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# Social Worker and Midwife Decision Making Regarding Child Protection Risk and the Unborn Baby: A Qualitative Study

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A newborn baby is vulnerable to abuse and neglect, and the professional role may involve assessment before the baby is born. The aim of this paper is to explore the perspectives and experiences of midwives and child protection social workers regarding the protection of unborn babies within Northern Ireland. Data were gathered using four focus groups (14 midwives and 16 child protection social workers) within one Health and Social Care Trust. The data were analysed in terms of understanding risk factors and forming a professional judgement. The mental wellbeing of the pregnant woman, drug use, alcohol use, domestic violence, the pregnant woman's childhood experiences, gestation period and antenatal care attendance were the main risks identified. Observations, engaging with the pregnant woman and using 'soft intelligence' were key aspects in forming a professional judgement. The appraisal of the ability of the pregnant woman to recognise danger was an important moderating factor, and perhaps formed part of a professional judgement heuristic to assist in making sense of wide-ranging information about diverse risks.

Key Practitioner Messages:

- Identified risk factors included mental wellbeing, age, feelings about the pregnancy, drug and alcohol use, domestic violence, the pregnant woman's childhood experiences, gestation period and antenatal care attendance.
- Pregnant women were unable to recognise the dangers in misusing illegal or prescription drugs, excessive alcohol consumption and initiating/maintaining relationships with sex offenders.
- Key skills in forming a professional judgement involved engagement with the pregnant woman, professionals' experience and observations, and the use of 'soft intelligence'.

Key Words: decision making; unborn baby; child protection; risk assessment

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**'Explore[s] the perspectives and experiences of midwives and child protection social workers regarding the protection of unborn babies within Northern Ireland'**


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## Introduction

Among the complex child protection situations facing professionals, one of the most challenging is when concerns arise during pregnancy. The concerns may relate to the care of previous children, or may relate to the health, behaviour, circumstances or history of the parents. The presenting risks must be analysed and understood using the best knowledge available (Whittaker and Taylor, 2018) so as to inform decision making (Taylor and Killick, 2013; Taylor and Whittaker, 2019). Early identification, assessment and appropriate supportive intervention are generally regarded as important (MacDonald *et al.,* 2012), but these present challenges. The relevant professionals must form a judgement as to whether the future behaviour of parents is likely to have a serious detrimental impact on their baby (Everitt *et al.,* 2017) and assess what possibilities there are for engaging the family in a safeguarding and helping process (Fengler and Taylor, 2019; Killick and Taylor, 2020).

**'Professionals must form a judgement as to whether the future behaviour of parents is likely to have a serious detrimental impact on their baby'**

The professional engaging in the decision-making process must take account of the relevant statutes, regulations, guidance, standards, policies and procedures (Everitt *et al.,* 2015). They must seek a practical way forward for the family and the care of the baby in keeping with professional and other ethical standards (Everitt *et al.,* 2017), ever mindful of protecting the unborn baby from serious harm yet aware of promoting family life where possible (Duffy *et al.,* 2006) and operating within the relevant governance arrangements (Taylor and Campbell, 2011). Organisational and legislative arrangements and professional roles vary across countries, but midwifery and child protection social work professions are the key professions in Britain and Ireland. Although doctors are involved in aspects of child protection decision making, in practice the task of making a child protection referral within a hospital setting is more often undertaken by a nurse (or midwife in maternity services) or a hospital social worker.

In Northern Ireland, the *Children (Northern Ireland) Order 1995* (particularly Articles 18 and 46) (Department of Health, Social Services and Public Safety (DHSSPS), 1995) places a statutory responsibility on the public health and social care (HSC) organisations to provide appropriate services (requiring professional assessment) if it is suspected that a child, including an unborn baby, is at risk of harm (Taylor, 2012; Taylor and Whittaker, 2019). Midwives and child protection social workers undertake a needs assessment using the Understanding the Needs of Children in Northern Ireland (UNOCINI) framework (DHSSPS, 2011) to determine if a baby is in need. HSC professionals are duty bound to make a referral to child protection services if a pregnant woman is under the age of 16 years, as this may indicate child abuse. Midwives, in consultation with their professional supervisor and the hospital social worker, initiate a referral to child protection services if they are concerned about an unborn baby (Nursing and Midwifery Council (NMC), 2019). Social workers receiving these referrals undertake assessment and use their professional judgement to weigh up the risks of harm and make recommendations about protective interventions within mandated child protection decision processes (Taylor, 2017a). Although the child protection social workers are employed in the same HSC organisation as the midwives, they are based in community offices whereas midwives are hospital based (South Eastern and Health and Social Care Trust (SEHSCT), 2017a). Social



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work services for families are organised into specialist teams, whereby child protection social workers in 'Gateway' teams undertake initial assessment. Other social work teams deal with placement and supervision of children in state care, those leaving care, adoption of children, inspection of early years services, etc. (SEHSCT, 2017b).

Various risk factors leading to referrals of unborn babies have been reported within previous research (Mc Elhinney *et al*., 2016; Mc Elhinney *et al.,* 2019). Such risk factors included domestic violence (Ayerle *et al.,* 2012), drug use (Latuskie *et al.,* 2019), alcohol use (McGrory *et al.,* 2019), mental wellbeing (Rusanen *et al.,* 2018), age of the pregnant woman (Ayerle *et al.,* 2012), feelings about the pregnancy (Ayerle *et al*., 2012) antenatal care (Willinck and Schubert, 2000) and the pregnant woman's childhood experiences (Broadhurst and Mason, 2013). These risk factors are often seen in combination, creating added complexity.

This study sought to provide an insight into the experiences and perceptions of professionals undertaking this work, and to ascertain how they observed and used the risk factors observed in pregnant women to inform their judgements about possible abuse or neglect.

Previous research focused heavily on the development and implementation of antenatal psychosocial assessment tools with pregnant women (Midmer *et al.,* 2004; Robertson Blackmore *et al*., 2006). There was little focus on qualitative data to identify experiences impacting HSC professionals' decision making to protect an unborn baby. Consequently, this paper provides an insight into the perspectives and experiences of HSC professionals around decision-making processes to protect an unborn baby.

### *Aim*

The aim of this study was to explore the perspectives and experiences of midwives and child protection social workers regarding the protection of unborn babies. This paper reports findings in relation to risk factors and forming a professional judgement.

## Methods

### *Study Design*

This qualitative study used focus groups with midwives and child protection social workers in one Health and Social Care Trust (HSCT) in Northern Ireland. The five HSCTs in Northern Ireland deliver publicly funded hospital and community HSC services to the population of approximately 2 million people (Taylor, 2012). This includes both maternity services and a range of social work and social care services.

### *Recruitment*

Social workers were recruited from four different children's services social work teams (Single Point of Entry, Gateway, Family Intervention Teams and 16 + teams) located within the community, and midwives were recruited from three hospital and community sites all from within one HSCT. Participants

**'This qualitative study used focus groups with midwives and child protection social workers in one Health and Social Care Trust (HSCT) in Northern Ireland'**




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were recruited by a manager from maternity services and a manager from children's services, respectively. Both managers used the inclusion criteria which specified that the midwives and social workers needed to have experience of initiating or receiving child protection referrals regarding an unborn baby. Information packs which included an invitation letter, Participant Information Sheet detailing terms of participation and a consent form were emailed to staff by managers who then responded regarding their availability to attend.

### *Participants*

**'Thirty professionals participated in the four focus groups'**

Thirty professionals participated in the four focus groups. Twenty-nine participants (5 male; 24 female) provided demographic information of which 14 were midwives (MW) and 15 were children's services social workers (SW). The age ranges of participants were as follows; 27–32 years ($n$ = 3), 33–38 years ($n$ = 7), 39–44 years ($n$ = 2), 45–50 years ($n$ = 6), 51–56 years (n = 6), 57–62 years ($n$ = 4) and 63 + years ($n$ = 1). Participants were employed full time (MW = 13, SW = 14) and part time (MW = 1, SW = 1). The majority of professionals (MW = 10, SW = 10) had been involved in between one to ten child protection cases involving a pregnant woman in the previous 12 months. Twenty-four participants (MW = 14, SW = 10) indicated that they had received child protection training, and five participants (MW = 5) indicated that they had not.

### *Data Collection*

**'Questions included the identification of risk factors impacting decisions to refer an unborn baby to children's services'**

The focus groups were undertaken in May–June 2015. In total, four mixed-profession focus groups with midwives and children's services social workers were undertaken at a convenient time and location for participants. A semi-structured approach was used and the focus group schedule included questions on professionals' experiences of child protection cases involving unborn babies. More specifically, questions included the identification of risk factors impacting decisions to refer an unborn baby to children's services, how they assess the risk of harm in pregnancy and other risk factors that they could identify from practice that impacted upon their decision to refer. The particular focus was on risk factors pertaining to referrals of unborn babies, approaches to risk assessment and decisions to refer. Risk factors identified from the literature were also discussed, particularly for relevance to their practice. Professionals were asked to reflect upon cases whereby these risk factors were present, how they were alerted to the risk factors and their perceived risk to the unborn baby. The primary researcher organised and facilitated the focus groups. The size of focus groups varied from 3 to 11 participants, and the average length was 90 minutes. Professionals attended the focus group session during their lunch break; a healthy lunch was provided as a mark of appreciation. Understanding was verbally checked, opportunity for questions about the process communicated and all consent forms checked for completion ahead of commencement of the focus groups. All focus groups were audio recorded and written notes were taken by a note taker to enhance the veracity of the data interpretation. The primary researcher briefly reflected on the meeting and provided summary points for confirmation by participants



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prior to the closure of the focus group. At the end of each focus group session, participants completed an anonymous demographic questionnaire.

### *Ethical Approval*

Ethical approval for the study was granted by Ulster University School of Nursing Research Governance Filter Committee and the Research and Development Office of the Health and Social Care Trust where the data was collected. Steps were taken to minimise risks to participants including confirming written consent, ensuring that participants were fully informed about what their participation entailed and confidentiality. Informed consent was obtained through the provision of a Participant Information Sheet and completion of Consent Forms. As this had the potential to be an emotive study, a risk assessment was undertaken, a disclosure protocol developed and a participant resource file with signposting to support services made available.

### *Data Analysis*

Several strategies were implemented to ensure trustworthiness of the data (Polit and Beck, 2010). A focus group schedule was developed and followed in all focus groups. Participants were also debriefed after each focus group to ensure that the information recorded was an accurate representation of the discussion. A discussion was undertaken immediately after each focus group between the researcher and note taker to corroborate findings. The data from the focus group recordings were transcribed verbatim, augmented by the written notes. Data analysis began after the initial focus group and this process continued until the final focus group (Charmaz, 2014). A thematic analysis was undertaken using the six-stage Newell and Burnard (2006) framework of thematic analysis (Newell and Burnard, 2006). Initial themes were colour-coded, and similar and overlapping themes were developed and colour-coded for reference. The researcher undertook a final review of the transcripts and final category codes were agreed upon with the research team (two senior academic supervisors) and an independent reviewer (an experienced midwife and academic), who had also followed the same rigorous process. The independent reviewer identified two further themes (physical disability and learning disability) which, after further discussion, were discarded. It was concluded that they did not feature as a significant risk factor influencing professionals' decision making in the focus groups. The agreed themes were discussed with a manager from maternity services who was a midwife and a manager from children's services who was a social worker.

## *Findings*

*Themes and Sub-Themes*

The findings are presented under the following themes and sub-themes:

- Understanding risk factors
    - Overview of risk factors identified
    - Maternal mental health and substance use
    - Pregnant women's ability to recognise danger




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- Forming professional judgements
  - Engagement with pregnant women
  - Professional experience
  - Use of soft intelligence

### *Understanding Risk Factors*

*Overview of Risk Factors Identified*

Risk factors for child abuse or neglect identified by respondents included: mental wellbeing of the pregnant woman, domestic violence, the age of the pregnant woman, drug use, alcohol use, the pregnant woman's childhood experiences, feelings about the pregnancy, gestation period and antenatal care attendance. The pregnant woman's childhood experiences presented as a major risk factor. Many of the women identified as being at risk had previous history of being in care themselves, experienced or witnessed abuse, had a history of self-harm, police involvement or an unstable home environment. The main reasons cited in the focus groups for undertaking a child protection referral of an unborn baby in the last 12 months were mental illness ($n$ = 18), domestic violence ($n$ = 15) and substance misuse ($n$ = 12).

**‘The pregnant woman's childhood experiences presented as a major risk factor’**

### *Maternal Mental Health and Substance Use*

The mental wellbeing of the pregnant woman was discussed frequently. Many women had a history of mental illness, were currently mentally ill or had mental health difficulties without a formal diagnosis. In some cases, women experienced a deterioration in their mental health during pregnancy. Attempted murder of a baby and infanticide by women were also reported in the postnatal period. Midwives found it difficult to discuss historical and current mental health issues (including anorexia) with pregnant women and felt that they lacked knowledge and were not trained or equipped to deal with a deterioration in the mental health of a pregnant woman. Further compounding these issues, many women lacked a formal diagnosis of a mental illness, making access to services more difficult. Some pregnant women had a history of attendance at a perinatal mental health clinic, others were placed under 24 hour observation during pregnancy while they received appropriate treatment for their illness. However, medication used in pregnancy for conditions including bipolar disorder and schizophrenia were also concerning with some pregnant women choosing to remove themselves from their medication without consulting their General Practitioner (GP).

Illegal or prescription drug use was cited as another risk factor within the focus groups. The misuse of prescription medication for chronic pain without knowledge that excess use could cause harm to an unborn baby was an issue with pregnant women. Cessation of medication for severe mental illness without GP/midwife knowledge resulted in a deterioration in mental health, posing a great risk to the unborn baby and pregnant woman. Excessive alcohol consumption in pregnancy and the inability of a pregnant woman to protect herself physically while under the influence of alcohol was cited. Professionals felt that they were better able to support pregnant women who disclosed alcohol use in pregnancy than those women who denied alcohol consumption so as to avoid detection.



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### *Pregnant Women's Ability to Recognise Danger*

In many cases, pregnant women failed to see the risks in their behaviour and the potential impact on the unborn baby. Some pregnant women were reported to be leading chaotic lifestyles, consuming alcohol in pregnancy and initiating/maintaining relationships with registered sex offenders. Anorexia in pregnant women and the impact on the unborn baby was also discussed. Pregnant women did not fully understand the impact that refusing to eat could have on their baby, potentially leading to a stillbirth.

Midwives spoke of the inability of pregnant women to recognise the impact of consuming high doses of prescription pain medication had on an unborn baby. To manage pain, women needed medication, but were oblivious that high doses or misuse could have a detrimental impact on an unborn baby:

> 'Despite the fact she had taken such a heavy amount of pain medication, the baby actually went through withdrawal after it was born, and the subsequent baby had to be put on observation. She just did not seem to realise what she was putting in was impacting.' (FG2 MW1)

Learned behaviour contributed to the lack of awareness by pregnant women to the potential effects of risky behaviours on an unborn baby. A history of poor social circumstances and history of care may mean that they perceive their behaviours as normal comparing it with what they experienced and using that as a frame of reference. Those who grew up in care lacked a parenting role model to which they could model their current parenting behaviour on, thus breaking the cycle. Cases were individual; circumstances differed depending upon the attitude and awareness of pregnant women:

> 'For a lot of young people in care that is a big question in their head. You know they have a lot of feelings about having to come into care because quite possibly their parents weren't able to give them the childhood they deserved and needed. They don't want to make that same mistake themselves.' (FG1 SW1)

However, other pregnant women had the capacity to take on board the enormity of the situation and realised that they were living risky lifestyles, had made many mistakes and vowed to parent their baby in a better way.

**'In many cases, pregnant women failed to see the risks in their behaviour and the potential impact on the unborn baby'**

### *Forming Professional Judgements*

#### *Engagement with Pregnant Women*

It was evident from these focus groups that professionals adopted a compassionate and empathetic approach towards pregnant women in their care. There was particular emphasis placed on the importance of continuity of care, building rapport and developing and maintaining transparent relationships with pregnant women to inform decision making. This process was easier with pregnant women who themselves had a history of care and were now subjected to risk assessment, as trusting and transparent relationships had previously been formed. However, professionals relied heavily on self-disclosure by pregnant women to make the process of undertaking assessments less arduous. Professionals spoke of the challenges of encountering disguised compliance whereby pregnant women, particularly those who had children's services support in previous pregnancies, misled and deceived professionals.

**'Professionals relied heavily on self-disclosure by pregnant women to make the process of undertaking assessments less arduous'**




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Self-disclosure can be beneficial for the assessment of a pregnant woman, however, non-disclosure can be enormously challenging for professionals. In particular, in cases of domestic violence in pregnancy, the risks to the unborn baby can include irreparable damage and even cause stillbirth. Cases of domestic violence occurred in pregnant women from both affluent and more impoverished backgrounds within this research. Pregnant women seemed torn between protecting their abuser and revealing domestic violence to midwives:

> 'It's a hard area too because women who are actually going through domestic violence, they have this whole thing where they love the other side (perpetrator). Even though they are trying to get help, on the other part they are not telling you the truth all the time. So, they hide a lot as well and that makes it more dangerous because you might be coming in too late.' (FG3 MW3)

### *Professional Experience*

It was apparent from this study that professional experience enabled professionals to tease out issues with pregnant women. Observation of parental behaviour provided key insights into cases and potential issues with regards to parental capacity. Notably, the potential of pregnancy to resurrect memories of sexual abuse for women was discussed. Midwives observed pregnant women's discomfort with intimate examinations, suturing and the fear of contact with their baby. A midwife recalls observations at an antenatal appointment whereby sexual abuse was suspected, possibly resulting in the pregnancy:

> 'She wasn't giving any information about family history and it was queried that there was a very close bond between her and her father who was attending the appointments as well and was going to be her birth partner. That's not usual that your dad would be with you in that situation.' (FG2 MW2)

Midwives observed that in some cases of unplanned and unwanted pregnancies that pregnant women appeared disinterested in their pregnancy and unborn baby. Concerns arose around the circumstances of conception, the pregnant woman's ability to bond with her unborn baby and her general capacity to parent. A baby born as a result of her mother having been sex trafficked was also placed in care as a protective measure by her mother to prevent the child also becoming a victim of sex trafficking.

The age of the pregnant woman was cited as a risk factor, more so for midwives who were obliged to automatically make a referral if the pregnant woman was under the age of consent (16 years old in Northern Ireland). However, social workers undertaking these assessments weigh up the factors to inform their decision making around accountability. The gestation period was considered a risk factor as the further into the pregnancy the greater the need to refer to children's services to initiate a plan of action before birth. Referrals made later in pregnancy restricted the timeframe for assessment, case planning, monitoring and initiation of appropriate support services to families. Referrals received by social services a month before the birth of a baby or premature delivery limited their ability to complete a full pre-birth risk assessment. This caused frustration when professionals believed that cases were closed too soon due to large caseloads which influenced thresholding.



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A case was referred to the community social work team regarding domestic violence and substance misuse in the partner of the pregnant woman which a social worker felt was closed too soon:

> 'Community (social work team) have been involved but I only found out today that they have closed it. When I talk to colleagues in the community, they would share a lot of these concerns, but the reality is that because of the volume of work, "it's closed, we can always re-open when a new referral comes in". I sometimes think when you look at Serious Case Reviews that that process is probably dangerous on some occasions.' (FG4 SW3)

Pregnant women who refused to engage with antenatal services were also of concern. Consequently, those who presented late in pregnancy for antenatal care raised concerns regarding the circumstances around conception and potential history of social services involvement. Late attendance may have been an attempt to avoid further referrals in the current pregnancy.

**'Pregnant women who refused to engage with antenatal services were also of concern'**

### *Use of Soft Intelligence*

Midwives and social workers discussed the importance and value of the observations, thoughts, feelings and feedback (soft intelligence) shared between professionals in child protection cases. This type of communication was invaluable in assisting professionals to ascertain further information on cases. Midwives relayed their concerns regarding cases to social workers who documented and brought this information forward for discussion at case conferences. It was also highlighted that midwives have informal discussions about cases among members of their own profession to help in clarifying their concerns and the need for referral:

> 'So then other staff members, having looked after this girl … say … what is your opinion? Have you come across this? And then once everyone kind of sat down "Oh yea, I heard her say that or she did that so". Right then so let's phone the social workers.' (FG2 MW1)

Professional decision making is also guided by intuition and familiarity with previous cases involving a pregnant woman or her extended family. Professionals working and living within community settings had an added advantage of being aware of intergenerational cases living locally within their community. Domestic violence was one of the more prominent risk factors reported by professionals with many pregnant women presenting with signs of abuse at antenatal appointments. A midwife recalled her experience of a case whereby a pregnant woman attended a booking clinic where no concerns were detected at assessment. However, the midwife recognised her partner who was also in attendance and discussed the case with a social worker, both remembered that there had been a history of previous child protection issues with another child:

**'Professionals working and living within community settings had an added advantage of being aware of intergenerational cases living locally within their community'**

> 'I thought, I know him from somewhere and I couldn't think of who or what had happened. I thought, "his face is familiar to me". If I hadn't have had my suspicions or a wee inkling from a memory from ten years ago nobody would have known.' (FG4 MW2)

Intuition and the presentation of physical evidence on a pregnant woman at an antenatal appointment alerted midwives to a potential case of domestic




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violence. A referral to social services was initiated by a midwife and, as part of the assessment process, the social worker sought an explanation for the presence of abdominal bruising:

> 'She gave this account of being on the staircase and a puppy on the staircase and tripping on the puppy and holding onto the banisters when she got to the bottom. They didn't make sense; they didn't correlate with the bruises which were not entirely fresh or prominent.' (FG4 SW5)

## Discussion

The study was restricted to two HSC professions, albeit the two key professions dealing with the initiation and receipt of child protection referrals concerning an unborn baby in this jurisdiction (Icheku, 2011). Data collection was restricted to one HSCT in Northern Ireland. However, there is no reason to suppose that the experience of professionals in this Trust regarding risk factors and individual professional judgements are likely to be distinctly different from the other four Trusts. The catchment included both urban and rural settings. The data was gathered in 2015 and it is acknowledged that the experience of staff in working environments can change over time. However, our ongoing contact with the services suggests that major change has not occurred since the study data was gathered.

**'Pregnant women without a formal diagnosis of mental illness were of great concern to professionals, particularly as this prohibited access to appropriate support services'**

Pregnant women without a formal diagnosis of mental illness were of great concern to professionals, particularly as this prohibited access to appropriate support services (Rusanen *et al.,* 2018). Furthermore, unsupervised cessation of medication taken for mental illness risks a deterioration in mental health which could be potentially harmful to a pregnant woman and her unborn baby. To further compound the issue, professionals felt that they lacked knowledge and training to deal with deterioration in mental health of pregnant women. A recent report into perinatal mental health service provision indicated that Northern Ireland had the poorest level of perinatal mental health provision, with only one of the five HSCTs providing services and no regional mother and baby unit (Regulation and Quality Improvement Authority (RQIA), 2017). It is clear that there is a need for an improvement in perinatal mental health services, provision of mental health training for staff, and an increase in resources to improve detection and adequate service provision to avoid women and babies being separated while undergoing treatment for mental illness.

Awareness of pregnant women about the risks of misusing both prescription and illicit drugs in pregnancy was reportedly lacking in this study. Drug use has a direct impact on a pregnant woman, but also poses a detrimental risk to the development of an unborn baby and its welfare in the postnatal period (World Health Organization (WHO), 2014). More specifically, pregnant women were unaware that excessive use of pain medication could have a harmful effect on their unborn baby (Sinclair *et al.,* 2017). Some believed that they were protecting their baby by ceasing medication taken for severe mental illnesses (often without the knowledge of professionals), which resulted in deterioration in their mental health (Doran, 2013) and presented a challenge



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for inexperienced professionals to detect and treat, placing an additional burden on already stretched mental health services (RQIA, 2017).

Ingesting other substances in pregnancy, such as alcohol, poses a high risk to pregnant women and unborn babies. Alcohol consumption in pregnancy could potentially cause Foetal Alcohol Spectrum Disorder (FASD) or Foetal Alcohol Syndrome (FAS), but could also reduce the ability of a pregnant woman to protect against danger (McGrory *et al.,* 2019; Peadon *et al.,* 2010). Disclosure of alcohol consumption in pregnancy and continuity of midwifery care is key in the behaviour change regarding alcohol use in pregnancy. This allows for consistent and thorough assessment by midwives who have already formed trusting relationships with pregnant women (Reid *et al.,* 2019).

Continuity of care helps to reinforce relationships between professionals and pregnant women and allows for the development of trust and disclosure of sensitive issues (Oni *et al.,* 2020). The importance of building good relationships with pregnant women to inform decision making was stressed by professionals in this study (Ayerle *et al.,* 2012; Critchley, 2020). Adopting a non-judgemental, empathetic and compassionate approach towards pregnant women was paramount to inform and support the process of risk assessment (Reamer, 2013). It was discussed that disguised compliance or indeed non-compliance made the risk assessment process more difficult at times, particularly in cases of suspected domestic violence.

**‘Adopting a non-judgemental, empathetic and compassionate approach towards pregnant women was paramount to inform and support the process of risk assessment’**

Classified as a severe public health issue jeopardising the life of a pregnant woman and unborn baby (Finnbogadóttir and Dykes, 2016), domestic violence in pregnancy can result in violence being directed at both the pregnant woman and her unborn baby (Lima *et al.,* 2019). Pregnancy can act as both a protective factor and risk factor for the occurrence of domestic violence (O'Reilly and Peters, 2018); however, anticipatory fear of threats of violence causes prolonged undue stress on pregnant women and unborn babies (Chisholm *et al.,* 2017). Midwives are well placed to undertake screening for domestic violence, which quite often involves observing risk factors when witnessing the interaction between pregnant women and partners at antenatal appointments (Leneghan *et al.,* 2012). While these observations were crucial for risk assessment, the presence of the possible perpetrator hindered the task of undertaking routine screening of domestic abuse (Watson and Rodwell, 2014).

The potential intergenerational impact of pregnant women's adverse childhood experiences (Bartlett *et al.,* 2017) was discussed, with particular reference to attachments or the lack thereof in childhood. For those women who grew up in care, attachments may never have been formed, and an absence of a parental role model on which they could base their own parenting skills could cause problems in bonding with their own baby (Macdonald *et al.,* 2012). Intergenerational continuity and transmission of negative parenting behaviours can have a devastating impact on the ability of a pregnant woman to effectively parent her baby (Schofield *et al.,* 2017). However, some pregnant women who had negative childhood experiences were determined not to repeat those with their own baby, and made positive changes supported by professionals in charge of their care (Panisch *et al.,* 2020).

Professional experience and observations of parental behaviour influenced decision making around capacity to parent, notably around suspected cases of current or historical sexual abuse. The way a pregnant woman felt about




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the pregnancy was considered a risk factor (Ayerle *et al.,* 2012). If the baby was the result of incest or sex trafficking this was highlighted as a risk factor (WHO, 2019). Additionally, the age of the pregnant woman was of concern, particularly to midwives. Underage pregnancy, classified as those under the age of 16 years old, was regarded as requiring referral by a midwife to children's social work services for further investigation, particularly surrounding the circumstances around conception (NMC, 2019).

Late antenatal care attendance or missed appointments raised alarms in cases where women had a previous history of children's social services input and were attempting to conceal potential child protection concerns from midwives (Medforth *et al.,* 2017). Social workers reported that many of their clients who were pregnant did not engage with antenatal services, but would present at maternity services when in labour. This meant that midwives had no record of the pregnant woman much less knowledge of a social work history causing additional issues for risk assessment. A later referral could cause issues with initiating support services. It is recommended that pre-birth risk assessment should be undertaken as soon as an unborn baby has been deemed to be at risk (Health and Social Care Board (HSCB), 2016). However, babies born prematurely restricted the timeframe for professionals to undertake a pre-birth initial child protection case conference, which can only be initiated after the 24 weeks' gestation period (HSCB, 2016) when an unborn baby is deemed 'viable'. There was some suggestion that this short timeframe may result in missed opportunities for pregnant women to get support and instigate changes to keep their baby, especially for those who were subject to pre-birth risk assessments in previous pregnancies (Broadhurst and Mason, 2013).

The comments about appraising the ability of the pregnant woman to recognise danger (such as in relationships or from over-use of prescription medications) were noteworthy. This concept represents perhaps a heuristic or 'mental shortcut' (Taylor, 2017b) by which the professionals used a moderating factor to judge the seriousness of the risk factor. The use of 'soft intelligence' within the judgement process might be viewed similarly (Martin *et al.,* 2015). It was reported by Clayton (2013) that the level of experience of the assessor impacted upon decision making and invoked intuitive reasoning, which was gained through personal knowledge, experiences, values and wisdom. It was conveyed by both midwives and social workers that in many cases previous experience with families and intuition, or 'gut instinct' as it was referred to, guided their assessment. Seeking to understand the models of decision making used by professionals (Taylor, 2012), so as to be able to teach novices (Taylor, 2020), are important aspects for further research.

## Conclusion

The risk factors identified by the midwives and child protection social workers were informative. The mental wellbeing of the pregnant woman was highlighted by respondents as a risk factor, as were concerns about drug and alcohol use, domestic violence, age of the pregnant woman, the pregnant women's own childhood experiences, feelings about the pregnancy, gestation period and antenatal care attendance. Skills in observation and in engaging with pregnant women were important aspects of the professional judgement



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process. The use of 'soft intelligence' was an important part of the process of appraising the seriousness of risks. The appraisal of the ability of the pregnant woman to recognise danger was an important moderating factor, and perhaps formed part of a professional judgement heuristic. Building trusting relationships with pregnant women, multi-professional communication, continuity of care alongside consistent and accurate evidence gathering were paramount in the assessment and decision-making processes to protect an unborn baby.

**'The use of 'soft intelligence' was an important part of the process of appraising the seriousness of risks'**

## Implications for Practice

Recommendations which could influence clinical practice in the area of child protection of unborn babies include: the need for perinatal mental health training for midwives and social workers; the improvement of perinatal mental health services to allow for early detection and support of perinatal mental illness; the provision of additional resources to facilitate the continuity of midwifery care; interventions to protect unborn babies at risk of harm; and the further development of joint safeguarding training for both midwives and social workers to increase knowledge and understanding of respective roles.

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