I phoned IT and this woman just told me that the save and delete buttons had the same function. I thought she had gone mad, or that the cleaner or some one had answered the phone for a joke! So I said that I thought she was wrong but she said she wasn't. Then I got mad with her and told her to get some one who knew what they were talking about. This bloke came on the phone and after telling me not to shout at his staff told me the same and that my work had been lost. I couldn't F believe it! Some others in the team lost their work as well. We sent an email around the teams to say don't do your assessments on the system because it ends up in a game of Russian roulette when it comes to saving. They did sort this one out pretty quickly but when it takes hours to fill in an assessment. It takes longer to do the assessment than give birth!*
(Family Support Team social worker)

The paperless office approach meant that printers had been removed from the social work offices and only the administrative staff had access to printing facilities. However, the nature of social work practice is that most work does not take place in the office and, in relation to pre-birth assessment, this is often the family home, hospital or medical centre. Although some of the social workers had access to laptops, they were not able to link remotely via the internet, to the EDB. When going out on a visit social workers, therefore, had to make a hand written note of any information they may need (names, addresses, dates of birth and any significant information which may be needed during the visit or meeting) to take with them. Hand writing information, often on a sheet of paper not attached to anything else, negated the advantages of having password access to electronic data as there was a risk of hand written notes getting lost or misplaced. If a printed copy of a report was required social workers had to request a copy in advance and administrative staff complained that the EDB did not allow for information to be printed quickly or easily. This was seen by social workers as a laborious and time-wasting process but it also meant there was immense difficulty in working openly with families by providing copies of reports and other information written about them. One social worker commented on a case she had where the parent had reading difficulties. Because of the time involved in writing reports and then printing them, this meant the time available for the parent to read a report before a meeting was significantly reduced.

Whilst the issues identified above were significant there was another issue that was growing on a daily basis during my fieldwork and served to undermine all of the advantages of a computerised system. The LA had a protocol for case file management that had been in operation for many years but this related to paper based filing systems and took account of different teams holding different types of file according to their specific function. A new protocol relevant to the EDB was in the process of being developed when I was gathering data but was very much in the early discussion stages with no written or uniform guidance issued. Staff were, therefore, adapting the paper based case file protocols to the EDB as they went along and in accordance with their own team's customs and practices. On top of this, as outlined shortly, different recording styles and approaches, different understanding of the purpose of the various documents linked to the EDB and ICS, different attitudes to adopting an electronic system and different levels of skill and competency in using an electronic case file all added to the picture of inconsistency. What this meant in practice was that whilst there was uniformity in the EDB provided by the layout of various screens and pages and uniformity in the ICS documentation in use, how, where and when information was put onto the system was anything but uniform.

6.4.3 Developing alternative systems

As identified above, staff had differing levels of computer literacy but, even those who were skilled in their use of a computer, found many aspects of the system difficult to cope with and had therefore begun to find methods of working around the EDB.

During my time in the team offices many, if not all, of the administrative staff, social workers and managers I met with spoke of having lost information on the EDB and that sometimes documents that were saved and were there one day but could not be found on other days. Social workers and front line managers also commented on how difficult it was to actually type information onto the lengthy documents such as the Core Assessment (CA) and child protection reports because the free text boxes did not always provide sufficient space for what was to be recorded. The system also had a 'time out' data protection mechanism designed to ensure that if a case file were left open without being worked on the file would automatically shut down. However, to work on documents such as a CA the system opened up another page, or tab, which was independent of the electronic case file and therefore, when working on certain documents the system timed out and shut down. Staff would assume they were logged in because they were working on a document opened from the electronic case file but were actually working on a form which was in 'computer limbo' and not contained in the EDB and not contained in a word processing world. What this then meant was that input onto the CA (or any other lengthy document generated by the EDB) could only be done in short bursts (although no one seemed totally sure of how long a short burst actually was) to avoid being timed out. When completing a lengthy document the worker would not be aware the system had timed out until they came to save the document and would be unable to do so. To get around this problem the key documents relevant to the Initial and Core Assessment process, Safeguarding Reports and Looked After Child Paperwork were all created as word based documents and so could be worked on without accessing the EDB. These forms could then be uploaded onto the EDB at a later date.

In my enquiries about the system, staff in the computer teams reported that front line staff did not use the system properly which resulted in documents being lost. In interviews conducted in relation to the in-depth cases and in office discussions front line staff complained that the system was not fit for purpose and randomly lost work. Whatever the reason, front line staff spoke of a high degree of mistrust in the system and were developing their own case recording and storing processes. As one social worker commented when I said I could not find a pre-birth assessment on a case file:

No, that's because it isn't on the electronic file. I don't trust it. Stuff just disappears never to be seen again. I keep all my copies of assessments and reports, anything that comes to me all together in my drawer. Then at the end of the proceedings I give it all to admin and they scan it into the system. They don't like this because it is a major pain for them but I can't stand the idea of anything getting lost during court proceedings. I am the one who has to stand on the witness stand and I am not going to look an idiot and say sorry because the information is lost on the system and the original document has been shredded!

(Carla. Family Support Team social worker interviewed in relation to in-depth cases)

Another social worker said:

I type everything onto Word, like I always have. That way I know where everything is and if I get a phone call asking for something I can produce it there and then. I cut and paste things into the EDB when I have finished working on things or when I am closing the case. The thing is, if you upload them and then work on them again you don't always remember which is the latest version. If I keep it on my word files then I can record which is the latest version as I go along.

(Rosie. Family Support Team social worker interviewed in relation to in-depth cases)

With regard to letters and reports posted to the LA, one social worker reported:

What happens is admin open all post apart from that marked personal and confidential. So I have started telling other professionals to either send reports as an email attachment to me so I can then save on my desktop or to post them marked personal and confidential so it doesn't get opened. I was asking them to fax things, and then I would stand by the fax machine so admin didn't get their hands on it, but then [name of admin manager] spotted what I was doing and I got a bit of a telling off for not letting admin staff put stuff on the system when they should do (laugh).

(Carla. Family Support Team social worker interviewed in relation to in-depth cases)

As I spoke to different staff I found that keeping paper and word based documents that were not uploaded onto the system on a routine or regular basis was commonplace. One social worker said:

Most of us have started keeping info written down and hidden in our desks. It's the only way you can work. It takes so long sometimes to get from the EDB even basic info like the child's date of birth. It's impossible to memorise the basic details of all of the kids you work with and if you didn't write it down and keep it in your desk you would spend half your life messing about trying to find it.

(Family Support social worker, December 08)

Along with the LA's move toward the paperless system the LA had removed filing cabinets from the team offices prompting one social worker to say:

The thing is they have taken all of our filing cabinets! I keep as much as I can in my desk drawer but with all the other junk I keep in there, you know spare pair of tights for court, chocolate, cuppa soup, sometimes it is bulging with stuff. You can't just leave confidential things around the office in boxes so I took as much as I could out of my desk that wasn't confidential and started keeping that in a box but that wasn't enough. You know what its like these days, there's a bit of paper for everything and one child's file can take up a whole filing cabinet drawer. Even the unborns generate a ton of paper. So I now keep stuff in the photocopy room. Some of the others in the team do that as well.

(Family Support social worker, December 08)

In the different social work offices I encountered many staff made similar comments to those quoted above. However, in addition to the systems social workers were developing, there was an undercurrent of panic developing amongst managers in relation to the likelihood of an unannounced Ofsted (a non ministerial department responsible for inspecting children's services inspection) inspection. As one social worker said:

I hate the computer system. I am not the worlds best at typing and so I find it harder than some of the younger social workers. At first we were not allowed to put things in admin to type but now they are letting us because they are worried about an inspection and anyone finding out how bad things are.

(Family Support Social Worker November 08)

When I looked into the story behind the quote above I was told (by an administration manager and a team manager) that originally all social work and other front line staff had been advised by senior managers that they were responsible for their own case records. Administration staff would not be doing typing and instead administration time would be given to the scanning of documents and reception duties. Initially administration staff had been fearful for their jobs but it soon became apparent that not all social workers were able to keep up with their typing, general case recording and maintaining the electronic case file. As a result of this social workers and managers had advised senior managers that case notes were not up to date and, in response, senior managers had agreed additional administrative staff time to type up any handwritten notes. I was shown, in one team office, typing baskets full of hand written notes and reports awaiting input onto the EDB. Administrative staff also advised me that some typing had been taken to other bases (such as head office and support teams) so other typists could assist with the getting up-to-date with the backlog.

Apart from the potential impact of all the above on the quality of work with children and families, from a research perspective, I was, therefore, faced with the situation that not all information about an unborn child would necessarily be held on the electronic case file. Instead information could be held in several different formats with electronic data being stored on individual desk top computers and paper documents held in an array of different places

including social workers' desk drawers, typing baskets and some might even be physically in transit (usually in a manager's car) from one office base to another.

6.4.4 The impact of the EDB on the fieldwork

The systems employed by social workers to 'manage' the EDB did not all come to light at first. In the early stages of fieldwork I was based predominantly in the Initial Assessment Team offices and whilst this raised a few issues, staff there were involved in the early stages of building a case file and dealing with a smaller volume of 'paper work'. Key issues in relation to the audit of referrals are outlined in the next chapter but in the early stages of data gathering I assumed the difficulties would relate predominantly to the 'interrogating' of a database for information. It was only when I moved on to looking in more detail at the case files that the impact of the EDB on the progress of my research really began to become apparent.

A major, and highly significant issue, was that case file information was being held in an array of different offices and places around the department. So, to ensure a degree of consistency in my approach, I took the decision to only access data that had been uploaded onto the EDB. Whilst this potentially meant I might not see some key documents my rationale for this approach was twofold. Firstly, to engage in a 'paper chase' of other documents would not necessarily result in my finding everything and would, more to the point, require me to sift through information about children and families (also stored in desk drawers, typing trays and on computers) that I did not have consent to access. Secondly, the departmental stance was that each child's electronic case file was the definitive record of LA assessment, actions, decision-making and planning. By only looking at information on the electronic case file I saw what the host LA 'officially' regarded as their information about the unborn children they were working with.

I also found actually reading the information on the EDB difficult and extremely time consuming. Each child's electronic file was split into folders and pages, but, unlike with a paper-based system, it was impossible to hold a page open and then flick from one page to another. I found the system frequently crashed or ran slowly at times when there were high levels of activity (most often first thing in the morning) and when this happened the only course of action was to sit and wait for indefinite periods of time. Each file had folders headed 'referral', 'assessment' and 'looked after child' (LAC) and under each of these folders was a sub-section for case notes. The case note sub-sections were not linked up to each other and so information inserted in the referral case notes section did not show up in the assessment section or LAC sub-section and vice versa. Case notes within any of the given sub folders were not always presented in the actual chronological order events took place because staff had an

option to record the date and time of day of a visit or just the action. If no date or time of day had been inserted the system set a default time of midnight and, if several case notes were inserted with the same date and the default time of midnight, they were presented on the screen in the order they were typed.

Given these system configurations then, each case note (or event) recorded on the system could only be read as an individual item and so reading case notes involved the following actions for each insert onto the system:

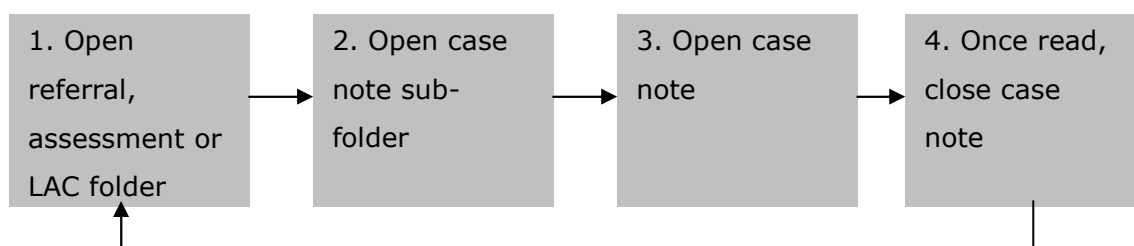


Figure 6 – Action for reading/inserting information onto electronic case notes

When a case note was read and then closed the reader was then taken back to the original starting point of the referral, assessment or LAC folder. The only way to read the ongoing case note 'story' was to check each sub-section and read every case note (not necessarily presented in date and time order) and so, even in cases that were not particularly complex, it was difficult to gain a chronological understanding of what had happened.

The impact was that what follows by way of research findings and analysis reflects only the information kept electronically on the EDB. It is possible, therefore, that some key documents and other information may not have been accessed and studied when looking at the in-depth cases. Also, due to the difficulty in actually reading the electronic case files, it is possible I inadvertently missed information.

6.5 The wider social and political context

During the course of my research there were several factors that impacted directly on the practice of the social workers in the host LA. The time line identified in Chapter 1 in figure 1 provides an overview of the key influencing events and the stage at which they occurred in relation to the research.

6.5.1 The Fran Lyon Case

The first event which had a degree of impact was media coverage of the Fran Lyon case in September 2007 (described in Chapter 1 and referred to in Chapter 5). This actually occurred prior to my beginning data gathering in the host LA and so the case had an impact on Northumberland LSCB procedures but had no impact on the host agency or local LSCB procedures. Staff in the offices were, however, aware of the case but comments were general in nature, relating to the media misrepresenting information about the process of child protection conferences rather than specifically about pre-birth assessment.

6.5.2 The Electronic Database and Integrated Children's System

As identified above, the implementation of the EDB had a significant impact on case recording and practice in the host LA. The implementation process of the ICS had begun in April 2007 and LAs throughout England were at various stages of implementation from this date. Due to the radical changes resulting from the computerised system the host LA had opted to become fully compliant with ICS on the same date the EDB went live, namely April 1st 2008. This had created an interesting link between the EDB and ICS in the minds of social workers and in many conversations social workers clearly regarded them as one and the same thing.

6.5.3 Staff shortages and pay issues

Staff shortages were a significant feature of practice during the data-gathering period. One family support team was down to two rather than six qualified social workers and whilst this was the worst instance, all teams experienced staffing difficulties. In a host LA report to its 'cabinet office' (Cabinet Report, Host Agency – full reference withheld for confidentiality) it was reported there were an average of 12 social worker posts vacant, from what should be a total of 44 full time equivalent posts in the Initial Assessment and Family Support teams (staffing figures for the other teams were not provided). Although some recruitment had taken place, this was cancelled out by other social workers leaving. The host agency had recruited agency social workers and, at the time of the report to cabinet, stated that all 12 vacant posts had been filled by agency social workers. However, subsequently, in September 2009, all agency social work contracts were abruptly ended in response to budgetary constraints experienced by the LA as a whole. As one team manager commented:

The agency SWs helped quite a bit and for once we managed to get some good agency staff. We had some who had been with us longer than some of our own staff. But then they [senior managers] just said we had to get rid of them all, no warning or anything, because of budget cuts. They are all going to leave next week

and I don't know what the hell we are going to do regarding allocation. (Team Manager, September 09)

However, shortly (approximately two weeks) after the agency staff contracts had been ended and staff had left, senior managers reversed the decision, adding to the frustrations of social workers and team managers. Team Managers, in particular, complained that the sudden nature of the decision to end contracts had made the LA unattractive to agency workers. The more experienced agency social workers had quickly secured contracts (guaranteed for six-months) with neighbouring LAs and were unwilling to return to the host LA.

Along with the social work staffing issues managers' pay had not been increased for a considerable time and, as a direct result, four teams were without a line manager because they had opted to take posts in neighbouring LAs who were paying higher salaries for equivalent work. Having worked for the host LA myself only one year earlier, I returned to conduct my research thinking there would be many familiar faces but the high staff turnover meant I knew only a handful of staff. Most notably, experienced staff who had worked in the agency for several years had chosen to leave and work for neighbouring LAs. Staff morale was low and although most social workers reported feeling supported by their immediate line manager many reported feeling anxious and unsupported by senior managers.

6.5.4 The baby Peter Connolly case

Alongside the unrest brought about by new systems and reduced staffing levels there was the significant impact of the news surrounding the death of baby Peter Connolly, the media furore and the subsequent government responses. On the 11th November 2008 Jason Owen and Steven Barker were found guilty of causing the death of baby Peter Connolly. Earlier in the trial Peter's mother, Tracey Connolly, had pleaded guilty to causing his death. On the 20th November 2008 Ed Balls, Secretary of State for Children, Schools and Families made a statement to the House of Commons and said:

The case has also raised serious questions of public concern about how such a thing could have happened again, despite numerous contacts with social workers, police and health professionals – and in Haringey, too, the same borough where Victoria Climbié died eight years ago. We need to know what actions are urgently needed in Haringey to ensure the safety of other vulnerable children in that borough and proper accountability of what went wrong, and what further steps are needed to ensure that all children are safe across the country. (Hansard, November 2008 column 372).

In the same statement Ed Balls outlined that Lord Laming had been asked to provide an urgent report, the scope of which included identifying *'key features of good practice and whether they are being universally applied across the country'* (Hansard Nov 2008 column 373).

The report following the death of Peter Connelly by Lord Laming was published on the 12th March 2009 (Laming 2009) and the government accepted all of the recommendations. In May 2009 the government published '*The protection of children in England: action plan. The government's response to Lord Laming*' (DfCSF 2009) that detailed the actions already taken and those to follow. Ed Balls announced the government was taking '*immediate action to start to transform the social work profession*' and set up the Social Work Taskforce (DfCSF 2009, p2). In July 2009 the Taskforce produced an interim report and, in the foreword, Moira Gibb (chair) stated:

Many of the key conditions that make for a confident, effective profession are not being fully met – not least having the right number of suitably trained staff in stable front line teams. There is good practice, but not enough, and the profession is struggling to explain and demonstrate its effectiveness. (DH & DfCSF 2009, p 3).

The report also identified that social workers felt staff shortages and bureaucracy left them with insufficient time to devote directly to those they aimed to help (DH& DfCSF 2009).

My data gathering process in the host LA began on the 1st October 2008 with the six-month audit of referrals and just over 5 weeks later, on the 11th November 2008 the death of baby Peter was national news. The six-month audit lasted until the 31st March 2009 and during this period of time Lord Laming was preparing his report and the Social Work Taskforce was beginning its review of social work practice. In the host agency the impact of baby Peter's death began to be felt with an increase in child protection work. Between the first of January 2009 and the 31st March 2009 (when my six month audit ended) the host agency reported dealing with 124 child protection investigations, which had led to 112 Initial Child Protection Conferences and a jump from 223 children with a safeguarding plan in September 2009 to 324 by June 2009 (Cabinet report, Host Agency)

The study of in-depth cases and interviews with social workers took place from March to December 2009. This was after the publication of the Government's response to Lord Laming's report in May 2009 and during a period of ongoing media interest in how children were, or were not, being protected by Local Authorities in England. The sentencing, in May 2009, of Baby Peter's killers and other cases, such as two brothers who, in September 2009, were convicted of an attack on two other boys in Doncaster assisted in maintaining the media interest in child protection services. Social workers and front line managers in the host agency remained under pressure from high numbers of cases as a result, in addition to the relentless demands of managing the computer based system of case recording and monitoring.

6.6 Conclusion

This chapter forms the basis of understanding the following three chapters which relate to the data gathered directly from the host LA. Social workers and other front line staff were seen to be under varying levels of stress brought about by team structures that did not necessarily provide a consistent flow of work from one team to another. Alongside the difficulties created by splitting the team functions there were many issues associated with the electronic case recording systems.

The EDB created numerous difficulties for front line staff and it was apparent that, although there were many potential advantages of cases being stored in a 'virtual' electronic file, the difficulties experienced by staff outweighed the advantages. Staff were developing methods of 'managing' the system that ran contrary to ensuring all information was stored securely and centrally on the system and this had a direct impact on the structure of family case files which, in turn, had a direct impact on how and what data I gathered.

Alongside the issues that arose for staff as a direct result of organisational structures and the EDB, there was the wider political and social context that was placing additional pressures on front line services. Social work practice was under media scrutiny as a result of several cases, not least of which was the news of the death of Peter Connelly. The government announced reform of front line social work services and, whilst the social work task force had begun the process of finding out what was happening, it was too early to see any actual change for the better in service provision. The LA were experiencing high levels of staff turnover in the social work teams, partly as a result of the responses to budgetary issues for the LA as a whole, but also as a result of low staff morale. In conclusion, the research was undertaken in a LA environment that was responding to a wide range of different pressures, all of which had considerable potential to impact on social workers' approaches to pre-birth assessment work, as will be seen in the results that follow.

Chapter 7

Phase 3 Results: Audit of new referrals made over a six month period

7.1 Introduction

The referral audit took place between the 1st October 2008 and the 31st March 2009 inclusive. The audit aimed to track all pre-birth referrals made to the host LA during the six-month period to address the research question:

ii) What are Local Authority processes in relation to pre-birth assessment?

In order to know how to track referrals consideration had been given to what such a referral actually might be and what the anticipated trajectory of a pre-birth referral might look like. This chapter briefly describes my preliminary understanding of the referral process, locating it within the context of *Working Together* (HM Government 2006) and the host LA's guidance and practice. I will then move on to consider the findings from the audit relating to the actual process of referral tracking and the numbers of pre-birth assessments found before considering the detail relating to referral content and categorisation. Finally the chapter outlines findings in relation to Initial and Core Assessments and the decision making process.

7.2 An outline of the referral process

Working Together (HM Government 2006) stated:

If somebody believes that a child may be suffering, or be at risk of suffering, significant harm, then they should always refer their concerns to LA children's social care.
(HM Government 2006 5.1)

With regard to when it was appropriate to make a referral *Working Together* (2006) stated:

They [LA] should agree with LSCB partners, criteria with local services and professionals as to when it is appropriate to make a referral to LA children's social care in respect of a child in need.....The Common Assessment Framework offers a basis for early referral and information-sharing between organisations. (HM Government 2006, 5.15)

During the audit period the host agency had operational guidance outlining their referral process and with regard to a definition of a referral quoted the *Assessment Framework* (DH 2000) as follows:

The Assessment Framework (paragraph 3.8) defines a referral as:
"A request for services to be provided by the council with social services responsibilities. The response may include no action, but that itself is a decision and should be made promptly and recorded."
(Host agency operational guidance 2006)

The LA operated a 'one stop' system of referrals with the Access Point team (see team structures in Chapter 6) covering the whole of the LA district and taking calls from professionals and members of the public 24 hours a day, 365 days a year. All social workers in the Access Point worked to operational guidance that, at the time of the audit, stated:

The process of receiving a referral is largely about eliciting information about the reason why services might be required. It is a complex process, which may involve dealing with distress, confusion, anger or a range of emotions. It involves clear thinking and continual analysis about what information is needed and how best to get it. It may involve being clear or assertive with other agencies about their responsibilities.

The referral as it proceeds should make clear who has been contacted for further information and why. It should contain the maximum amount of factual information that is available whilst remaining proportionate to the task and within a reasonable timeframe. Remember the assessment should be holistic and multi-agency in its approach. It should be child-centred and rooted in child-development.

(Host LA Operational Guidance 2006)

During the course of the referral audit period of data gathering, the host LA were using an electronic data base (EDB) which was compliant with government requirements surrounding the *Integrated Children's System* (ICS). The referral record used by the host agency was based on the ICS 'Referral and Information Record' (see appendix 7). For children with no previous contact with the LA the Access Point Staff had responsibility for creating a new electronic case file. For children where there had been previous contact, but the case had been closed, the Access Point staff re-opened the original electronic case file and created a new referral record. In addition to creating the referral record the Access Point social worker might begin the early stage enquires. In cases where there were immediate child protection concerns, as covered by section 47 of the Children Act 1989, the Access Point social worker would begin the process of contacting key agencies. They would then ensure the case was passed as quickly as possible to the Initial Assessment Team who would complete the process and make any visits, conduct interviews, hold strategy discussions and complete an Initial or Core Assessment. The exception to this would be a child protection referral made out of hours

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when the Access Point Social Worker would conduct the investigation and make the necessary visits, complete the assessment and take action to ensure the child's immediate safety.

New information about a child who had an open referral in their name was passed directly to the allocated team or social worker. The exception to this would be cases where information was passed to the Access Point team out of normal office hours that required immediate action. In relation to pre-birth assessment the EDB allowed team social workers to note on the electronic case file the action required should the baby arrive out of normal office hours. In cases where the electronic case file was up-to-date Access Point staff could also see any core assessments, risk assessments reports from other agencies and planning documents and therefore could intervene in full knowledge of the process of decision making and planning. The Access Point staff could then update the system so that when the allocated social worker returned to work they were made aware of the birth and any subsequent actions taken.

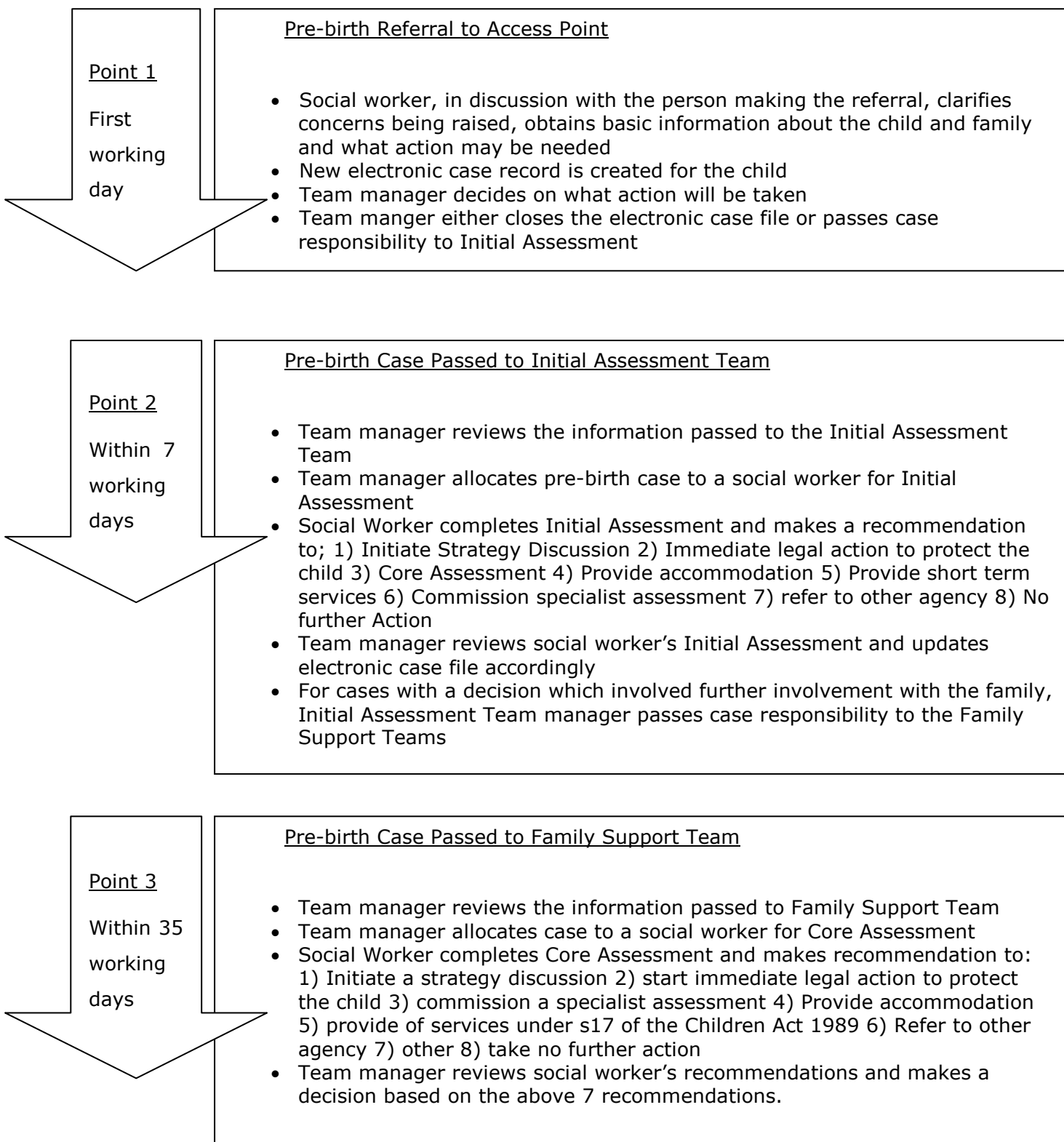
7.3 Referral tracking

Before accessing the EDB I had anticipated what the pre-birth case trajectory would look like, based on information about referrals and assessment gathered from the following sources:

- *Working Together (HM Government 2006)*
- *The Assessment Framework Maximum Timescales for Analysing the Needs of Children and Parenting Capacity* (DH 2000 See Appendix 6)
- *ICS Referral and Information Record* (DH 2003, see Appendix 7)
- *ICS Initial Assessment Record* (DH 2003, see Appendix 8)
- *ICS Core Assessment Record Pre-birth to Child age 12 months* (DH 2003, see Appendix 9)
- Team roles and functions in the host LA

I anticipated that, from the point of pre-birth referral, a case would go through a process of decision-making and assessment ending either at the point of birth or when a team manager made a decision to close the case. See figure 7 for my anticipated case trajectory.

Figure 7 Anticipated case trajectory



I devised a '*case audit*' data tool (see appendix 2) based on the *ICS Referral and Information Record* (DH 2003) and the data boxes on the host agency referral screens. The purpose of the data tool was to capture and record quantitative and qualitative information taken by the Access Point social workers from first contact through to possible transfer and action in the Initial Assessment Team.

7.4 Referral tracking in action: the reality of doing research

During the audit period several difficulties were encountered in the process of referral tracking, the first of which was actually related to identifying pre-birth referrals on the system. The EDB did not allow the creation of a case file without the name boxes being completed but the first name box could be bypassed by clicking the option to record the child as unborn. Therefore my first searches of the EDB were completed using the search field 'first name unborn' for all case records from 1st October 2008. I subsequently found (thanks to the support from a member of an administration team) that there were different search facilities contained within the system and using the different search facilities yielded different results. I repeated my searches and found pre-birth referrals missed from my original searches. I was unable to ascertain, from the administration staff or the information technology staff, any reason why different search tools yielded different results; that remains a mystery.

The system of scanning and shredding information caused a further major difficulty four months into the audit period when my research notes were mistaken for scanned information requiring shredding. Whilst the destruction of my case notes was, to say the least, a major trauma for me at the time, it turned out to be a significant event in other ways. Firstly, it highlighted that whilst I had 'only' lost research notes, contemporaneous notes (sometimes called for as evidence in court) and very personal information such as letters and pictures from parents to their children in LA care or with adoptive families (not all such information could be passed on immediately but would always be held on file for when the child was older) were also being scanned and shredded. Whilst scanned documents were easy to store, the importance of the original document, for reasons of authenticity or the emotional connection, was being totally disregarded.

Secondly, the shredding of my notes identified a significant problem with searching the system and ensuring all pre-birth referrals were included in the audit. I found that when I began to repeat the audit I was unable to locate some of the pre-birth referrals that I had tracked prior to the document-shredding incident. In the process of working out why some of the unborn children were no longer showing up on the system I discovered that, as soon as a baby was

born and had a name, the child's details were changed to include the name. The EDB system then automatically propagated basic details onto all forms and documents that were not closed. Individual assessments documents were closed when the assessment period finished but the referral document remained open until all case involvement ended and so the system automatically updated the child's name and date of birth on the referral form. Thus, prior to the notes being shredded, when I had searched using 'unborn' I was only locating referrals for children whose names were not yet known. The original searches had, therefore, missed children whose parents had chosen a name (because they knew the sex of their unborn), and any children who had been referred and born shortly after, in between the times I had accessed the database. The search procedure was once again revised and, following much discussion with staff in the IT team, the only way to ensure the audit captured all newly created case records for unborn children was to look for referrals where the age was recorded as zero.

This quickly revealed another significant difficulty in conducting the audit because the EDB covered all case files held by the LA and the following groups of people were all recorded to be aged zero:

- People who had made an application for a disabled person's car badge (the car badge team continued to use a paper file system and therefore only recorded the applicant's name on the electronic system with no other details at all)
- People who had made an enquiry about becoming a foster carer or adopter
- Referrals where the age of the person was not known and had not been estimated
- Referrals where the name had not been recorded and there was no obvious reason for the omission
- Children under the age of one including unborn children

All of the above groups had to be searched through to locate pre-birth referrals and whilst some of the referrals linked to particular teams (such as the car badge unit) were easily identifiable as not being about a pre-birth referral, others had to be opened and read in order to ascertain the nature of the referral.

7.5 Numbers of Pre-Birth Referrals

Notwithstanding the difficulties outlined above, during the audit period of 1st October 2008 and the 31st March 2009 I found 56 pre-birth referrals that had resulted in a new electronic case file being created. The LA were required to produce statistics for central government on

the numbers of referrals they received and were able to generate statistics from the EDB. These statistics were purely numerical and, unfortunately for the purposes of my research, did not allow for individual cases to be traced or analysed. In order to ascertain if I had actually managed to trace all of the referrals during the audit period I requested the LA's figures and was supplied with the following information pertinent to the period 1st October 2008 and 31st March 2009 inclusive:

- Total referrals for children services 2032
- Total pre-birth referrals 49

Thus there was a discrepancy of 7 between my total and the EDB-generated total, a not insignificant number. Even after discussion with staff in the audit team, the IT team and social work managers, I was unable to ascertain why there was such a discrepancy between the numbers of pre-birth referrals identified by the EDB audit function and those found in my audit.

Toward the end of the audit period I noticed there had been no referrals for teenagers who were in the care of the LA and pregnant and so contacted a senior manager with responsibility for children's residential care to find out if there was yet another 'problem' in how I was searching the system. The senior manager gave me the names of two teenage mothers who were, at the time, in mother and baby foster placements. It transpired one case had not been located because the baby had actually been born prior to the audit period. The other was a pre-birth case which had become known to a social worker and, during the audit period, had undergone a pre-birth assessment with the baby subsequently being placed in foster care with the mother. However, there had been no initial referral, no documents or any other form of case record specifically generated in relation to the baby. As there was no referral or other form of record held by the LA this case does not feature in the referral audit but I took the decision to include it in the in-depth study (referred to as Zalika) because of the interesting data it yielded.

Another anomaly with regard to numbers related to a mother pregnant with twins. One referral was created although there were actually two unborn babies. The twins were born prematurely and one twin died hours after birth and the other twin died a few weeks later. Although the mother gave birth to two children only one referral and case file was used and the information about the twin who died within hours of birth was recorded on the same case file as the twin who survived for a few weeks.

Notwithstanding the above anomalies, for the purpose of the audit, the following data is based on the 56 referrals I located in my searches and which resulted in the creation of an electronic case file.

7.6 Referral details

The Access Team social worker was required to complete several data fields in the process of recording the referral in line with the ICS Referral and Information Record (DH 2003) (see appendix 7). Information on the referral record was organised around three areas:

- 1) Basic details
- 2) Details about the referrer
- 3) Details about the reason for the referral and additional information

Reflecting the organisation of the referral record the findings from my audit are presented using the above three areas of information.

7.6.1 Basic Details

The '*basic details*' section of the LA referral page is compatible with the *ICS Referral and Information Record* (DH 2003) and focussed on quantitative information relating to ethnicity, information about the parents, and numbers of siblings.

Ethnicity

The ICS Referral and Information Record (DH 2003) contained the following categories for recording ethnic origin:

Black or Black British	Asian or Asian British	White	Mixed	Other Ethnic Groups
<ul style="list-style-type: none"> • Caribbean • African • Any other black background 	<ul style="list-style-type: none"> • Indian • Pakistani • Bangladeshi • Any other Asian background 	<ul style="list-style-type: none"> • White British • White Irish • Any White Background 	<ul style="list-style-type: none"> • White & Black Caribbean • White & Black African • White & Asian • Any other mixed background 	<ul style="list-style-type: none"> • Chinese • Any other ethnic group not given
Further details regarding child/young person's ethnicity				
Child/young person's religion				

Table 1 Ethnic origin categories

The ethnicity of the children referred to the LA before birth was recorded as:

Ethnicity	Children
White British	38
Not recorded	10
Not known	2
African	1
African / Polish	1
Asian	1
Any other mixed race	1
White other	1
White Asian	1
TOTAL	56

Table 2 Ethnic origin of referred pre-birth cases

Thus the vast majority of referrals related to White British children, although 10 unborn children (18%) had no information about their ethnicity recorded at all.

Information about the parents

In all of the referrals basic details about the mother's name and address were recorded but the mother's age was not recorded on 15 of the referrals (27%). For the cases where the mother's age was recorded the age span was from age 16 to 44 years.

Maternal Age (NR = not recorded)

Age	16-19	20-24	25-29	30-34	35-40	40-44	NR	TOTAL
Number	7	9	11	8	5	1	15	56

Table 3 Maternal age

With regard to paternal details, 31 cases (55%) did not have name, address or age recorded for the father. Thus only 25 (45%) cases had a name, address and age recorded of the father.

Paternal Age (NR = not recorded)

Age	16-19	20-24	25-29	30-34	35-40	40-44	NR	TOTAL
Number	3	4	5	4	5	4	31	56

Table 4 Paternal age

What these tables show is that, firstly, a considerable amount of basic detail was missing, b) information about the mother was more often recorded than information about the father and c) where ages were recorded the majority of the mothers (27 out of 41 or 66%) were under the age of 30 whilst fathers' ages were more evenly spread across the age range.

7.6.2 Details about the referrer

With regard to the person making the referral, the LA electronic case file referral page used two drop down menu boxes of '*agency*' and '*role*' (job title) from which the Access Point social worker had to select.

The first box, '*agency*' was a fixed data field and required the social worker to choose from a menu listing 19 agencies relevant to both adults' and children's services and also included '*public*' as a category. The second box for '*role*' provided a list of job titles relevant to the agency selected as well as, in relation to the public, options to choose either '*self referral*,' '*family*' or '*friend/neighbour*'. Table 5 shows the number of referrals during the audit period broken down by '*agency*' and '*role*' as selected by the Access Point social worker.

Agency	Total referrals	Percentage of Total 56 referrals	Role	Total	Percentage
CAFCASS	1	2%	Social Worker	1	2%
Primary Health	19	34%	Midwife	15	27%
			Drug liaison midwife	2	3%
			Therapist	1	2%
			NHS direct	1	2%
Housing Homeless unit	1	2%	Housing officer	1	2%
LA (own)	15	27%	Social Worker	13	23%
			ASW	1	2%
			Family Worker	1	2%
LA (other)	4	7%	Social Worker	4	7%
Police	6	11%	Domestic Violence Unit	4	7%
			Child Protection Unit	2	3%
Prison	2	3%	Probation	1	2%
			Social worker	1	2%
Probation	2	3%	Probation officer	2	3%
Public	6	11%	Self referral	3	5.5%
			Family	3	5.5%
TOTAL	56	100%	TOTAL	56	100%

Table 5 Referrals by agency and role

This table show that referrals were made by a range of different people in a range of different settings but the majority were from midwives (27%) in the primary health sector and social workers in the host LA (23%). It was not clear what the distinction was between the category of midwife and drug liaison midwife as some referrals appeared to have been made by a specialist drug liaison midwife but recorded as midwife. It is perhaps not surprising that midwives would be a primary source of referral given their role in the process of supporting pregnant women. The referrals from social workers in the host LA related to cases where there was ongoing involvement with older siblings and the mother had become pregnant again.

7.6.3 Reasons for referral

The '*reason for referral*' consisted of three data boxes for the Access Point social worker to complete. The first box was headed '*child in need*' and comprised a drop down menu relating to the primary need of the child as defined by the Department for Children Schools and Families (DCSF 2008). Table 6 shows the numbers of pre-birth referrals recorded under each heading.

Dcsf child in need code		Numbers recorded	Percentage of the total 56 referrals
N0	Not stated	17	29%
N1	Abuse or Neglect	21	38%
N2	Child's disability/ illness	1	2%
N3	Parental Illness/ Disability	0	0%
N4	Family in acute stress	3	5%
N5	Family dysfunction	8	14%
N6	Socially unacceptable behaviour	1	2%
N7	Low income	1	2%
N8	Absent parenting	2	4%
N9	Cases other than child in need	2	4%
	Total	56	100%

Table 6 Child in need codes and numbers of pre-birth referrals

The second was a fixed data field entitled '*reason*' which comprised 36 categories, or reasons for referral as defined by the host LA. Table 7 shows the 36 pre-determined reasons and the numbers of referrals recorded under each category.

Fixed field reason heading	Number	Percentage of the total 56 referrals
Access to personal records		
Adoption enquiry	3	5%
Advice/information	4	7%
Aftercare		
Assessment of communication		
Asylum seeker /refugee		
Behavioural problems		
Benefits advice		
Care leaver aftercare service		
Carers inability to cope		
Child disability		
Child in need	3	5%
Child protection	37	66%
Deaf registration		
Disability registration		
Domestic violence	2	4%
Family support	1	2%
Financial assistance	1	2%
Foster parent enquiry		
General concerns	1	2%
Hospital admission		
Juvenile justice		
Missing child		
OT enquiry		
Other LA		
Out of country child		
Parental illness, impairment or substance use	1	2%
Parental illness		
Police caution		
Registration		
Request for assessment	3	5%
Sec 51 tracing relatives		
Supporting people – needs assessment		
Supporting people – service assessment		
Transition		
Visual impairment registration		
Total	56	100%

Table 7 Reason for referral

With 'abuse or neglect' selected in 21 cases or 38% (using the DCSF child in need codes) and 'child protection' selected in 37 cases or 66% (using the LA reason codes), what these tables indicate is that the majority of cases referred to the LA apparently related to child protection concerns for unborn children. Only very small numbers of cases were categorised under the other categories, apart from in the DCSF fixed field box where 'family dysfunction' was given

as the reason for referral in 8 cases (14%). However, in addition to the '*reason*' fixed data box there was also a box entitled '*reason for referral*' that allowed free text information to be inserted. The free text contained the information referred to the LA as summarised by the Access Point social worker. The free text box had a limit of approximately 150 words but if the information could not be summarised within this length any additional information could be recorded in the case notes. Outlined below is the type of information contained under each heading that indicates that the LA fixed field '*reason*' headings were a relatively crude measure:

Adoption Enquiry (3 referrals)

The three referrals categorised as '*adoption enquiry*' each involved mothers who contacted the LA requesting for their baby to be adopted. In relation to two of these, one mother was not in a relationship with the father and felt she could not cope with the baby. The other mother was in prison, had no family in England and no support and the father was also in prison. However both of these mothers withdrew their request during the Initial Assessment Process.

The third referral was from an Asian woman who said her life would be at risk if her father found out she was pregnant. This was the only case requesting adoption that actually resulted in the adoption of the baby.

Advice/Information (4 referrals)

Of the four referrals in this category one contained only the mother's name, address and age and the phrase '*probation enquiry*'. Similarly, another referral categorised in this way indicated another LA had made contact to find out if the host LA held information about a pregnant woman they were now working with. There was no other information on the referral and no indication as to what (if any) information had been shared between LAs.

One referral consisted of a record of a discussion with a midwife. During the course of the discussion it had become clear the family in question lived in another LA area and so the midwife had been advised to make the referral to the relevant LA. Although the host LA took no action a referral was created and the electronic case file closed on the same day.

The fourth referral was from a midwife who had, during the course of working with a pregnant mother, found out that her eldest child (aged eight years old) lived with grandparents. The mother had disclosed a history of drug taking and had been in a violent relationship and so her

eldest child had gone to live with grandparents. The situation had now changed and the mother was in a new relationship and was free from her use of drugs. The midwife was advised the case did not meet the threshold for an initial assessment.

Child In Need (3 referrals)

One of the cases categorised as a child in need was about a mother of African origin who had recently moved to the area and had no support from family or friends. A request was made by the midwife for someone to look after the older sibling when mother went into labour. Five days after the original referral, a pre-birth initial assessment document was created and then closed but it was blank. Beyond the mother's name and address and the original referral information from the midwife there was no other information on the case file and the case was closed after the Initial Assessment.

A midwife, concerned for a mother and father who were homeless, made the second of the referrals in this category. There was a history of drug use and domestic violence between the parents and the unborn baby had a sibling who was in the care of grandparents. Subsequently a pre-birth child protection conference was held and a safeguarding plan was put in place.

The third case was a referral from a social worker in another area notifying the host LA of a one year old and unborn sibling who were already subject to a safeguarding plan and had moved into the host LA area of responsibility. The case was transferred directly to a Family Support Team.

Child Protection (37 referrals)

This category, by far the largest. Sixteen of the 37 referrals in this category (or 43%), involved unborn children where there was ongoing or previous involvement with older siblings. Of these 16 cases three involved mothers who had had children removed from their care but where there was no current involvement. Four cases had ongoing court proceedings in relation to older siblings. Eight referrals related to unborn children who had older siblings subject to safeguarding plans. One referral was made because older siblings had been subject to a safeguarding plan in the past but there was no ongoing involvement and no specific concerns raised at the point of referral.

Four of the cases categorised as child protection involved domestic violence. The police, who had attended incidents when a mother had requested assistance in response to physical and

verbal violence from her partner, referred two of the cases. Another was referred by a probation officer working with a father who had just finished a custodial sentence for a violent assault on his mother and sister. The fourth was made by a midwife who reported the unborn child's father was violent and aggressive toward the mother and professionals. Family members had also raised concerns that the father had access to fire arms and he had been involved in a car accident where he had boasted he had deliberately run a woman over.

Six referrals categorised as 'child protection' involved mothers where drug or alcohol use was a concern. Midwives working with mothers using heroin and/or methadone and who were not engaging fully with drug support agencies made three of these referrals. Another referral came from a housing officer involved in supporting a homeless pregnant mother in getting accommodation who thought both mother and father were under the influence of drugs. The fifth referral was made by a family member who claimed the unborn child's mother was drinking alcohol and taking cocaine and had made no preparations for the baby and the final referral was from an unborn baby's grandmother who was concerned her daughter was on a methadone programme but was still taking other drugs.

Four further referrals categorised as 'child protection' were in response to concerns about potential sexual abuse. One was in relation to a pregnant mother who had been sexually abused by her father as a child. Her father had served a prison sentence for the abuse but now the pregnant mother had returned to live with him. Another referral related to the father of the unborn child as he was a registered sex offender and subject to a court order stating he should not have unsupervised contact with children. Two referrals related to ongoing investigations by the police into fathers of unborn children. One of the fathers was being investigated for child pornography and one for an allegation of rape against a teenage girl.

The remaining seven referrals were all quite different. A midwife, who reported multiple risk factors for the baby due to the father having hepatitis C, the mother having a high Body Mass Index and a latex allergy and several missed antenatal appointments made one. Another referral related to a pregnant mother who had moved to live with a family where two children (not related to her) were subject to safeguarding plans. The third referral was made by another LA in order to share information about a case they were responsible for but where the host LA might need to take action if the baby arrived out of office hours and an emergency response was needed. The fourth referral was from a pregnant mother asking for financial support. In the process of checking for previous information the Access Point social worker had noticed a missing person alert made by another LA. The fifth referral came from a social worker involved in preparing a report for court about a father known to be extremely violent toward women and children. In the course of the court proceedings it had become known that

the father was in another relationship and that his partner was pregnant. Another referral had been made by an addiction therapist (working with a GP practice) who had been told by her client that his ex-partner was placing his children at risk. The final referral stated '*as per policy all referrals need to be recorded on the system*'. There was no other information on the unborn baby's file but there was involvement with a support team in relation to a six-year old sibling that indicated the parents had successfully completed the parenting programme.

Domestic Violence (2 referrals)

The two referrals regarding domestic violence were both from the police domestic violence unit. Both cases involved the father being drunk and the mother calling the police for assistance. Both cases were followed up with an Initial Assessment although for one of the cases the Initial Assessment occurred after the baby was born.

Family Support (1 referral)

In the '*reason for referral*' free text box the Access Point social worker had recorded:

Four children already and struggling to cope. House overcrowded.
(Referral research notes 2008)

Under the referrer's details the case was recorded as being referred by *Family, Friend Neighbour* there was no other information recorded on the referral. I subsequently discovered that when the case was transferred and an Initial Assessment conducted it resulted in a child protection conference. The child protection conference report indicated concerns with regard to the father dealing drugs. There were also concerns regarding anti-social behaviour by the three older children (who were aged 15, 13 and 11) that included physical and verbal violence, firearms offences criminal damage and arson. The anti-social behaviour unit were reporting a lack of co-operation from the parents and teachers were reporting that the children were frequently excluded from attending school. None of this information was evident on the referral.

Financial Assistance (1 referral)

The referral categorised as a request for financial assistance was from a mother who contacted the Access Point team because her benefits had been stolen. The referral was opened and closed on the same day and financial assistance was provided to the mother.

General Concerns (1 referral)

This referral involved a mother who had been on the child protection register herself as a child. The midwife referred the case because the mother was using drugs. Also the midwife had information that indicated the unborn baby's grandfather might be a convicted paedophile and the grandparents had convictions for drug dealing. The referral also said there had been domestic violence between the unborn baby's parents that resulted in the mother being admitted to hospital with broken bones. The parents were aggressive to professionals and the police had been called to the hospital to restrain both parents. The midwife no longer visited the family home due to concerns for her own safety.

Parental Illness, impairment or substance use (1 referral)

The case categorised as '*parental illness, impairment or substance use*' was made by a specialist drug liaison midwife. The unborn child's mother and father were on a methadone programme but were also continuing to use heroin and the father also used alcohol. The referral was made approximately eight weeks before the birth but no action was taken and an Initial Assessment was not completed until four months after the baby was born.

Request for assessment (3 referrals)

One of the referrals, which was categorised as a request for assessment, came from a CAFCASS social worker working with another family in court proceedings. During the court proceedings it had come to light that the father, who was extremely violent, was now in a relationship with another woman who was pregnant.

A second referral involved a mother who informed a member of staff at a children's centre that she was pregnant and that, previously, her older two children had been removed from her care and were now adopted.

The third referral categorised as a request for assessment was from the drug liaison midwife who contacted the LA about a mother she was working with who was now on a methadone programme. The mother had significant debt problems and was unable to afford basic commodities such as gas and electricity. Her older children had been on the child protection register but were now in the care of their grandparents.

7.6.4 Summary

Between them, the two fixed data boxes created the impression that the majority of referrals were of a child protection nature, with the most often used DCSF child in need code indicating most pre-birth cases were in response to concerns of 'abuse or neglect' (21 or 37.5%) and with 37 of the cases (66%) of cases being categorised as 'child protection' according to the LA codes. However, the LA free text boxes provided more detailed information which suggested that the initial process of categorisation is not a reliable indicator of the actual nature or content of the referral. For example, the referral categorised as '*general concern*' which contained information to indicate the mother had herself been subject to child protection registration, was now using drugs and had experienced domestic violence during pregnancy could readily be categorised as child protection. Equally the referral categorised as '*Child protection*' that stated nothing more than '*as per policy all referrals need to be recorded on the system*' did not obviously present as a child protection concern and the purpose of the referral could be called into question per-se.

The host LA, at the time of the audit, routinely submitted the figures drawn from the EDB in relation to the *Child in Need* codes to central government as part of the statistical data relating to children and families. Looking at the more detailed information contained in the free text boxes calls into question the validity and worth of such statistics as the initial process of categorisation appeared based on the Access Point social worker's own interpretation. As such there appeared to be some inconsistency in how cases were categorised. In Chapter 6 I identified that the Access Point social worker taking a child protection referral could be an inexperienced social worker or an experienced social worker but experienced in adult or mental health social work. It may, therefore, not be an arbitrary process of categorisation but a choice that reflects skills and experience. Equally, the system demands that the referral cannot be completed unless certain data boxes and fields are completed and, therefore, some boxes may have been selected in response to system demands rather than with thought being given to the actual content of the referral. Whatever the reason, what emerges is a picture in which information is captured in a number of formats that do not necessarily correlate with each other.

Aside from the lack of clarity about the nature of the referrals what the free text boxes demonstrated was that there was a wide range of information that might prompt a referral to the LA. Information that was received by the Access Point team marked the start of a series of actions and decisions and, in the next part of this chapter, what happened following receipt of the referrals is outlined.

7.7 Tracking actions and decisions

Following referral, social workers undertaking an Initial Assessment (IA) or Core Assessment (CA) were required to open the relevant assessment document on the child's case file. When an assessment form was opened it triggered the EDB to time how long the assessment took to complete. If an assessment was not completed within the required 7 days for the IA or 35 working days for the CA an alert was triggered on the child's file to notify the social worker that an assessment had gone over the timescale. The information on the EDB relating to the numbers of assessments and time taken to complete them is submitted periodically to central government and contribute to the national statistics. The national statistics for the year ending 31st March 2009 showed:

Of the 349,000 initial assessments completed in the year, 250,500 (72%) were completed within 7 working days of referral. This compares with 226,300 (71%) out of a total of 319,900 for the previous year.

Of the 120,600 core assessments undertaken in the year, 94,300 (78%) were completed within 35 working days. This compares with 83,700 (80%) out of a total of 105,100 for the previous year.

(DFCF Statistics Sept 2009, no page number)

The EDB counted the start date of an assessment as the day the IA or CA document was opened on the child's case file. When a social worker completed the assessment document they made a recommendation on the next course of action and the system flagged up to the manager the case required a decision. The manager then electronically signed off an assessment by choosing a decision option and then clicking a box to close the document and the EDB counted this as the end of the assessment period.

The actual practice of social workers in the Initial Assessment Team was however, to only open an assessment document when they had sufficient time to type the information they had gathered into the document ensuring it could be closed within the seven-day time frame, even if the assessment had actually been commenced much earlier than 7 days' previously. Social workers in the Initial Assessment team reported that it took an average of one working day to type up one IA document.

7.7.1 Pre-birth case trajectories

I had anticipated the pre-birth referrals would follow an assessment trajectory as per figure 7 on page 129. The following results report what I found were the actual trajectories of the 56 referrals.

A) Case closed without any form of assessment being undertaken

Of the 56 referrals resulting in a new electronic case file, eight cases (or 14%) were closed without any form of assessment being undertaken. The reasons for closure were:

- 1) The 'probation enquiry' (categorised as Advice/Information) where no other information was recorded.
- 2) The request for information from another LA on a case they were assessing (categorised as Advice/Information).
- 3) The case which had been allocated for an assessment but the pregnancy ended in miscarriage before assessment started (categorised as Request for Assessment)
- 4) The referral from a midwife but the mother actually lived in another LA area (categorised as Advice/Information).
- 5) The information shared with the host LA about a violent prisoner because the Access Point Team might be called on for assistance if the baby were to be born out of hours (categorised as Child Protection).
- 6) A midwife referred a mother because she had been involved in drug taking in the past and her first child (now eight years old) was living with grandparents. There were no current concerns and the mother was no longer taking drugs and so, eventually, the manager in the Initial Assessment team reviewed the information and decided there were insufficient grounds to complete an assessment (categorised as Advice/Information)
- 7) The mother who requested financial assistance, which was provided (categorised as Financial Assistance).
- 8) The father, a registered sex offender, who was living with his own children. Case files for older siblings contained assessments of the older siblings in relationship to the risk their father posed and concluded no further involvement was needed (categorised as Child Protection)

These cases indicated that there was no easy means of differentiating between referrals and requests for information and so some children had had case files created (and therefore

became a referral statistic and their details remained on the EDB) when there had been no direct involvement. As was indicated in the categorising of cases earlier in this chapter, there also seemed to be an unclear approach as to what information passed the threshold for requiring intervention. Case number 6, for example, had been regarded by one team manager as reaching the threshold and so had transferred the case on for IA, only for the Initial Assessment Team Manager to decide it did not reach the threshold and close the case.

B) Files with a Pre-birth Initial Assessments and no Core Assessment

There were 20 pre-birth referrals (36%) that had an IA document on the electronic case file but no CA. Of the 20, three cases did not have a clear decision or recommendation following the IA. One related to the referral made approximately 5 weeks before the birth but where an IA document was started three months after the baby was born and not completed (categorised as child protection). Another related to the father under police investigation for child pornography where a blank IA was on file and the LA had had no active involvement for a period of 10 months (categorised as Child Protection). The third had an IA that had been opened on 22nd January, closed on 25th February (indicating it had been completed pre-birth) but which contained information about the birth in April, suggesting it had actually been completed post-birth (categorised as Request for Assessment). I was advised by a social worker that it was possible (and not necessarily unusual when there was a backlog in writing cases up) to effectively go back in time on the system and open and close an assessment document retrospectively. This meant, therefore, that it was not unusual to find information in an assessment that did not necessarily correspond with the formal EDB dates for the assessment.

The remaining 17 referrals that had an IA all had a decision recorded as per table 8. The social worker was required to electronically tick a box to indicate what further action they deemed to be needed and the options available to social workers in the host LA corresponded to those on the ICS Initial Assessment pro forma (DH 2003 see appendix 8).

Initial Assessment Decision	
Initial strategy discussion	
Immediate legal action to protect the child	
Core Assessment	5
Provide accommodation	1
Provide short term services	
Commission specialist assessment	
Referral to other agency	4
No further action	7
Total	17

Table 8 Initial Assessment Decisions

The detail and outcome following the IA decision was as follows.

Core Assessment recommended post IA but not undertaken (5 cases)

In these five cases the CA was not actually undertaken for the following reasons:

- 1) The case related to a mother and her partner now living with her father who had served a prison sentence for sexually abusing her (categorised as Child Protection). A closing summary was inserted on the case notes which indicated court proceedings had been initiated in relation to older siblings of the unborn child and the unborn child's grandfather was assessed as a risk to pubescent girls. The unborn child's parents had, however, put safeguards in place to protect all their children and the older siblings had not expressed concerns at school.
- 2) The IA had recorded throughout 'unable to assess baby not born'. The referral (categorised as Child Protection) related to a twin pregnancy with parents where there was domestic violence and violence toward professionals and concerns about firearms in the home. The pregnancy ended prematurely and the twins died shortly after they were born.
- 3) The case (categorised as General Concerns) was referred in December following concerns of mother using heroin, cocaine street diazepam and alcohol. The

grandfather was thought to have a conviction for sexual offences against children and there was violence between the parents, which had resulted in the mother needing hospital treatment for broken bones, and both parents had been aggressive toward professionals. The case was left unallocated until April when an IA was completed. The case then transferred to the Family Support Team in May but no CA was completed and there was no indication on the file as to why this was so. A child protection conference was held after the baby was born.

- 4) A case (categorised as Domestic Violence) referred in mid March following a domestic violence incident. The IA was completed in late April and transferred to the Family Support team for a CA but was left unallocated until after the baby was born. During the period when the case was awaiting allocation the police responded to another domestic violence incident and a health professional also contacted the LA concerned for the mother.
- 5) The referral (categorised as Child Protection) made because a midwife was aware the mother had been subject to child protection procedures herself as a child. The IA was positive indicating the parents coped well with the unborn child's older siblings, one of which had additional needs due to disability. When the case was passed to the Family Support team they requested a family centre work with the family. After one visit the family, however, the family centre worker reported there was no requirement for LA intervention.

Provide Accommodation (1 case)

This IA, relating to the pregnant Asian woman and categorised as Adoption Enquiry, was dated as having been completed on the same day as the baby was born but the information read as if it had been completed in the pre-birth period. Also completed on the day the baby was born, was the *Looked After Child* paperwork and on this documentation the child was categorised as 'relinquished for adoption'. This child was subsequently placed for adoption.

Referral to other agency (4 cases)

Referral to other agency suggested to me a referral to an agency outside of the LA remit, such as the health service or voluntary agency, for example. However, in all four cases with the decision for a referral to other agency the SW completing the IA had actually requested the case be passed to a Family Support Team within the host LA, rather than an agency outside of the LA remit. One case was passed directly to a Looked After Child team because the mother had requested her baby be placed for adoption (categorised as Child Protection), which was

the eventual outcome for the child. The other three cases were passed to the Family Support teams and all three cases were discussed at pre-birth child protection conferences and safeguarding plans put in place. All three cases are discussed in Chapter 8 as 'Jodie', 'Harvey' and 'Molly'.

No further Action

These cases had the following outcomes;

- 1) The referral made by the midwife and categorised as 'child protection' because the mother was not attending antenatal appointments and there were multiple risk factors. During the IA the mother claimed she had been attending hospital antenatal appointments, which the hospital confirmed when the social worker checked. The hospital also said the other risk factors had been assessed and they had no ongoing concerns for the unborn baby.
- 2) The case referred by the midwife and categorised as 'Parental Illness or substance misuse' due to concerns about the mother's none compliance with a methadone programme. The social worker completed an IA that contained information about the older siblings and did not mention the unborn child at all.
- 3) The case (categorised as Child in Need) as the mother had moved to area and had no support and the midwife was requesting support to look after the other children when the mother went into hospital to have the baby. There was a blank IA with no information other than the mother's name and address and the decision for no further action.
- 4) The referral (categorised as Adoption Enquiry) made by a mother who requested her baby be adopted at birth. When the social worker had visited, however, the mother reported that she had changed her mind.
- 5) The referral (categorised as Child Protection) related to a mother who had moved in with a family where children were subject to safeguarding plans. When the social worker visited the pregnant mother to do the IA she had already moved back home to her family and there were no concerns.
- 6) The referral (categorised as Child Protection) which was made following a domestic violence incident where the father had punched the pregnant mother. The referral indicated there was a history of 19 other domestic violence incidents that included both physical and verbal assaults by the father on the mother. The referral also indicated that the Access Point social worker had contacted school who indicated there were concerns about the oldest sibling's attendance but no concerns reported for the younger sibling. The IA was completed approximately two weeks after the

referral and contained cut and pasted information from the referral but no additional information. There was no information to indicate why or how the decision for no further action had been arrived at.

- 7) The referral (categorised as Child Protection) where a midwife made the referral because the mother and father were on a methadone programme but were also using heroin. This case was referred in March and was allocated to a social worker for assessment who recommended the case be closed. No management action was taken to close the case and the baby was born in May. There were no case notes or other information on the file beyond the original referral information until an IA was completed in September (four months after the baby was born) and it was recommended then that no further action be taken and the case was then closed.

Whilst some of the above cases indicated clear reasons to end involvement following the IA (for example cases 4 and 5) others (cases 2, 3 and 6) did not have information which could be seen to have logically underpinned the decision for no further action. Case 7 seemed to have 'slipped through the net'.

C) Pre-birth files containing an Initial and Core Assessment

There were 15 pre-birth referrals that had an IA and then went on to have a CA (or 27% of the total 56 referrals). During the period of the audit, interestingly, a decision was taken at management level to complete some core assessments in the IA team. The reason given by management for this decision was to ease pressure on the Family Support Teams although several social workers commented that they thought it was in order to increase the numbers of CAs for the end of year statistics.

Of the 15, four had a CA document started but not completed and remained on the system as an open document with no decision recorded. Of these four cases, three were discussed at pre-birth child protection conferences and safeguarding plans were put in place (one categorised as Child in Need and two categorised as Child Protection). The fourth involved a child who was removed from the parents shortly after birth (categorised as Request for Assessment). In addition to the four CAs not completed, one had been completed and closed but with no decision record (Categorised as Child Protection). Another had a CA document opened and closed with no information on it other than to refer the reader to an assessment completed by another LA which had been scanned and stored on the case file (categorised as Child Protection). The scanned assessment was a document relating to a 14 year old girl (not a member of the unborn child's family) and had been completed as part of a child protection investigation following allegations of rape against the unborn child's father. There were no

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indications on the case files why these six cases did not have a CA which was completed with a decision recorded.

Of the nine remaining cases which progressed to CA the decisions were recorded per table 9. At the end of the CA the social worker recommends a decision and the manager then has responsibility for either agreeing the recommendation and electronically signing off and closing the assessment or not agreeing and passing it back to the social worker for additional work to be undertaken. The decision options used by the LA concur with those contained in the ICS Core Assessment form (DH 2003, see appendix 9)

Core Assessment Decision	Number and specified reason
Initial strategy discussion	1
Immediate legal action to protect the child	
Commission specialist assessment	
Provide accommodation	1
Provision of services (s.17)	1
Referral to other agency	
Other (please specify)	1. Hold safeguarding conference 2. Hold child protection conference 3. (the terminology of hold a safeguarding conference and child protection conference reflects the social workers choice of terminology) 4. Recommend further pre-birth assessment 5. Further assessment including pre-birth assessment 6. Refer to other team in LA and DV team 7. Refer to Family Support team 8. Continue with safeguarding plan
TOTAL	9

Table 9 Core Assessment Decisions

Initial strategy discussion (1 case, originally categorised as Family Support)

This CA proceeded to a pre-birth child protection conference and the child protection report contained information about the family circumstances that was not recorded anywhere else on file. The host LA had a child protection report format that contained the same headings as the ICS CA (DH 2003). On the child protection report the social worker had recorded that the child

protection report and CA were 'doubling up' rather than writing two separate, but similar reports.

Provide Accommodation (1 case, originally categorised as Child Protection)

This CA was recorded as having been completed the day before the baby was born although the original referral indicated the mother was 22 weeks pregnant at the point of referral. The CA listed mother's sexual partners and indicated that one had died the day before the CA commenced. The CA also listed meetings the LA had had held in relation to the case planning process and the legal process to remove the baby at birth.

Provision of Services (1 case, originally categorised as Child Protection?)

This CA actually recommended the case be closed but whilst the case was awaiting the necessary administrative actions to close the electronic case file the police had made another referral. The case remained allocated to a social worker and support was being provided under section 17 of the Children Act.

Other (7 cases)

Each of these cases had specified reasons (as per table 9) as to what 'other' comprised. Six of the seven cases had an IA that was a blank document because the CA had been completed by an Initial Assessment Team social worker.

The case (originally categorised as Child Protection) where the recommendation was to hold a 'safeguarding' conference (the use of terminology is the social workers choice) had a CA which consisted only of information that had been cut and pasted from the referral. A pre-birth child protection conference was held following the CA and the case transferred to the Family Support Team. When the baby was born the LA made an application to court and the baby was removed from the parents' care but no further CA or any other information was on file to indicate how this decision and plan had been arrived at.

The CA which concluded with the decision to hold a child protection conference originated from a referral from a pregnant mother requesting financial assistance (and originally categorised as Child Protection). At the point of referral the Access Point social worker had found the mother was subject to a missing person alert. The CA contained no additional information and 'unable to assess as baby unborn' was inserted in the text boxes on the CA. The case was transferred

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to a Family Support team and a pre-birth child protection conference was held and a safeguarding plan put in place but, yet again, there was no information on the file to indicate the reasons for this decision.

The CA that specified further assessment including pre-birth assessment (which related to a referral originally categorised as Child Protection) again had many boxes that had not been completed or had the phrase 'unable to assess as baby unborn'. When this case transferred to the Family Support Team the SW completed a pre-birth assessment that did not follow the CA format. Instead it was a 23 page (A4) document setting out the family history, positives and concerns. It contained a recommendation to remove the baby at birth and specified reasons why this recommendation was being made. This assessment was subsequently submitted to court and the child was removed shortly after birth.

The CA about a referral, originally categorised as Child Protection, that concluded with the decision to refer to the Family Support Team resulted in a pre-birth child protection conference being held but I could not ascertain from the file the reasons for this decision and the child protection report and minutes were not recorded on the file.

The CA that had the decision 'other' and specified referral to another team in LA and the DV team was about a case where the unborn child had older siblings and the original referral had been made following a domestic violence incident where the father had hit and spat at the mother (originally categorised as Domestic Violence). The referral details indicated the mother was pregnant and on the referral page the child was recorded as being unborn. The CA was the form for a child aged 5-10 years old and spoke of the father spitting on the child. The CA also spoke of the child being 'monitored at school'. The social worker who had completed the assessment had left the LA so I was unable to unravel this CA.

The final CA, about a referral originally categorised as child protection (included in the in-depth cases discussed in Chapter 8 as 'Jordan's case'), did not go to the Initial Assessment team because a social worker in the Family Support team was already working with the older siblings who were subject to safeguarding plans. There was no IA and the CA had no specific information about the unborn child but had information cut and pasted from a CA on an older sibling.

D. Ongoing involvement but no Initial or Core Assessment

12 of the 56 pre-birth referrals (21%) resulted in ongoing pre-birth involvement with no IA or CA document having been completed. Although there was no assessment document specifically relating to the unborn child, four of the 12 cases involved siblings who were subject to ongoing court proceedings (all four categorised as Child Protection, one of which is included in the in-depth cases discussed in Chapter 8 as 'Amy's case'). Therefore, the plans for the unborn child were regarded as the same as for the siblings and legal action at birth was based on information already before the court in relation to the family.

Four cases had older siblings subject to a safeguarding plan (all four categorised as Child Protection) and, as for the court cases, the plans for the older siblings were also put in place for the unborn child.

One unborn child referral involved safeguarding, responsibility transferring to the host LA from another LA as a result of the family moving home (Categorised as child in need, case included in the in-depth cases discussed in chapter 8 as 'Bethany's case'). The case file indicated the originating LA had conducted assessments, but no assessment documentation was held on the electronic case file.

Another case file contained an assessment entitled 'risk assessment' but this did not follow the IA or CA format (Categorised as General Concern). The risk assessment consisted of various questions about the risk the child may pose to the foster carer and any other children in the placement. All of the questions had been answered with the phrase 'non – unborn baby'. There was no other information on the file to indicate what plans or actions were to be taken post-birth.

One of the cases (categorised as Child Protection) had no active involvement before or after birth but appeared to be an open file because a support team were working with the parents in relation to an older sibling.

The final referral that did not have an IA or CA involved an unborn child who had two older half siblings who were subject to ongoing court proceedings by another LA and had been removed from their mother's care (categorised as Family Support). No IA or CA was completed but a 15 A4 page report entitled 'pre-birth assessment' was on file. The report did not follow the IA or CA format or reflect any of the domains of the *Assessment Framework* (DH 2000). The assessment had been completed (at the request of the case-holding social worker) by a

parenting support team. It is worth noting that the team who completed the report had two qualified social workers (one of whom was the team manager) and five other staff who held no formal childcare qualifications and it was not evident from the report if a qualified social worker had completed the pre-birth assessment and report. The report focussed on practical issues such as material provision for the baby and the mother's intention to breastfeed. There was no information about why the siblings had been removed from the mother's care and how she had responded to or reflected on this action. Also, there was no information about risk or protective factors or what support might be beneficial and yet the report concluded the baby should remain in the care of the mother. The LA maintained involvement with the baby post birth under section 17 of the Children Act 1989 but there was no information on file to indicate what support was being provided.

7.7.2 Summary

The *Assessment Framework* (DH 2000) provides a systematic way of assessing children's needs and the ICS (DH 2003) system adopted by the host LA contained IA and CA documents. However, as the above analysis demonstrates, social workers and team managers did not always follow this format in the process of assessing unborn children from the point of referral. It was often not at all clear why some cases had been assessed following the IA and CA process and others had not. Even in cases where there were levels of concern significant enough to have resulted in older siblings being removed from the parent(s), this did not necessarily equate to a CA always being completed.

In summary, it appeared to an outside researcher that the process of assessing unborn child referrals was haphazard and complex, with different social workers arriving at various conclusions based on their own interpretation of the information available to them. As with the process of recording referrals, the act of reducing complex information to a simple one or two word categorisation is a subjective process and not one which is readily standardised. Despite the requirements, driven by the electronic case records system, to assign categories and record decisions the information on files did not always indicate how a decision was arrived at and upon what information it was based. In some instances there were no ICS compliant assessment documents and, in some cases, information was cut and pasted from the referral or from one assessment to another and then used as a basis for decision-making.

7.8 Conclusion

The type of information and concerns that might trigger a pre-birth assessment are very varied and because of this it would not be unreasonable to anticipate a range of different outcomes to the referrals. The findings from the audit are analysed in more detail in Chapter 10 but for now there are several points worth summarising and noting.

Firstly, throughout the audit period, I encountered many difficulties in relation to accessing the data as a direct result of the complex systems of case recording and case management in place at the time of my research. Paperless offices and the EDB made access to unborn children's case files cumbersome and, at regular intervals, when the computer systems failed, totally inaccessible.

From the starting point of an anticipated pre-birth case trajectory based on *Working Together* (HM Government 2006) and the *Assessment Framework* (DH 2000) I expected a linear process punctuated by points of decision-making. My findings were, however, that the process involved several stages where the nature of the referral, and therefore information about the unborn child, were categorised according to (unhelpful) pre-determined fields and terminology. This process of fitting children's situations into such boxes resulted in responses to information about unborn children and their families looking arbitrary and not easy to understand.

In addition, with regard to the process of assessment itself, and based on the electronic case file, there often seemed to be no clear reason why some pre-birth cases appeared to have followed the complete process of IA and CA whilst others had not. The content of assessments also varied with some documents following the IA and CA format, some being blank documents or documents containing the phrase '*unable to assess, baby not born*' others not following the *Assessment Framework* (DH 2000) at all.

Finally, the nature of the process of referral categorisation, assessment approach and decision-making did not necessarily seem to reflect the levels of concern identified for the child. Cases with plans to remove a baby at birth were no more likely to have an assessment or case notes on file that reflected the levels of concern and reasons for actions than any other case would.

Chapter 8

Phase 3 Findings: In-depth Study of Pre-Birth Cases

8.1 Introduction

As discussed in Chapter 3 the research was split into three phases with the third, and final phase, being a case study of one LA. The first part of the case study involved an audit of referrals over a six-month period, the findings from which were discussed in Chapter 7. For the second stage of the LA case study it was planned to select ten pre-birth assessment cases to analyse in detail. In this chapter I outline the process of selection, which resulted in seven cases being considered in detail. The chapter then comprises the findings from the documentary analysis, married to the specific comments about the cases from the respective case-holding social worker during my semi-structured interviews with them.

8.2 Case Selection

From the referrals tracked during the audit period my original plan was to select 10 cases for in-depth analysis. The selection was based on the following five possible intervention plans that I had identified could be in place at birth:

- 1) An emergency application to protect the child at birth either by using the police powers of protection under section 43(7) of the Children Act 1989 ,or an application by the LA to court for an Emergency Protection Order under section 44 of the Children Act 1989.
- 2) A planned application to court at birth under section 31 of the Children Act 1989 for an Interim Care Order
- 3) A planned application to court at birth under section 31 of the Children Act 1989 for an Interim Supervision Order
- 4) An investigation under section 47 of the Children Act 1989 followed by a pre-birth child protection conference and a decision for a safeguarding plan in place prior to birth
- 5) Child defined as in need under section 17 of the Children Act 1989 and a package of support provided in agreement with the mother but no intervention as identified in points 1-4 above.

I aimed to select two case examples from each of the five categories, thus arriving at the figure of 10 cases, all of which would be drawn from the six-month audit. Following documentary analysis of each of the in-depth cases my intention was to then interview the case-holding social worker. By undertaking the documentary analysis and semi-structured interviews I aimed to gather data that would illuminate how national policy and procedure interfaced with the LA level and then translated into practice, thereby gathering data linked to all four research questions:

- i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?
- ii) What are Local Authority processes in relation to pre-birth assessment?
- iii) What are social workers' views about pre-birth assessment?
- iv) How do social workers approach the task of pre-birth assessment?

At the start of the data gathering process I had anticipated the intervention plans would be recorded on a Core Assessment (CA) or in the case notes. However, as described in Chapter 6, how information was recorded on the electronic data base (EDB) was not consistent from one social worker to another and, as described in Chapter 7, how information was categorised also differed considerably. This meant that it was not always easy to identify which were the in-depth cases as some had very little information actually on the case file. Also, some planning occurred very close to the birth date and when information had been recorded retrospectively it was not always done in a way that identified pre and post-birth planning. The intention was to obtain parental consent post birth to negate any risk of my research impacting on the pre-birth assessment process. It transpired, however, that I was only able to identify some categories of cases post-birth when the administration staff updated key pieces of information about procedural issues such as safeguarding or court plans. There was also one case that had no file at all and was only identified post-birth as a result of a discussion with a senior manager. In conclusion, although I aimed to stay as closely to my original case selection plan as possible, the eventual selection did not occur as I originally planned.

8.2.1 Cases not meeting the selection criteria

Of the 56 cases identified in the six-month audit, 34 met the criteria of having intervention appropriate for selection for in-depth analysis. As Table 10 indicates, twenty-two cases were not included because there was no additional information on the file other than that captured

in the six-month audit. However, although they were not included in selection for in-depth analysis this is not to say these cases have no relevance in terms of research data and findings; indeed quite the opposite is the case.

Closed at point of referral	Closed following IA	IA decision for CA but case closed by Family Support Team	Pregnancy ended prematurely	Case remained unallocated	Total
8	7	2	2	3	22

Table 10 Breakdown of cases with no additional information

Eight of the original 56 cases in the six-month audit were closed at the point of referral and a further seven were closed following the Initial Assessment (IA) and the reasons are listed in Chapter 7 page 146. These cases are of interest in that they were not deemed at this very early stage of intervention as meeting the threshold of a child in need although there was no clear indication of what did meet the threshold.

Of the cases which did meet the threshold two had an IA on file that recommended a Core Assessment (CA) but were then closed by a Family Support Team Manager without further intervention. These cases are particularly interesting as they highlight different processes of decision-making employed by different managers and further highlight the lack of clarity of what constituted the threshold for undertaking a CA. In each of these cases there was no additional information on the file that would prompt a different conclusion and there was no evidence of further discussion with the assessing social worker. What appeared to occur was the Family Support Manager arrived at a different conclusion and then 'overrode' the Initial Assessment Manager's decision. It is however, also worth noting that the staffing issues (discussed in Chapter 6) were having an impact on the numbers of cases that were being held but not allocated to a social worker in the Family Support Teams. With significant allocation pressures, Family Support managers constantly had to review which of the unallocated cases took priority with cases deemed as child in need taking least priority. Some of the child in need cases remained unallocated for several months, often way beyond the duration of the pregnancy potentially adding to the pressure, or logic, to close cases that would not be allocated.

Two cases ended because the pregnancy ended prematurely. One case was passed to the Family Support team and allocated to a social worker for ongoing involvement but the pregnancy ended in miscarriage before the social worker made contact with the mother. Another case was a twin pregnancy (one referral was made and so although there were two

children it counted as one case in the six-month audit) and the case notes indicated high levels of professional concern. However, the children were born extremely prematurely and both children died shortly after birth.

Three cases were held in the Family Support Teams but were not allocated to a social worker and so received no further pre-birth assessment or intervention. The decision not to allocate these cases was, apparently, based on the information contained in the IA and case notes. The decision not to allocate was similar to the decision to close a case as there were elements of 'overriding' the Initial Assessment team social worker and manager's recommendation for a CA or ongoing involvement.

What transpired was a decision making process that 'screened out' child in need cases. The first stage of this process occurred at the Access Point Team and cases 'screened out' at this stage did not meet the criteria of child in need. The second stage of assessment and decision-making occurred as the IA stage and cases closed at this point were also deemed not to reach the threshold of child in need. All cases progressing past these stages would therefore, be unborn children deemed to be in need or at risk of significant harm and should have been allocated for further in-depth CA and/or support. At the Family Support team stage, pre-birth cases that didn't meet their specific criteria of likely to require safeguarding or legal intervention were then screened out of the assessment process altogether.

Ultimately I had 34 cases identified in the six-month audit to draw from plus the one case for which there was no electronic case file making a final pool of 35 cases from which to select for in-depth analysis.

8.2.2 Cases with legal intervention at birth

Out of the 5 original case selection criteria the first three (identified on page 158) were linked to legal intervention at birth. Of the 34 cases that progressed beyond the IA stage and were allocated for further assessment 14 had a plan that involved some form of legal intervention at birth (see table 11).

Baby placed in LA care for adoption, at request of mother	LA plan to initiate legal proceedings at birth	Pre-birth safeguarding plan plus plan for legal proceedings
2	9	3

Table 11 Cases with legal intervention at birth

Two children were voluntarily placed by their mothers in the LA care with a request for the baby to be adopted. In both of these cases adoption continued to be the plan with legal

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intervention under the Adoption and Children Act 2002. In my original outline of the five categories of involvement I had not considered this outcome and had, therefore, not included legal proceedings as a result of a parental request. I did consider including at least one of these cases for in-depth analysis but ultimately I was unable to do so for ethical reasons (discussed further in section 8.2.4).

Nine cases had a plan for the LA to initiate legal proceedings at birth. A further three had both a Safeguarding plan in place and a plan to initiate legal proceedings, thus fitting two of my original five categories giving a total of 12 cases fitting the category of a legal order at birth. As there was no protocol for what or how things should be recorded on the case file it was not possible to identify exactly what legal order was considered prior to birth in all cases. In some cases it was not possible to identify what order was actually applied for at birth! I therefore selected cases that appeared, from the case records, to broadly fit my original three criteria linked to legal intervention.

8.2.3 Cases with a safeguarding plan at birth

Including the three cases with planned legal intervention, there were 22 cases that had a safeguarding plan in place before the baby was born. *Working Together* (HM Government 2006), under the section '*Key Definitions and Concepts*' states that '*abuse and neglect are forms of maltreatment of a child*' (HM Government 2006, 1.29) and sub divides abuse and neglect into the four categories of physical abuse, emotional abuse, sexual abuse and neglect. Under each of these a description, or broad definition, is given for what could be considered within the category. Neglect is the only category where reference is made to unborn children stating:

Neglect is the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. (HM Government 2006, 1.33)

For children where a safeguarding plan is considered appropriate, it is stated the chair of the child protection conference should determine which of the four categories of registration the most appropriate (HM Government 2006) is. The categories are then recorded and feed into national statistics and, for the period during my data gathering were included in '*Referrals, Assessment and Children and Young People who are the Subject of a Child Protection Plan, England Year Ending March 2009*' (DfCSF, 19 September 2009). As neglect was the only category that *Working Together* (HM Government 2006), indicated as being applicable to unborn children I had expected neglect being the only category applied. However, in the host LA the 22 unborn children who were subject to a plan were categorised as per table 12.

Neglect	Emotional abuse	Physical abuse	Sexual abuse	Not recorded	Total
10	3	5	3	1	22

Table 12 Categories of Pre-birth Safeguarding Plans

As I only intended to select two cases that had a safeguarding plan I opted to select one from the category of neglect and one another category to try and capture any information that may indicate why different categories were used.

8.2.4 De-selection of cases

Having identified 35 potential cases for in-depth study, the second stage of case selection involved making decisions about which to include in the final sample. As already stated, I had intended to interview the case-holding social worker in order to capture their views about the assessment and hence obtain an additional dimension to my documentary analysis. However, as indicated, what had become apparent during the audit was that not all cases resulted in a core assessment and I had also found that the social worker with case responsibility at the point of birth was not necessarily the person who had completed the recorded assessments. This being the case, I felt it was even more important to interview the social worker who had held case at the point of birth as they had been the professional charged with responsibility of making sense of all of the available information and drawing up a plan.

However, holding to the decision to interview the case-holding social worker resulted in 20 cases being deselected from the 35 cases for reasons indicated by table 13:

Reason for de-selection	Number
Agency social worker contract ended and case was unallocated	7
I previously managed the social worker	5
Social worker agreed to be part of the research but did not obtain initial consent from parent	2
Social worker retired	1
Ethical reasons	2
Parent refused consent	3
Total number of cases de-selected	20

Table 13 Reasons for de-selecting cases from the process of in-depth analysis

Of the 20 cases there were 15 where it was not possible to combine reading the case file with interviewing the case-holding social worker. Seven of these cases were de-selected as a direct result of the management decision (discussed in Chapter 6) to end all agency social work contracts. I did give some consideration to attempting to contact the agency workers but this was not possible because the LA had made use of several different agencies and to trace the social workers would have required accessing personnel files, which I clearly did not have the authority to do.

The next five cases de-selected related to my decision not to interview social workers I had previously managed when employed by the LA. I wanted to avoid the possibility that my management of their work may have influenced their approach and/or that my previous relationship with these social workers might compromise my research role and inhibit their responses.

There were two cases where the social worker had expressed interest in taking part in the research and had been briefed on obtaining parental consent. However, despite both social workers saying they understood the consent process, the initial stages of discussion with the parent did not take place. After several discussions with the two social workers to establish if there was an underlying reason for not pursuing consent time factors became an overriding consideration. Although both social workers insisted they wanted to take part in the research I was unable to wait indefinitely and eventually the cases were de-selected because it was impossible to undertake the process of data gathering, interview and transcription within the available research time.

The case that was de-selected as a result of the social worker retiring came as a surprise to me. The social worker concerned had originally agreed to take part in the research and I had obtained parental consent and had begun the process of gathering data from the case file. I only became aware of the social worker's retirement when trying to arrange the interview. It transpired the social worker had made a request to retire in response to a department wide voluntary severance scheme and the request was accepted and responded to extremely quickly. Given the staffing issues in the social work teams, the acceptance of an early retirement request from a social worker who had many years' experience seemed somewhat strange. Also, nationally, the Local Government Association Group had published '*Respect and Protect*' (LGA March 2009) which identified difficulties in recruitment and retention of experienced social workers and suggested workers who had left retired or left the profession should be encouraged to return. In listening to conversations in the team offices I was left with a clear impression from the team manager, social workers and administration staff that the reason for accepting the early retirement request was the social worker's inability to use

the computerised case recording systems. Ironically, having retired from the host LA, the social worker had quickly secured work with an agency and was undertaking front line children and family work in a similar team in a neighbouring LA.

The two cases that had a plan for adoption at the request of the mother raised ethical issues in relation to obtaining consent that ultimately resulted in the cases being de-selected from the pool of 35 available cases. In the first of the two cases the files indicated that after placing the baby in LA care, the social worker had not been able to maintain contact with the mother because she had moved house and did not answer telephone calls or respond to letters or messages. I therefore felt that it would be equally difficult for me to make contact but also, based on the withdrawal from contact with her baby and the LA social worker, it seemed likely the mother was facing a range of complex emotions and an approach for consent to look at the case file would not be morally or ethically appropriate. The second adoption case related to an Asian young mother who said her life would be at risk if her father and extended family found out she was pregnant. On the case file were notes which detailed steps which were taken to ensure the mother's safety, which included a directive for no correspondence or telephone calls to the mother by staff in the LA and midwifery services. I felt an approach for consent to include the case in the study in these circumstance would not only be un-ethical but had potential to place the mother at serious risk.

Finally, three cases could not be included because parental consent was refused when the social worker made the initial contact with the family. In each of these cases the social worker had reported ongoing difficulties in working with the families and I had wondered if an initial approach by me, or another person, might have elicited a positive response to the consent request. However, I chose not to pursue this option, as I did not want an approach by me to exacerbate the difficulties already being experienced and hence, potentially place the child at increased risk.

8.2.5 Final selection of cases

Based on the originally identified 5 categories for case selection, I found that, in the pool of cases I could select from, there was only one case which fitted:

(Category 3) A planned application to court at birth under section 31 of the Children Act 1989 for an Interim Supervision Order

Also, there were no cases that fell into:

(Category 5) Child defined as in need under section 17 of the Children Act 1989.

Therefore my anticipated ten cases that represented the cross section I planned were reduced to seven. I chose not to select cases from other categories to make up the total of ten as I felt this might result in certain cases being over represented and it was also apparent that there would still be a wealth of data upon which to draw from the reduced number. In addition to the seven cases selected from the audit work I also had the case for which there was no case file. At the point of case selection I was of the opinion that the lack of a case file was probably a direct result of a social worker keeping records in other formats and that at some point an electronic case file would be created. Thus I expected to be able to study 8 cases in depth.

Ultimately, one of the eight cases was withdrawn from the research because of issues with consent: The case in question had fallen under the category of:

An emergency application to protect the child at birth either by using the police powers of protection under section 43(7) of the Children Act 1989 ,or an application by the LA to court for an Emergency Protection Order under section 44 of the Children Act 1989.

Everyone taking part in the research was advised that they could withdraw their consent to data relevant to them at any time. Consent from parents in the withdrawn case was obtained following the birth of the baby and following the baby being removed from their care and placed in LA foster care. Several weeks later the baby was placed with grandparents, who subsequently objected to the case being included in the research, despite the social worker explaining the nature of the research. The social worker thought that the consent issue was related to relationship difficulties between the parents and grandparents and she was happy for her interview to be included in the research data. I felt that although 'technically' the parents and the LA (by virtue of the Care Order) held parental responsibility, the grandparents' view should still be considered given that they were the full time carers of the baby and were most likely to assume parental responsibility in the longer term plans. I concluded that, from an ethical and moral perspective, if any party was not in agreement with the data being used then it should be withdrawn. This was a disheartening decision as, by this point, I had gathered information from the case file, interviewed the social worker and completed the transcription and was about to start writing the case up in first draft format for inclusion in the final thesis. Nonetheless, I feel it was the correct decision for the child and the family.

The final seven cases selected were as follows (all names are pseudonyms):

Case number	Name	Intervention at birth
1	Jodie	Emergency Protection Order
2	Amy	Interim Care Order
3	Molly	Interim Care Order
4	Harvey	Interim Supervision Order
5	Jordan	Safeguarding plan
6	Bethany	Safeguarding plan
7	Zalika	No case file

Table 14 Selected in-depth cases

8.3 Data Gathering

As already described, based on my understanding of procedures contained in the *Assessment Framework* (DH 2000) and *Working Together* (HM Government 2006) I was well aware of the process of referral IA and CA and I also knew the host LA were using a database which was compliant with government requirements surrounding the *Integrated Children's System* (ICS). Based on this national guidance and LA procedures I had devised a set of data tools, one for use in the six-month audit (see appendix 2) and one for use with the cases selected for in-depth analysis of cases (see appendix 3).

The in-depth data tool reflected my plan to access key documents along a continuum of assessment from referral to birth. I had anticipated reading a range of documents including the ICS referral and assessment forms, case notes, reports and minutes of meeting which would fit together to build a picture of the assessment process as per figure 8:

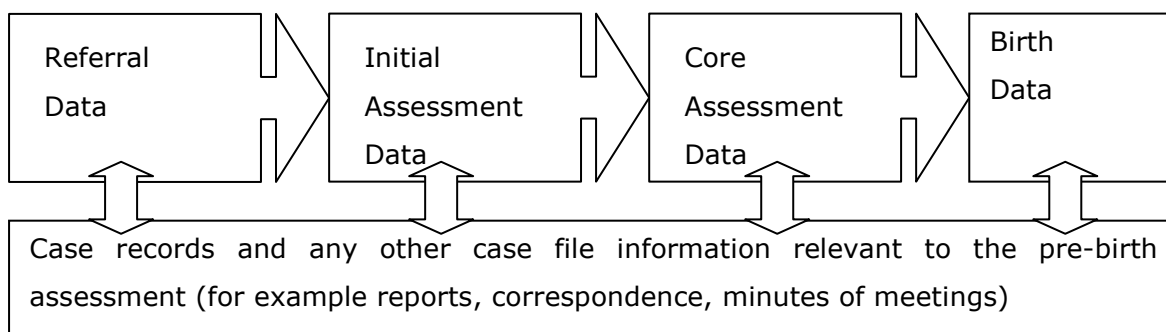


Figure 8 Anticipated process of assessment and planning

Having used the data tool for the six-month audit and found it a useful aid in organising my approach and for recording data I did not anticipate the difficulty I found in using the second tool for the in-depth data gathering from my selected cases. What had become evident during the six-month audit was that cases could take any number of different paths and trajectories from the point of referral to the birth of the baby. I began the process of selecting cases for in-depth analysis while the six-month audit was ongoing and, once parental permission to look at the file in detail was granted, I began trying to record data using the tool I had designed. It quickly became clear, however, that a pre-designed data tool was too rigid or limiting, to allow capture of the data in a way which would facilitate a method of recording which could be used for future analysis. The reason for this was the wide variations in approaches to case recording, not only from one case to another but also within the same case. I therefore abandoned the use of a data tool and approached each case individually, making notes and recording information about the assessment process.

8.4 An overview of each of the cases

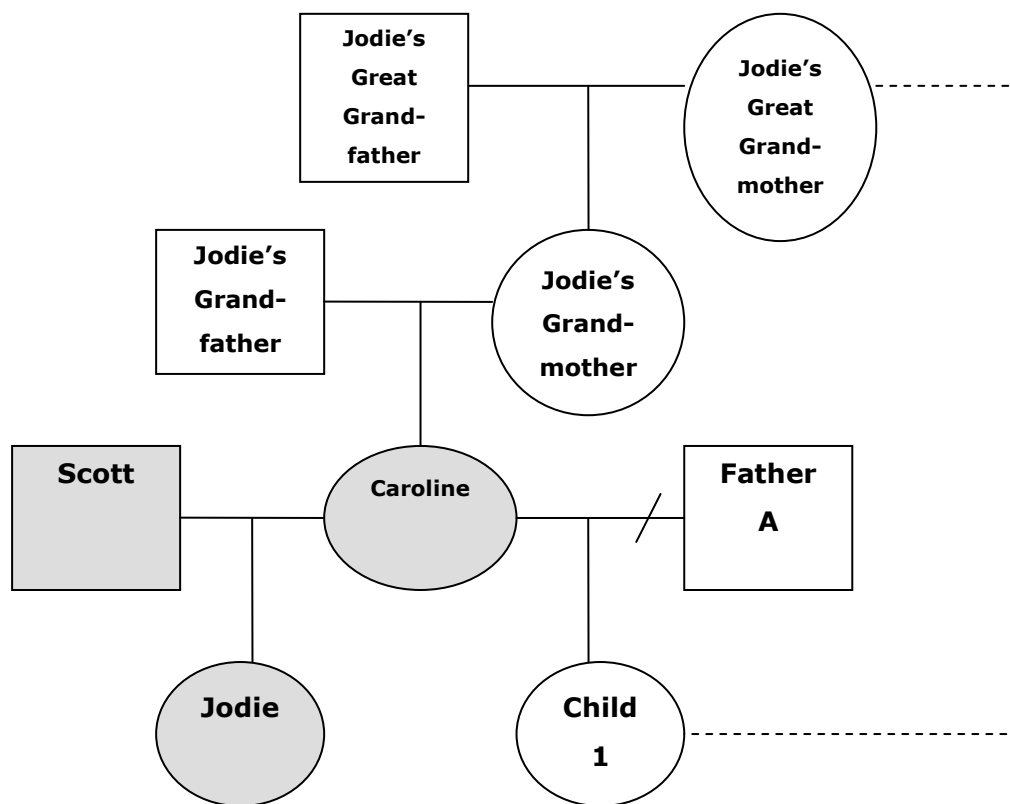
In this section an overview of each of the cases is provided, drawing on an analysis of the information on the file and on what the case-holding social worker said about the case during the semi-structured interview. In each social work interview the social worker was asked to talk about the pre-birth assessment case selected for in-depth analysis as well as talk about pre-birth assessment in general. The themes emerging from the interviews that related to more general views about pre-birth assessment are dealt with in Chapter 9.

All family and social worker names are pseudonyms. Where examples of case recording are quoted I have done so accurately apart from removing any information which could compromise anonymity and in doing so I have replicated typing, spelling and syntactical errors.

8.4.1 Jodie

At the initial point of referral Jodie's case had been categorised as '*Reason for Referral, child protection*' and no '*child in need code*' recorded. Jodie's case was discussed at a pre-birth child protection conference and there was a safeguarding plan in place under the category of '*neglect*'. Shortly after her birth Jodie was made subject to an Emergency Protection Order. Such orders are exceptional and would only be applied for in the most concerning of situations where there is an immediate threat to a child's safety. The case-holding social worker at birth was Ruth, who had been qualified for one year and had worked for the host LA since qualification.

The immediate family composition was:



Child	Jodie
Mother	Caroline (age 22, ethnic origin White British)
Father	Scott (age and ethnic origin not recorded)

The referral was made by a Community Midwife who indicated Caroline had another daughter (child 1 on the genogram) who was placed in the care of Caroline's grandmother. The referral also indicated there was an issue of domestic violence between Caroline and Scott and that they were using heroin and methadone.

Jodie was Caroline's second child and Scott's first. Caroline's first child was two years old and had been removed from her care when she was a baby and placed in the care of Caroline's maternal grandparents (the baby's great grandparents). There was no information on file with regard to Scott's family.

The referral was made on the 1st October 2008 when Caroline was approximately 21 weeks into her pregnancy. Also on the 1st October the case was transferred to the Initial Assessment

Team where a social worker completed (the same day) the IA. The same social worker completed a CA on the 8th October 2008, following which the case was transferred to the Family Support Team and allocated to Ruth. The only information contained on the IA was cut and pasted from the referral and the tick box section headed '*further action arising from the Initial Assessment*' (See DH 2003, IA Record Appendix 8) had the Core Assessment box ticked and the team manager had agreed the decision.

The CA comprised information automatically transferred onto the form by the computer system (names, address, expected date of delivery), information cut and pasted from the original referral and some new information relating to Caroline's health and Caroline and Scott's relationship gathered during the home visit. Not all questions on the CA were completed but the information which was there indicated Caroline was not eating well but scans had shown the baby was growing and developing normally. Caroline had not regularly attended medical appointments and when she did she '*insisted*' (CA record) Scott was not in the treatment room. Caroline had begun using cannabis at the age of 15 and also began to misuse alcohol, which had been a contributing factor to her first child being removed from her care. Later she began using heroin and although on a methadone treatment programme at the time of the CA the midwife reported all urine samples had tested positive for heroin and methadone.

With regard to Caroline and Scott's relationship the following excerpt is the CA question typed in bold followed by the social worker's response.

UB12. Expectant mother is in a relationship with a violent person

*Yes. Caroline has shared information to suggest that Scott is controlling. During the home visit carried out by (name of Initial Assessment Social Worker and Midwife) Scott displayed behaviours that would be suggestive of an individual who is controlling, difficult and intimidating. Caroline was able to recognise that Scott is controlling (in Scott's absence) and stated that he often treats her 'like I am his daughter'. Caroline believes that he displays these behaviours because 'he carers'.[sic]
(CA, Jodie, 2008)*

There was no other information recorded anywhere on the CA with regard to domestic violence or Scott and Caroline's relationship.

Page 6 of the CA is headed 'Parenting Capacity' (DH 2003) box UB 14 'Expectant parents' home is safe for the baby' was ticked 'yes' but no other information was recorded in the free text box to indicate why the social worker regarded the home as safe. With regard to how Caroline felt about the birth the following was recorded:

UB 15. Expectant mother feels positive about having the baby

Yes. Caroline is looking forward to the birth of the baby but is isolated and turns to her grandmother for support

(CA, Jodie, 2008)

The bottom of page 6 of the CA directs the social worker to proceed to page 15 which deals with the parents' attributes but for Jodie's CA pages 15 to 22 were not completed. Page 23 was the next part of the CA record completed and provided the summary of the case as follows:

Analysis of the Information Gathered During The Core Assessment

There is significant concern in relation to Caroline's drug use and the impact upon her unborn child. The midwife informed that Caroline's baby would have a chance of an [sic] normal development with an appropriate programme of withdrawal (by the mother) from methadone. However, since seeking a prescription for methadone in March Caroline has continued to use heroin on top. She has continued to test positive for heroin use. Scott is also reported to use heroin and is also subject to a methadone programme. Full details have not been obtained at this stage. Scott was extremely difficult to engage and refused to share information, questioning at each stage why workers would require information about him.

(CA, Jodie, 2008)

The 'Decisions Following the Core Assessment' was ticked 'referral to other agency' and 'commission specialist assessment' (DH 2003 CA p23). The sections relating to the CA having been discussed with parents (DH 2003 CA p 23) and the section headed 'Parents'/carers' comments' (DH 2003 p 25) were not completed.

At the point of transfer from the Initial Assessment Team to the Family Support Team the written information contained in the CA (excluding names and addresses) equated to not more than 800 words. Based on this information the Family Support team manager allocated the case to Ruth, who at that point had been qualified for one year and had never conducted a pre-birth assessment before. In interview Ruth said the manager had thought it was a family support case or a possible child protection case and so had felt it matched Ruth's level of skill and post qualification experience. Ruth said that the IA and CA had not indicated any of the concerns she found when she began working with the family and so she soon felt overwhelmed by the complexity and Scott's attitude toward her. Despite the complexity Ruth remained the allocated social worker but also received assistance from a more experienced social worker.

In the period of time between allocation to Ruth on October the 8th 2008 and Jodie's birth in late February 2009 there were regular (some daily and at the very least weekly) case notes detailing actions taken, letters to the family, letters to professionals, reports for meetings, minutes of meetings, notes from supervision sessions between Ruth and her manager and a chronology of events. The case notes indicated that Ruth maintained regular contact with

Caroline and Scott via telephone, text messaging, letter and face-to-face meetings at the family home and at the social work office. The case notes, and the subsequent interview, also indicate Ruth had contact with staff in the housing department, the community midwife, hospital midwives, support workers at the drug agency and the police. It was evident Ruth had worked most closely with the community midwife and that they had made joint visits to the family and frequently contacted each other to share information. There was also information on the file that indicated Ruth had provided copies of reports to Caroline and Scott and in interview she spoke of discussing information shared by other professionals with Caroline and Scott.

Throughout the case file there were comments about parents not wanting to engage and about Scott being aggressive and this also came out in the interview. Ruth described how gradually, over a few weeks, Caroline and Scott's relationship seemed to falter and how each then began to talk about the other. Ruth explained that the more she visited Caroline and Scott the more her assessment was based on what she could see rather than what Caroline and Scott did, or did not say.

Whilst the case notes provided an overview of what was happening the decision-making and pre-birth planning process was also recorded via the reports and minutes for a series of meetings. The first of the meetings took place on the 8th December in the form of a legal meeting held in accordance with the Public Law Outline (Ministry of Justice 2008). Caroline and Scott had been told of the LA plan prior to the meeting but Ruth said she was anxious about how they would respond in the formal situation. She described how Scott had been verbally aggressive and would stand close to people (including professionals) and shout in their faces, she commented:

Scared! (laugh) I think me and (name of the other social worker) nearly got smashed around the face a few times! I was worried if I would say the right thing, how would I come across, if we were certain. Obviously we had our reasons but it was more how they would react, and they reacted very differently. Mum was very upset and subdued and dad was really very aggressive and quite intimidating. And you think god! You start questioning yourself you know. (Interview, Ruth 2009)

The minutes of the legal meeting indicated Caroline and Scott were present along with their solicitor. The midwife and social worker had presented written and verbal information and the multi-agency decision made in the meeting was that the LA would be making an application to court for an Interim Care Order following the birth of the baby.

In addition to the plan to apply to court at birth Ruth also arranged a pre-birth child protection conference that was held in January. At the conference the social worker, midwife, drugs team

and police provided written reports and verbal information about the family. Caroline and Scott did not attend the conference but their solicitor attended on their behalf. The minutes of the meeting indicate all professionals present had concerns with regard to the parents' drug use, a lack of consistency in accessing drug rehabilitation services, relationship difficulties between the parents and a lack of practical preparation for the baby. The outcome of the conference was to decide that the unborn baby was at risk of significant harm under the category of neglect and a safeguarding plan was made.

In the interview Ruth said she had found the child protection conference quite frustrating as much of the information had already been discussed in the legal planning meeting. She also felt the chair had ignored work which had already been undertaken by insisting the work was repeated. An example was the chair had recorded in the Safeguarding plan that Caroline's grandparents were to be contacted to ascertain if they could be full time carers for the baby. At the time of the Safeguarding conference Ruth had met with Caroline's grandparents on at least 3 occasions to complete what was referred to in the case notes as a 'viability assessment'. Following the three meetings it was evident that the grandparents did not feel they could offer full time care and, whilst they were upset at the prospect of their great grandchild being adopted, they were not in a position to change their view.

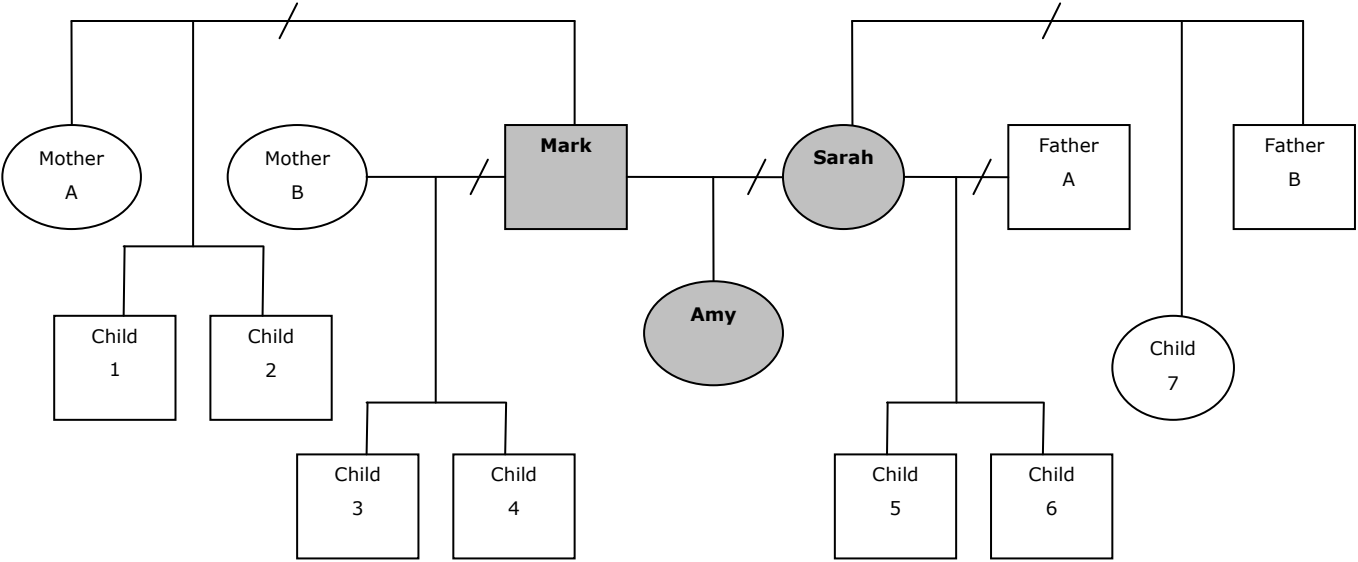
At the point at which Jodie was born there was a chronology that highlighted missed health and social work appointments and drug test results that indicated continuing use of methadone and heroin. The file indicated that there had been a multi-agency approach to the assessment process and that the LA, health services and drugs agency all felt the baby would be at significant risk of harm if it were to remain with Scott and Caroline. No alternative family were available to provide care and so the plan was to make an application to court to place the baby in the care of the LA. Caroline attended a hospital in a neighbouring authority to give birth but as Ruth and the midwife had alerted all local hospitals to this possibility the hospital made urgent contact with Caroline's community midwife and Ruth. There were concerns that Caroline and Scott may try and remove the baby from the hospital and therefore the decision was taken to make an application to court for an emergency order. The court granted the order and Jodie was placed in foster care upon discharge from hospital. When I interviewed Ruth Jodie was nearly six-months old and had remained in the care of the LA. The plan before the court was for her to be adopted.

8.4.2 Amy

At the point of referral the '*reason for referral*' category was '*child protection*' with the '*Child in Need Code N5 Family dysfunction*'. Amy was subject to an Interim Care order shortly after her

birth. An interim Care Order allows the LA to share parental responsibility and in this case provided the LA with the legal grounds to place Amy in foster care. The case-holding social worker was Paul who had been qualified for approximately 20 years and worked in the host LA for 6 years.

The immediate family composition was:



Child	Amy
Mother	Sarah (age 20, ethnic origin White British)
Father	Mark (age and ethnic origin not recorded)

Amy was Mark's 5th child and Sarah's 4th. Both Sarah and Mark had children to previous relationships but Amy was their first child together. Mark had two children to one relationship (mother A on the genogram) but had no on-going contact with them and two children to another relationship (mother B) and these children were in foster care and Mark had contact with them twice a year. Sarah had two boys to one relationship (father A) and these children were adopted. She had a child to father B and this child lived with paternal grandparents.

Amy's case file began in October 2008, 10 days before her birth. Police had found Sarah in the town centre and they had taken her to the hospital with concerns for her mental health and general well being. The referral was made by a mental health social worker (ASW) who had been called onto the ward. Sarah was reported to be aggressive toward the police and hospital staff and had also threatened to kill herself. The ASW forwarded the following information to the LA at the point of referral:

*Sarah said she was tired, had taken amphetamines but had no intention of killing herself or harming the baby
(Referral information, Amy, 2008)*

The ASW also told the Access Point social worker that hospital midwifery staff thought the plan would be to remove the baby at birth because three previous children had been removed and not returned.

At the point of referral the Access Point social worker checked the electronic database and found court care proceedings in relation to Sarah's 3rd child (child 7 on the genogram) had concluded only a few days earlier. Paul had been the social worker during the court proceedings and therefore Amy's case was allocated to him on the same day as the referral was made. Also on the same day a standard letter was sent out in accordance with procedures and guidance contained in the Public Law Outline (Ministry of Justice, 2008) which gave notice to Sarah and Mark of the LA's intention to issue court proceedings.

The following day, on the 11th October, Sarah came to the Family Support team office and Paul recorded in the case notes:

Mum presented at office. Situation with regard to plan to remove baby discussed. Mum asked about accommodation as staying with a friend but had been asked to leave tomorrow. Advised mum to return to office following day. (Amy, case notes, 2008)

Sarah did return the following day and the case notes indicated that Paul found her some bed and breakfast accommodation and provided her with money for food under a budget held by the team under section 17 of the Children Act 1989. This budget is available because Part III of the Children Act 1989 contains provisions on the services that a LA must or may provide for children and section 17(6) states that in exception circumstances this may include providing cash.

The next case note related to a call from the hospital, 11 days after the referral, to the Access Point team advising them that Sarah had given birth to Amy. The Access Point social worker recorded on the case note that there was no plan on file other than:

Not to allow baby to leave hospital with mother and a legal meeting scheduled for 22nd (Amy, case notes, 2008)

There were three points of data entry onto Amy's case file for the period before she was born - the referral, the social work case note about Sarah's visit to the office and the access point

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social worker's case note reporting the birth. There was nothing that could be regarded as a pre-birth assessment and nothing to indicate a process of planning or decision-making prior to (or even after) the birth. Even in the period after Amy's birth, there were no letters, documents or reports written by the LA social worker and no information from any other agency on file that related directly to Amy. The only report on file (which had been uploaded onto Amy's file after her birth) was from a psychologist who had been commissioned to complete an assessment as part of the court proceedings in relation to Sarah's 3rd child (child 7 on the genogram). The report, therefore, contained no information with regard to Mark and his family history or in relation to Sarah's pregnancy with Amy. What the report did outline was Sarah's history and provided information with regard to Sarah's family members and dates of birth, which were not recorded in the family details section of Amy's electronic case file. The psychologist's report contained information which indicated Sarah had herself been placed in the care of the host LA when she was three years old and she had remained in foster care until moving to live with father A on the genogram. Since leaving care Sarah's life had involved periods of homelessness, LA intervention and the removal of her children from her care and occasional use of illegal drugs. The psychologist reported that Sarah seemed to lack understanding as to the reasons for the removal of children from her care and lacked understanding of the needs of a child.

In the interview Paul explained that during Sarah's pregnancy with her third child (child 7 on the genogram) professionals had lost contact with her. He spoke at length about how Sarah repeatedly became homeless and this impacted on his assessment process. At one point she and father B were living in a caravan but this got burnt out and eventually were found by the Midwife to be living in the back of a transit van. Paul said that when they were found he began the pre-birth assessment and that his memory was that the assessment was completed one month before the baby was born. Paul explained that during the course of this pre-birth assessment, and with support from staff in a housing team, Sarah and father B had been given a house, but Paul said Sarah was '*drifting from one boyfriend to another*' (Interview Paul 2009) and the whole situation was far from settled.

Paul explained he became aware of Sarah being pregnant with Amy in February or March 2008. Mark had been attending a contact session with his eldest children (children 3 and 4 on the genogram) and during the contact he had told the member of staff that Sarah was pregnant. Upon return to the office the member of staff had told Paul. Paul then spoke of a pre-birth assessment in relation to Amy and said:

Only 4 or 5 months on and we are doing another assessment on the same people in respect of another child. So in a way it was superfluous in that respect but, maybe

to give them a fair crack of the whip, you know we have to be seen to be right with them and it was fair in that way I suppose. (Interview Paul 2009)

Paul explained how two colleagues (a social worker and a family worker in the same team as Paul) had completed the pre-birth assessment in relation to Amy for him because:

I thought I had already taken one child from them so we would have a fresh look at it and see what came about. And that assessment was negative anyway, because even though they (Sarah and Mark) had been together for a while by then they were still moving about and Mark has a long history of domestic violence having 4 of his own children removed. (Interview Paul 2009)

In March or April Sarah alleged that Mark had pushed her down the stairs and she had been taken to hospital where she had a miscarriage but Paul said it was soon obvious Sarah was still pregnant and so his colleagues had gone ahead and completed the pre-birth assessment. Whilst living in the Bed and Breakfast accommodation the couple were told that the outcome of the pre-birth assessment was that there would be a recommendation to remove the baby. Paul recalled this was in August and that shortly after this the couple were moved to a homeless persons' hostel. The couple were evicted from the hostel shortly before Amy was born as there had been an incident where Sarah had attacked another resident and Mark had threatened to shoot the two security guards who had been called to intervene. During this incident both parents were reported to be under the influence of alcohol.

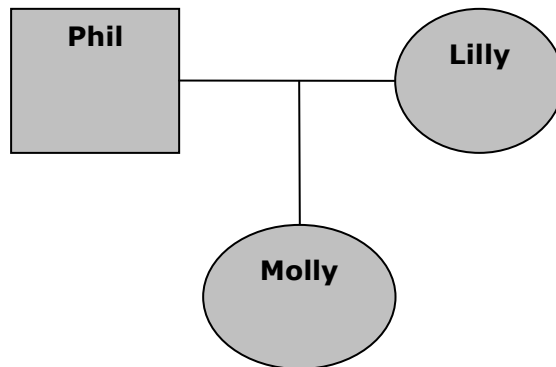
Paul did not make any reference to a process of multi-agency assessment but did talk of working with the midwife and that all professionals had agreed that Amy could not remain in the care of her parents.

When Amy was born she was kept under observation in the hospital because Sarah had been using amphetamines and there were concerns Amy might experience withdrawal symptoms. During the time while Amy was in hospital the LA made an application to court and an Interim Care Order was granted. The LA placed Amy in foster care when she was 7 days old. She remained in foster care with a plan for her to be placed for adoption.

8.4.3 Molly

At the point of referral Molly's case was categorised as '*Reason for referral, child protection*' and '*Child in Need Code, N4 Family in acute distress*'. Molly was subject to an Interim Care order shortly after her birth. The Interim Care Order allowed the LA to share parental responsibility and place Molly in foster care upon discharge from hospital. The case-holding social worker, Carla, had been qualified for eight years and had worked with the host LA since qualification.

The immediate family composition was:



Child	Molly
Mother	Lilly (age 30, ethnic origin White British)
Father	Phil (Age 38, ethnic origin White British)

A midwife made the original referral on the 18th October 2008 when Lilly was 30 weeks pregnant. Also on the 18th October the case transferred to the Initial Assessment Team and was allocated to a social worker. The IA was completed 12 days later on the 30th October. The reason for the referral was cut and pasted into the reason for the IA and stated:

Mum is 30 weeks pregnant and is continuing to inject heroin, couple have debt problems and housing conditions are poor. Mum and dad do not seem to have capacity to change. (Molly Referral record and IA record 2008)

Throughout the IA there were references to maternal health and parental drug use. It was also recorded that the pregnancy was planned. The information in the IA was summarised as follows:

Analysis of information gathered during IA

Although currently the pregnancy is progressing well, it is of concern that Mum and dad have been unable to commit to and sustain a drug free lifestyle. Both are on methadone programmes but continue to inject heroine [sic] and have rarely given a negative sample at turning point.

The current housing situation also rises extreme concerns, bedsits are notorious for drug problems, issues of prostitution and are unclean [sic] and unsafe. Lilly has significant debts, including to district housing who will not issue them with housing until these debts are repaid and although they have had the money to do this, they have yet to pay them or even apply for housing elsewhere. Current housing is unsafe [sic] for mum and will certainly not be suitable for a baby in terms of cleanliness, structural and the risk from other residents. Continuing assessment and monitoring of the risks and parenting abilities is required and significant intervention will be needed if the couple are to successfully [sic] parent the baby. (Molly IA record)

Under the section headed '*Decisions*' the boxes '*Core Assessment*' and '*Referral to Other Agency*' were ticked with the following information recorded:

Referral for continual monitoring, longer term work and risk assessment
(Molly IA record)

The Initial Assessment had been electronically signed and closed by the team manager on the 20th October. The case had then remained in the Initial Assessment Team and on the 7th November the following case note, which contained more detail with regard to housing conditions and debt issues, was inserted:

7th November case transfers note: Mum and dad are both heroine users, they are both on methadone programme but are topping this up by injecting heroine [sic]. Mum is 31 weeks pregnant and although this is progressing well Mum is only attending her medical appointments due to the hard work of [name of midwife]. Both Mum and dad are aware of health risks of injecting heroine [sic] to themselves and their unborn baby but are not committed to stopping and have no positive plans in place to bring about change. Also of concern is the current housing and the lack of reaction and action in seeking new housing. Mum and dad live in a bedsit with shared kitchen and bathroom facilities. While their room is clean and tidy there is a large damp patch on the wall and daylight can almost be seen as there are bricks and plaster missing on an outer wall. The shared areas, kitchen, bathroom, staircase are extremely dirty, mould infested, dark and dingy places. Flats are well known for their attraction of drug users, prostitutes and generally unsavoury characters and there was also evidence of rats in the bedsits. The couple have arrears of £375 outstanding to DH and although they have had the money they have not seen fit to use it for that purpose, it is my opinion that their money is used for the purchase of illegal substances. Baby does have clothes etc but these have all been purchased by Maternal grandmother. On a more positive note, the pregnancy was planned and baby will be loved, however i [sic] am unsure if Mum and Dad will be able to place their babies [sic] needs before their own. Bedsit is extremely unsafe and unfit for a newborn baby. Continuous monitoring and risk assessment will be needed both during the pregnancy and after the birth to ensure the safety and well being of the baby.

(Molly Case notes 2008)

The case was then transferred to the Family Support Team on the 14th November. At this point the transfer summary indicates Lilly would be 32 weeks pregnant but the referral indicates she would be 34 weeks pregnant. The case was allocated on the 14th November to an agency social worker but there was no other information on the case file until it was allocated to Carla on the 14th December. By this point Lilly was approximately 38 weeks pregnant.

A legal planning meeting held in accordance with the Public Law Outline (Ministry of Justice, 2008) was held on the 21st December. The minutes of the meeting indicated that Carla had provided a verbal summary of the information on the IA and that she had visited the parents at home but there was no indication that she had any more substantive information. In

interview Carla explained that she had been allocated the case very late in the pregnancy, shortly before Christmas. This caused significant problems in the assessment process because Carla explained how she had some leave booked and when she had been in the office fewer staff around meant having to cover work on other people's case loads.

Molly was born on the 12th January and spent the first few days of her life in hospital with Lilly. The LA made a successful application to court for an Interim Care Order and Molly was discharged from hospital into foster care.

Throughout the interview Carla returned to the impact the late allocation had on the assessment and when first asked to describe the case she said:

I think we got involved way too late, but we did have to do the pre-birth assessment. We did sessions with mum sessions with dad sessions both together, separate sessions, we liaised with drug agencies, extended family members. You know if the baby does have to be removed at birth there is all agencies involved. (Interview, Carla 2009)

In relation to making the decision about what action should be taken at birth Carla said:

At the time we had to make the decision mum and dad were still using heron. It is only since we became involved, the minute we became involved, she turned the situation around. But because of the lateness of our involvement there was not the time for her to turn it around before the birth. They turned it around when we became involved. (Interview, Carla 2009)

Carla was clear throughout the interview that it was the time scale and not lack of motivation on the part of parents that had resulted in Molly being removed from her parents. She commented on how Lilly and Phil had made some significant changes in their life since she had been allocated the case and since Molly had been born. These changes included ending their use of heroin, working with the drug rehabilitation team on a long-term strategy to remain drug free, obtaining appropriate accommodation and remaining debt free. Overall she described the case as:

'Well it's a success story for me because the baby went home and it was a case I felt passionate about and I fought hard for the parents and I feel I produced a good piece of work. By the same token you can only work with parents as well as they will allow you to. These parents were absolutely brilliant and turned it around and they worked well with me.' (Interview, Carla 2009)

Carla explained how she had offered support in relation to re-housing but the parents were self-motivated, paid their debts, made appointments with various housing agencies and moved

to more appropriate accommodation. Carla commented on how, in her opinion, the parents had been treated quite badly as a result of the delay in case allocation and that by the time she had become involved the only decision that could be made was to remove the baby at birth. She spoke of the parents having to go through the '*unnecessary trauma and stress of a court hearing*' (Interview, Carla 2009) because she had not had the opportunity to assess the case properly. I asked Carla if the parents had made any comments about the allocation delays and she replied:

To be fair mum took total full responsibility for her drug use and didn't blame us because she said it was a result of her behaviour. (Interview, Carla 2009)

Throughout the interview Carla spoke of various professionals who had been involved post-birth and of the support they had also given. She explained how staff at the drug-rehabilitation team had attended meetings and had always been honest with the parents, letting them know information about their progress would be shared with Carla and ultimately with the court. Carla said the Drug Liaison midwife, the community midwife and hospital midwives had also been helpful and supportive. Carla explained that things had not been totally straightforward with regard to the support from the Health Visitor but this was not about lack of inter-professional co-operation but about the health service's geographical area boundaries and issues of resource allocation. The Health Visitor Molly had in foster care was different to the HV assigned to her when she returned home and the first Health Visitor had only visited Molly in foster placement and had had no contact with Lilly and Phil. The second Health Visitor only became involved when Molly actually went home and therefore she had to, very quickly, understand the family background and LA involvement.

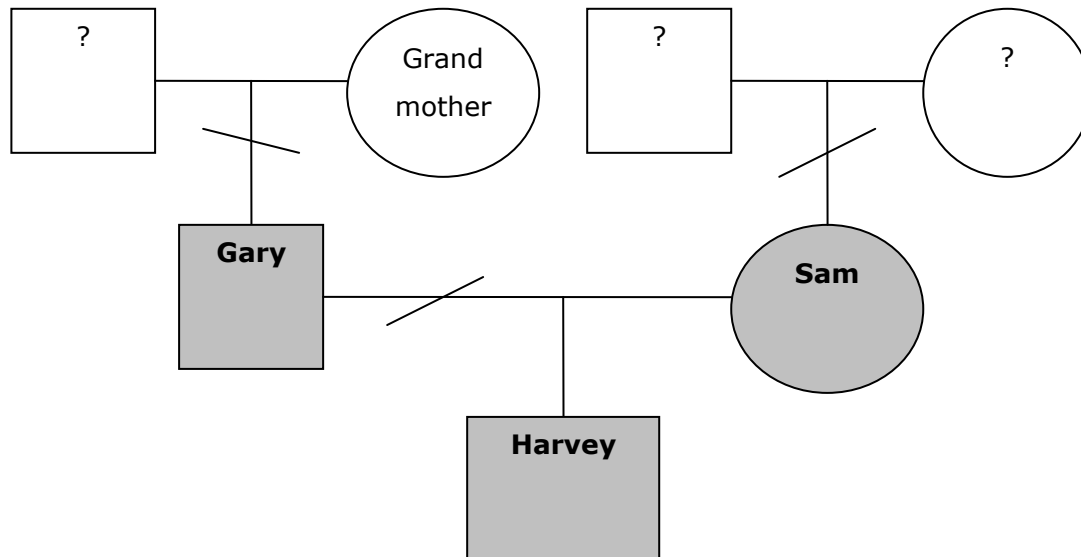
When I interviewed Carla the court proceedings were ongoing but Molly had been returned to her parents' care. Carla was confident the final plan would be for Molly to remain with her parents.

8.4.4 Harvey

At the point of referral Harvey's case was categorised as '*Reason for referral Child Protection*' and '*Child in Need Code, N4 Family in Acute Distress*'. In interview the social worker spoke of a pre-birth child protection conference but there was no record of this on the case file. Harvey was made subject to an Interim Supervision Order shortly after his birth. An Interim Supervision Order does not give the LA any parental responsibility but puts the child under the supervision of the designated LA. The LA then have the duty to advise, assist and befriend the child (Children Act 1989 s31). The case-holding social worker at birth was Jane who had been qualified for one year but who had worked for the LA for approximately seven years as a family

worker until the LA seconded her to a social work qualifying course. Another key professional involved in the support of Harvey but not interviewed as part of the research was the probation officer.

The immediate family composition was:



Child	Harvey
Mother	Sam (age 25, ethnic origin White British)
Father	Gary (age 20, ethnic origin White British)

Harvey was the first child of Sam and Gary.

The original referral was made in January (approximately 20 weeks gestation) by the probation officer, Trevor, who had been working with Gary following his release from a young offenders' institution (YOI) three weeks earlier. Upon release Gary was subject to a community order that had a requirement for him to maintain regular contact with the probation service. During the course of a probation meeting on the day of the referral, Gary had disclosed to Trevor that his girlfriend, Sam, was pregnant. Gary also disclosed that he had assaulted Sam whilst she was pregnant and the police were called but she had refused to pursue any charges.

The referral information supplied to the LA by Trevor was detailed and lengthy. Trevor stressed that Gary was a high risk to anyone and that there were concerns for the unborn baby and for social work staff if they visited him. Trevor also expressed anxiety that despite making some enquiries he was unable to obtain details in relation to Gary's girlfriend. Trevor had told Gary he would be making a referral to the LA and so Gary had refused to provide any further

information. Trevor had phoned several local GP practices but had been told information could not be shared for reasons of patient confidentiality.

Following the referral the Access point social worker had also completed checks of other case files held by the LA in relation to Gary, the LA had no previous information about Sam. The information gathered at the point of referral was considerably more than the 'Reason for Referral' data box would allow and so the Access Point social worker had summarised that there were significant concerns for the unborn baby as a result of Gary's history of violence toward his family. The Access Point social worker had then indicate that there was a detailed case note of the discussion with Trevor, a copy of a court report complied by probation prior to Gary's imprisonment, an up-to-date probation risk assessment, a police report detailing a recent assault on a member of the public and a link to the case files the LA held in relation to Gary. Anyone reading the referral had a clear signpost of where and what type of information was held in the electronic case file.

In summary, the information on Harvey's file at the point of referral indicated that Gary had a long history of violent assaults against his mother, his sisters, previous girlfriends and a recent assault on a stranger. Gary had been involved with the criminal justice system since he was 10 years old and had a total of 10 offences for criminal damage and 18 for violence. Gary's recent custodial sentence had been as a result of an assault on his mother and his sister following an incident where Gary had wanted money and his mother had refused to give him any. The police were called and Gary was arrested and subsequently received a custodial sentence. Since his release from the YOI there had been another assault on a member of the public. The police report of the incident indicated that the assault occurred at a local take-away restaurant at about eight pm when Gary violently attacked a member of the public (someone he didn't know at all) because of the way he looked at him.

Checks completed by the Access Point social worker indicated there had been a history of LA involvement with Gary and his siblings, although the summary of involvement did not indicate when involvement began. During the LA involvement Gary and his siblings' names had been on the (then) Child Protection Register and Gary had spent time in the care of the LA. In 2005, when Gary was approximately 16 years old, the Looked After Children Team had completed a risk assessment on Gary. In this risk assessment another serious assault on his mother was recorded whereby Gary had left his residential placement (without permission) to visit his family home. During the visit he had assaulted his mother breaking her jaw, other bones in her face and arms and leaving her in need of urgent medical attention. The risk assessment had indicated that throughout LA involvement there had been attempts to work

with Gary's mother but she was always verbally aggressive and had made threats of physical violence toward staff and managers.

The case notes indicate that the Access Point social worker made contact with the community midwives serving the area where Gary lived and explained the nature of the referral. Later the same day a midwife contacted the LA with details of Sam (name, current address and contact details) and confirmed that she was receiving antenatal care.

The case transferred to the Initial Assessment Team on the same day the referral was made and was allocated to a social worker for assessment. The case notes following allocation read as follows:

8th January

Probation call back to inform of MAPPA meeting outcome and that level is still 2.

9th January

Phone contact with Sam but phone switched off.

15th January

unannounced visit to Sam. No reply.

16th January

Phone call from probation officer. He has visited Gary at home and has spoken with Garys moth [sic] on the phone. Garys [sic] mother has gone with his sister to stay at her other sons house and remains in the family home. Gary reported he is no longer in a relationship with Sam and that she is upset that social services are involved with her unborn child as a result of her relationship with Gary.

19th January

Tried to phone Sam again but phone switched off.

5th February

Probation phoned to say there are reported incidents of Gary assaulting Sam but no charges have been made as Sam has refused to make any.

6th February

unannounced home visit to Sam no reply.

9th February

checked Sams details with probation but probation confirmed they were the same details they had.

9th February

telephone call by [name of SW] to Sam phone switched off.

(Harvey, case notes)

The only other information inserted onto the electronic case record after the 9th February was an IA record which was recorded to have started on the 22nd January and finished on the 25th February. This record did not indicate if Sam or Gary had been seen or if they were aware of the IA. The information on the IA was cut and pasted from the information recorded by the Access Point social worker at the point of referral with the addition of a note that Gary had assaulted Sam on the 1st March (a date which fell after the IA was recorded to have been completed) but there was no other information about the detail of the assault or what happened after.

The case then transferred to the Family Support team on the 7th April and was allocated to Jane on the 14th April. From the 14th April onward there were no further case notes, reports or assessments added to the file other than a scanned copy of a forensic psychiatric report that had been submitted to court in response to the assault on the member of the public in a take away restaurant.

The forensic report provided an account of Gary's childhood and history that detailed how, as a child, he had witnessed domestic violence against his mother by one of her partners. He had been expelled from school aged six and had not been engaged in formal education after the age of seven. Gary had reported the exclusion was for breaking property and assaulting teachers and other staff and that the LA social workers had tried to make him attend school but he actually only attended for two weeks when he was about 13 years old. Literacy and numeracy tests by the forensic psychiatrist indicated Gary was able to read simple texts but he was not able to complete forms and he could only complete simple low number additions. Gary said he was unable to work out if he had been given the right amount of change in shops and was unable to use a mobile phone because he could not text or use some of its complicated functions. The forensic report also indicated that Gary began abusing substances and became involved in criminal activity at the age of seven. At the age of seven he started smoking cannabis and at the age of 13 was using amphetamines, cocaine and ecstasy on a daily basis. Gary reported stopping taking cocaine at the age of 14 because he believed it gave him adverse side effects but he continued to use other substances. Gary also reported that he began drinking alcohol at the age of 12 and by the age of 16 was spending approximately £40 per day on strong lager. Prior to his most recent remand in custody he had been drinking one bottle of vodka a day plus lager.

The forensic psychiatric report indicated that Gary had spoken about his history of violence and recognised he had been violent to his family, partner and staff in the LA children's homes. Gary had openly reported carrying knives and bats as weapons and said that, as a child, he had enjoyed violence. The report concluded that there was no evidence of a psychiatric

disorder but that there was evidence of several maladaptive personality traits including low tolerance to frustration, low threshold for discharge of violence, difficulties forming stable relationships and failure to learn from experience. These problems were exacerbated by his use of illicit substances.

As there were no other case notes on file the process of pre-birth assessment is drawn from the interview with Jane. She described being allocated the case and there having been no work completed on the case other than the work undertaken by the probation service with Gary. Jane said she really started working with the case in May when the baby was due in July. Jane was very clear that the levels of violence made her feel anxious about her approach but she also recognised that the violence also meant she needed to make contact with Sam and begin the assessment.

Jane said that she actually began her pre-birth assessment in late May. Prior to meeting Sam, Jane felt that she had sufficient information on Gary to say he was a danger to the baby and therefore she did not feel it would be appropriate to put herself at risk and meet with him. Jane sought advice from her manager and the legal team and a decision was taken that Gary would not be interviewed as part of the pre-birth assessment. The decision not to include Gary had made him very angry and whilst, in the first instance, he had been avoiding contact with the LA, when he was advised the LA would not be meeting with him he phoned Jane, and made threats of physical violence toward her, including threats to kill her.

Jane then spoke of being very honest and clear with Sam that there were serious concerns for her and the baby and that if Sam could not separate from Gary then the LA would have no choice but to apply to court to remove the baby. Jane said:

She assured us she would and then three days later she had gone to meet him, he had locked her in a shed and battered her. He battered her for over a period of about three and a half hours and then tried to set fire to the shed with her in it. Neighbours phoned the police and they found her curled up in the shed in a right state. She ended up in casualty and was admitted onto the ward so that was then ICO [Interim Care Order] time and we remove at birth. And that was a very definite plan in supervision and agreed by senior manager. And that was it!
(Interview, Jane 2009)

Jane described how in the week following the above incident the child protection conference and the legal planning meeting were held. Sam attended both meetings:

She sat there, pregnant and covered in bruises... just the devastation really and you could see she was at rock bottom. I really felt for her. It was awful.
(Interview, Jane 2009)

Jane spoke at length of working with the community midwife, the housing department and Trevor to collate information but also to support Sam. Sam continued to maintain her appointments with the midwife and, with support from the housing team, moved into hostel accommodation. Gary had been placed back in the YOI for 20 weeks but with a plan for release after 10 weeks. Jane spoke of her meetings with Sam and how she always took a cake and had coffee with Sam and they would talk about the future. Jane said that, at times, she felt cruel talking about what it would be like for Sam if she remained with Gary and the baby was removed but equally she felt it was important that Sam understood the consequences if she went back into the violent relationship. Jane said that Sam knew she was having a boy and he had been named Harvey before his birth and so Jane always referred to him as Harvey rather than 'the baby' in an attempt to ensure his life seemed very real to Sam.

During the final stages of the pregnancy Jane worked very closely with Trevor who agreed, that to give Sam the best opportunity to bond with her baby, it would be beneficial if Gary were to remain in the YOI. Trevor submitted a report to the prison service advising that Gary serve the whole 20 weeks of his sentence and that the reason for this was to protect Harvey and Sam. The recommendation was accepted. The housing department found an out of area hostel which specialised in supporting women and children fleeing domestic violence and, at the eleventh hour, a place became available for Sam and Harvey.

The hostel placement for Sam and the acceptance of the plan for Gary to remain in custody only came to fruition shortly before Sam went into labour. Jane spoke of feeling upset that Sam went through the birth of Harvey still thinking he was going to be removed from her care:

When I went to see her in the hospital she was cuddling Harvey in her arms. She froze when she saw me. It was then I realised I hadn't even had time to tell her we had changed the plan. She thought I was there to take him away from her. I think I assumed the midwives would have told her but no one had. They must have thought she knew and.... Well I suppose you don't go on and on about it being good news that you can keep your baby... you just go on as if that was always the plan. And so the midwives never said anything because they assumed she had been told.

(Interview, Jane 2009)

When I interviewed Jane, Sam and Harvey were living in a hostel out of the LA area. Sam was making good progress and there was no indication that she had any intention of going back with Gary. Gary had been released from his custodial sentence and had phoned the LA and made some very serious threats to harm Jane if she did not disclose the whereabouts of Sam and Harvey. Meetings had been held to ensure Jane's safety and, whilst Jane was worried, she also recognised that Gary would be unlikely to travel to the office where she was based. A few

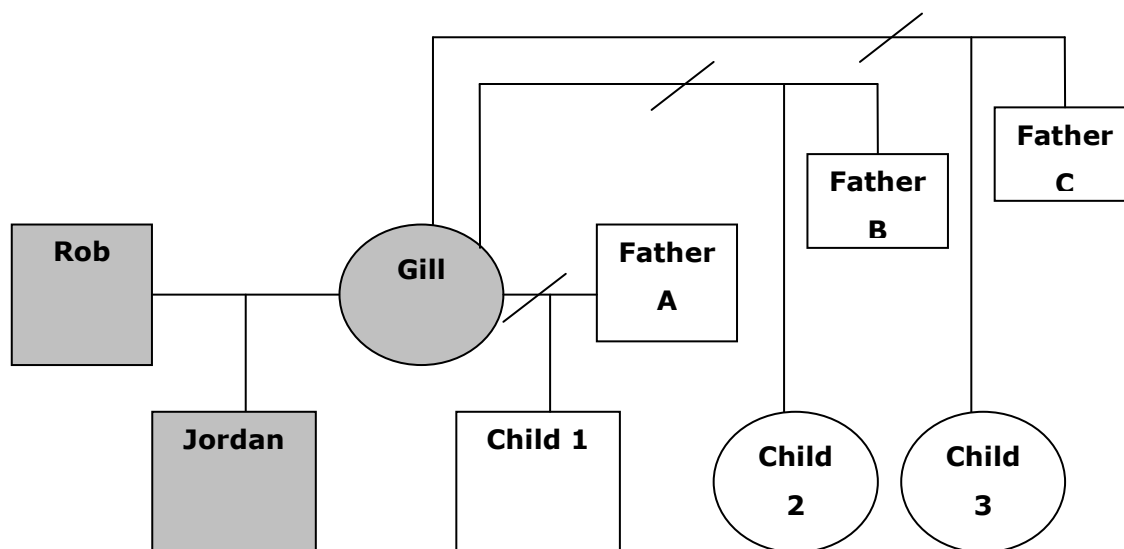
weeks after the interview Gary was arrested and placed in custody, this time for an armed robbery.

8.4.5 Jordan

At the point of referral Jordan's case was categorised as '*referral, Child Protection*' and '*Child in need code, N1 abuse or neglect*'. Jordan was discussed at a pre-birth child protection conference and was made subject to a safeguarding plan and the case notes indicated this was under the category of '*risk of physical and emotional harm*'. In the six-month audit, Jordan's case was not one the cases recorded as having a safeguarding plan in place as there was nothing on his file to indicate such because the details of the child protection conference were all held on one of his siblings' electronic case records.

Rosie, the case social worker, was experienced and at the point of interview had been qualified for seven years. When first qualified she had specialised in working with women who had experienced domestic violence but had been working in the host LA in the Family Support Team for four years.

The family composition was:



Child Jordan

Mother Gill (age 38, ethnic origin not recorded)

Father Rob (age 39, ethnic origin not recorded)

Jordan was Gill's fourth child. Gill had 2 daughters aged four and three and a son aged two. All four of her children had different fathers. There was no information on file or in the social work interview that indicated if Jordan was Rob's only child or if he had children to previous relationships.

The LA already knew Gill and her eldest three children before Rob moved into the family home. The electronic case file indicated that there had been requests for family support dating back to 2001. Some of the information on Jordan's case file pre-dated the pre-birth referral because when the LA became aware of the pregnancy Rosie was already working with Jordan's siblings. On Jordan's electronic case file there were four referrals that indicated that between October 2001 and December 2007 there had been various requests for family support. There were no details to indicate who had made these referrals or if any support or action had been taken. In December 2007 there was another referral that said there had been a domestic violence incident that had been reported by the police but all that was recorded on the case file was:

DV incident reported
(Jordon, referral record 2007)

On the 9th of January 2008 the police had made another referral to the LA following Rob being arrested for assault. In this incident Gill had phoned the police after she had been woken up by Rob who had accused her of cheating on him and had then held a pillow over her face and punched her on her body several times. A manager in the Access Point Team had closed this referral with no further action being taken.

On the 31st January 2008 Access Point had received an anonymous referral from a member of the public who said they were concerned about the children because Gill had taken an overdose and had been admitted to hospital. They also said the older children were often late for school because their mother was an amphetamine user. This referral was then passed from the Access Point Team to the Initial Assessment team and an IA was undertaken. On the 7th February 2008 a social worker from the Initial Assessment team made an unannounced visit to the family home. Rob was not present during the visit and Gill had told the social worker that he had guns and knives hidden around the house. As a result of this information the social worker had contacted the police to request assistance. The case note for the 7th February indicated the police conducted a search of the property and confiscated several knives but did not find any guns. The social worker recorded in the IA:

I observed ornamental samurai swords in the living room, a kitchen knife sticking from a pile of mud in the back garden and mother brought 2 other large knives from the bedroom. Although Gill did not feel that Rob would use the weapons against her or the children.
IA, Jordon, 2008

Following the police search Gill and the children had been moved to a shelter for families fleeing domestic violence. On the 26th February the Initial Assessment team social worker had presented the case at a child protection conference and the three older siblings were made subject to a Safeguarding plan under the category of risk of physical harm. The case had transferred to the Family Support team and was allocated to Rosie.

In interview Rosie spoke of how she felt when she read the information on the Initial Assessment and the case file stating:

"It's difficult. On the one hand you want to go with a clean slate, tell the family you are there to work with them and to help. On the other I was shit scared of the knives! I spoke with my manager about asking the family to visit the office but he was not happy with that because I needed to see the children. In the end I did invite parents into the office for the first meeting and they were pretty angry about the child protection registration but eventually I managed to get them to calm down. After this I visited at home." (Interview, Rosie 2009)

Rosie explained how Rob had been very angry that there had been a child protection conference and people had discussed him even though he had not been there. Rosie explained how she had used this to explain to Rob how important it was for him to work with her as there would be other meetings and a lack of co-operation on his part would not mean the LA could just ignore the situation.

When describing the case Rosie said she felt '*frustrated*' because Gill seemed determined to remain with Rob even though their relationship was not a positive one. In April Gill and the three older children had returned to live with Rob and the case records indicated that Rosie and the health visitor continued to work with the family and to try and persuade Gill to access support to end her use of amphetamines. The case file also indicated there were ongoing domestic violence incidents and the police were called on 3 separate occasions. A case note made by Rosie in July stated:

Mum is pregnant again. Core Assessment is progressing slowly as Dad is not meeting with SW and is '*superficial*' when he is there. There is concern that dad may be buying guns again.
(Case notes, Jordon, 2008)

In early August 2008 Gill agreed with the social worker that it would be safer if the two oldest girls went to stay with one member of the family and Gill and the youngest child to stay with another. Rosie took the older girls to the relative and Gill said she would go to her relatives

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when the youngest child woke from his afternoon sleep. However, she never arrived at the relatives and so family members and Rosie alerted the police, concerned that Rob may have harmed her. Rosie discovered later that there had been a domestic violence incident and Rob had punched Gill and this seemed to have been the trigger to Gill running away. Rosie described how there was a '*huge police hunt*' (Interview, Rosie 2009) and that all the extended family were really worried for Gill. The police searched using dogs and the helicopter and Gill was eventually found the next day when, having traced her mobile phone signal, she was located in Scotland. Gill was staying with friends but the situation was not one the police thought to be suitable for a child so the police and social workers in Scotland, in agreement with Rosie, persuaded Gill to allow her son to be placed in foster care on a voluntary basis. Later the same day Gill returned home to Rob and left her son in foster care in Scotland. Rosie drove to Scotland a few days later and brought Gill's son back to the LA area and took him to stay with his maternal aunt.

It was then Rosie found out that a member of Gill's family had sexually abused Gill when she was a child. The abuse had happened in the village where Gill had been found. Rosie said that during her work with Gill she had tried numerous times to talk to Gill about the abuse but Gill refused to speak to Rosie or anyone else about it. Rosie said she had also tried to make enquires in the area where Gill had lived as a child to see if there were any old case files but this had been unsuccessful.

The next entry on the pre-birth case record stated:

17 August Gill took an overdose of Tamazapan, a sleeping pill and then took herself to A&E at [name] Hospital. She was not felt to require sectioning under the Mental Health Act, however it is recommended that she spend a few days as a voluntary inpatient at the psychiatric hospital (Case notes, Jordon, 2009)

Upon discharge from hospital Gill once again went to Scotland. On this occasion she called and collected her children from their aunt's house and took all three of them with her. This time the LA went to court for an Emergency Protection Order, which was granted and Rosie drove up to Scotland and brought Gill and the children back. When they arrived back home the children were placed in Foster care. An Emergency Protection Order is, as the name suggests, granted in emergency situations and is a short term order covering a period of 72 hours. At the end of the 72 hour period the LA made an application to court for an Interim Care Order which would enable them to keep the children in foster care. The file note on Jordan's electronic case file on the 28th August (prior to his birth) stated:

When the LA returned to court for an ICO this was rejected by the magistrates and the child was returned to care of relatives.
(Jordon, case notes, 2008)

In interview Rosie spoke at length about her frustrations with the case since the application to court. She said that after Gill had run away to Scotland with the children for the second time she really felt she could not trust her to keep her children safe. Rob was one type of risk with his violence but Gill was another type of risk with her fragile mental health, history of abuse and the instability she caused the children from being moved around. Rosie talked of feeling quite tired about the driving to and from Scotland and all of the work, and paperwork, the application to court created. She said that when she returned to court at the end of the Emergency Protection Order she was confident the magistrates would also see the risks to the children and the need to provide stability in foster care. She said:

The application was denied and this had a hugely negative impact on the working relationship with the family. I was shocked that the application was denied and the only reason I could see for it was how well mum had presented in court. In court she had promised the magistrates she would leave Rob and her family had also attended and said they would look after the children. The magistrates ignored all of the other evidence and just believed Gill would now move out and find somewhere for her and the children. (Interview, Rosie 2009)

Rosie saw this as a downturn in her relationship with both parents. She said:

I am not saying I would use court as a threat but most parents see it as a threat. You know that... if you go to court you lose your kids. In this case the opposite happened, they had lost their kids for a few days and the court gave them back. I think they saw this as everything they were doing was ok and the only problem was I wouldn't see things their way. (Interview, Rosie 2009)

Rosie said the only saving grace had been the support of Gill's family who had been willing to carry on looking after the children in the short term, although they did not want to carry on in the long term. Rosie said she and Gill's family were worried about how they would stop Gill or Rob turning up at their houses and removing the children if they wanted to but they had no option to just try and carry on and deal with that situation if it arose.

The children remained in the care of relatives and a case note in October said Gill and Rob anticipated the children would be returned to them by Christmas.

Rosie made the referral in relation to Jordan in October 2008, three months before his birth and on the 4th October a pre-birth child protection conference was held. Four weeks after the Child Protection Conference a multi-agency core group meeting was held and attended by the

health visitor, school nurse, drugs team worker, Gill, Rob and two other extended family members who were caring for the older children. The midwife and a representative from school were not present. The core group minutes indicated that everyone at the meeting felt that the children living with relatives would give Gill and Rob a chance to address some of the issues that were causing concern, in particular the drug use, relationship issues and provide a period of stability in their lives.

In interview Rosie said that Gill and Rob did start to make a few changes. Rob took part in an anger management programme as part of his probation order but Rosie felt very aware that parents were living without the added pressures of caring for the children and were just looking forward to the birth of Jordan. Rosie said she felt unhappy at the idea of a new-born baby going home with Gill and Rob because of the risk the other children may feel left out if they did not go home and she worried that the pressure of caring for a new born baby may undo the changes which had been made. Rosie said she discussed this with her line manager and had asked if there could be a legal planning meeting:

He [line manager] just said that if my assessment was that it was safe for the baby to go home then it would be safe for all four children to be there. I felt trapped by my own assessment, there had been no more domestic violence incidents and probation were giving Rob a glowing report but that is so different to having four kids under the age of 5 in the house!
(Interview, Rosie, 2009)

Rosie said her ideal plan would have been to go to court and to have Interim Care Order in place and to let then let the children go home for teatime and weekend visits and then eventually full-time, if parents could cope. The objection from the line manager had been that senior managers were not accepting of plans which involved the LA holding shared parental responsibility for children who were not in LA care.

Rosie said that eventually she felt she was left with no option, she had already presented the case to court when things were far worse and did not get a care order, her manger was not supportive of another application to court and she could not change her assessment and say things at home and between Gill and Rob were not getting any better when clearly, without the children, they were.

During the interview I commented that Rosie had not specifically spoken about the pre-birth assessment. In response she said:

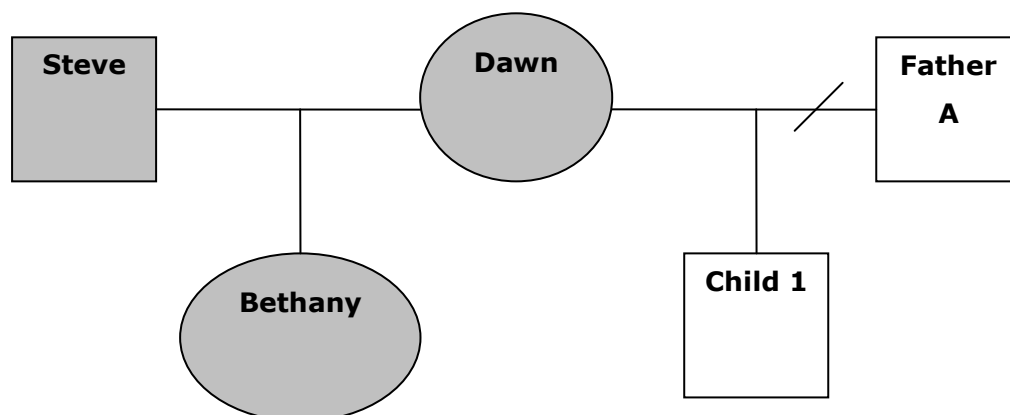
No... well even though I did a pre-birth core assessment and went to conference [child protection conference] the unborn baby just seemed to be part of everything else that was going on. I sort of looked at what was happening for the other three children and this was a measure of what would happen for the fourth child. The only added bit was assessing how a baby would add to the existing chaos. (Interview, Rosie 2009)

When I interviewed Rosie all four of the children were back home and the situation was far from one that Rosie felt comfortable with. The children continued to be subject to safeguarding plans and Rosie was once again trying to persuade her manager to consider legal proceedings. A few months later Rob was arrested for a firearms offence and received a custodial sentence. The children remained with Gill.

8.4.6 Bethany

At the point of referral Bethany's case was categorised as '*reason, child in need*' and '*child in need code, N1 Abuse or neglect*'. Bethany was subject to a pre-birth safeguarding plan under the category of neglect. The allocated social worker was Marie who had been qualified for four years and had worked in the Family Support team at the host LA since she qualified.

The immediate family composition was:



Child Bethany

Mother Dawn

Age: not recorded, ethnic origin: not recorded

Father Steve

Age: not recorded, ethnic origin: not recorded

Bethany was the second child of Dawn and the first child of Steve. Although the ages of Dawn and Steve were not recorded anywhere on the referral record the interview with the social worker indicated Dawn and Steve were approximately 18 years old.

Dawn had been the subject of violence from her mother and so had run away, with her eldest child Dylan, to a seaside town where she met Steve. Dawn and Steve were involved in drug use and Steve had been violent toward Dawn on several occasions. As a result, a child protection conference was held and a safeguarding plan was put in place for Dylan. The seaside LA were considering issuing court proceedings to remove Dylan from Dawn's care and at this point Dawn then decided to leave Steve and move to the host LA area.

Bethany's case file indicated that a referral in relation to Dylan was made in August (before the pre-birth audit period) by a social worker from the seaside LA to let the host LA know that a child subject to a Safeguarding plan was now living in their area. These pre-referral case notes indicated there had been a three-month period before the host LA actually became involved. During this time there had been ongoing debate, by letter and telephone, about which LA should hold case responsibility. The host LA's position was that because Dawn and Dylan were in temporary hostel accommodation there was a possibility they may not remain in the area. The seaside LA position was that Dawn and Dylan were no longer residents in the seaside town and the distance of 50 miles between towns meant managing the safeguarding plan was extremely difficult. There was nothing on the file to indicate how the safeguarding plan was being managed during the intervening period.

Marie explained that it was the potential for court proceedings which had, in her opinion, resulted in the host LA being reluctant to accept case responsibility:

At the point at which she moved out of [seaside town] they were about to issue proceedings in relation to Dylan and they were quite adamant that this child needed to come into care because she couldn't achieve any change and couldn't maintain anything. I think that was part of the problem with not taking the case from them, the manager at access point and [name of safeguarding manager] felt they were trying to dump care proceedings on us and that if she had run to get away from proceedings then they should be the ones to start proceedings. It felt as if they just thought 'oh well that's one job off our list, they can start proceedings and it isn't our problem now'.

(Interview, Marie 2009)

The host LA agreed to accept case responsibility in November and a transfer child protection conference was held which the social workers from the seaside LA attended. There was no copy of the a child protection report on the electronic case file but the minutes of the conference indicated the social workers from the seaside LA had presented a report which outlined that Dawn had fled domestic violence and that there were concerns regarding both Dawn and Steve using heroin.

The first entry onto the case file by Marie was on the 24th November when it indicated she had undertaken a home visit to complete the pre-birth assessment. The next case note was for the 14th January and indicated that Marie went to the seaside town to visit Steve as part of the pre-birth assessment. On the 16th January Marie recorded in the case notes:

Assessment session. See report on file.
(Bethany, case notes)

There was not a report or any form of assessment on Bethany's file and no file had been inserted when I checked the case file for the last time in December 2009. Marie explained that she had not actually had chance to finish writing up the assessment but still had plans to do so over the December 2009 Christmas holidays.

During the interview Marie explained that when she started working with Dawn and Dylan they had been living in a hostel for approximately five weeks and had managed with very minimal intervention from social workers in the seaside LA. Staff at the hostel had provided a high level of monitoring and they were not reporting any particular difficulties or problems for Dawn or Dylan. Dawn had (on her initiative) made contact with the local children's centre and was beginning to make contacts and networks there. Marie said that when she and Dawn first met:

We established a really good relationship and she started to work with us really well. Obviously she was pregnant and so I had to do a pre-birth assessment. A core assessment had already been done for Dylan by [name of social worker at the seaside LA] and I was able to use quite a lot of information that came over from there really, about her background and her history.
(Interview, Marie 2009)

Throughout the interview Marie spoke of how Dawn worked well with her and staff at the children centre:

Dawn did feel quite targeted by [seaside town] social workers and even stopped speaking to the social worker, and when they had conversations you could tell, she didn't really support her. You know you can tell the way people talk, some social workers don't really have time for some families and Dawn seemed to be one of them. I just thought, I don't know, I could just see something in her and could see that vulnerability, and she needed that support. And once she got that from us and all the other agencies that were involved I think she felt a bit more confident and secure so she really started to open up, in herself and with [name of staff member] at the children centre.

(Interview, Marie 2009)

Marie then went on to talk about the pre-birth assessment:

So then we did the pre-birth assessment. Obviously we used the information for the pre-birth around Dylan as well and how she had started to stabilise her life really, in the hostel, which she did do. Complied to all the rules and everything and at that point Dylan was demonstrating quite unruly behaviour, it was more than the terrible twos, he was swearing at her, he was calling her a bitch, it was obviously that lack of control, guidance and boundaries. So she did Webster Stratton [a parenting programme], which she had never engaged in before and came on leaps and bounds really. So I was able to use her parenting with Dylan to help with the pre-birth as well. To help work out what we would do, and [seaside town], we were still liaising with them but they were really quite clear that these children should really be in care. My question was well why aren't they? They were 'well we were going to issue proceedings but obviously she has come to you now'. So that's how it came around to doing the pre-birth.

(Interview, Marie 2009)

Marie spoke about trying to engage the baby's father in the assessment but he had little input into the assessment and took the approach that if Bethany wanted to visit him when she was older that would be acceptable but he did not regard it as important that he was in her life. Marie also spoke of supporting Dawn in recognising that she would need to cope on her own and that Steve was unlikely to take any active part in caring for Bethany.

Overall Marie felt there had been an element of risk in the assessment. She identified that it was quite difficult to have an assessment from another social worker that recommended removing a child and then to go against that assessment. She also spoke of the impact Dawn's life had on Dylan and in particular that he had experienced living at 18 different addresses in a six-month period and that he had probably witnessed drug use and violence in his short life. Marie then spoke of the child protection conference and how other professionals were quite anxious about the prospect of the baby making the situation even worse. Marie, however, felt that because she had the case quite early in the pregnancy and Dawn was coping well in the hostel she had time to build a relationship with Dawn and work with her to ensure the safety of the children.

Marie spoke at length about how the health visitor, hostel staff and family centre staff had helped Dawn in relation to managing Dylan's behaviour, budgeting and keeping her flat clean. The result was Dawn was able to manage her money and keep her home clean and, when she moved out of the hostel into her own house, she maintained the standards she had demonstrated in the hostel. Marie also said there had never been any issues with Dawn taking drugs while she had been working with her. Marie's view was that Dawn had tried drugs while living in the seaside town in order to be part of the crowd she was associating with but, away from that environment, things were different. Marie put the success of the support package down to the efforts Dawn made herself and her willingness to work with everyone. Marie also commented on the degree of openness everyone had and how Dawn soon came to recognise that the professionals shared information and were open with her.

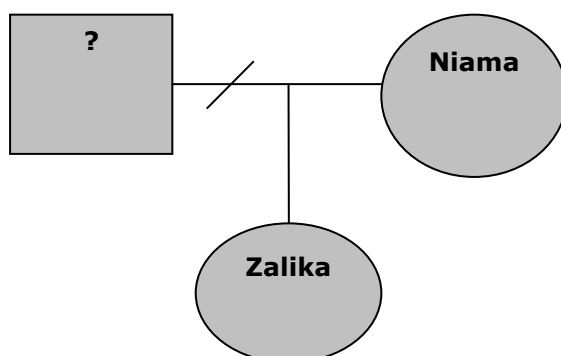
The plans were that at the next Safeguarding conference all professionals would recommend that there was no ongoing need for the children to be subject to such a formal level of support and that Dawn could continue to work with everyone on a voluntary basis.

8.4.7 Zalika

Rachel, the case-holding social worker, had been qualified for two years and had worked in the Looked After Children Team in the host LA since qualifying.

Zalika's case was somewhat unusual as there was no pre or post-birth case file for her and therefore all information was gathered from my discussions with Rachel in the research interview and at my meeting with Zalika's mother to obtain consent to include the case in the research. The family details were:

Child	Zalika
Mother	Niama age: 14, ethnic origin: African
Father	Unknown



I had found out about Zalika following my discussions with a senior manager about pre-birth assessment and looked after children who was aware of the case and that a pre-birth assessment had been undertaken. Because no referral had been made and no electronic case record created, Zalika's case has not formed part of any of the data generated from the six-month audit. With Niama and Rachel's permission I did access Niama's case file as I had assumed Zalika's case notes would be stored there. However, I found that although Niama had the status of a looked after child (LAC) and so was subject to all of the procedures associated with this status, such as placement reviews and looked after child ICS documentation, Zalika had no such status. There were no records of a pre-birth, or any other, form of assessment and no case notes about Zalika. The LA had no case records at all that made reference to Niama having a baby.

Niama was 14 years old when she gave birth to Zalika. Niama had entered England on a tourist visa and was, allegedly, accompanied by her father. Her Father had then returned to their country of origin and left Niama with two males who were alleged to be cousins. The police and immigration services undertook a raid of the cousins' house and had arrested the men, as they did not have valid visas to be in the country. Niama was found at the property (along with another teenage girl) and was placed in the care of the Local Authority. At this point she was 13 years old and no one was aware she was pregnant.

Niama's case had been allocated to Rachel just two days after the police and immigration services had found her. The LA procedure was that all cases involving unaccompanied asylum seekers under the age of 18 were passed directly to the Looked after Children (LAC) Team. The rationale for this was to reduce the numbers of social workers the young person was introduced to and in recognition that the young person would be remaining in the care system.

Rachel explained that when she had first been allocated the case she was told she would only hold it for a month because Niama did not have the right documentation and so she would be deported back to her country of origin. However, as Rachel began to do some research into the case she found the circumstances were not as straightforward as she had first anticipated. Rachel spoke of sorting out the LAC paperwork and arranging dental and medical appointments for Niama. At this stage Rachel was not aware Niama was pregnant. When the pregnancy had become apparent, Rachel then started looking for a mother and baby placement for Niama because, although the placement she was in was meeting her needs, the foster carer was not registered to look after teenagers and their babies. Talking about the placement lead into Rachel talking about the pre-birth assessment:

The reason for a pre-birth assessment was to justify the need for a mother and baby placement, that's what our...er... that's what I was told before I carried it out.

She was due in June so it must have been... [Rachel paused and then began turning the pages of her note book]. We had a planning meeting on the 23rd February and she was due at the end of June [another pause while looking in the note book] So I think it would have been at that planning meeting that Dianne [another social worker in the LAC team] was assigned to work the case with me. And it took us a while because both of us were so blooming chocka block with stuff and we didn't have ...[another pause while looking in the note book] so the first one was the 11th March and it was pretty intense after that truly. That was to explain what we were going to do ... [another pause while looking in the note book] And then 24th March was the first session. The 25th was the second and I think [another pause while looking in the note book] Dianne must have done a third at the back end of that week. And then the 4th was on the following week. 5th session on the week after that, 7th April, she had a review in the middle of all of that. We went to visit my mum (laugh). It must have been it, yes... I was in the middle of looking for a placement then. That must have been 5 sessions I think altogether. Although I believe there were 6, Dianne must have done a 6th session by herself at the end. And we sat and wrote it up together.

(Interview, Rachel, 2009)

Rachel then began to talk about what was assessed and commented that there were difficulties with regard to language and with Niama fearing immigration and so not wanting to say anything that would get her into trouble. With regard to the language barrier Niama spoke Wolof as her first language, her second language being French, but there were no Wolof interpreters in the host LA area. Therefore, a French interpreter was used and as Niama began to learn English some communication took place without an interpreter. Rachel said:

Part of the assessment was whether she was going to co-operate with the assessment and we spent quite a lot of time in that first one just trying to get that across. She understood that that was what we were looking for from her and she did that really well. Probably the first time that she had ever said anything at any length.So that was the first thing we were looking for, co-operation really, and a willingness to share information with us that would help us to assess whether she was going to be ok.

(Interview, Rachel, 2009)

Throughout the interview Rachel spoke of looking for Niama to be 'open and honest' in several different situations. The most notable of these was in relation to discussing becoming pregnant. Rachel explained that Niama had told her midwife that she had been raped. As a result of this a police investigation was started and Niama was taken to the child protection unit for an evidential video interview. Rachel explained that during the police video interview Niama was asked about sex but did not answer the question, which was then interpreted as not being open and honest. Rachel then explained that during the course of the pre-birth assessment she began to believe that Niama did not actually know what sex was:

One of the questions was when did you start your periods and she said what is that? And we had to explain when this happened and she had no concept that, that was what that was called. Obviously it was happening to her but no one had ever educated her about what that was, she didn't know what male genitalia was, she didn't know that what had happened to her resulted in pregnancy, she didn't know how a baby was made.

(Interview, Rachel 2009)

The other element of the pre-birth assessment Rachel spoke of was the practical task of caring for a baby. She spoke of asking Niama questions about how to hold and dress a baby. In an attempt to assess Niama's skills Rachel used a doll so she could show how to dress a baby but this was not a lifelike doll and Niama had just ended up playing with it. Rachel also used a book designed for working with parents with learning disability that had pictures of parents and children. She said this allowed Niama to explain, in French, what was happening in the pictures. Rachel also spoke of making a referral to a local Children's Centre for them to undertake some practical sessions such as showing Niama how to make up a bottle. Rachel said Niama had been quite adamant she was going to breastfeed but the practical sessions would also include how to bath the baby. Rachel was not sure exactly what staff at the Children's Centre had done but said:

The lady who was the worker who was doing the practical sessions, I don't know how many they did, but the outcome of that was good and she said that she had no concerns that Niama would be able to parent without causing risks to the child.

(Interview, Rachel 2009)

Another point Rachel made was that Niama had not wanted a baby boy. She spoke of concern that Niama would not form an attachment if she had a baby boy and that her concern was such that she was 'twin track planning' with the intention of the baby being placed for adoption if it were a boy. Rachel did not provide any reason for why she was concerned there would be any attachment difficulties if Niama had a baby boy other than to say:

She was raised by her step-mother but very much as I am not yours. So she hasn't really got a positive history of attachment herself.

(Interview, Rachel 2009)

Rachel did express relief that it was a girl and that from the moment Niama knew she was having a girl there were no real concerns.

As there was no case file I asked Rachel about this and she explained that because there were no concerns about Niama's ability to care for her baby the baby was in her care and not the care of the LA. Rachel also explained that this was not good in some ways because Niama was having to apply for state benefits as a single parent because Zaliha was not financially supported by the host LA.

After the tape machine was switched off and we were leaving the interview room Rachel began to tell me about how helpful the interpreter had been. She explained that Niama had asked for the interpreter to be present when she went into labour and the interpreter had agreed. Rachel also said it had been 'lucky' that the interpreter had been present because when Niama went into labour she had refused to be examined. Throughout her labour she had become more and more distressed and had said she did not want men in the room. Rachel explained that the interpreter had tried to explain the need for an examination but Niama continued to refuse to allow one and as a direct result the hospital had to perform a caesarean operation. I expressed my surprise at this information but Rachel simply said that the hospital had no choice. Rachel did not speak of having contacted the hospital herself either before or after the birth of the baby.

When I met Niama she presented as comfortable caring for her baby. She was in full time education and Zalika was in nursery during the day. Niama's solicitor was making an application to the immigration office for her and Zalika to remain in England.

8.5 Summary of in-depth cases similarities and differences

When analysing the information it became evident there were several similarities and differences between the cases both in relation to the case details and LA processes. In this section I will highlight some of the key themes arising from the analysis of the in-depth cases.

8.5.1 Case content

One of the most notable features was that six of the seven cases (Zalika being the exception) had information on file to indicate one or both of the parents had involvement with drug use. Whilst Harvey's mother was not reported to be using drugs herself his father's use of differing illegal substances and alcohol were a significant feature of his life. Maternal use of illegal substances during pregnancy was a feature in Jodie, Amy and, Molly's cases with Bethany's mother having used illegal substances previously but not necessarily during pregnancy.

The second notable feature was the issues of violence which arose in all but Molly and Zalika's cases. In all of the cases where violence was reported this was male violence toward the pregnant mother although Bethany's mother had also experienced violence as a child from her mother. In Harvey and Jordan's cases their fathers' violence also included the use of weapons, violence toward people outside of the couple relationship. In each of these cases risks to the social workers and other professionals were identified.

In all but Molly and Zalika's cases there had been previous LA involvement with the family either with the parents themselves when they were children or with unborn child's older siblings. The access to previous case files was something of a mixed blessing with information about different siblings being held on each other's files. From a research perspective this was interesting as it demonstrated the volume and range of information available but also highlighted the enormity and complexity of maintaining individual files for individual children. The inherent risk was that key information regarding the pre-birth case could be overlooked and, as was demonstrated in Amy's case, at the point of birth there was nothing on file to inform planning and decision making if the baby arrived when the allocated social worker was not available.

Financial and accommodation issues featured to some degree or in some form in all of the cases. Debt or lack of money in their own right was a feature for all the mothers at some point during the pregnancy. In Zalika's case her mother was also a child and as such was placed in the care of the LA when her situation came to light, however Zalika was not classed as a child in need and was therefore in the very complicated position of her mother having to try and claim state benefits for her.

The issue of co-operation featured throughout all of the cases to some degree or another although it was not necessarily the issue of co-operation which ultimately impacted on the case outcome. What I found most interesting was that in Jodie and Amy's cases the parents were evasive (and sometimes hostile) toward social work involvement and yet professionals managed to maintain links with the hospital midwifery services ensuring the LA were notified at birth.

8.5.2 Pre-birth assessment processes

With regard to processes of undertaking pre-birth assessment there was very little similarity between the cases. The main issue which was consistent in all of the cases was some evidence of working with other professionals during the pre-birth stages. Harvey's case particularly highlights how the involvement of other professionals and agencies can yield both information and have a profound impact on the plan in place at birth. Without support from the probation officer and the housing team and the co-ordination of information by the social worker Harvey would not have been able to remain in the care of his mother.

What constituted a pre-birth assessment varied considerably from case to case. In Jodie's case an IA and CA had been completed prior to transfer to the Family Support team but the

content of these documents did not convey to the Family Support manager and social worker the seriousness of the situation. In Molly's case there was an IA which concluded further intervention and assessment was required but despite this the case fell through the allocation net until very close to the birth. In Harvey's case the referral information was comprehensive and, although an IA was completed, this added no new information. Neither Molly nor Harvey's cases had a CA on file.

Amy, Jordan, Bethany and Zalika had no IA or CA on file although there was either IA or CAs relating to older siblings on the pre-birth file or, in all cases except Zalika's, the case-holding social worker reported in interview that an IA or a CA existed. Zalika's case was a total exception with no file existing at all and no information about her being held on her mother's file; her mother being a looked after child herself.

The stage during pregnancy when cases were referred varied although Amy, Jordan, Bethany and Zalika were known about because of on-going involvement with their mothers when they became pregnant. However, Amy's social worker did not make the referral, even though he was aware of the pregnancy; this eventually being done by the ASW late in pregnancy. Jodie was referred at 21 weeks gestation and Molly at 30 weeks gestation and both were referred to the LA by a midwife. Harvey was referred by probation at approximately 20 weeks gestation. The stage of pregnancy at which a referral was made or the social worker became aware of the pregnancy seemed to have no bearing on the assessment trajectory at all. However, all of the case-holding social workers drew on information from a range of sources including case files, reports and verbal information to inform the plan at birth. In all of the cases the case-holding social worker identified that intervention at birth was necessary to safeguard the baby. Jodie, Amy and Molly were removed from their mother's care at birth with Jodie and Amy eventually being adopted and only Molly being returned to her parents when she was a few months old. There was a plan to remove Harvey at birth but this was changed at birth as a result of 'eleventh hour' changes in circumstances but there was legal intervention in the form of an Interim Supervision Order reflecting the serious concerns of the LA. Jordan and Bethany were both subject to safeguarding plans having been discussed at a pre-birth safeguarding conference. Whilst Zalika's social worker did not regard her as a child in need or a looked after child she was still placed in a mother and baby foster placement, affording her the security such a placement offers.

8.6 Conclusion

The plan was to draw cases for in-depth analysis from cases identified in the six-month audit selecting cases which met 5 pre-defined set of criteria. A process of selection and screening

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resulted in identification of seven cases which fitted my criteria. There was also one additional case which was not identified in the audit as no electronic case file existed. During the process of data gathering one case had to be withdrawn when family withdrew their consent to take part in the research and so ultimately seven cases were subject to in-depth analysis.

My early plans had the built-in assumption that staff in the host LA would be following pre-determined patterns of case recording and file management which would be relatively easy to track. However, as was found in the six-month audit, the actual case trajectories were extremely complex. The in-depth study did provide more detail regarding what actions social workers and managers took during the process of intervention and assessment. However, this served to highlight further the findings in Chapter 7 surrounding the lack of clear thresholds for intervention. The in-depth study also added to the findings in Chapter 7 surrounding the screening out of cases of a child in need nature and focus on cases of a child protection nature.

The complexity of the pre-birth cases was extremely evident with social workers having to assimilate, judge and act upon a wide range of information from an equally wide range of sources. What was also evident was that pre-birth assessment is a multi-agency process with midwives frequently contributing information and practical support. However, a range of other professionals and agencies held important information and had access to relevant resources which could impact on both decision making and the support offered pre-and post-birth.

During the interviews the social workers commented on information specific to the cases as well as making more general comments about pre-birth assessment. It is to the wider comments I turn in Chapter 9.

Chapter 9

Phase 3 results: Interviews with the social workers

9.1 Introduction

In addition to providing information directly relevant to the in-depth cases the social workers were asked to talk about pre-birth assessment in more general terms. The interview schedule discussed in Chapter 3 and contained in appendix 4 was used as a guide and to prompt questioning if necessary. All of the social workers were more than willing to discuss their experiences of pre-birth assessment and so all of the interviews lasted at least one hour. As the interviewed social workers were willing to engage in the process I had very limited need to prompt discussion and so the order of discussion did not follow exactly the interview schedule. In presenting these results, the chapter firstly outlines the level of experience of the social workers and then considers the key themes that emerged in the interviews.

9.2 Practice experience and assessment experience (Relating to Qs 1, 2 and 3 of The Interview Schedule, Appendix 4)

The social workers interviewed ranged in experience from one year to twenty years' experience, as can be seen in table 15:

Name of social worker	In-depth case	Years qualified	Length of time in host LA children's services
Ruth	Jodie	1 year	1 year
Jane	Harvey	1 year	7 years (six as Family Worker)
Rachel	Zalika	2 years	2 years
Marie	Bethany	4 years	4 years
Rosie	Jordan	7 years	4 years
Carla	Molly	8 years	8 years
Paul	Amy	20 years	6 years

Table 15 Experience levels of interviewed social workers

Only two of the social workers, Rosie and Paul, had had experience of working anywhere other than the host LA. Paul had specialised in adult residential care and mental health social work with another LA and Rosie had worked in an agency supporting women fleeing domestic

violence, also in another LA. Jane had worked for the host LA for seven years and had been seconded to university for two years to complete her social work training. Ruth, Jane, Rachel, and Carla had worked for the host LA since qualification and so had no experience of practice or procedures in other LAs.

Six of the seven social workers spoke of assessment work in general as being part of their daily work activity. The case included in the in-depth study, *Jodie*, had been Ruth's first experience of conducting a pre-birth assessment although she had conducted core assessments and had co-worked complex assessments held by more experienced social workers. The other five social workers had all completed pre-birth assessments prior to their allocated cases selected in this study.

Rachel was the only worker who said she had not conducted any CAs prior to undertaking Zalika's pre-birth assessment. When talking about how she felt about the pre-birth assessment Rachel said:

... a bit overwhelmed to be honest, really. I had never done one before. I sort of had an idea what it entailed from being in LAC (Looked After Children Team) but a bit daunting, the thought of doing it myself!..... I had done little bits of core assessments but this case was pretty much my first case from when I came here, so I was pretty much thrown in at the deep end.
(Interview with Rachel 2009)

Rachel explained that because she worked in the Looked After Children team (LAC) there were no opportunities to undertake core assessments and her experience of doing 'little bits of core assessments' related to when she was a student and on placement in another LA. Rachel said the LAC team social workers rarely did assessments because they were always done before the case transferred to their teams. When I asked about updating core assessments for children who had been in the care system for any length of time, Rachel said this was not something that was routinely done. Rachel explained that when it came to the assessment of Zalika only one of her LAC team colleagues had undertaken any core assessments and therefore she had no expertise or support to draw on to assist her.

9.3 The legal, policy and procedure framework (Relating to Qs 7 and 8 of Interview Schedule, Appendix 4)

All of the social workers were asked about the legal, policy and procedure framework they worked within, either in relation to the specific case under discussion or in more general terms. All of the social workers were aware that unborn children had no legal rights but none of the social workers saw this as something that would prevent a pre-birth assessment being

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undertaken. No reasons were given by this but it appeared that the legal status was not really questioned; focus was far more on having plans in place rather than on questioning the rationale.

9.3.1 Avoiding the assessment

The potential that a mother may leave the LA area to avoid assessment was an issue which was considered by Calder (2000 and 2003), Hart (2000 and 2010) and something which featured in LSCB procedures. This concern was not replicated in the interviews I conducted. Five of the social workers felt that access to financial benefits, housing and support networks often prevented families moving area easily and their experience was that when families did move they often only moved to neighbouring LAs and were easily traced. The need for medical support during labour was also seen as a factor that helped find mothers if they did try and move away. As Carla said:

At any stage a mother can up sticks and disappear. A mother of mine drove to (name of town approx 60 miles away) in labour but still had to turn up at a hospital when it got too painful.
(Interview, Carla 2009)

In this respect all of the social workers spoke of the importance of working with the family as the key to preventing, or lessening, the risk of mothers moving away. All but Paul and Rachel spoke of ensuring there were good inter-professional links with the community midwife in order to ensure clear communication with the hospital midwifery teams and, if necessary, to set up an alert mechanism in the event of a mother turning up at a hospital she was not due to give birth in.

9.3.2 Court orders

With regard to applications to court, the time delay between birth, making an application and then getting a court order was seen as an area of potential difficulty in safeguarding a child by all but Rachel. This was particularly seen as a problem in relation to the risk of parents trying to remove the baby from the hospital or placement. However, no one commented on whether or why the period after the birth and before the obtaining of the legal order might be potentially more volatile than any other kind of case involving older children. Marie commented in relation to a case which was not included in the in-depth study:

It's really difficult, like on this other case that I have got.... The baby was born on Sunday and he was placed with grandma yesterday upon discharge from hospital but he has gone on no order.
(Interview, Marie 2009)

Similarly Paul commented:

No I think there should be something where you can go before court because you end up on the day the baby is born... you go down to hospital and you might have an idea about if they are going to agree to voluntary accommodation, or you may not. And in a way they still have a hope they will keep the baby until they go to court. I think we should be able to go about a month before the baby is born. At least they know as well where they stand.

(Interview, Paul 2009)

When asked about relevant guidance, all of the social workers identified the *Assessment Framework* (DH 2000) as relevant to pre-birth assessment work. However, none of the social workers identified any procedures such as in *Working Together* (HM Government 2006) or in their Local Area Safeguarding Procedures specific to pre-birth assessment work. Paul went one stage further and said:

Well for pre-birth assessment there doesn't seem to be any real procedure does there? (laugh) You just get it and someone might say to you in supervision where are you with this and that's it! As far as I know for pre-birth there is no set procedure not that I know of.

(Interview, Paul 2009)

There were, therefore, no comments about what procedures were (or should) be followed and no indication of any specific guidance the social workers referred to in relation to pre-birth assessment or intervention work, other than the more general guidance of the *Assessment Framework* (DH 2000).

9.4 The multi-agency component of pre-birth assessments (Relating to Q 10 of the Interview Schedule Appendix 4)

Jodie's case was the only file which contained a comprehensive collection of documents from other agencies and case note examples of social workers and other professionals working together. However, in the interviews, the nature of multi-agency work became much more evident. All of the social workers spoke of other professionals and agencies, the most common being midwifery services and drug support team workers. What was also evident from the interviews was that, in most instances, the process of working with other agencies was regarded as positive and integral to pre-birth assessment and planning.

The ways in which the multi-agency support network was seen as important related primarily to the sharing of information. As Paul commented in relation to a case not included in the in-depth study:

The [referral] came from the midwife to say about amphetamine... well her substance misuse which turned out to be amphetamine misuse and also the drug liaison midwife had got involved with that as well and it went from there. Originally nobody knew where [name of mother] was and eventually we, well the midwife tracked her down eventually
(Interview, Paul 2009)

In a similar vein Rosie said:

It is hard because you don't always work with the same GP practice or same hospital team so you don't get to know the midwives very well. Having said that you work with them closely for a short period of time and I they are usually really good. I once had an incident where the hospital midwives were angry with me when I went to the hospital to take the baby but that... well that is unusual. Generally they are really helpful. They also get to know all sorts of things because parents don't see them the same as the social worker, even though they know the midwife tells us everything.
(Interview, Rosie 2009)

The professional network was not limited to those professionals who would perhaps be the most obvious contributors to a pre-birth assessment. In *Harvey's* case the professional network was diverse and contained many whose primary focus was working with adults (namely housing and probation). However, *Harvey's* case and Jane's interview highlighted how a professional focus on adults did not necessarily equate to ignoring the needs of an unborn child. The multi-agency assessment and support package, co-ordinated by the social worker, resulted in mother and baby being able to remain together as opposed to a legal order to remove *Harvey* from his mother's care being activated. As Jane said:

The probation officer was really great. He was central to us being able to send Harvey home. It was just days before Harvey's birth and we started talking about how it would be better if Gary didn't come out of YOI [young offenders institution]. And he said he could recommend that he didn't and that he serve the full custodial sentence. And that is what he did. I wouldn't like to have been the one to tell Gary (laugh) but that made a difference. Knowing that we could work with her without Gary finding her and risking things. Then the housing officer managed to get the hostel place and it was all systems go.
(Interview, Jane 2009)

In the case of *Zalika*, the interpreter had been a key figure and had offered support over and above bridging a verbal and written communication gap. Rachel explained that when Niama went into labour she had asked for the interpreter to accompany her. This request was agreed and ultimately resulted in the interpreter also taking the role and responsibility of birth partner for Niama; a role significantly beyond that which would normally be expected in such circumstances. I later found out from a senior manager that there had been a dispute between the LA and the health service about payment for the interpreter as both agencies felt interpretation services were not actually needed during labour. The view was that Niama had

sufficient command of the English language to understand the basic instructions of the medical team and this dispute resulted in the interpreter not actually getting paid for attending the birth.

The issue of payment highlighted how procedure often presented as more significant than practice. Neither Rachel nor the senior manager I spoke with made any reference to Niama needing a birth partner because she was a young and vulnerable girl. Also, there was no discussion about the LA's responsibility to offer support and care at a time of great stress and anxiety for any new mother, let alone a 14 year old girl living in foster care with no family support network at all. The interpreter had filled this gap and yet the only discussions focussed on payment for the interpretation services.

9.5 Social workers' descriptions of the assessment process (Relating to Q9 of the Interview Schedule Appendix 4)

All the social workers described their approach to the task of pre-birth assessment both in relation to the cases selected for in-depth analyses and in response to the final two questions on the interview schedule:

What are your views or opinions on pre-birth assessment in social work?

Are there any other points you wish to raise in relation to pre-birth assessment that we have not already covered?

(see appendix 4)

All seven social workers referred to the *Assessment Framework* (DH 2000) and the use of the assessment domains in the process of pre-birth assessment. However, each of the social workers differed in how they approached assessment and made use of the *Assessment Framework* (DH 2000). None of the social workers made any reference to theoretical perspectives that might underpin their practice or reference to any specific literature on pre-birth assessment.

9.5.1 Approaches to the assessment process

Rachel was somewhat of an exception in the interviews as she felt she had no experience of assessment upon which to draw. She did say that she had followed the domains of the *Assessment Framework* (DH 2000) and they had been useful. However, when I reviewed the transcript, I noticed she had not expanded on what she had found useful and her comments about her assessment related primarily to the language barrier and the use of a picture book

as a means of communicating. There were comments about using a doll to observe how Niamia would dress and bath her baby and to making a referral to another team for an assessment of parenting skills but no detailed discussion about how Rachel had actually related any of her observations to the domains of the *Assessment Framework* (DH 2000). When talking about the final decision to keep Niamia and Zalika together, this seemed related much more to accessing a mother and baby foster placement rather than as a result of a process of assessment and decision making. As mentioned in Chapter 8, Rachel rather saw the pre-birth assessment as a vehicle for obtaining the right placement for Niamia and her baby.

By contrast the other six social workers all spoke in some detail about how they approached pre-birth assessment. Marie particularly commented that the *Assessment Framework* (DH 2000) did not enable assessment of risk:

I find the framework for assessment, it's useful but it doesn't address risk. There is nowhere to address risk in that really. And that's always a separate category, well with any assessment but particularly with pre-birth.
(Interview, Marie 2009)

Marie described how she had devised her own form of report which followed the domains of the assessment framework but which also allowed her to add comments specific to risk factors.

9.5.2 Pre-birth assessment report formats

Not actually using the ICS compliant assessment document (appendix 4) was a common theme with the six social workers who had assessment experience. All of the social workers spoke of problems getting the information they gathered to fit into the pre-determined categories of the ICS format. As a result all but Rachel commented on preferring to write pre-birth assessments as a word processed report whilst drawing on the domains of the *Assessment Framework* (DH 2000). In particular they spoke of not feeling confident that the ICS format would be acceptable in the formal setting of a court where the social worker's knowledge about the family and skill in analysing and making judgments about future plans was relied upon. As Carla commented:

There is confusion as we have got ICS docs that are not fit for purpose, it is a ridiculous document and I would not ever produce that for a court document. Nobody dares to yet. I think if we did we would be instructed to leave the court room! It's a bit like the very old ticky box ones that we used to fill in, in pen. They are alright for a little snapshot that is put on the computer for an assessment and for a record but if you need a big thorough assessment you need to use the framework with the headings and you need to write under those headings.
(Interview, Carla 2009)

Similarly Ruth spoke of using the domains of the *Assessment Framework* (DH 2000) to structure her approach:

I wasn't confident but it was structured and it you could see where you were going with it. You have got aspects to write about and things you need to know and I liked that about it. Once I got into it I felt a bit better knowing what I needed to know and what I was asking and where I was... you build up a picture and you start to get a few sessions with people and you start to form views even before it's finished. You sort of like know where it is leading before you have got all of your information, which is interesting.
(Interview, Ruth, 2009)

Ruth had actually completed the ICS CA document but this contained quite limited information. She had, however, also written a word processed report which was structured around the domains of the *Assessment Framework* (DH 2000). In the interview Ruth spoke of drawing information from a wide range of professionals and how she was unable to then work out how or where to record this information within the ICA CA document. However, she spoke of her approach to writing up the assessment as akin to writing an essay at university and having to select key information to highlight the main areas of strength and weakness within the family.

9.5.3 Information used to inform the pre-birth assessment

There was a wide variation in what social workers looked for as indicators that the parents, or more specifically the mother, would be able to care for the baby when it arrived. A clear example of differing approaches was between Jane and Rosie who had quite opposing ideas about the need to observe a parent undertake practical tasks. Rosie spoke of using the family centre staff to offer support with making bottles, bathing and changing nappies. She explained that she would always make a referral to the family centre so they could undertake an assessment of a parent's practical skills and clearly regarded this as a key element of any pre-birth assessment. Jane, on the other hand, with specific reference to her assessment of Harvey said:

But some one that I was talking to about this assessment was saying why don't you check if she can make bottles! And I said no, I wouldn't do a session on making bottles, and they said well she needs to know how to make a bottle. And I said, you know I breast fed both of my two children I have never made a bottle, I wouldn't sodding know how to make a bottle, I wouldn't know but that doesn't make me someone who can't parent. I need to know if she can keep herself away from him and keep the baby safe. Knowing if she can make a bottle is irrelevant. The Health Visitor can teach her how to make a bottle or she can read on the back of the packet what to do.
(Interview, Jane 2009)

Jane worked in a different office to Rosie and the colleague she was referring to was another social worker who had offered her advice on how to approach the pre-birth assessment. However, the comment serves to highlight not only the range of factors which may be considered but also differing professional opinions about what parents needed to be able to do or demonstrate they could do.

The six social workers from the family support teams all spoke of the importance of spending time with the parents and understanding their history. As Carla commented:

I always do a single session with mum and dad and sometimes two sessions to get an extensive life history line. If you get a really good life history line, this can really inform the assessment. Again this is about building a relationship. I try and do it toward the end of the assessment because if you have built a relationship then you can get a better lifeline. If you can use that then you have got all of mum's past, all of dad's past you can use that to understand where they are today, which explains a lot as to where they are today where they have come from and why they are in the position they are in.

(Interview, Carla 2009)

Carla also spoke of looking for a range of indicators such as how well the parents looked after themselves, how well they had prepared in relation to considering what equipment they would need for a baby, what the parents' financial circumstances were and what family and friend support networks were available.

9.5.4 Pre-birth assessments where there were older siblings

What became evident from the interviews with Paul, Rosie and Marie was that, when carrying out an assessment where there were older siblings, the process relied significantly on what had been observed in relation to the care of those siblings. In relation to the assessment of Amy (whose parents had both had children removed from their care) Paul said:

But with all that history we were going down and proving that what had been said previously was still there, and there had been no real change. ...But having said that it was a new couple together and they needed to be given a chance. ...But we are talking only 4 or 5 months on and we are doing another parenting assessment on the same people in respect of another child so in a way it was superfluous in that respect but maybe to give them a fair crack of the whip .. you know we have to be seen to be right with them and it was fair in that way I suppose.

(Interview, Paul 2009)

Throughout discussion about Amy's case Paul seemed to waver between holding a view that parents should be given the opportunity to show they had changed and a recognition that, in some cases, this was very unlikely. Paul commented on how it was important that, in legal cases, the court could see that all efforts had been made to allow the parents to show they had

changed. However, he also felt that at times this was actually quite 'cruel' (Paul's word) as not all parents understood the process and sometimes had false hopes raised by virtue of an assessment being undertaken. In speaking about Amy's parents Paul commented that, whilst they did not have a specific learning disability, their ability to comprehend the complexity of court proceedings was limited and so repeatedly including them in the assessment process only served to add to their distress:

So in that way that would have saved some time and perhaps in a way for them it would have been better for them in a sort of being cruel to be kind sort of way to say to them that's where we are going.
(Interview, Paul 2009)

Marie and Rosie discussed assessing a child when there was a safeguarding plan in place for older siblings. Rosie said:

What happens is the pre-birth assessment just gets joined in with the assessment of the other children. Whatever is happening for them will be likely to happen for the baby. The only additional information to consider is how will another child impact on the picture as a whole?
(Interview, Rosie 2009)

Both Maria and Rosie commented that having older siblings meant that the assessment was easier because there was a whole family dynamic to observe. There were also parental interactions with older siblings to use as a comparison and so more information upon which to base the assessment.

9.6 The time-scale and complexity of a pre-birth assessment (Relating to Q3 of the Interview Schedule, Appendix4)

In the interviews all but Rachel referred to pre-birth assessments as being different to, and often more complex than other assessments. Time-scales was one factor in this with the time between the allocation of the case and the child's birth being an important consideration.

9.6.1 The time needed to complete an assessment

As identified in Chapter 8, Molly was placed in the care of the LA at birth and subsequently returned to her parents. Carla had been allocated the case very late in the pregnancy and legal planning process and therefore felt unable to make any other decision at birth than to remove the baby. When discussing the ideal time frame for beginning work on such a case, Carla said:

In a perfect world the minute some one is pregnant. In a case where there already has been a child removed basically as soon as you know because if there is any preventative work to be done then you need the time to do it.
(Interview Carla 2009)

Ruth reported that she had four months to complete the pre-birth assessment for *Jodie* and that she had needed all of that time. She said she felt anxious about knowing if she had enough information to make the decision to remove the baby from her mother:

Another thing I really worried about was making sure I had covered everything in enough detail. Because I had never done one before it was ...have I done this right, am I asking the right sort of questions, is it offensive, am I going into too much detail, am I invading their privacy. But there all the things you need to know. But sometimes it is a bit uncomfortable but that's you know all the questions and getting in there. I know how I would feel if somebody was asking me a lot of sensitive things, I'd be I'm not telling you. It's good to reflect on really.
(Interview Ruth 2009)

Paul said he felt an eight-week time frame was appropriate to conduct a pre-birth assessment as this allowed time for six sessions to meet directly with the parents and two weeks to write the assessment. Paul also felt that this eight-week time frame should occur no later than 5 months into the pregnancy.

9.6.2 Pre or post-birth assessment?

One very notable comment made about pre-birth assessment came from Jane in relation to *Harvey* when she stated she had done the pre-birth assessment after *Harvey* was born:

Anyway we got an Interim Supervision Order and she went to the refuge with Harvey with her. And it was after that that I properly started my pre-birth assessment because prior to that, I had become involved in May, it was so chaotic at that stage that I couldn't do a pre-birth assessment.....

How can I do an assessment when she is getting locked in sheds, I could assess that but the longer term I couldn't assess longer term because she wasn't in the right frame of mind. So the difficulty was actually picking the time to start the assessment. I don't know if anybody else has experienced that but I was. So I did the pre-birth assessment after the baby was born.
(Interview, Jane 2009)

This comment seemed somewhat at odds with the definition of a pre-birth assessment and so I asked Jane to explain her comment a little more. Jane talked about some of the factors that she could include in the assessment once *Harvey* had arrived, such as being able to observe how his mother held him, looked at him and attended to his needs. Jane then explained that, whilst she had presented a statement and a chronology to the court as well as reports from the

probation and housing officers, she had not presented anything called 'an assessment'. Jane had clearly split the skills involved in gathering a wide range of information from different sources, analysing the significance of the information and using that to then inform the decision making process from the process of writing up the assessment. In other words she only counted the written document as the assessment. Jane's detailed report which pulled together all of the information and provided the court with an up to date account of how Harvey and his mother were coping in the refuge was submitted to court a few weeks after Harvey's birth. It was this report Jane referred to as the pre-birth assessment.

9.6.3 Added layers of complexity

The issue of time seemed to be closely linked to the complexity of assessments. As Carla said:

With a pre-birth assessment you can only do so much because until the baby has actually been born you can assess all you like... you can say 'yes they can do A they can do B', basically they can talk the talk but can they walk the walk when the baby is born? You can get a lot of information, you can get your background information and start to form some ideas. I think there is not enough pre-birth assessments done, because I think we tend to be reactive, oh quick this baby is born, quick do an assessment rather than having the time to do a full pre-birth. If we could do more we could probably do more preventative stuff...rather than rushing out to do an assessment.

(Interview Carla 2009)

When talking about general approaches to assessment, not actually having a baby to assess was a feature. All of the social workers spoke of focussing the assessment more on the mother rather than on the baby:

The baby.... I know how this sounds.... Well no I don't know how this sounds... the baby has not yet been born. Ultimately unless the mother is a heroin user, heavy smoker or drinker then basically the baby is safe.

(Interview Rosie 2009)

Marie also talked about some of the issues she felt pre-birth assessment raised for her. In particular she spoke of feeling like there was a process that sometimes made her need to:

... step back and think, this is the baby's life and there are parents and other people involved.

(Interview, Marie, 2009)

She also reported that there was an issue in relation to thinking about the future of the baby:

In the pre-birth we also have to look at the future, its not just about when the baby is born and what will happen then. Working out with mother what the other alternatives are, what happens when the child is older and starts asking questions about what happened to them. And you have to discuss all that with them in the

pre-birth, and it's hard. And it's hard for them sometimes to even think about that and they will ask, what are you asking me that for?
(Interview Marie 2009)

Marie also made comments in relation to feeling that pre-birth assessment resulted in pregnant women being put under pressure, particularly when a mother might well be trying to cope too with the hormonal changes brought about by the pregnancy. She also spoke of mothers often being upset during pre-birth assessments and being worried that they were going to have their baby taken from them, even in cases where this was actually not the plan. Marie reported feeling uncomfortable about being honest with parents that there was a possibility that their child may be removed if there was no positive change in their situation. Whilst Marie recognised the importance of being honest, she also felt this sometimes felt more like an issuing of threats about what might happen. Interestingly, at the end of the interview, Marie said she had never really stopped and given pre-birth assessment any significant thought. The interview had prompted her to do this and she concluded by saying:

But unpicking it like that it is really difficult. You know, you think well how did I come to that conclusion when the baby is not even here?
(Interview, Marie 2009)

9.7 Focus on fathers

It was only when I was reviewing the transcripts that I noticed in all of the cases the social worker had mentioned the unborn child's father. In the case of Zalika the father was unknown but in the other six cases the father was known. In the six cases where the father was known five of the social workers reported meeting the father, but there were varying degrees as to how far he was then included in the assessment process.

Harvey's was the only case where the social worker did not have a face-to-face meeting with the father; a decision that was a direct result of the risk of violence the father posed. Interestingly, however, *Harvey's* case related very much to the risks posed by his father and whilst the social worker did not meet with him, the probation officer did. In the interview the social worker, Jane, identified that *Harvey's* father was indeed the focus of the assessment and the ability of *Harvey's* mother to break away from the relationship was a pivotal issue for the entire assessment and the subsequent decision to keep mother and baby together.

The importance of fathers was something which featured in the interviews to a greater extent than the case files had indicated. Rosie also spoke of the importance of meeting with the father in a pre-birth assessment as it was not unusual for her to have to identify his role in ensuring the baby would be safe. Notably Paul said that he could only think of one occasion in

his six-years working with the host LA, where he had undertaken a pre-birth assessment of a single mother.

9.8 Other issues and considerations

As well as discussing issues specific to pre-birth assessment, there were other factors which impacted upon the social workers' approaches to the task, primarily support and workloads.

9.8.1 Access to support from colleagues and managers

The least experienced social workers, Ruth and Rachel, both reported feeling 'out of their depth' when it came to knowing what to do and what factors were important. In Ruth's case she was clearly able to seek support from her line manager and a more experienced social worker:

Yes. I had supervision with (TM name) and then I think H got involved... I think I did about 2 months on my own and then H came in. And that really helped because she has been qualified a lot longer and so she had had a lot more experience and knew of similar situations through other cases she had worked with so yes it was good to have her view and perspective on things. And to see if what I was thinking was similar to what she was thinking. Yes I like joint working. It gives you some support, you are not out there on your own.
(Interview, Ruth 2009)

Rachel, on the other hand, did not mention getting any support from her manager and the social worker to whom she turned for support had no experience of pre-birth assessment either and only limited experience of conducting a core assessment.

Access to support and supervision was regarded as important to all of the interviewed social workers. Jane said that her manager had been someone she could turn to when she needed to discuss the information she had gathered and who had been supportive when the plan had changed. Jane said that after they had taken the decision to keep *Harvey* and his mother together some professionals at a MAPPA (Multi agency public protection assessment) meeting had complained about Jane's assessment. Jane's manager had been contacted and she had defended Jane's assessment and the decision to keep *Harvey* and his mother together. Shortly after *Harvey's* assessment had been completed, Jane's line manager left the LA to work in another LA. Jane explained this left her feeling vulnerable as a newly qualified worker and that she had been considering also moving and following her manager.

Lack of managerial support was something Rosie commented upon at length. She explained that her manager had very little experience of working with complex cases and so when it came to considering removing children at birth he was not someone to whom she could turn.

Indeed, Rosie was so concerned about lack of support she had taken steps to move to another Family Support team in the host LA.

9.8.2 Workloads

Perhaps the most striking issue was the volume of work the social workers were all dealing with. Alongside the in depth cases I had interviewed them about, all of the social workers were dealing with other complex and demanding cases. For example, at the time of her interview, Carla was managing 3 sets of care proceedings, including *Molly's*, supervising 5 families where the children were subject to safeguarding plans and several child in need cases. In addition, Carla was also an Approved Social Worker (ASW) and so had additional responsibilities and commitments including being called upon by the adults' teams to undertake mental health assessments. Carla was a practice educator and regularly took responsibility for students (usually two per year) and also provided day placements for students from other professions such as health and education. The team manager regarded Carla as a key professional in his team and would regularly ask her to work alongside less experienced social workers to guide them and to assist them with their assessments.

Carla was not the exception and even the social workers with less experience were managing caseloads that consisted of court work and cases where there was a safeguarding plan in place. When I spoke with Ruth's manager he said that he was very unhappy about newly qualified staff working with very complex cases. He spoke of not having the time to offer the necessary support to Ruth and of his worry that his lack of time might result in her leaving the team. He clearly regarded Ruth as a competent and capable social worker and someone who would be a loss to the LA if she did leave. However, he also spoke of his anxiety when he was faced with making decisions on cases that had been assessed by someone with limited experience.

9.9 Conclusion

This chapter has highlighted several themes that emerged as a result of the interviews with the social workers. The interviewees had differing levels of practice experience ranging from being one year post qualified to having 20 years' social work experience. There was also a range of assessment experience with all but one social worker having experience of completing CAs although *Jodie's* case in the in-depth study was the first experience of pre-birth assessment work for one social worker. The interviews revealed that the primary method of developing skills around pre-birth assessment was seeking support from colleagues and managers and building on previous CA experience, thus 'learning by doing pre-birth

assessments', in the context of a lack of detailed guidance or procedure on pre-birth assessment work at either a local or national level. In this sense, the social workers can be seen as street level bureaucrats negotiating and adapting a legal and procedural framework not actually designed for pre-birth assessment work.

All of the social workers were aware that an unborn child had no legal status but did not regard this as a difficulty with regard to undertaking pre-birth assessment. The issue identified within the pre-birth assessment literature by Calder (2000 and 2003) and Hart (2000 and 2010) that the mother may attempt to avoid assessment by moving area was not something the interviewees regarded as a particular concern either. Access to housing and financial benefits were regarded as the primary factors in preventing families attempting to avoid assessment by moving area and access to medical support, particularly during labour, made mothers traceable if they did try and avoid LA intervention. Not being able to apply to court until birth was, however, seen as something of an issue by all but one of the interviewees and concerns were identified with regard to parents attempting to remove the baby from hospital before an order was granted.

In the in-depth study of cases there were varying degrees of information on the files to indicate the extent of the involvement of other agencies in the pre-birth assessment. However, in interviews, all of the social workers spoke of involvement with other professionals indicating a regular and comprehensive approach to multi-agency working in the pre-birth stages. Not surprisingly, midwives were referred to most often but a wide range of professionals, including probation officers, interpreters and housing officers, were also reported to be involved in the multi-agency support and assessment process.

When it came to describing the assessment process there appeared to be no one single approach adopted and none of the social workers identified relevant literature or research specific to pre-birth assessment work. Each interviewee spoke of meeting with the mother to obtain their views and to gain an understanding of their history and circumstances. The social workers also spoke of involving fathers if the father was known but one social worker spoke of a notable exception (*Harvey* in the in-depth study) where there was considerable information already available to indicate the father posed a serious risk of violence to professionals. When analysing the interview transcripts the information relevant to involving parents in the pre-birth assessment process seemed to be linked primarily to the *Assessment Framework* (DH 2000) domain of *Family and Environmental Factors*. However, there was also evidence of attempts to gather information relevant to the *Assessment Framework* (DH 2000) domain of *Parenting Capacity*. In cases where there were older siblings, parenting capacity, as it related to the pre-birth assessment, was often based on observation and historical information relating

to the care of the older siblings. However, in first pregnancy cases, there was more emphasis on trying to predict parenting capacity and here there were notable differences in social work approaches. One interviewee spoke of the importance of parents being able to demonstrate competence in practical tasks such as making bottles and this forming a routine part of pre-birth assessments whereas another social worker was of the view that mothers could readily learn practical skills and therefore the focus should be on assessing ability to offer protection to the baby.

The LA's ICS compliant CA was universally regarded by the interviewees as unhelpful in that it was not easy to fit the information gathered in a pre-birth assessment into the pre-determined boxes. What was evident was that the interviewees chose to use the *Assessment Framework* (DH 2000) domains as a guide to gathering information and then record their assessments in word processed documents. This is perhaps a refreshing finding given that the philosophy underpinning the *Assessment Framework* (DH 2000) is that it should be adapted to suit the individual needs and circumstances of each child and family. The complexity of pre-birth assessment is perhaps one reason for social workers not feeling the CA pro-forma adopted by the host LA was appropriate. The interviewees spoke of not actually having a baby to observe as factor which made pre-birth assessments challenging. However, considering the stories of the cases in the in-depth study and the finding that only the most concerning cases ever achieved the 'status' of allocation, it is probable that not having a baby to observe was one complexity amongst many others. Another interesting issue which arose in the interviews was one social worker who had clearly divorced the process of gathering and analysing information which could be used to inform plans at birth from the end product of assessment. In this instance 'assessment' was the written document that resulted and not a skill inherent within professional practice.

In conclusion what the interviews highlighted was that pre-birth assessment is regarded as complex process and one that typically required the social worker to draw on a range of pre-existing skills developed in more general assessment work. The *Assessment Framework* (DH 2000) was regarded as a useful starting point for structuring pre-birth assessments but the ICS compliant documents were seen as unhelpful as they were restrictive and not easy to adapt to fit the individual family information. Moreover, all of the social workers interviewed were grappling with the complexities of pre-birth assessment whilst also dealing with other complex work and large caseloads.

Chapter 10

Analysis and Critical Discussion of the Research Findings

10.1 Introduction

The preceding chapters have mapped my journey from my original interest in pre-birth assessment and my literature review through to data gathering of various kinds in order to address my overall research aim and research questions. This chapter begins by looking back at my starting point, the platform upon which the entire research was based and which, therefore, underpins the final analysis. The chapter moves on to look at the findings from the three phases of the research and discusses how the national picture and Local Area Safeguarding Children Boards procedures interlink and impact on front line practice in one LA. Thus this chapter comprises a critical discussion of the research findings, with reference to the literature reviewed in chapter 2.

10.2 Starting out and the analytical approaches

My interest in pre-birth assessment has been long standing and grew from two cases in particular, both discussed in more detail in Chapter 1. The first was a pre-birth assessment I completed as a social worker involving a teenage mother living in LA care. In this case the baby was removed at birth, which highlighted for me the emotive nature of pre-birth assessment as well as the complexity of the task. The second case arose when I was a manager and supervised a social worker who undertook a pre-birth assessment that concluded with the mother keeping her child. This was the mother's second child, her first having been removed. This case highlighted how different social workers can draw significantly different conclusions about a family's circumstances which set off a chain of life changing consequences for those involved.

Several years after my involvement in the above cases I was in the fortunate position of being able to undertake full-time PhD studies on pre-birth assessment. When conducting the early stages of the literature review it soon became apparent that, whilst there is a wide body of literature relating to social work assessment, the literature specific to pre-birth assessment is

limited to Corner (1997) Calder (2000 and 2003), and Hart (2001 and 2010). Given my practice experience and the lack of directly relevant literature I arrived at the research aim of:

To explore what is currently known about pre-birth assessment within the context of Local Authority social work practice.

While I was engaged in the early stages of the PhD the case of Fran Lyon, a young mother who had been the focus of a pre-birth safeguarding conference in Northumberland, was in the media. Fran Lyon alleged social workers were planning to take her baby at birth based on a pre-birth assessment which she felt drew on incorrect and inaccurate information about her (ITV, 2007). The media focussed on Fran Lyon's rights as a mother and highlighted again the emotive nature of potentially separating a mother and child at birth.

I felt an exploratory study was appropriate because pre-birth assessment was a relatively un-researched area and I identified the following research questions:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

ii) What are Local Authority processes in relation to pre-birth assessment?

iii) What are social workers' views about pre-birth assessment?

iv) How do social workers approach the task of pre-birth assessment?

In order to address these questions my research design comprised three distinct but interconnected phases. Looking first at the national picture, with the purpose of exploring the legal and procedural framework surrounding pre-birth assessment practice in England, Phase 1 was to act as a platform upon which to build the following two phases. In Phase 2 Local Safeguarding Children Board (LSCB) procedures were surveyed with the purpose of exploring how the national framework translated into procedures which reflected local needs. The third phase comprised a case study within one LA, which itself involved various elements, including gathering information about pre-birth assessment referrals, undertaking a more detailed study of a small sample of cases and conducting interviews with social workers. A mixture of quantitative and qualitative data were collected and subsequently analysed.

In the context of pursuing an exploratory study through a social constructionist lens, I felt a mixed methods approach was most appropriate as this allowed me to consider my chosen topic from several perspectives, thus enhancing data triangulation. The research methods chosen were:

- Documentary analysis of national documents (legal and procedural documents), local authority area documents (LSCB procedures) and case specific documents (case files);
- An audit of referrals in one LA over a six-month period;
- Semi-structured interviews with social workers in one LA.

Cresswell and Clark (2011) comment that data analysis can occur at multiple points in a research project and Gibbs (2007) states that analysis should start when data gathering starts. My own research involved data analysis from the start with information gathered during Phase 1, for example, being used to inform the data templates used in Phases 2 and 3 and the interview schedule for Phase 3. Thus there has been on-going analysis of emerging data which has subsequently shaped the final findings.

As I dealt with relatively small quantities of data I opted not to use computerised data analysis programmes, instead choosing to use the data templates (see appendix 1 & 2) to organise manually information gathered from documents and case files. The national documents drawn on during Phase 1 and described in Chapter 4 were read for key themes and references relevant to pre-birth assessment. The data gathered in Phase 1 informed the data tools used in Phase 2, the documentary analysis of LSCB procedural guidance in England and the six-month audit in Phase 3.

Data gathered in relation to the sample of seven cases were in the form of detailed field notes and the transcripts of interviews with social workers. As Gibbs states:

The idea of analysis implies some kind of transformation. You start with some (often voluminous) collection of qualitative data and then you process it, through analytical procedures, into a clear, understandable, insightful, trustworthy and even original analysis (Gibbs, 2007, p 1)

I aimed to transcribe the interviews as quickly as possible after each interview took place in order to ensure I remembered and tried to capture any inference or context which may be forgotten over time. Mishler (1991) draws parallels between a transcript and a photograph in that a multi-dimensional conversation is turned into a one dimensional written record and I was conscious of this as I undertook the immense transcription process. I therefore aimed to transcribe the words and language used as closely as possible but, as Gibbs (2007) comments, people do not always speak in a manner which follows the constructs of written language. I therefore recognised that, when adding punctuation, there was potential for the contextual meaning of comments to be changed. However, as I completed all of my own transcriptions, the process also provided the opportunity to become familiar with the data and begin the process of analysis.

The final stage of the analysis involved a process of 'playing' with the data, exploring how various elements did or did not interlink with each other, thinking about how the emergent themes related to the literature review as well as to each other. This process assisted in my development of the final analysis which is presented in the remainder of this chapter.

10.3 Findings from phase 1: The national picture

Phase 1 of the research explored the national picture and considered the research question:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

The purpose of this phase was to explore the legal and procedural framework within which social work pre-birth assessment practice sits. The literature review identified that the English legal and procedural framework surrounding pre-birth assessment has evolved from a historical backdrop that has its origins in ensuring a healthy workforce for an industrialised nation. The work of charitable organisations in the 19th century highlighted the middle class concern about child cruelty and neglect amongst the poorer classes with early legal interventions to protect children reliant upon the use of animal cruelty laws. In 1889 the NSPCC was founded and became the principal agency in the development of child protection policy and procedures (Parton 2007; Ferguson 2004). By the 1940s there were changes in social attitudes with the creation of the welfare state (see Ferguson 2004; Parker 1995; Parton 2007; Fraser 2009) and access to maternity care for all women throughout pregnancy. The 1960s saw a shift from child protection with a criminal perspective to the notion that abuse could be diagnosed and treated (Parton 2006) but this began to change following the death of Maria Colwell.

The enquiry following the death of Maria Colwell in 1973 (DH 1974) was critical of social workers and NSPCC inspectors and highlighted a lack of inter-agency systems for dealing with child abuse (Parton 2006). Subsequent child death enquiries raised questions about professional intervention and the media portrayal was that professionals were to blame, resulting in moves toward strengthened procedures and the control aspects of social work (Munro 2008). However, in 1987 the news of child protection practice in Cleveland raised questions about professionals over-reacting, highlighting the need for a balance between protecting children whilst at the same time protecting families from over intrusive interference (Frost and Parton 2009). The resultant Children Act 1989, rather than focusing solely on child protection, placed wider emphasis on the provision of services to children in need, with the definition of need including health, development and disability (Frost and Parton 2009). In

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2000 news broke of the death of Victoria Climbié and the subsequent inquiry by the Lord Laming highlighted systemic failures across agencies responsible for protecting children (Cm, 5730, 2003). Recommendations were made relating to greater accountability of agencies and a strengthening of interagency recording procedures and further legislation followed in the form of the Children Act 2004 (Corby 2006). The 2004 Act did not change the Children Act 1989 but focussed on administrative functions and further guidance followed with another edition of *Working Together* (HM Government 2006). Plans were also made to improve electronic recording systems to ensure children could not fall through the safety net of professional involvement (Cleaver *et al* 2008).

The literature review identified how child death enquiries and socio-political influences have shaped a legal and procedural framework which contains the principle of promoting the well-being of all children and protecting the most vulnerable. However, while the unborn child does not have the status of personhood (Hart 2001) and, therefore the Children Acts 1989 and 2004 do not apply pre-birth, the statutory guidance *Working Together* made clear statements that procedures and timescales relevant to children also applied to the unborn child (HM Government 2006, 5.14). Alongside the statutory guidance stating that when working with unborn children professionals should follow the same procedures and timescales was a growing knowledge and understanding of fetal development. Increased understanding of the impact of maternal drug and alcohol use during pregnancy along with a growing knowledge base surrounding pre and post-birth brain development has highlighted the importance of early intervention and support. However, although *Working Together* (2006) was a substantial document of 239 pages, the guidance relevant to unborn children was limited to just three points:

- 1) Neglect can occur during pregnancy as a result of maternal substance abuse. (HM Government 2006, 1.33)
- 2) Procedures applicable to children are also applicable to unborn children. (HM Government 2006, 5.14)
- 3) Where there are concerns that an unborn child may be at future risk of harm an initial child protection conference can be convened prior to birth. (HM Government 2006, 5.140).

Whilst the above represent minimal comments, the implications of the comments are wide reaching in that they made it clear that all of the statutory procedural guidance contained in *Working Together* (HM Government 2006) applied equally to unborn children in the same way as to all children. However, inherent within the above three points of reference, was the assumption that what applied for a child could be applied pre-birth. Analysis of other legal

frameworks aside from the Children Acts 1989 and 2004 began to highlight the complexity of pre-birth assessment and how extending the existing procedures to cover the needs of unborn children is not a straightforward matter.

Working Together, in its various editions, is a document which 'sets out how organisations should work together to safeguard and promote the welfare of children' (HM Government 2006, p9). In doing so it pays no attention to maternal rights, and in particular the mother's right to make choices about what happens to her own body and subsequently that of the unborn child's. Throughout the research process as a whole I have 'dipped into' and subsequently resisted the temptation to engage in ethical analysis linked to literature surrounding the abortion debate as I feel this extends beyond the remit of my current study. However, the door to this debate does need to be at least opened as it highlights the anomalies inherent within the legal and guidance framework surrounding pre-birth assessment. The Human Embryo and Fertilisation Act 1990 reduced the time limit for termination of pregnancy to 24 weeks to reflect the stage at which a fetus is viable. Pre-birth assessment early in pregnancy may afford a woman the right to choose termination in situations where the outcome would be removing her child at birth. Whilst this notion sits comfortably with the maternal right to choice it does not allow for the notion that during the remainder of the pregnancy the mother and family may make changes which result in a different assessment outcome. Equally, the notion of terminating a pregnancy does not fit at all alongside the notion contained within *Working Together* (HM Government 2006) that:

Where there is risk to the life of a child or likelihood of serious immediate harm, an agency with statutory child protection powers **should act quickly to secure the immediate safety of the child** [guidance emphasis in bold]. (HM Government 2006.5.49)

Considering the right of a mother to seek a termination of her pregnancy alongside the statutory guidance for professionals working with children makes it very clear that the notion of an 'unborn child' is something of an oxymoron. The statutory guidance as it applies in the first 24 weeks of pregnancy is, therefore, questionable as it does not address how professionals should deal with situations where termination may be the mother's chosen response to a pre-birth assessment. In turn, this also raises questions surrounding the impact the individual views and opinions held by social workers may have on assessment recommendations and decisions. For example, could a social worker with strong anti or pro-abortion views ever conduct an objective, early pregnancy, pre-birth assessment?

Although the statutory guidance pays no heed to the wider legal framework as it applies in the first 24 weeks of pregnancy the situation is no clearer even after the 24th week. The notion that neglect can occur as a result of substance abuse (HM Government 2006, 1.33) is equally

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embedded with the notion that maternal choice is not something which has any validity in pre-birth assessment. What constitutes 'substance abuse' is not defined and so leaves professionals with no clear guidance when faced with making judgements. For any child the threshold beyond which a child is deemed to be neglected is always difficult to establish and is often embedded within socially constructed notions of what is and is not acceptable. Establishing such thresholds during pregnancy is not only embedded within a framework of socially constructed ideals but is also subject to changes in medical knowledge. As was highlighted in the literature review, it is within fairly recent history that the development of x-rays and ultrasound has increased awareness of the impact maternal health has on the health of the unborn child (Kent 2000). However, despite developing knowledge about maternal health, in England at least, there has been no link made between maternal actions and choice during pregnancy and child protection other than the link between neglect and substance abuse made in *Working Together* (HM Government, 2006).

The issue of maternal choice is however only one aspect of the argument. The context and driving principles of the statutory guidance is the safeguarding and wellbeing of all children, including unborn children. Limiting comment regarding neglect and early intervention in statutory guidance to the extent identified above negates the significant body of knowledge relating to fetal development and the importance of the first years of life for long term wellbeing. As was identified in the literature review, since the 1960s and the recognition that prescription of Thalidomide during pregnancy caused birth deformities (Thalidomide Trust, accessed online November 2011) and the 1970s when awareness grew regarding fetal alcohol syndrome (see Jones and Smith 1973 and Jones *et al* 1973) there has been a growing awareness of the impact of substance use during pregnancy. Studies of brain development have not only demonstrated that brain cells (neurons) are formed between the sixth and eighteenth week after conception (Belsky and de Haan 2011) but that the brains structure and functions are highly dependent on early parenting and emotional experiences (Ward and Glaser 2010). As such there is a legitimate and important rationale for pre-birth assessment and early intervention with regard to securing and protecting the long term needs of the child.

I feel the underlying issue surrounding the national guidance relevant to pre-birth assessment is the same issue the House of Lords grappled with when considering the stabbing of a pregnant woman and the subsequent death of her child. Namely that an unborn child is a '*unique organism*' and:

To apply to such an organism the principles of a law evolved in relation to autonomous beings is bound to mislead. (UK House of Lords Decisions 1994. no page number)

However, regardless of the unique status of the unborn child, social workers are charged with the responsibility of completing pre-birth assessments of children and their families and do so using the *Assessment Framework* (DH 2000). Issued under section 7 of the Local Authority Social Services Act 1970 the *Assessment Framework* (DH 2000) should be complied with unless there are exceptional circumstances which indicate otherwise. Like the Children Act 1989 and the *Working Together* (HM Government, 2006) the *Assessment Framework* (DH 2000) embodies the principle of promoting the welfare of children as opposed to focussing a narrow and forensic view on child protection and yet for unborn children there is no clarity regarding what constitutes wellbeing. This places social workers and other professionals in a position of interpreting the notion of pre-birth welfare of the child and then adapting the legal and procedural framework accordingly.

Following the death of Victoria Climbié the report by Lord Laming made recommendations for greater accountability of agencies and strengthening of interagency recording procedures (Cm 5730, 2003 and Corby 2006) and, as such, the introduction of the Integrated Children's System (ICS) was part of plans to ensure children could not fall through the safety net of professional support. In 2003 ICS compliant exemplar forms were produced based on the three domains of the *Assessment Framework* (DH 2000). For unborn children the *Referral and Information Record*, (DH 2003, see appendix 8) and the *Initial Assessment Record* (DH 2003, see appendix 9) do not differentiate between pre and post-birth. However the *Core Assessment Record* (DH 2003, see appendix 3) was split into age ranges and covers pre-birth to one year. Although exemplar forms have been produced the *Assessment Framework* (DH 2000) is not designed to provide step-by step assessment procedure and the assumption is that assessments should be adapted and used to suit the individual needs and circumstances of each child and family being assessed (DH 2000). Therefore, although the statutory guidance is unclear in relation to pre-birth assessment, when it comes to the actually conducting assessments, social workers have professional scope to adapt the assessment tools to fit. However, the point at which professional autonomy can flourish and the point at which professionals are left unsupported by policy is a complex one.

Lipsky (1980) identified that street level bureaucrats interpret and apply policy and in so doing exercise discretion in determining the delivery of services. In this respect social workers using the *Assessment Framework* (DH 2000) do so within a context of procedural guidance which encourages professional autonomy and discretion. However, Hart (2003, unpublished thesis) found the complexity of pre-birth assessment was compounded by the lack of clear mandate for intervention. With the unborn child having no legal rights social workers are placed in the position of interpreting and implementing guidance that ignores the legally enshrined maternal rights to choose what happens to her body. In a critique of street level bureaucracy, social

work and discretion Evans and Harris (2004) analysed how managerial systems can be regarded as curtailing professional autonomy by requiring adherence to procedural guidance. However, Evans and Harris (2004) also identified that the creation of policy actually creates an environment within which discretion and street level bureaucracy flourish by virtue of requiring social workers to adapt policy to fit complex individual circumstances. With an unclear mandate for intervention social workers conducting pre-birth assessment have to adapt policy derived from a socio-political drive to protect children within a legal framework derived from the principle of a woman's right to choose what happens to her body. As such the statutory guidance is highly confusing with minimal, but none the less significant, attention paid to unborn children. Social workers are required to make sense of information about the family and then follow confusing procedural guidance and so will inevitably need to use discretion in how they do so. However, before moving on to consider how front line social workers make sense of this ambiguity, Phase 2 of the research considered how national guidance was interpreted and turned into local guidance by senior professionals with strategic responsibility for children's services.

10.4 Findings from Phase 2: Local Area Safeguarding Children Boards

The documentary analysis of a 100% sample of Local Area Safeguarding Children Boards (LSCB) procedures in England was designed to build on Phase 1 and considered how the national framework translated into local procedural guidance. Phase 2 therefore related to the research questions:

i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?

ii) What are Local Authority processes in relation to pre-birth assessment?

The Children Act 2004 introduced changes in the administrative functions surrounding children's services and LAs were given the task of establishing LSCBs. On the 1st April 2006 statutory LSCBs replaced the non-statutory Area Child Protection Committees and embodied the principle that multi-agency co-operation should span all levels of children's services. *Working Together* (HM Government 2006) provided clear guidance that LSCBs should reflect local services and local needs and members should hold strategic responsibility for the agency they represent. A key function of LSCBs is to devise procedures and guidelines for all agencies and individuals working with children within each LSCB area and to set out thresholds for referrals to children's social care and the process of multi-agency assessment (HM Government 2006, 3.19). In essence, therefore, LSCB procedures sit at the interface between the national

legal and procedural framework and provide the framework for Local Authority processes in relation to pre-birth assessment.

The purpose of a 100% sample was to reflect the different demographic factors across England which may impact on LSCB procedures. The first finding was that some neighbouring LSCBs had joined forces in developing local procedures and so in April 2008, the 144 LSCB areas were covered by a total of 73 sets of procedural guidance. At the start of the documentary analysis I anticipated the LSCB procedures would, at the very least, replicate the guidance contained in *Working Together* (HM Government 2006). However, I found seven sets of procedures (10%) had no reference to unborn children at all. Sixty six of the 73 sets of procedures (90%) contained references that indicated the procedures did apply to unborn children, with 24 (36% of the 66 sets or 32% of the total 73 sets) containing either exact replication or paraphrased versions of paragraphs 5.14 and 5.140 of *Working Together* (HM Government 2006). Forty two (64% of the 66 sets or 58% of the total 73 sets) went beyond just replicating national guidance and attempted to provide more in-depth or locally relevant guidance. It was not possible to compare LSCB procedures directly as they were produced in a range of different formats such as word processed documents, PDF documents and electronic databases. However, it was evident that in the 42 sets of procedures which did provide additional guidance that the quantity and content of information relating to unborn children varied significantly.

Whilst there was variation in the 42 sets of procedures that contained additional information, the themes of well-being and welfare were evident, even in those that provided only modest additional information. The following examples (also quoted in Chapter 5) highlight the use of terminology focussed on support:

Pre-birth core assessments may be carried out following a referral from a professional who is concerned that prospective parents may need support to care for their baby, without which they may not be able to provide for the baby's well-being and welfare, or where there are concerns the baby may be at risk of significant harm.

(Wigan Safeguarding Children procedures accessed online April 08)

And

It is vital that assessments are started early and that information is shared so that the child and family have the necessary support and best start to family life thereby minimising the need for child protection intervention.

(South West Safeguarding Children Procedures accessed online April 08)

What the above quotes demonstrate is how the language of well-being and welfare and support builds on the core legal framework of the Children Acts 1989 and 2004 and permeates LSCB procedures.

One LSCB which had expanded guidance was Northumberland who had received media attention following their involvement with Fran Lyon in September 2007. Fran Lyon had gone to the media following a pre-birth child protection conference and she alleged the plan was for social workers to remove her baby at birth. In a press release the Chair of Northumberland LSCB outlined how, due to legal reasons, only one side of the case was heard in the media (Doughty 27th November 2007). Whatever the actual circumstances of the case Northumberland LSCB did attempt to provide comprehensive guidance to professionals in the local area for completing a pre-birth assessment and so this may be an example of procedural development being influenced directly by media and public interest in social work practice.

Another set of procedures stepped into ethically 'dangerous' areas with the comment:

Wherever possible, the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to Children's Social Care, unless this action may place the unborn child at risk, for example, through termination of the pregnancy or the parent(s) possibly making their whereabouts unknown.
(North Yorkshire LSCB procedures)

The above quote, I feel, sits at the heart of the ethical debate surrounding maternal rights and choice, which was found in Phase 1 not to be addressed in the national guidance. However, in stepping beyond the basic guidance and in attempting to address the issue of termination of a pregnancy North Yorkshire's LSCB procedures highlight how this is not a simple matter. Whilst the above quote provides some guidance to professionals it is embedded within the view that a termination of pregnancy is a 'risk' to the unborn child. Arguably this is an inherently anti-abortion stance and one which can be seen to deny maternal rights. In doing so there is an argument to be had that the procedures are inherently oppressive in the denial of a woman's right to choose, a right which is legally given.

In conclusion therefore, Phase 2 of the research identified that the majority of LSCB guidance at least replicated national guidance, with just over half of the LSCB procedures attempting to provide additional guidance. The extent of the additional guidance was variable but what was consistent throughout was language and emphasis on promoting the welfare of all children. However, as with the national guidance, the fundamental issue of the unique situation of the unborn child and the maternal rights were not addressed. Nor was comment made with regard to the importance of early assessment in the process of predicting situations where maternal substance use, the mother's own childhood experience of attachment or wider social factors might compromise parenting.

Findings from Phase 1 and 2 seemed to indicate that, from a perspective of street level bureaucracy, front line social workers would not only be having to adapt policy to meet the needs of a particular aspect of service but, by virtue of the lack of clear legal and procedural guidance, would be having to create policy. Lipsky argues that there is a core of discretion in street level bureaucracies which is essential to make policy work (Evans 2011). Considering the tensions within Lipsky's theory Evans (2011) highlights how critics argue that street level bureaucracy provides a boost when advocating for professional discretion. However, when applying Lipsky's theory to pre-birth assessment, discretion is the only option open to professionals given the absence of clear procedural guidance. Moreover, Lipsky suggests management focus is on results consistent with the agency objectives:

They are concerned with performance, the cost of securing performance, and only those aspects of process that expose them to critical scrutiny. (Lipsky, 1980 p19)

With an assessment framework set within the context of safeguarding live children, pre-birth assessment activity should, arguably, not occur pre-24 weeks' gestation as this exposes elements of critical scrutiny linked to abortion legislation and debates. However, in relation to a post 24 week gestation pre-birth assessment the situation seemed no clearer. Pre-birth assessment is not particularly unique with regard to social workers acting as street level bureaucrats applying unclear frameworks for intervention with children. However, what is significant is that the legislation designed to safeguard children, the Children Acts 1989 and 2004, do not apply pre-birth. Added to this national statutory guidance was confusing and local guidance ignored or added to the confusion. In this respect pre-birth assessment occurs within a national framework which is fundamentally confused but which requires social workers to make sense of the confusion and apply the guidance appropriately.

Having identified the theoretical position social workers would occupy in relation to implementation of policy I now turn to the findings of Phase 3 based on case study of on LA.

10.5 Findings from Phase 3: The case study in one Local Authority

The findings from Phase 3 are drawn, firstly, from the six-month audit of all pre-birth referrals made to the host LA between the 1st October 2008 and the 31st March 2009 inclusive. The second stage of the case study in the host LA involved a documentary analysis of seven cases selected against a set of pre-defined criteria designed to capture a cross section of pre-birth assessment activity and the final stage of the case study involved semi-structured interviews with the case-holding social workers for those cases.

The case study of one LA was devised to address research questions:

ii) What are Local Authority processes in relation to pre-birth assessment?

iii) What are social workers' views about pre-birth assessment?

iv) How do social workers approach the task of pre-birth assessment?

The national and LSCB procedures indicated that social workers would be approaching pre-birth assessments from the perspective of an unclear guidance framework. The *Assessment Framework* (DH 2000) provided a structure to support a holistic assessment process but which also allowed for considerable professional discretion in the gathering and analysis of information about families. The literature review had highlighted that there were many factors which influence how social workers approach assessments. Horwath (2007) suggests that personal, professional and organisational factors all have an influence on the assessment process whilst Holland (2004) and Platt (2007) commented upon how social workers' perceptions of parental co-operation could also influence assessment outcomes. Therefore, drawing on my practice experience, the literature review and early findings from phase 1 and 2 I anticipated social workers would make use of the *Assessment Framework* (DH 2000) but that I would see many adaptations of it to fit the particular pre-birth needs of the referred families.

The host LA was fairly typical of many other LAs in England in that it covered city, town, urban and rural communities. Changing employment opportunities within the LA boundary meant there were some areas of economic affluence as well as deprivation and poverty. The LA children's services social work teams followed a model of intervention based on generic cover for emergency and duty intervention, with specialised children and family teams dealing with Initial Assessments (IA) and short term intervention, Core Assessments (CA) and longer term intervention and Looked After Children (see Chapter 6 for a comprehensive description of the team structures and staffing). Based on my practice knowledge, the literature review and my research of LSCB procedures there was nothing to suggest the host LA's approach to pre-birth assessment would be particularly different to that of other LAs. However, what was quite unusual was their approach to electronic recording and case files, which proved to be both interesting and challenging from a research perspective.

Along with all LAs in England, the host LA was required to comply with the Integrated Children's System (ICS) and in doing so had opted to take the additional step of creating a paperless office. On the 1st April 2008 (six-months before I began data gathering) the host LA began the process of scanning all paper files and converting them into electronic files and shredding all paper based information. When I began data gathering I was faced with an electronic system (capable of storing everything from reports and case notes to photographs and drawings) and an office environment devoid of filing cabinets; not a world of which I had

any prior professional experience. The paperless office quite clearly had a direct impact on the host LA's process in relation to all assessment and intervention work with children of all ages although my focus was the impact on cases referred pre-birth.

In the following sections of this chapter I consider findings in relation to each of the stages of the case study, attempting to separate out those which seemed to be the result of the impact of the paperless office and those which related to social work approaches.

10.5.1 Audit Findings

The host LA had adopted the series of ICS pro-forma (DH 2003) as their template for recording referrals, IAs and CAs. Each pro-forma had been re-created as electronic pages on the electronic database (EDB). The first pages, containing the referral information, required the Access Point social worker to record basic information relating to names addresses, date of birth/expected date of delivery, dates of birth for the parent(s) and details relating to ethnicity. The referral form was used for all children's referrals and there was nothing to distinguish a pre-birth referral other than the recording of the expected date of delivery rather than date of birth. The reasons for the referral were interpreted and converted, by the Access Point social worker, into a series of pre-defined categories with one free text box to summarise, in approximately 150 words, the information provided by the referrer. The initial referral information provided the core of data for the six-month audit along with data relating to the case trajectory from point of referral to birth (or case closure if that occurred pre-birth).

One of the key findings from the audit was that it was impossible to arrive at a definitive figure which represented the volume of pre-birth activity in the host LA. My figure of 56 pre-birth cases identified in the six-month audit was at odds with the 49 cases the EDB had recorded. A difference of 7 cases over such a short period of time is not insignificant and as I also found one case, '*Zalika*', that was not recorded on the system at all (pre or post-birth), it was evident the amount of pre-birth assessment activity could not accurately be measured. This is not to suggest a paper based system would have been any more accurate, but what my findings indicate is that the EDB was not creating consistency in even the most basic of data surrounding numbers of pre-birth cases.

Another area of inconsistency was in the information recorded about parents. The majority of referrals were for families of white British origin although in 10 cases (18%) no ethnicity was recorded. All of the referrals had basic details about the mother's name and address but maternal age was not recorded on 15 (27%) of the referrals. The details of the father were not recorded at all in 31 (55%) of the cases. On the one hand, it may be a matter of lack of

attention to detail or genuine gaps in the information about families with which the LA were working. However, it also raises questions which may be of a significant nature in relation to missing information about the fathers. With over half of the cases having no information about the father recorded this means either there were many single pregnant women or fathers were somewhat 'invisible' in LA involvement.

As the literature review identified, pre-birth assessment is somewhat different to assessments of children in that the father does not have rights until the child is born. As Barker (1997) pointed out a LA may choose to involve the putative father in actions concerning the unborn child but the father does not actually have any right to be consulted, even if married to the mother. However, paternal involvement and a lack of basic details on file about the father are two quite different issues, particularly given some of the findings relating to the reasons for the referrals. Issues of domestic violence and drug use by one or both of the parents were significant features in both the audit and the in-depth study of cases. Interestingly, at the time of the six-month audit news was breaking about the death of baby Peter Connelly and the issue about his mother having a male friend but his presence within the household and their relationship not being known. One of the key findings from the serious case review into Peter's death was that despite a great deal of professional input the nature of the relationship between Peter's mother and her partner remained unknown (Haringey LSCB November 2008). Likewise, Lord Laming's report '*The Protection of Children in England: A Progress Report*' (HM Government 2009) highlighted that effective multi-agency working and information sharing was essential in the process of protecting children living with issues of domestic violence and drug use. A report by Ofsted which considered 482 serious case reviews carried out between April 2007 and March 2011 identified that in cases for babies less than one year old the role of fathers had been marginalised (Ofsted 2011). Yet in the host LA the most basic information about the father was not recorded creating the potential for key information central to the unborn child's life and circumstances being lost or overlooked entirely. Within this context it must, therefore, be regarded as noteworthy that over half of the pre-birth case records in the host LA contained no details regarding fathers, let alone men known to the mother and that such an omission is indicative of a primary focus on the mother possibly at the expense of an understanding of the wider picture.

When considering where the referrals came from it was evident there was a wide range of sources including self-referrals, referrals from probation services and housing agencies to name but a few. This potentially indicates a multi-agency awareness of the importance of alerting children's services to concerns. The majority (27%) of referrals, however, came from midwives, something which is perhaps not surprising given their role in supporting pregnant women. The second highest referring group were social workers in the host LA (23%) who

were already involved with older siblings. What this data demonstrated was that there was evidence, right from the beginning, of multi-agency involvement during the pre-birth period and that a high percentage of pre-birth referrals related to families already known to the LA.

The type of information which would trigger a referral was interesting along with how this information was subsequently treated, particularly in relation to the process of case categorisation. As stated earlier, the Access Point social worker was required to complete certain data fields when dealing with a referral. At the time of the audit, the host LA routinely submitted the figures drawn from the EDB to central government as part of national statistical data relating to children and families. One key area of data related to children in need and so one data box comprised a drop down menu corresponding to the primary need of the child as defined by the Department for Children Schools and Families (DCSF 2008). The categories were:

- N0 Not stated
- N1 Abuse or Neglect
- N2 Child's disability/illness
- N3 Parental illness/disability
- N4 Family in acute stress
- N5 Family dysfunction
- N6 Socially unacceptable behaviour.

The most commonly chosen categories were Abuse or Neglect with 21 or 38% of referrals being categorised in this way and 17 (29%) were recorded as not stated. The next largest category chosen was Family Dysfunction with eight (14%), with the remaining 10 referrals being spread across the other seven categories. As well as the *Child in Need* codes cases were also categorised in another data box with a drop down menu comprised of a further 36 categories. The full list of categories and data breakdown of how they were used is held on page 138 table number 7 but what is of note is that the largest category was Child Protection which accounted for 37 (66%) of referrals, suggesting the majority of referrals were defined as a child protection, as opposed to a child in need nature.

Alongside the fixed data boxes the social worker taking the referral also completed a free text box summarising the detail of the referral. What became apparent in the analysis of information in the free text box was that there was a lack of consistency in what type of information constituted child protection. For example one referral categorised as '*Child Protection*' stated nothing more than '*as per policy all referrals need to be recorded on the system*'. Another which had been categorised under the drop down menu of 36 categories as

'*general concern*' contained free text information indicating concerns (amongst other factors) about paternal and paternal grandparents' use of drugs; information which could suggest child protection concerns.

There are a number of underlying reasons why there was an emphasis on information being categorised as child protection, the first of which relates to content of the primary information and how it was socially constructed and then assimilated into categories. The first stage of the information filtering process occurs when the referrer decides what information reaches their threshold for further intervention and then what information to pass on to Children's Services. The second stage of filtering occurs when the Access Point social worker interprets the verbal information and then converts it into written information on the EDB. Any number of subjective factors may impact on the process of category selection including the experience and knowledge base of both parties involved in the initial referral discussion. As Horwath (2007) identified factors such professional and organisational issues may impact on assessments and it is quite probable that a wide range of factors including team dynamics, individual use of the EDB and the numbers of referrals made could all impact on the categorisation process. Whatever the underlying reasons, what transpired was the LA figures indicated that the majority of their pre-birth involvement was of a child protection nature.

Evans and Harris (2004) considered the impact of managerial systems designed to curtail the scope for individual discretion and found that, paradoxically, increased elaboration of rules, guidance and procedures could actually create greater uncertainty and scope for individual discretion. By having the six nationally determined child in need categories combined with a further 36 locally defined categories the LA had created an environment where multiple options for case categorisation were available but there was no clear definition of what each meant. Therefore, each case was subject to interpretation based on individual and professional views about what each category could mean and, with some of the Access Point social workers being adult rather than child specialists, there was considerable scope for differing interpretations. Also, having to look through so many categories was time consuming and it is highly conceivable that a busy social worker might make quick category selections rather than spend time deliberating on what best fitted the referral information. Thus the managerial systems within the host LA which sought to record accurately the 'type' of cases could actually create uncertainty about how to label cases and hence increased optionality.

Whilst the LA version of ICS prompted early and complicated processes of categorisation it is important not to lose sight of the primary function of ICS. Cleaver *et al* (2008) stated that the purpose of ICS was to provide an electronic record of professional involvement, assessment, decision making and review from first point of contact to case closure. Forming part of the

wider remit of ensuring children achieve their optimum potential, the purpose behind ICS was to ensure information technology enhanced professional practice (Cleaver *et al.*, 2008). What transpired in the host LA, however, was that, throughout pre-birth involvement, there were key points linked to case transfer, allocation to a social worker and assessment where decisions were made. However, in the host ICS system, I found a lack of clarity and consistency about the basis on which decisions were made and thresholds reached.

A total of 20 referrals (36% of the 56 referrals) made to the host LA during the six month audit went on to have an IA and 15 (27% of the 56 pre-birth referrals) went on to have an IA and CA recorded on the EDB. However, the statistical data was only part of the story with the recorded decisions actually producing some interesting data. What emerged when looking in more detail at the case trajectories was that, whilst over half of the cases did result in an assessment, there was a wide range of possible actions following the assessment. Notable examples were cases which, having been assessed at the IA or CA stage as requiring further intervention, were either left unallocated or closed pre-birth without further assessment or intervention. At the same time 12 cases (21% of the total 56 referrals) had on-going intervention without any form of assessment appearing to take place.

Allocation pressures brought about by staff workload issues certainly accounted for some allocation decisions, something which became more apparent in the in-depth case findings discussed in Chapter 8. However, what the assessment and allocation decisions further highlighted was there were differing thresholds applied at different points in the case trajectory. As was found in Chapter 5, *Working Together* (HM Government, 2006) guidance detailed that LSCBs had a core objective of developing policies and procedures in relation to actions to be taken where there were concerns for a child as well as '*setting thresholds for intervention*' (HM Government, 2006, 3.18). Given that there are numerous points in the process of decision making when subjectivity can occur it is perhaps asking a great deal of LSCBs to set such thresholds. Also, given the workload pressures I observed brought about by the volume of cases, difficulties with the EDB and managerial decisions about agency staffing (see Chapter 6) it was not surprising that not all cases received full attention.

Pressures within the teams in the host LA apparently influence the level at which the threshold for assessment and intervention was set which in turn meant only the most concerning of cases were allocated. Broadhurst *et al* (2009) identified that during the initial stages of referral and assessment the teams they studied developed strategies such as deflecting cases back to the referrer for additional information in order to manage workloads and workflow. Broadhurst *et al* (2009) concluded that managerial systems which attempted to increase accountability potentially created conditions for error as social workers focus turned to developing systems to

manage the procedures rather than spending time with children. Sentiments echoed in the Munro report (2011) which identified managerial systems had become burdensome and prescriptive limiting the capacity of front line workers to engage with families. There was certainly evidence in my research that issues associated with electronic case management systems and processes echoed the findings of Broadhurst *et al* (2009) and Munro (2011) but from a Lipskyan perspective the issue resources is a key one. Hjärne *et al* commented that if *'demand and supply were in balance, no dilemma would exist'* (Hjärne *et al*, 2010 p 305) and Lipsky stated:

Bureaucratic decision making takes place under conditions of limited time and information. Decision makers typically are constrained by the cost of obtaining information relative to their resources, by their capacity to absorb information, and by the unavailability of information. (Lipsky 1980, p29)

Whilst there has been recent discussion surrounding the impact of managerial systems on social work practice a Lipskyan perspective suggest there will always be a dilemma with regard to resource allocation. As such thresholds for intervention will inevitably be an issue, the 'level' at which the threshold is set being the area of debate. With regard to pre-birth assessment this raises a particular issue with regard to the stage at which during pregnancy a referral is made. With case load pressures, it is not inconceivable that referrals made early in pregnancy could be regarded as less concerning because no immediate action was needed as the child cannot actually be protected until it is born. In situations where high thresholds for intervention exist in social work teams and allocation pressures prevail the need to intervene pre-birth is likely to be pushed along an axis which places allocation closer and closer to the expected date of delivery. In turn this has potential to condense the time available to assess a situation and, given the unpredictable nature of labour and delivery, place social workers in the position of completing difficult assessments in highly condensed time frames. However, this axis is somewhat at odds with research in the field of early child development which indicates the importance of attachment and parenting on brain development in the earliest months, pre-birth and post birth.

Research which highlights the impact of substance use during pregnancy (see Ward and Glaser 2010) and importance of parenting on brain development (see Belsky and de Haan 2011) highlight the significance of the pre-birth period as well as the first year of life in shaping the long term emotional needs and attachment patterns of the child. Likewise, literature drawn from the field of midwifery indicates the importance of the empowerment of women in terms of engaging them in the process of choice and solution to health related concerns (Portela and Sanatrelli 2003). It therefore seems counter-productive to securing positive outcomes at birth (positive either in terms of early intervention to remove a child from the care of the family and

place them in a secure foster placement where their emotional needs can be met or positive in terms of providing appropriate support to enable the mother to care for her baby) to leave pre-birth assessment to the latter stages of pregnancy.

In conclusion, what emerged from the six-month audit was that the actual level of pre-birth involvement and assessment activity was unclear and probably under recorded by the host LA systems. Whilst the national legal and procedural framework is one which has at the core the notion of promoting the well-being and welfare of all children the process of case categorisation and prioritisation in the host LA was one which focussed on child protection. In addition, the ICS, as embraced by the host LA, had been designed to support the decision making process to enhance professional practice but it emerged that basic and potentially key data were not always recorded. Therefore, with regard to research question *ii) What are Local Authority processes in relation to pre-birth assessment?* I found that pre-birth assessment work in the host LA was complex, with no clearly defined threshold for intervention.

10.5.2 In-depth analysis of 7 cases

The in-depth analysis of the seven cases was the point at which Lipskyan theory really came to the fore with much evidence of social workers interpreting the procedural context and creating policy to meet the specific requirements of pre-birth assessments. In particular, the key area where policy was most obviously created was in relation to what constituted the work of the teams, or perhaps more precisely, what met the threshold for pre-birth intervention. During the six-month audit of referrals the threshold for intervention was unclear with social workers and managers across the teams apparently interpreting information differently. During the analysis of the seven cases it became evident that what actually constituted meeting the threshold was very much focussed on cases where there were multiple risk factors and a likelihood of legal proceedings at birth or implementation of pre-birth safeguarding procedures. In other words, a narrow forensic approach to assessment and intervention focussed on child protection rather than supporting children in need was in evidence. Staffing issues may have been one of the reasons for this focus on child protection as only those cases which caused concern to the manager achieved the 'status' of allocated with the mechanism for determining what cases needed allocating being the ICS based IA and CA processes.

Initial and Core Assessments as a mechanism for determining allocation thresholds

When looking in detail at the six-in depth cases that had files, it was evident that the '*Referral and Information Record*' (DH 2003) focused on basic details with only a brief summary of information. However the IA which should be '*a brief assessment of each child referred to children's services with a request for services to be provided*' (DH, 2000, 3.9) also contained only a limited amount of additional information. Only four of the seven cases studied in-depth had an IA. Of those four, *Jodie's*, *Molly's* and *Harvey's* IAs contained significant amounts of information cut and pasted from the original referral document. The IA is defined by the DH as a tool for recording salient information and to assist in determining if a CA is necessary (DH, 2000 3.12) and so the cutting and pasting of information from the referral, to the extent it was, suggests a high degree of reliance was placed on the referral information being accurate. *Jodie's*, *Molly's* and *Harvey's* cases were typified by high levels of concern from the outset with issues of previous LA involvement, domestic violence and drug use all featuring in the concerns identified by the referrers and so it seemed that these concerns themselves triggered the IA conclusion that a CA was required. Thus completing the IA seemed more akin to a procedural process as opposed to an attempt to begin to understand the needs of the child.

There were some cases which had a CA conducted by the Initial Assessment Team. Whilst I was unable to get any clear rationale for why the Initial Assessment Team were undertaking CAs, management and team rhetoric suggested this was either to ease allocation pressures in the Family Support Teams or to increase the LA's figures on the numbers of IAs and CAs completed. One case looked at in-depth, *Jodie's* case, was one of the cases which had a IA and CA completed by the Initial Assessment team. *Jodie's* IA seemed to have been bypassed because it was recorded on the EDB as having been completed the same day the case was referred and passed to the Initial Assessment Team social worker. The CA was completed one week later and was based on one visit to the family home. The CA had information cut and pasted from the referral and although there was additional information gathered during the visit, in total, the CA comprised just 800 words. In this respect the CA did not appear to be fulfilling the aim of:

... an in-depth assessment which addresses the central or most important aspects of the needs of a child and the capacity of his or her parent or caregivers to respond appropriately to those needs within the wider family and community context. (DH 2000, 3.11)

On the contrary, it seemed that the host LA social workers and their managers appeared to have developed systems whereby the IA and CA were mainly being used to identify cases which required allocation. The written information contained on the IA and CA was central to

the decision by the Family Support Manager to allocate a case or leave it unallocated (although three cases remained unallocated throughout the pregnancy despite having an IA indicating allocation was appropriate). Family Support Managers also seemed to be deciding which cases should or should not be allocated to social workers for longer term involvement without discussion with the social worker who had completed the original assessment, so placing a high value on the written word. This again seemed at odds with the process of holistic assessment of the child's needs as identified in the *Assessment Framework* (DH 2000). In *Jodie's* case, for example, the Family Support Team Manager identified the case as meeting the threshold for possibly requiring a pre-birth safeguarding conference and decided it would be appropriate for allocation to a relatively inexperienced social worker. In making this judgement the manager engaged in an extremely complex process of analysis in balancing what he assumed the situation would be in several weeks' time when the baby was born and the skill level of the social worker, an analysis and decision making process all of which was based on an assessment of no more than the 800 words. What became clear, however, when the Family Support social worker began her assessment, was that the IA and CA had not conveyed the complexity of the situation and, had the case not been allocated, *Jodie* would have been at great risk if left in her parents' care.

There were also five cases which were transferred to the Family Support Teams but, based on the IA and or CA information, they were deemed not to meet the threshold for allocation. Two of the five cases were closed without further intervention and a further three were left unallocated throughout the pre-birth stage. It is conceivable, based on these case examples, that cases which did require child protection intervention were being closed. It also suggests that the focus was only on cases which raised the highest degree of concern (even though some were not allocated) and that the national procedural emphasis on promoting the welfare of all children was lacking in the host LA's Family Support teams' services.

Pre-birth initial and core assessments

In the six-month audit it became clear that not all pre-birth cases followed a simple trajectory of referral, IA and CA and when undertaking the in-depth study of the seven cases the notion of a clear definition of a pre-birth assessment became even more elusive.

Despite a high value being placed on the information contained in an IA or CA not all cases underwent the procedural process of transition through the stages of referral, IA and CA. Three of the seven cases, *Jodie*, *Molly* and *Harvey*, had an IA on file and of these only *Jodie's* case had an IA and CA on file. Cases where there was already social work involvement – the cases of *Amy*, *Jordan*, and *Bethany* - achieved the status of requiring allocation by virtue of

their siblings' situations and *Zalika* achieved the status of requiring allocation because of social work involvement with her mother who was a looked after child. In these four cases the social workers spoke of completing pre-birth assessments but the IA or CAs documents used by the host LA were not completed or recorded on the EDB in any way. In terms of LA systems unborn siblings did not present on the EDB as having an assessment of their individual needs but were merged in with their siblings' needs and information about them added into other reports (such as reports and minutes of child protection conferences) and case notes.

Thus there appeared to be two types of pre-birth assessment: those which were contained on the IA and CA forms and those which were not. Looking at those that followed the IA and CA format as identified above, they seemed more linked to the process of allocation as opposed to being a holistic assessment of need. This may be a direct result of the extent to which pre-birth assessment was addressed by the ICS IA and CA documents used by the host LA. On the IA there was nothing to prompt or direct the social worker to consider issues specific to the unborn child's circumstances and on the CA there were only two out of a total 24 pages of questions which related specifically to pre-birth assessment (see appendix 8 and 9). Chapter 2 identified that research into assessments conducted under the 'Orange Book' found that whilst the guidance offered some structure there was a tendency to use the guidance as a check list, which was not the intended approach (Katz 1997). With regard to the IA and CA documents sampled in this research there was evidence to suggest that in relation to pre-birth assessment the same tendency was occurring. This may have been because the IA and CA did not prompt the social worker to think about pre-birth assessment and because of the forensic approach to assessment but, whatever the reason, the outcome was that unborn children were not getting a holistic assessment of their individual needs when the assessment was completed using the IA and CA paperwork.

A requirement of the IA and CA process is that the social worker meets with the family and sees the child (DH 2000, 3.10). There is an obvious problem with this requirement when conducting a pre-birth assessment but there appeared to be minimal emphasis on meeting the parents. There was only evidence of one meeting in *Jodie's* case to complete the IA and CA, one meeting in *Molly's* case to complete the IA and no record of the Initial Assessment Team social worker meeting any of the family in *Harvey's* case. Given the findings by Platt (2001) that, at the first point of contact, some families found the experience of a social worker at the door 'bad enough' (Platt, 2001,p139) it is questionable how effective one visit to complete an IA or CA would be. Equally, one visit seems unlikely to generate the conditions whereby the *Assessment Framework* (DH 2000) 'if used with skill and sensitivity' (Corby *et al* 2002, p13) could help in supporting parents to change. In this respect, the host LA IAs and CAs did not seem to be fulfilling the purpose of an assessment of the child's needs, further supporting the

notion that the IA and CAs seemed far more linked to allocation decisions rather than a process of engaging parents in the process of change.

Calder (2000 and 2003), Corner (1997) and Hart (2001 and 2010) all provided practice suggestions in relation to completing pre-birth assessments which were discussed in Chapter 2 and condensed into figure 3. A key feature of all three models was the importance of ensuring a wide range of information was gathered. The case files studied in depth had differing amounts of information gathered from the family and other agencies with *Jodie's* case containing reports, letters, minutes of meetings and case notes detailing discussions with a wide range of people. *Amy's* and *Zalika's* cases were at the other end of the continuum with no written documentation to indicate what information had helped shape the social worker's assessment. However, in the semi-structured interviews, all but *Zaklia's* social worker spoke of gathering information from a range of sources and of having discussions with parents. In all of the seven cases the social workers spoke of engagement with the parents and, whilst there were differing levels of engagement achieved, the relationship between the social worker and the mother was often a key factor in the assessment process. In *Harvey's* case the meetings and interactions between the mother and the social worker were central to the decision to keep mother and child together. By spending time with *Harvey's* mother the social worker was able to identify that, with support, mother and child could remain together. Likewise, in *Molly's* case, without parental cooperation, *Molly* would not have been returned to her family. This wealth of information was not contained or pulled together into any written document which could be regarded as an assessment. Assessment had taken place but this appeared to be something less tangible to anyone wishing to make sense of the process. The social workers had clearly gathered, analysed and processed a wealth of information to inform their decision but the only way of knowing this was to talk directly to them.

What became evident was that there was a separation of the process of completing pre-birth IAs and CAs from the process of completing 'a' pre-birth assessment and this is discussed in more detail in the section of this chapter dealing with the social workers' interviews. However, when considering the seven in-depth cases, what this suggested was that although the managers and social workers were regarding cases such as these as the most concerning (namely the ones most likely to require legal or safeguarding intervention) they were unlikely to have a document on file which pulled the relevant information together. They were, in this respect, potentially less likely to conform to government ideals of accountability in planning and decision making as contained within the ethos of ICS.

Case similarities and differences

There were several themes which figured across a number of the cases particularly in relation to the issues and circumstances faced by the parents. Apart from in *Zalika's* case, drug use during pregnancy by one or both parents was an issue. Domestic violence was also a theme running through the cases, again in all but *Zalik's* case. However, what was most striking were the multiple concerns with all seven cases involving unborn children facing a very uncertain future. In this respect the audit highlighted the fine balance which occurs in cases where there has to be a decision to remove a baby at birth or not. Again, referring to the three models of assessment in figure 3, all three models identify the family history and access to support networks as significant features and encourage consideration of protective factors. However, the models of Corner (1997) and Calder's (2000 and 2003) also prompt consideration of parental drug and/or alcohol use and parents' capacity to change and to co-operate with professionals. The *Assessment Framework* (DH 2000) with its focus on the child's needs, prompts consideration of parental capacity and social and family and environmental factors but with regard to the child's needs, couching this in terms of development somehow seems not to capture the unique circumstances of the unborn child.

One of the key features inherent within the discussions with the case-holding social workers for the seven in-depth cases was a focus on risk factors. In analysing the data it appeared that pre-birth assessment processes had emerged to capture some issues, the most notable one being parental co-operation with drug treatment and testing programmes. Reports, minutes of meetings, case notes and interviews with social workers highlighted multi-agency working with drug liaison midwives and support workers in the drug treatment agencies who commented on parental compliance with treatment programmes. Other issues such as capacity to change seemed much more difficult to capture and here much store appeared to be placed on how well parents, and more particularly mothers, engaged with professionals. The midwife and social worker were key professionals throughout all of the cases and engagement with midwifery services was a key factor in measuring the extent to which mothers complied with health service intervention.

In the process of 'judging parental capacity' the maternal right to choice is most notably absent in pre-birth assessment. Hart highlighted that '*by definition pre-birth assessment is triggered by the characteristics of the parents*' (Hart 2010, p 230). This is perhaps somewhat different to post-birth assessment which may also be triggered by observations of the child and actions or omissions in the care of a child which may impact negatively on the child's physical care and emotional well-being. In the comparison of three models of intervention (figure 3) Corner (1997) and Calder (2000 and 2003) identify antenatal care as an element of

pre-birth assessment. Although the domains of the *Assessment Framework* (DH 2000) do not specifically include ante-natal care the ICS CA form states:

Expectant mother regularly attends antenatal/GP clinic once the pregnancy has been confirmed. (DH 2000, question, UB4)

This implies that women undergoing pre-birth assessments have little or no choice with regard to accessing medical care. As was identified in Chapter 4, maternal right to refuse medical treatment, even if doing so would cause harm to the unborn child, is enshrined within medical law. The case cited in Chapter 4 involved the extreme case of a mother who appealed against an enforced caesarean operation (England and Wales High Court (Administrative Court) Decisions 7th May, 1998) and as such represents the more extreme end of the scale. However, the right to refuse any medical intervention, even the routine screening and monitoring exists. Yet, for the in-depth cases, focus was on attendance at ante-natal care and not on underlying reasons why mothers did, or did not, comply with appointments.

The paperless office and the impact of 'work around' systems

The ICS and the host LA approach to the paperless office had prompted social workers to develop a range of strategies to 'get around' the system. As was identified in Chapter 6, social workers had lost confidence in the EDB and so were maintaining 'secret files' held in desk drawers and on personal computers. Research by Broadhurst *et al* (2009) on the IA stage of intervention had highlighted how performance management in the public sector constrained workers to follow certain steps but that social workers were adapting various strategies in order to manage their workloads and their team's workflow. Whilst my research focussed on pre-birth assessment rather than IA, my findings concurred with Broadhurst *et al* (2009) to quite a striking degree. Firstly, as identified above, social workers were not routinely completing pre-birth IAs or CAs and, when they were, they seemed more about allocation issues than about case planning purposes. In all but *Jodie's* case I, as a researcher, was unable to understand the pre-birth story from reading the case files alone and there was no obvious path through a decision making process. However, at no stage was I left with the impression the social workers' actions were designed to deliberately undermine the procedures and maintenance of the EDB, although this was one consequence of their actions. Rather, with regard to the process of pre-birth assessment, their actions were in response to the system not providing a mechanism for being able to quickly and reliably retrieve information. There were also concerns about losing information and, as noted above, with the complexity of the information relevant to the in-depth cases, there was potentially a lot of information which could be lost. Along with developing alternative case management systems which ensured

there was ease of access to paper based documents the social workers recognised the importance of information because of its 'value' as a contemporaneous document or its 'value' to the child in later years. However, whilst the motivation for maintaining alternative systems was not seen to be malicious, the consequences could have serious implications.

My study did, however, highlight one aspect of the potential usefulness of the EDB in that it provided a centralised record of involvement which out of hours staff could refer to when necessary. Given that babies are just as likely to arrive outside of the allocated social worker's normal working hours having a centralised record could aid out of hours planning. However, in the case of *Amy*, there was no information on file and so the Access Point social worker was unable to advise hospital staff what to do. In this case there was no immediate risk but not being able to pass on such vital information could have had significant implications. In March 2008 a judge ruled that Nottingham Children's Services and the hospital had acted unlawfully by separating a mother and her child at birth without a court order (*G.R v Nottingham City Council* 2008). In this case the baby had arrived out of normal office hours and the hospital had contacted the Children's Services department who had advised them to follow the plan of separating mother and baby at birth. Consequently, the baby was placed on the special care baby unit and the mother on the ward. The mother, however, then requested her baby be brought to the ward and this request was refused. The judge ruled that the hospital staff had not acted appropriately in separating mother and baby without a court order allowing this to happen. The hospital staff argued that they had contacted Children's Services for advice and had acted upon this advice.

Perhaps the most notable case with regard to the EDB was *Zalika's*. This case was extremely complex involving a 13 year old mother of African origin who spoke no English and, having apparently been abandoned in England by her father, having a very unclear immigration status. A child herself, *Zalika's* mother was living in a very different culture to the one she knew and could only communicate with her foster carer, social worker and midwife via an interpreter who spoke her second, not first language. The allocated social worker spoke of a pre-birth assessment having been undertaken and ultimately *Zalika* was placed in her mother's care in a foster placement. Despite the pre-birth assessment and the placement in the care of the LA no electronic case file had been created at all. The social worker's rationale for this was that *Zalika* was not a child in need, her mother was capable of caring for her and so the LA were not actually involved. *Zalika's* case and lack of recording on the EDB highlighted how, despite a complex computerised system, the legal framework of the Children Acts 1989 and 2004 and procedural guidance in *Working Together* (HM Government 2006) and the *Assessment Framework* (DH 2000) *Zalika* had 'slipped under the radar'. The reason for this

was the social worker had apparently regarded *Zalika* as not being a child in need and therefore had decided there was no reason to make an electronic case file for her.

Summary of findings from the seven cases

The complexity of the cases cannot be overstated with the families all facing multiple issues and challenges in their lives. *Working Together* (HM Government 2006) indicated that neglect can occur during pregnancy as a result of substance misuse but, given the complexity of the 7 cases, it seems somewhat simplistic to suggest that maternal substance misuse is the only way neglect can occur pre-birth.

In each of the seven cases the social workers were engaged in a process which ultimately required a decision to either remove a child at birth or to allow the child to be discharged from hospital to the parent(s). This is a significant decision and one which has far reaching consequences if the social worker 'gets it wrong' and so great emphasis must be placed on the process of assessment. In an attempt to ensure the most vulnerable cases were identified managers placed great emphasis on the (often limited) written information contained in the IA and CA forms and a narrow, forensic approach seemed to be adopted in the process of allocating cases. However, for those cases which were allocated, there was evidence to suggest the social workers used a wide range of assessment approaches and techniques to gather information. Drawing on the available information and working in collaboration with other professionals, social workers weighed a great deal of complex information and responded to this information by devising plans to be implemented at birth.

10.5.3 Interviews with Social Workers

The case-holding social workers were each interviewed about the case selected for in-depth study and also about pre-birth assessment in general. The interviewed social workers had a range of different post qualifying experience with all but one (Rachel, *Zalika's* social worker) having at least some experience of completing assessments. What was evident in all of the interviews was that the social workers were drawing on their own and their colleagues' practice wisdom as a basis for their assessments. Horwath (2005) identified that individual subjectivity and team dynamics influenced the process of assessment even when workers used a pre-defined framework for assessment. In this host LA the less experienced social workers turned to the more experienced for advice and guidance and the main factors shaping pre-birth assessment practice were the attitudes, knowledge and approaches of those workers with prior experience.

What became evident when looking at the seven in-depth cases was that there was a splitting of the process of completing the IA or CA paperwork and the process of 'doing' a pre-birth assessment. In the interviews this became more obvious to the extent that social workers in the Family Support Teams had disregarded the IA and CA forms in use, primarily because they did not feel they could fit the information about the family and the unborn child into the prescriptive format. As a result they were acting very much as street level bureaucrats and developing their own individual methods of completing pre-birth assessments. There were differences in what the social workers regarded as relevant and indicative of whether the baby could, or could not, remain in the care of the mother. However, the overall attitude was that the *Assessment Framework* (DH 2000) provided guidance but that the ICS compliant forms used by the host LA were too prescriptive.

It was evident that the social workers were drawing on the assessment domains contained within the *Assessment Framework* (DH 2000) but they were adapting this to meet the needs of the family and the specific needs of a pre-birth assessment. This is in line with the notion of the framework being, as Rose (2010) suggested, a fundamental part of policy and practice frameworks in children's services as social workers did see it as the key guidance in structuring and shaping pre-birth assessments. It was also evident that the ethos of the *Assessment Framework* (DH 2000) in promoting holistic assessment and early intervention (Horwath 2001; Horwath 2010; Cleaver and Walker 2004) was a concept the social workers in the host LA had embraced. However, in answer to the research question '*How do social workers approach the task of pre-birth assessment*' there were a range of different approaches.

Rosie (*Jordan's* social worker) and Rachel (*Zalika's* social worker) identified the importance of testing out practical skills such as making bottles, dressing and bathing a baby and practically tested these skills pre-birth by using dolls. Carla (*Molly's* social worker) and Jane (*Harvey's* social worker) were more interested in family history and functioning and so spent time finding out about family history, the parents' views and opinions about their own circumstances and their plans for the future. Thinking about this within the context of the *Assessment Framework* (DH 2000) focus on practical skills could fall within the domain of '*parenting capacity*' with emphasis on '*ensuring safety*' whereas focus on the family history and functioning falls readily within the domain of '*family and environmental factors*' (see page 82 figure 5 for the assessment triangle and domains). None of the social workers spoke of any methods which could fit within the domain of the child's *developmental needs*, and this may be because the domain itself does not contain any prompts which seem directly fitting for an unborn child, for example '*self-care skills, identity, social presentation*' (DH 2000).

The tendency to focus on the practical aspects of *parenting capacity* and *'family and environmental factors'* may be in response to some aspects of family life being easier to measure than others. Attendance at antenatal appointments and compliance with drug management programmes can be measured whereas attitudes and opinions can be much harder to measure and assess. Research by Holland (2000), discussed in Chapter 2, found that in assessments there was a high reliance upon verbal interactions, with social workers' perceptions of service users' personalities and levels of co-operation being key elements of the assessment process. Furthermore Holland (2000) found that parents who conformed to a social worker's expectations were more likely to form a positive relationship with the social worker and that the relationship was central to the outcome of the assessment.

Certainly in *Harvey* and *Molly's* cases, conforming to the assessment was a key element of the assessment outcome because it enabled the social workers to identify that, with a package of support, each child could safely be in the care of their parents. However, the extent to which this reflected parental attitudes to working with professionals or the social worker's skill in engaging the family is a question beyond the scope of this research. What was evident was that all of the cases were extremely complex and a high degree of skill was needed to gather, interpret and analyse the information and arrive at an assessment which would inform the plan at birth.

As was found in the audit and analysis of the in-depth cases, the cases which achieved the status of allocated were the ones identified by the managers as most likely to require legal or safeguarding intervention. Social workers were assessing families who faced multiple difficulties and the professionals themselves could be (as in the examples of *Harvey* and *Jordan*) facing the risk of violence from the male partners living in the family household. Looking at the three models of assessment identified by Calder (2000 and 2003), Corner (1997) and Hart (2001 and 2010) (see figure 3) it was evident that when talking about pre-birth assessment the social workers were aware of all of the factors identified in the models but were quite focussed on risk measurement and management. In the interview with Marie she commented specifically on how she felt the *Assessment Framework* (DH 2000) did not address risk and of how she had devised her own report format within which she specifically addressed potential risks to the baby. In some ways the focus on risk mirrors findings by Thornburn *et al* (1997) whereby under the guidance of the *Orange Book* child protection assessments focussed on risk rather than considering the child's needs as a whole. It may also be that the forensic approach to pre-birth assessment evidenced in this study pre-disposed social workers toward a risk assessment process.

Whatever factors were directing the process of assessment it was clear pre-birth assessments were being undertaken in an environment which was not always conducive to supporting the front line practitioners. There were differing levels of managerial support to the social workers across the Family Support teams and high volumes of work to deal with for all. Platt (2001) and Cleaver and Walker (2004) had commented on the impact reduced staffing might have on the implementation of the *Assessment Framework* (DH 2000) and certainly in the host LA reduced staffing was having an impact. Social workers were faced with managing large and demanding caseloads whilst also working within the national and local procedural requirements. Consistent with findings in Horwath (2011) which looked at the experience of 62 practitioners and front line managers responsible for conducting assessments using the *Assessment Framework* (DH 2000), high case loads, managerial systems and practitioner experience all impacted on assessment practice. It is important for social workers to have the line management support and caseloads consistent with their level of experience and practice capacity if the needs of children are to be identified and met (Horwath 2011).

I had wondered if pre-birth assessment might (by virtue of there not actually being a child to actually deal with) get less attention but I saw no evidence that this was the case. What I did see was that social workers were drawing on their knowledge and practice experience of dealing with other types of assessment (and that of their colleagues) and then adapting this to fit pre-birth assessment. In the absence of any research or specific guidance they were left with no option but to develop systems and approaches and in so doing there was great scope for diversity in how this was achieved.

10.6 Conclusion

The first of my research questions asked where pre-birth assessment fitted within the legal, procedural and practice framework. My first conclusion is that at a legal level there is an apparent degree of simplicity: the unborn child has no legal rights. Moreover, another fundamental issue is that which was addressed in the House of Lords (UK House of Lords Decisions 1994), namely that procedures which have evolved for the living cannot be applied directly to the unique circumstances of the pregnant woman and her unborn child. Thus, at the outset, there is a doubt – what are social workers accountable for – the protection of the unborn child or maintaining maternal rights to choice or both?

Yet, as consideration of national guidance, local guidance and front line practice progresses the picture becomes even less clear. At a procedural level attempts to provide guidance seem to create even more uncertainty and so, at a front line level, social workers are left creating policy and developing approaches to pre-birth assessment work based on implicit knowledge

and practice wisdom developed in relation to post-birth assessment work with children and families.

Evans and Harris (2004) and Evans (2011) identify that procedures can provide a reference for good practice but, when considering the impact on street level bureaucrats, prescriptive guidance and managerial systems based on reducing professional discretion do not necessarily result in curtailment of discretion. What the findings indicate is that throughout the process of pre-birth assessment are layers of subjectivity starting first with the process of case categorisation where it was evident that prescriptive categories do not necessarily result in consistency. IA and CA activities appear to have been adopted as primarily mechanisms for identifying which cases should or should not be allocated, but with different managers interpreting the need for allocation differently.

Amidst this there was no clear picture of the volume of pre-birth assessment activity that was occurring, with even the most basic figures relating to the numbers of pre-birth referrals not being available. Within the context of a paperless office and systems designed to increase accountability social workers had also differentiated the completion of IA and CAs from the process of 'doing' a pre-birth assessment. It was, therefore, impossible for me as a researcher to gain a full insight into any of the cases from reading the case files alone and in one case there was not even a case file. Interviews with social workers, however, indicated that they were gathering and analysing a great deal of complex information which they then used to inform the process of decision making on some very difficult and challenging cases.

Interestingly, the very system which had been designed to increase accountability and centralise case recording seemed to be the very thing which had made it difficult for me to understand pre-birth assessment in the host LA. In a practice environment developed from a socio-political rhetoric which demanded greater accountability and transparency social workers were developing systems to manage their workloads and ensure they had access to paper based documents when they needed them. Written information was held in desk drawers and on word based documents not uploaded onto the EDB making it impossible to identify any one definitive record of the unborn child's case. Pre-birth assessment, therefore, seemed to be occurring within the context of limited national guidance and unhelpful electronic systems, with problematic staffing levels and workload pressures adding to the difficulties faced by front line staff. Within this context, nevertheless, social workers were developing approaches to pre-birth assessment and were engaging with families to support change.

Chapter 11

Reflection on the Research Journey and Thesis Conclusion

My thesis has tracked the journey from original interest and ideas, through the process of data gathering and to the final analysis of findings. In doing so I have highlighted that, whilst sitting within the context of assessment literature as a whole, pre-birth assessment has attracted limited specific research interest.

The research journey has, however, been about a lot more than undertaking PhD, it has also been about my personal journey from practitioner to researcher. In concluding the thesis I wish therefore, to firstly reflect on my research journey and then to use this as the context for the final conclusion.

11.1 Reflection on the research journey

When I began the research I had very broad aim of studying pre-birth assessments which, deep down, incorporated a naïve notion that I would produce a thesis which other social workers could use to help them produce 'good' assessments. The following quote is from some of my earliest notes and writing and highlights perfectly where I began:

There is no doubt pre-birth assessment is a complex and emotive area of work and this study will explore what influences social workers when conducting such assessments. The key aim is to develop an understanding of influencing factors and ultimately to improve this area of assessment. (Res R first Draft 2007)

The early stages of the research were fundamental, and highly important, in refining the research aims and questions and the support of my supervisors was invaluable in this process. The literature review and initial research planning highlighted that pre-birth assessment literature was limited to Calder (2000 and 2003), Corner (1997) and Hart (2001 and 2010 and unpublished thesis 2003) with only Corner and Hart undertaking research into pre-birth assessment. To a degree this was concerning as I could not believe a practice issue as significant as pre-birth assessment had not attracted more research interest. At the same time I was pleased to realise that I had an area of research which was an open field for exploration.

As a direct result of early supervisory discussions and the early stages of the literature review it seemed appropriate that the study was exploratory in nature. Again my naivety as a new researcher was evident as I continued with the notion that by conducting an exploratory study I would find the answer. When I began the process of actually gathering the data my research inexperience really began to show and the process of transforming myself from practitioner to researcher began in earnest. Supervision discussions and early writing frequently highlighted my tendency to approach, gather and analyse data with a managerial practice head. I frequently tried to 'solve the problem' of pre-birth assessment and became quite frustrated with some of my findings.

The difficulty of approaching research from the stance of practitioner rather than objective researcher was most notable when conducting the documentary analysis of the LSCB procedures. I found myself constantly questioning why more guidance was not being provided without really considering the underlying reasons for this. I questioned what social workers did without LSCB guidance without recognising a key part of my research design was to actually explore what they do. The practitioner as opposed to researcher approach employed during the documentary analysis of LSCB procedures became extremely evident to me when it came to the final stages of analysis and write up of the data. I found my completed research data tools and research notes resembled those of an inspector or auditor looking for shortfalls as opposed to an objective researcher recording relevant data. This, in turn, created immense difficulty in the process of writing Chapter 5 as I felt I had limited credible research data upon which to base my findings. Moreover, I was unable to go back and repeat the documentary analysis as many of the procedures had been updated and changed in the intervening period. On reflection I feel I had actually managed to obtain some key credible data about LSCB procedures which was highly relevant to the research as a whole but from the perspective of my development as a researcher I learnt a great deal from this exercise. Not least of which was the importance of recording rather than reacting to the data as a social worker.

During the process of gathering data from the host LA there were still tendencies to think about the data as a manager rather than a researcher but gradually this began to diminish. The lack of information in some of the case files frustrated me immensely but I gradually began to recognise this tendency more and more. White (1997) identified that there are similarities in the process of social work assessment and the process of being a researcher and gradually I have begun to adapt my skills of information gathering to my research.

The point when I really began to feel I had significantly moved from a primarily practice based focus to a more researcher based approach was when faced with *Zalika's* case. Here I identified the balance between my professional views and ethics and my research views and

ethics. On one level practice and research ethics were the same in that in the event of uncovering any information which suggested children were not being protected then I had a professional obligation to report it to the relevant agency. However there were many points when I found my managerial experience had to be suppressed in order to maintain my research stance. When I became aware of *Zalika* I was faced with a baby who I (as a professional social worker) regarded to be a child in need but who was not regarded as such by the LA. I grappled with feeling that I should advise the case-holding worker to create a case file and treat *Zalika* as a child in need but knew it was not my place to do so. I eventually rationalised the situation by acknowledging that the line manager, senior manager, fostering team social worker and independent reviewing officer were all aware of *Zalika* and so she was not at any risk of harm by virtue of not having a case file. Decisions and actions regarding case file management were not within the remit of my responsibility as a researcher. Moreover, if I were to comment on the lack of a file then I was breaching my ethical agreement with the interviewees that I would not be undertaking a case file audit for senior managers.

Robson (2002) comments on the researcher practitioner tension but also highlights how having 'insider' knowledge can be a help. One of the disadvantages of having first hand professional knowledge was that there was a danger I did not view things objectively. However, the advantage to being known to the agency was that I was trusted and I am sure this helped in gaining access to information. It certainly helped in that I was able to find my way around the host LA and knew the key people to contact to gain access to information and to solve some of the problems I encountered. However, what was striking was how quickly the agency had changed when I returned to undertake the data gathering. Changes of staff and the introduction of electronic case recording systems, which in turn had resulted in the LA's goal of creating a paperless office, meant I was faced with an agency I did not really recognise. More significantly, when analysing and writing the thesis I looked back at the data and felt as if this was an agency I had never worked in as a practitioner.

When it came to writing up the thesis it became very clear that I had a vast quantity of data and one of the biggest challenges has been selecting what to include and what to leave out. In this respect the thesis has generated much data which I intend to adapt and use for subsequent publications. I have also been able to use the data to provide a platform of understanding for other work and research relevant to pre-birth assessment. At the final stages of writing the thesis I recognised I had moved considerably from my starting position in 2007. Employed as a lecturer and engaged in funded research looking a multi-agency pre-birth intervention team the PhD has helped me develop and practise many skills and but I realise I still have an immense amount to learn.

11.2 Conclusion

11.2.1 Key Findings

The thesis began by introducing my interest in pre-birth assessment and the process of setting out the overall research aim of:

To explore what is currently known about pre-birth assessment within the context of Local Authority social work practice.

Using a mixed methods approach the research was designed to capture the national context of the law, policy and procedural guidance, the Local Safeguarding Children Board (LSCB) and front line procedures and practice in one LA children's services department. The literature review highlighted that research into pre-birth assessment was limited to two small-scale research projects undertaken by Corner (1997) and Hart (2002 unpublished). My exploratory study found that pre-birth assessment in social work is a complex process guided by procedural framework that does not recognise the unique status of the unborn child.

Current children and family social work assessment practice has evolved from a historical perspective based on protecting children. Public interest in child death enquiries during the 1970s and 80s resulted in policy developments being both condemned for not preventing child deaths but also regarded as over intrusive. To strike the balance between support and protection the Children Act 1989 encompassed the principles of supporting children in need rather than primarily focussing on child protection (Frost and Parton 2009). However, in 1997 the social services inspectorate identified problems with assessment practice, particularly that the needs of families were not sufficiently understood and assessments were '*poorly co-ordinated, lacked structure, and had poor content*' (Department of Health 1997, 10.11). The then Labour government placed emphasis on early intervention and improved and timely assessments which differentiated between levels and types of need with the resultant *Assessment Framework* (DH 2000) being introduced (Horwath 2001 and Horwath 2010). Following the death of Victoria Climbié the Inquiry by Lord Laming emphasised systemic failures across agencies responsible for protecting children (Cm, 5730, 2003). Recommendations for greater accountability and strengthening of interagency recording procedures were made (Cm 5730, 2003 and Corby 2006) and the Children Act 2004 and another edition of '*Working Together*' (HM Government 2006) followed. In 2007 the Integrated Children's System (ICS) which encompassed the aim of providing an electronic record of professional involvement, assessment, decision making and review became operational in England (Cleaver *et al.*, 2008).

Within the context of supporting children in need, timely intervention and professional accountability LA social workers in England are charged with the responsibility for co-ordinating multi-agency pre-birth assessments using the *Assessment Framework* (DH 2000) as guidance. However, the unborn child has no legal status and the Children Acts 1989 and 2000 do not apply pre-birth and, as Hart commented:

A pregnant woman is not a human incubator, but retains autonomy over her own body and as a consequence that of her baby' (Hart 2001, p237).

Procedural confusion was embedded in *Working Together* (HM Government 2006) which provided statutory and non-statutory practice guidance for all agencies and individuals working with children. *Working Together* (HM Government 2006) contains a clear statement that the procedural guidance it provided was also applicable to unborn children (HM Government 2006, 5.14) and herein lies a conundrum. Paying no heed to the unborn child's lack of legal status and a mother's right to choose what happens to her body means professionals are left to interpret how and when to apply statutory guidance. A clear example lies in the mother's right to seek a termination of her pregnancy before the 24th week of gestation. Such right does not sit alongside guidance which directs professionals to act immediately to secure the safety of a child (including an unborn child) where there are risks to a child's life. In 1994 the House of Lords considered a case in which a pregnant woman had been stabbed, resulting in a premature labour. The baby died 121 days after the birth and legal questions were raised with regard to if the crime was murder or not as the stabbing had occurred before birth. In considering the case the House of Lords concluded this was not a simple matter and stated that the '*mother and the foetus were two distinct organisms living symbiotically, not a single organism with two aspects*' therefore describing the unborn child as a '*unique organism*' (UK House of Lords Decisions 1994. no page number). The House of Lords conclusion was that to apply principles of law which had evolved in relation to autonomous beings was a misleading approach to take. My research clearly found that in relation to pre-birth assessment statutory guidance which had evolved to protect children was applied to unborn children and so was misleading.

Not only is it misleading to apply statutory guidance to the unborn child, simple application of the guidance does not incorporate recent scientific knowledge relating to fetal development and the importance of parenting in the first months and years of life for healthy brain development. Child development does not begin at birth, it begins from the point of conception and is a continuum which is impacted upon by physical factors (such as substance use), emotional factors (such as attachment patterns) and environmental factors (such as poverty). Although *Working Together* contains a clear statement that neglect can occur during

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pregnancy (HM Government 2006, 1.33) there is no further guidance or recognition of what this might actually mean for the long term life chances and experiences of children. Nor is there any recognition of the importance of early intervention and support to both identify potential neglect and to intervene to mitigate against the consequences of neglect. As highlighted by Ward and Glaser (2010) maternal drug and alcohol use during pregnancy can have serious long term consequences for the child. However, as Huth-Bocks *et al* (2004) have found, in the last trimester of pregnancy it was possible to predict, based on maternal representations of their baby and the available social support, the mother and child's post-birth attachment patterns.

At a local level LSCBs have the statutory responsibility to devise procedures which reflect local need. *Working Together* (2006) set out the role of the LSCB and detailed core objectives which included the development of policy and procedures (HM Government, 2006). My documentary analysis of a 100% sample of LSCB procedures in 2008 found that the majority at least made some reference to unborn children with only 7 (10% of the total 73 sets of procedures) making no reference at all. Of those which did make reference to unborn children the extent to which comment was made varied but focus was predominantly on procedural issues surrounding referrals and time scales. Where LSCB guidance attempted to add clarity the procedures they served to build on the existing anomalies in the national guidance. What was evident was that local guidance was evolving without considering the ethical, moral or practical aspects of pre-birth assessment.

Having looked at the national and LSCB context my research then turned to the case study of one LA in England. In conducting a six-month audit of referrals to the host LA the most fundamental finding was that it was impossible to arrive at an agreed number of pre-birth referrals. My figure of 56 pre-birth referrals was at odds with the 49 pre-birth referrals the host LAs electronic database had counted. In addition I identified one case which had not been recorded on the LA system at all despite a pre-birth assessment having been undertaken and the teenage mother and baby ultimately being placed with a foster carer. What this amounted to was a significant underrepresentation of the amount of pre-birth assessment activity social workers were engaged in during one six-month period.

Following on from the point of referral the system was designed to move cases from the first point of contact at the Access Point Team, through to the Initial Assessment Teams and onto the longer term Family Support Teams. The host LA had implemented an electronic case management system which incorporated ICS compliant referral, initial assessment (IA) and core assessment (CA) documents. The electronic forms and pages prompted staff to categorise cases requiring complex information to be reduced to a one or two word category.

As a result social work staff arrived at various conclusions based on their interpretation of the available information with emphasis being on categories linked to child protection. Although the content of referrals did not always indicate child protection concerns, what I found was that a process of screening resulted in a narrow forensic approach to pre-birth assessment. This was contrary to the national context of promoting the well-being of all children as ultimately, in the host LA, only those cases deemed by managers to be the most concerning achieved the 'status' of allocated.

My most surprising finding was that, in the host LA, pre-birth assessment had been split with the completion of the ICS IA and CA documents and the process of 'doing' a pre-birth assessment being two distinct activities. The rationale for this seemed embedded within a number of factors not least of which were the implementation of the ICS and the LAs approach to the paperless office, high social work caseloads and staffing issues. The ICS compliant IA and CA forms were being used as tick box processes with information cut and pasted from the referral and minimal time spent engaging with the family to obtain their views and opinions. The ICS compliant IA and CAs had become nothing more than vehicles for deciding which cases required allocation to a social worker and which could be closed or left unallocated for the duration of the pregnancy.

For those cases which were ultimately allocated to a social worker a complex process of pre-birth assessment occurred which encompassed the principles of a holistic assessment, engagement with the family and multi-agency working. Social workers used the *Assessment Framework* (DH 2000) to guide their assessment and, in the absence of formal training or relevant literature, were drawing on their own and their colleagues' practice wisdom as a basis for their approach. The extent to which the social workers interviewed for this research adhered to the principles of the *Assessment Framework* (DH 2000) varied, as did the factors they focussed on and regarded as significant indicators for the future safety and wellbeing of the child. For some of the social workers interviewed, particularly Ruth, Jane and Carla, high importance was placed on parental perceptions such as attitudes toward childhood and positive experiences as well as an understanding of their own history and current circumstances. For others, namely Rosie and Paul, emphasis on practical skills (such as making bottles) and current circumstances (such as home environment) seemed to prevail in the pre-birth assessment process. Consistent with the findings of Munro (2011) and Horwath (2011) social workers were managing risk within a context of procedural guidance which, as noted above, focussed on the completion of IA and CA forms and high case loads. The methods by which social workers gathered information to complete such records was seen, however, to vary immensely.

Finally, it is important to recognise the impact of managerial systems. Although not specific to pre-birth assessment, issues associated with the electronic database and ICS ran through the research as a whole and ultimately impacted on the data gathering significantly. The impact of the electronic database and the LA approach to the paperless office resulted in social workers adapting systems to meet their professional needs. The experience of case notes and reports typed onto the electronic case files subsequently being lost and the idea of contemporaneous notes and other important documents being scanned and then shredded, meant social workers were reluctant to upload information onto the electronic system. As a result case notes, reports from other agencies and (significantly for my research) pre-birth assessment reports were being stored in 'secret files' in desk draws and various other places. This made it difficult, if not impossible, for me as a researcher to understand the process of decision making and planning. This mirrored research undertaken by Broadhurst *et al* (2009) in which they found front line practitioners adapting methods of working around complex managerial systems. Similarly the Munro report (2011) identified burdensome and prescriptive managerial systems limited the capacity of front line workers to engage with families. As a result, the electronic system in place in the host LA, which had been designed to increase accountability and centralise case recording, actually made understanding the child's story difficult and process of decision making difficult. Only when discussing the in-depth cases with the social worker was it possible to gain insight into the family circumstances and immense complexity of pre-birth assessment.

11.2.2 Practice recommendations

Practice recommendations have been viewed from two perspectives. Firstly from the perspective of reviewing existing policy and procedural guidance and the emphasis on managerial systems and secondly from the perspective of how practitioners approach pre-birth assessment. In order to outline how my research informs these two interlinked but individual aspects of pre-birth assessment I will look at each area in turn.

Firstly, in relation to policy and procedure, and as indicated in the introduction my data gathering in the host LA began in October 2008 and in November 2008 the news broke of the death of baby Peter Connelly. In his report, commissioned by the then Labour Government into child protection services, Lord Laming acknowledged the challenges faced by front line professionals and identified that, whilst progress had been made more needed to be done to ensure children were protected (Laming 2009). One of the government's responses was to set up the Social Work Task Force which, in November 2009 produced a final report outlining findings from research into front line social work practice. The Task Force's report identified the challenges facing social workers and made recommendations for how to improve social

work practice for the future (DCSF 2009). In 2010 the coalition government commissioned Professor Munro to conduct a review of child protection in England and in 2011, as I was in the final stages of thesis writing, the final report was published. The Munro report sets out proposals for reform intended to enable professionals to help children and families and identified that a key element of this was moving away from systems which had become over-bureaucratic (DfE 2011).

The Social Work Task Force final report (DCSF 2009) and the Munro report (2011) highlight issues which were evident in my findings. If government, LSCBs and LAs adopt the proposed changes then the focus on managerial systems which have actually undermined accountability will give way to enabling front line professionals to focus on working with families. Situations such as those in the host LA whereby key information about families is at risk of being lost or hidden in desks and IA and CAs had been reduced to methods of determining allocation will hopefully be scenes from the past. However, along with the changes to social work practice in general there also needs to be recognition of the unique circumstances of the unborn child and the impact early assessment can have on the long term experiences of children.

My research was conducted when *Working Together* (HM Government 2006) was statutory guidance and I found that far from offering clarity the guidance actually created a conundrum for practice by suggesting that procedures for safeguarding children could be applied equally to unborn children. The revised *Working Together* (HM Government 2010) says nothing more than the 2006 version about unborn children, despite being a substantially larger document. In order to ensure principles of anti-oppressive practice and accountability are enshrined within pre-birth assessment it is essential to consider the fundamental principles surrounding the lack of legal status of the unborn child and the maternal rights of choice. With procedures and guidance which has evolved from the perspective of protecting children there has been no consideration of how applicable this approach is during pregnancy. I am not suggesting that a complete re-evaluation of practice is needed but what I am questioning is how simple changes to terminology, namely referring to a fetus rather than an unborn child, might impact on the procedural framework as a whole. It seems evident that considerably more research is needed into this area of practice if only to address the core ethical questions surrounding how professionals protect unborn children.

Underpinning any approach to safeguard and promote the wellbeing of children is the need to conduct timely and comprehensive assessments which can inform intervention and support. Ofsted (2011) considered serious case reviews conducted between April 2007 and March 2011 and looked specifically at two age groups one of which was babies less than one year of age. The findings highlighted that timely and thorough pre-birth assessment was important in the

safeguarding of very young babies. My research has highlighted that early intervention during pregnancy may serve many purposes when it comes to both minimising risk in those vulnerable first few months as well as promoting the long term wellbeing of children. One potential benefit of early intervention is the increased time to support positive change in a family. As was evident in *Molly's* case, motivation to manage and subsequently end substance misuse by both parents was heightened by *Molly's* birth. Sadly in *Molly's* case, late allocation had not enabled multi-agency intervention to support the necessary changes in family circumstances before birth and, although re-united, *Molly* and her parents experienced the inevitable trauma of separation at birth. I strongly concur with the Ofsted (2011) findings that timely and thorough pre-birth assessment is essential not only for ensuring positive outcomes for children but also enabling parents to understand and arrive at solutions which meet their own needs and subsequently the long term needs of their children.

The *Assessment Framework* (DH 2000) was evidently guidance which the front line social workers I interviewed generally regarded as helpful in structuring pre-birth assessments. However the assessment domains relate primarily to children and not specifically to unborn children. When interviewing the social workers I found considerable evidence of professional skills employed in the process of engaging families in the assessment. However, without research and literature to draw upon social workers were reliant upon their practice wisdom and so individual approaches were developing. I am not suggesting that the *Assessment Framework* (DH 2000) is not appropriate for assessing the needs of unborn children, what I am suggesting is that supporting guidance and assessment paperwork should reflect more accurately the unique circumstances surrounding pregnancy and should prompt practitioners to consider early indicators of secure and safe parenting. As was seen in both the audit of referrals in the host LA (Chapter 7) and the in-depth study (Chapter 8), social workers indicated they were unable to assess certain aspects of family life and parenting capacity until the baby was actually born. This was consistent with Hart (unpublished thesis 2003) who found that in cases discussed at pre-birth child protection conferences there was a tendency to postpone decision making until post birth.

However, as was identified in the literature review, there are various areas of research that could inform pre-birth assessment practice but these have not yet filtered into informing such practice. For example, the research by Huth-Bocks (2004) highlighted how it is possible to anticipate in pregnancy the attachment behaviours which will transpire post birth. Likewise we know of the importance of secure placements for babies removed from the care of their families in promoting health attachment patterns in later life (Ward *et al* 2007) and of the importance of consistent and appropriate parenting for very young babies generally and for healthy brain development specifically (Belsky and de Haan, 2011). This emerging knowledge

supports the notion that pre-birth assessment can reasonably predict future parenting skills and attachment patterns which would inform and support very early intervention to meet a child's needs. My research findings suggest that social workers and other professionals are not currently being prompted or supported to consider such patterns of parenting and attachment during pre-birth assessment. Obviously, the practice of social workers in one LA cannot be used to claim that social workers in other areas of England are not focussing on attachment or predictive patterns of parenting. However, the decision in England to organise ICS compliant systems around a set of exemplar forms which themselves do not emphasise attachment and my study of safeguarding procedures in England which demonstrated a procedural perspective which predominantly ignores the importance of attachment, early brain development and long term emotional wellbeing, suggest that practice elsewhere may be similar. Instead there is emphasis on measurable factors such as attendance at health appointments and levels of maternal drug and alcohol use (see for example Appendix 9, Core Assessment Exemplar DoH 2002) rather than on less measurable factors such as parental understanding of their own history, perspectives on children and childhood and patterns of attachment.

As was seen in *Harvey's* case, the social worker's pre-birth assessment focussed on the mother's ability to imagine her baby and what life would be like if he remained in her care, or if she returned to her violent partner. This ability of *Harvey's* mother to represent what her life would be like with or without her son was significant in enabling the social worker and other professionals to devise a package of support which minimised risk and kept mother and child together. What was clear when interviewing the social worker in *Harvey's* case was that it was the approach which afforded the time for the social worker to understand the unique family circumstances and maternal perceptions. This approach then enabled *Harvey's* mother to consider the solutions and changes she wanted to make to ensure her baby was safe. Not only was this approach consistent with ensuring a secure attachment was formed at birth but it was highly consistent with maternal empowerment and the emphasis on long term commitment to change. However, despite conducting an assessment which complied with the domains of the *Assessment Framework* (DH 2000) and was fully consistent with the ethos of a holistic approach to the child's needs, the social worker did not regard her work as pre-birth assessment because it had not been recorded on the ICS compliant form. This is surely compelling evidence that the pre-birth procedural framework needs to reflect research into early child development and that supporting documents should prompt professionals to think more widely and creatively about what they actually need to know, as this social worker did.

The policy and procedural framework linked to pre-birth assessment not only needs to prompt a wider approach to thinking about predicting future parenting but also needs to incorporate recognition of the added layers of vulnerability and physical and hormonal changes pregnancy

brings for a woman. Anyone woman who has had a child and anyone who has emotionally supported a woman during pregnancy knows that pregnancy and child birth can be exciting but can also be a time of fear and anxiety. As was identified in Chapters 7 and 8 the circumstances surrounding the pregnant women referred to the host LA were complex and multi-layered with pregnancy creating an added layer of complexity and vulnerability to what were often already difficult family circumstances. However, an assessment procedural approach which focusses on the child contains the potential to neglect or ignore maternal issues and the impact quite normal fears and anxiety about pregnancy and child birth bring. Perhaps the case which most highlighted the need to consider the mother more was *Zalika's* case where significant factors such as the young age of the mother and her ethnic and cultural background were not taken into consideration. Focus was placed on the practical needs and care of *Zalika* and her mother's needs (in this case as a looked after child herself) were, seemingly as a direct result of the focus, ignored. In *Zalika's* case this resulted in no consideration being given to the actual labour and delivery, leaving the interpreter being the only person willing to emotionally support this 14 year old child during the birth of her baby. Whilst *Zalika's* case contained particularly poignant factors the issue of vulnerability is one which must arise in all pre-birth assessments by virtue of the nature of the intervention. Sensitivity must prevail when considering how a mother may feel undergoing an assessment which may ultimately decide if she will be able to keep her baby. The needs of the mother not only to support and care for her baby but also in her own right must not be forgotten.

Moving on now to consider recommendations relating to practitioners' approaches to pre-birth assessment I feel there needs to be much greater emphasis placed on researching pre-birth assessment along with support to social workers to afford the time to undertake meaningful and thorough pre-birth assessments. Two of the social workers interviewed for this research identified the importance of parents understanding their own history and experience of being parented along with their ability to represent and picture their child once born. However, they had apparently adopted these approaches based on their own practice and assessment experience and not on any specific research knowledge. Greater emphasis needs to be placed on the training available to social workers responsible for conducting pre-birth assessments to support them in making the links with other areas of research which can inform their practice during pregnancy. Along with training there needs to be further research into the content and approaches to pre-birth assessment in order to provide a platform for reviewing the effectiveness of the *Assessment Framework* (DH 2000) as well as to inform professionals.

Considering social workers from the perspective of street level bureaucracy highlighted the pivotal role social workers play in allocation of resources as well as in the interpretation of policy and procedures. At the same time social workers are also charged with the

responsibility of interpreting socially constructed ideology surrounding motherhood and risk and then re-framing these ideals into measurable factors such as thresholds for intervention. What was evident was that maternal and/or paternal drug and alcohol use featured significantly in the cases that were referred to the host LA. *Working Together* (HM Government 2006) imposes upon social workers the duty to identify the threshold at which an unborn child may be regarded as neglected or at risk as a result of substance use. There has also been growing knowledge that drug and alcohol use does impact on the developing fetus (Jones and Smith 1973, Jones *et al* 1973, Moe and Slinning 2002), however it is difficult to isolate impact of substance use from other factors such as poverty, poor maternal nutrition or domestic violence (Ward and Glaser 2010). As was identified in Chapter 4, the existing legal framework relevant to child protection does not actually apply to the unborn child and a mother retains the right to choose what happens to her own body, a right which extends to her right to choose to use drugs or alcohol during pregnancy. As a result of the legal and procedural position social workers are faced with complex decisions about the point at which maternal choices constitute neglect of an unborn baby and are asked to do so within a practice environment which demands accountability and transparency of practice about issues which are highly subjective in nature. When considering drug and alcohol there are two hugely different ends of a spectrum of use with one end of the scale being represented by poly-substance use on a regular and 'high dosage' level with the other end of the spectrum being represented by an occasional glass of wine. On-going training is therefore needed to support social workers in keeping apprised of the latest research about the impact of substance use on the developing fetus in order to help them make judgements about the point at which neglect or harm may occur.

Finally, and perhaps most importantly, social workers need the time to conduct thorough pre-birth assessments. Broadhurst *et al* (2009) and the Munro report (DfE 2011) identified that bureaucratic and managerial systems were limiting the time available for social workers to spend with families. In my study of the in-depth cases and in my interviews with the social workers, I heard about and read about many examples of good practice, demonstrating an emphasis on inclusion and a genuine commitment to ensuring the wellbeing of children and their families. However, this was often as a result of social workers managing their own time and work responsibilities effectively in spite of often complex and overly-demanding caseloads. Horwath (2011) has highlighted that practitioners must work within complex sets of expectations that include addressing the well-being of children within a context of organisational expectations. To do so effectively and consistently all social workers must have manageable caseloads and access to high quality supervision and, in order to ensure children's needs are met, we must also ensure that social workers' needs for training, support and time are met.

11.2.3 Strengths and limitations in the research

The main strength in my research is in beginning to explore an important, but under researched, area of social work assessment. In this respect I feel I have contributed to original knowledge and opened the door to further research in the field of pre-birth assessment. In questioning where pre-birth assessment fits within the English legal and procedural framework I identified that guidance contained the inherent assumption that procedures relevant to children can be directly applied to the unborn child. Statutory guidance which directs professionals to protect unborn children in the first 24 weeks of pregnancy when the law actually allows for a termination of a pregnancy is fundamentally flawed. Likewise, not allowing for a mother's right to refuse medical treatment even if doing so causes harm to the fetus creates procedures which are not totally consistent with the principles of anti-oppressive practice. Questioning how or if procedures which have evolved to protect children can be applied to unborn children feels rather like lifting the lid on Pandora's box and, from a research perspective, this feels rather exciting as the potential to influence practice is considerable.

It is therefore, reasonable to suggest that a strength in the research is the platform it provides for future research and potential to influence professional practice. Although my focus has been on social work practice this focus was adopted for methodological reasons. Whilst I aimed to capture a multi-agency dynamic this was not achieved to the degree I had at first anticipated, primarily because information from other professionals was not always captured on the host agencies electronic case records. However, whilst this has not been achieved to the extent I would have liked in this research the data relating to the national picture does provide a platform for future research into pre-birth assessment in other professional spheres.

In thinking about the limitations the most obvious one is that I have not considered the parents' perspective. In the process of obtaining consent to look at the in-depth cases I did meet with parents' and they were all willing to discuss with me their experiences of the pre-birth assessment process. Their views were very interesting and I did consider reviewing my methodological approach and seeking ethical approval to include their comments. However, by this stage I was over half way through the data gathering process and was beginning to formulate my analysis. The parental dimension would undoubtedly added to the research but would also have resulted in the research running over time scale. Also, given the volume of data I have been working with, additional data would have added significantly to the challenges of analysing and writing up the findings.

The research focuses on pre-birth assessment practice in England and from the outset I chose to set this limitation in order to ensure the research remained manageable. However, this does limit how well the findings can be applied to other parts of England and, indeed, to other parts of the United Kingdom. Similarly the focus on one LA in England means that my findings relating to front line practice may not be replicated in other LAs. As such the scalability of the research is limited and can only ever be regarded as a small, but important, stepping stone to future research.

11.2.4 Future research

Many friends and colleagues have asked if, in the final stages of the PhD, I have become bored with pre-birth assessment. The answer is absolutely not! I feel I have only begun to scratch the surface and the more I consider the subject the more there seems to be to research. As identified in the above limitations, I aim to build on my PhD and aim to consider multi-agency perspectives in much more detail and capture the parental viewpoint.

I am already beginning to make moves forward in my research career and at the time of writing up the thesis have begun working with fellow researchers on a funded evaluation of a project offering early intervention and support to families where drug and alcohol use compromises parenting. An element of the research is an evaluation of a multi-agency pre-birth assessment team which seeks to engage with pregnant women who use drugs and alcohol to ensure good outcomes for their babies. This research is providing the opportunity to consider the professional views of midwives, mental health workers, drug and alcohol support workers and social workers as well as the views of pregnant women who have been referred to the pre-birth assessment team.

Scaling the research beyond the English legal and procedural framework is already underway with my involvement in the Scottish Government's review of the 'Getting it Right for Every Child (GIRFEC) initiative. GIRFEC is an initiative which is directed at all professionals working with children and young people in Scotland and aims to help children and young people achieve their full potential (Scottish Government 2008). Early intervention and support are key elements of the initiative and this includes support and intervention during pregnancy. With my interest and knowledge base in pre-birth assessment I have begun working with a team of professionals including midwives, health visitors, social workers and children's services managers to review and develop the processes of assessment and intervention during pregnancy.

I feel the concluding words really belong to one of the social workers I interviewed as these words capture the reasons why further research into pre-birth assessment is important:

... step back and think, this is the baby's life and there are parents and other people involved.

(Interview, Marie 2009)

Appendices

Appendix 1

Data Tool 1 - Analysis of Safeguarding Procedures

Name of Safeguarding Board:

Edition or date of procedures:

- | | |
|--|--|
| 1. Is pre-birth assessment addressed in the procedures? | Yes/No |
| 2. If YES, how much space is allocated to it? | Number of pages in procedures.

Number of pages allocated to pre-birth assessment. |
| 3. Paragraph 5.14 (Chapter 5 individual circumstances) of Working Together states, <i>'The procedures and timescales set out in this chapter should also be followed when there are concerns about the welfare of an unborn child.'</i> Is this reflected in these procedures and if so how? | |
| 4. How far does the guidance reflect paragraph 5.140 of Working Together? | Yes/No |
| 5. Is distinction made between pre-birth and post birth assessment? | Yes/No |
| 6. Is the lack of legal status of a fetus addressed? | Yes/No |
| 7. Is there any guidance regarding a pregnant woman's right to autonomy over her own body? | Yes/No |
| 8. Is there any guidance regarding the timescale for intervention pre-birth? | Yes/No |
| 9. Is there any guidance regarding the timescale for intervention pre-birth? | Yes/No |

Appendix 2

Data Tool 2 - Case Audit Record

Referral Details

Id code:	Referral Date
SW code:	
Referred by:	Agency
	Role
	Name
Reason	Client aware of referral
Reason for referral:	
Cin Code	
Referral taken by	
Current Action	
Date of Action	

Personal Details

	Gender
	Dob
	Ethnic origin
	Subject to CP
	Legal Status
Mother	Age
	ethnic origin
	residing with child
Father	Age
	ethnic origin
	residing with child
Siblings:	age(s)
	circumstances

Assessment Details

IA:	Date started
	Date completed
	Decision date
	Decision

CA:	Date started
	Date Completed
	Decision

Notes

Appendix 3

Data tool 3 - In-depth case details

Core Assessment Details

How long did assessment take?

Number of visits to family during assessment?

Was mother seen alone?

Was mother given a copy of the assessment?

What did the SW record in relation to mothers/family views about the assessment?

Case file Details

What plan was followed?

How did the plan relate to procedural guidance?

What information was on file with regard to other agency/ professional involvement in the assessment and case planning (eg letters and reports, attendance at meetings, joint visits)

Planning and Decision Making

What decisions were made?

How were decisions conveyed to the family (eg formal meetings/discussion/letter)

Appendix 4

Data Tool 4 - Interview Schedule

Research Aims

- 1) To explore what is currently known about pre-birth assessment from the perspective of social work practice. This study will consider the following questions:**
 - i) Where does pre-birth assessment fit in the English legislative, procedural and practice framework?**
 - ii) What are Local Authority processes in relation to pre-birth assessment?**
 - iii) What are social workers' views about pre-birth assessment?**
 - iv) How do social workers approach the task of pre-birth assessment?**

Background and introduction questions.

The purpose of these questions is to open up the discussion and to assist the interviewee with relaxing and feeling more at ease with the interview. The questions are therefore geared to ascertaining the length of the interviewee's social work experience and their experience of assessment work generally.

Talking about their professional background may also indicate if there are any differences in approach between experienced or less experienced social workers.

1) Tell me about your social work experience.

- When did you qualify?
- Where have you worked?
- What social work fields have you been involved in (i.e. children and families, leaving care, adult mental health etc)?

2) Tell me about your experience of completing assessments in general.

- How many assessments have you been involved in over the last six months and how much time would you say you spend on assessment activity in an average week? (*It is anticipated that the volume of assessment will not be quantifiable in exact terms for more experienced SWs*).
- Tell me a little about the types of assessment you are, or have been involved with.

Experience of Pre-birth Assessment

These questions are designed to help the social worker get further engaged in the interview and to obtain some background information about their experience of pre-birth assessment work. They may well begin to express their views on pre-birth assessment here but, at the end there will be specific questions to elicit such views.

3) Tell me about the experience you have of pre-birth assessment.

- How many assessments have you undertaken? (It is anticipated this may be an easier number to approximate than the number of general assessments however this can also be presented as an average amount of time spent on PBA if this is easier for the SW);
- What kinds of pre-birth assessments have you undertaken? In what circumstances?
- How do they compare with the other kinds of assessment work you undertake?

Specific questions relating to selected case

It is intended that the social workers selected to take part in the interview will be the case holder for one of the 10 cases selected to study. These questions are primarily aimed at gathering data relating to research aims question (iv). The reason for asking these questions at this stage is to remain with areas of discussion which are potentially more familiar to the social worker and do not appear to demand them to have specific knowledge of the law or procedures.

4) When undertaking your assessment on case X what were your initial thoughts?

- What did you initially understand about the case?
- Where did you start in terms of making an assessment?
- What information did you regard as important and why?
- Was there anything you were concerned about?

5) How would you describe your relationship with the mother in case X.

- What was the relationship like at the initial point of contact?
- How did it develop over time?
- Did you feel comfortable/ uncomfortable when meeting with mother X?
- What reasons would you give for these feelings?

6) How would you describe the process of this assessment?

- What stage of the pregnancy did the assessment take place?
- Do you think the stage of the pregnancy had any impact on the assessment?

7) What legislative framework were you working within when completing the pre-birth assessment?

It is anticipated social workers will relate their work to the Children Act 1989 therefore supplementary questions may be as follows.

- Other than the Children Act 1989 can you think of any other legislation which may impact on the assessment?
- How does the legislation impact on the assessment?

8) What procedures does your agency have in place to support you in your assessment?

- Did you access these procedures?
- How do they impact on your completion of pre-birth assessments? Were they helpful or not?

9) Tell me about how you find using the Framework for the Assessment of Children in Need and Their Families when completing pre-birth assessments.

- How does it impact on your collection or organisation of information?
- How does it impact on your analysis and case planning?
- Are certain domains more applicable than others when gathering and collating information during the assessment?

10) What contacts did you have with other professionals when completing the pre-birth assessment?

- Which professionals were also involved and why?
- Were there any particular problems working with any of these professionals, due to the fact of the case involving a pre-birth assessment?

11) In relation to the outcome of the assessment, what were your feelings?

- What actually happened (at the time of the birth and immediately afterwards)?
- To what extent were you able to balance the rights of the unborn child with those of the mother/parents?

Questions relating to views and opinions about pre-birth assessment.

These questions have been left until the end with the aim of ensuring the interview ends with the SW being able to express their views and not left thinking about case specific details, law or procedures. It is intended this could be a cathartic end point for the SW as well as being valuable data for the interview.

12) Overall, what are your views or opinions on pre-birth assessment in social work?

- Is it an area you find interesting or not?
- Explanation for the above answer?
- Are there any aspects of pre-birth assessment you find difficult and if so why?
- Are there any aspects of pre-birth assessment you find easy and if so why?

Conclusion to Interview

12) Are there any other points you wish to raise in relation to pre-birth assessment that we have not already covered?

13) Are there any questions you have for me with regard to the interview or the research?

Thank you for your time.

Appendix 5

School Research Ethics Panel List of Documents

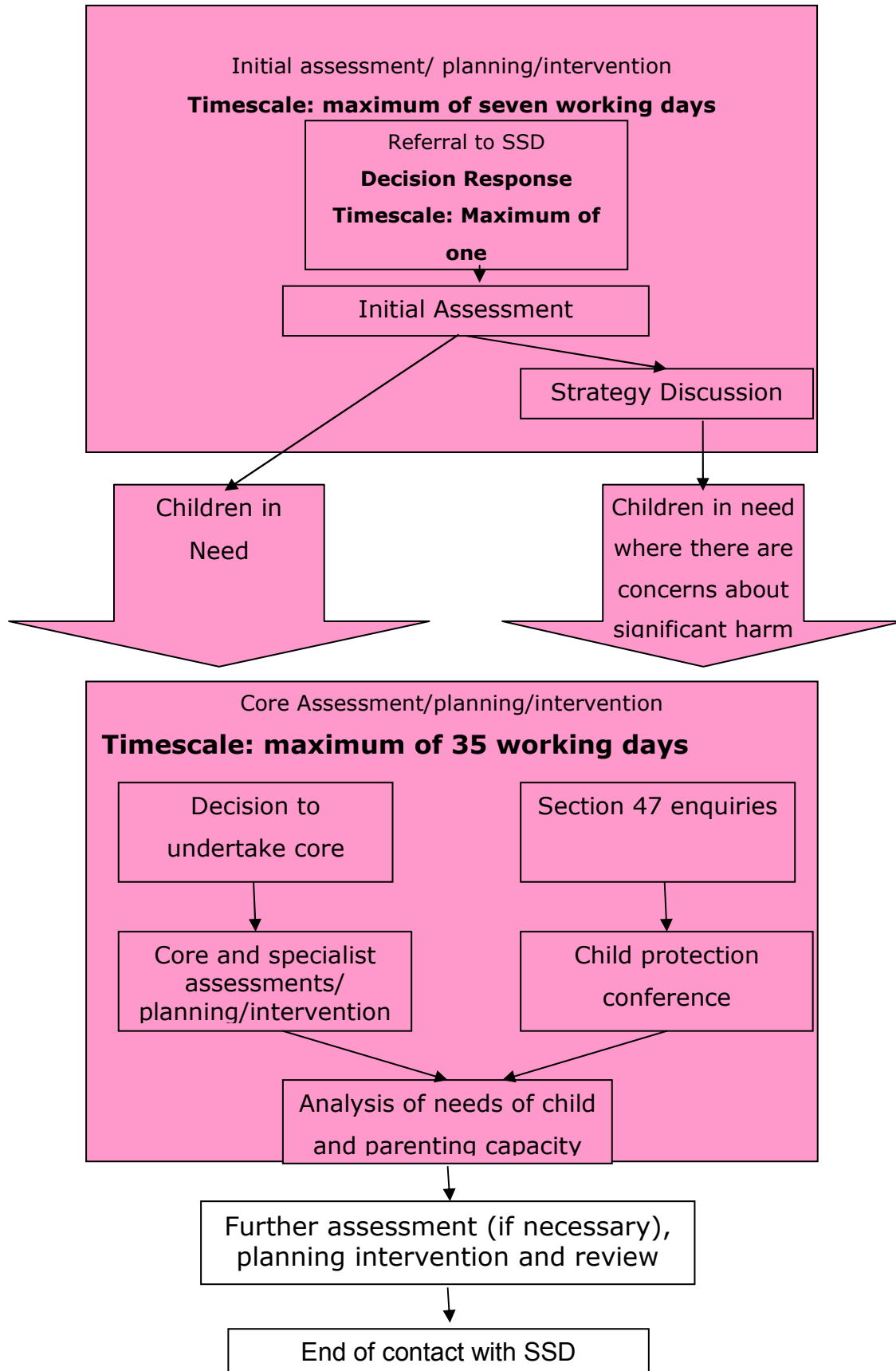
Document	Purpose	File date
Outline of proposal	Outline to SREP	19.3.08
Risk analysis and management form	Identify risks	19.3.08
Information sheet	Provide general info to all host agency staff directly and indirectly involved in the research.	19.3.08
Information Sheet for Initial Assessment Team Staff.	To provide specific information for IAT staff regarding reading files and tracking Initial Assessments.	19.3.08
Information Sheet for Interviewees	To provide specific information for social workers taking parting interviews.	19.3.08
Covering letter to Initial Assessment Team staff	To introduce myself. (to be sent with Information Sheet and Information Sheet for Initial Assessment Team Staff)	19.3.08
Covering letter to interviewees	To introduce myself. To be sent with: 1) Information Sheet, 2) Information Sheet for Interviewees 3) Consent Form	19.3.08
Proposed interview questions.	To provide guidance to researcher on subject areas to talk about during interview.	Draft
Consent Form	For completion by interviewees	19.3.08

Host Agency Ethical Approval Application Additional Documents

Document	Purpose	File Date
RGF Application form	Formal application to undertake research and outline plans	April 08
Information Sheet for Parents	To provide information for parents prior to seeking consent to contact them	12.6.08
Contact consent form	To record parents have agreed to meet to discuss research. Record basic details in order to make contact.	29.5.08
Case file consent form	To record parents have given consent for assessment to be included in research.	29.5.08

Appendix 6

Maximum Timescales for Analysing the Needs of Children and Parenting Capacity



Referral and Information Record

The Referral and Information Record gathers together the essential information about a child or young person. There is an expectation that within one working day of a referral being received there will be a decision about what response is required (paragraph 3.8, *Framework for the Assessment of Children in Need and their Families, 2000*).

A re-referral is defined as a referral about the same child/young person within twelve months of a previous referral to the same council (where the case is closed).

CSSR Case Number _____

Date referral received:

Is the parent/carer aware of the referral? Yes ☐ No ☐

Is this a re-referral? Yes ☐ No ☐

If Yes, does the reason for the re-referral indicate that the response to the original referral did not appropriately address the client's needs?

Yes ☐ No ☐

CHILD/YOUNG PERSON'S DETAILS

Please record all names the child and parents/carers have been known by.

This is the child/young person's usual or home address. Where the parents have shared care, the child/young person may have two addresses.

Responsible CSSR should be completed if a referral is being made regarding a child/young person who is the responsibility of an authority other than your own. For example, a child/young person on the Child Protection Register in another authority or looked after by another authority.

Family name _____ Given names _____

DoB or expected date of delivery:

Gender: Male ☐ Female ☐ Unborn ☐

Address _____

Postcode _____ Tel. _____

Child/young person's first language or preferred means of communication _____

Is an interpreter/signer required? Yes ☐ No ☐

Current address if different from above: _____

Postcode _____ Tel. _____

Social Services Team _____

Responsible CSSR _____

If the child/young person's main carers are users of social services, for example, if they are known to adult social services, their Social Services Case Numbers should be recorded.

Child/young person's main carers:

Name	Relationship to child/young person	Ethnicity	First language	Parental Responsibility
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Is an interpreter/signer required? Mother: Yes ☐ No ☐ Father: Yes ☐ No ☐

Other main carers (please specify name) _____ Yes ☐ No ☐

Are any of the main carers disabled? Mother: Yes ☐ No ☐ Father: Yes ☐ No ☐

Other main carers (please specify name) _____ Yes ☐ No ☐

If known to Social Services – name of main carer, name of CSSR and Case Number _____

Please record brief details about the reason for referral, or services requested by or on behalf of the child. It is important to record details even when services cannot be provided immediately or at all.

Reason for referral/request for services:

Referred by _____ Agency/rel. to child/young person _____

Address _____ Tel: _____

Does the referrer wish to remain anonymous? Yes ☐ No ☐

Appendix 8

Initial Assessment Version 1.0 (2003)



Initial Assessment Record

The Initial Assessment Record continues the process of systematic information gathering commenced in the Referral and Initial Information Record.

An initial assessment is deemed to have commenced at the point of referral to social services or when new information on an open case indicates an initial assessment should be repeated.

An initial assessment is defined as a brief assessment of each child referred to social services with a request for services to be provided. This should be undertaken within a maximum of 7 working days from the date of referral but could be very brief depending on the child's circumstances. In completing this initial assessment, if it is known that a core assessment will be required, social work staff should make a professional judgement about whether it is necessary to complete all sections before beginning a Core Assessment.

Date referral received:

Date initial assessment commenced:

CHILD/YOUNG PERSON'S DETAILS

Family Given names

DoB or expected date of delivery Gender: Male ☐ Female ☐ Unborn ☐

Address

Postcode Tel

CSSR Case Number:

The Initial Assessment Record provides a summary of the work undertaken by social services in collaboration with other agencies.

As part of an initial assessment, the child should be seen. This includes observation and communicating with the child in an age appropriate manner.

Reason for initial assessment, including views of child/young person and parent/carers:

SOURCES OF INFORMATION

Agencies should be consulted and involved as appropriate as part of the initial assessment. Parental permission to contact other agencies should be obtained unless permission seeking may itself place a child at risk of significant harm.

It should be ascertained whether other professionals agree to the information provided being shared with the child and/or family.

Date(s) child/young person and family members seen/interviewed:

Date	Name(s) of family member(s) interviewed	Please tick if child/young person seen during interview
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/>
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="checkbox"/>

Agencies contributing to initial assessment:

Please ensure that the agency's address and parental consent to contact are recorded in the Referral and Information Record.

Please tick if involved	Other agencies (please specify)
GP <input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>
HV <input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>
Nursery/school/educational establishment <input type="checkbox"/>	<input type="text"/> <input type="checkbox"/>

Appendix 9

Core Assessment (Prebirth – 12mths) Version 1 (2003)



Core Assessment Record

Prebirth to Child Aged 12 Months

Family name _____	Given names _____
DoB <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Not yet known <input type="checkbox"/>
Address _____	
_____	Postcode _____ Tel. _____
CSSR Case Number _____	

Families should be provided with the following information

Complaints procedures	Date provided <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Information on access to records	Date provided <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Other relevant/available information (please specify)	Date provided <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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