birth companions

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NPEU

Spotlight:

Understanding the circumstances, experiences and outcomes of women with children's social care involvement who died during or in the year after pregnancy.

Spotlight briefing

This briefing paper provides a summary of research conducted by partners at King's College London, University of Oxford, Birth Companions and other collaborators.*

The study analysed UK national maternal mortality surveillance data and carried out a detailed review of care records in order to better understand the experiences of women who died in pregnancy or the year after, while known to children's social care (CSC). This paper also outlines priorities for action, on the basis of this study, including recommendations for national policy development.

We are hugely grateful to the women with lived experience of children's social care involvement, including parenting assessment and the removal of babies, for their work to shape and reflect on this research.

The full study, including methodology, is available to read here.

The study

In the last decade there has been a two-fold increase in the proportion of women who died during pregnancy or in the early postnatal period (six weeks after birth) who had children's social care (CSC) involvement[1].

In order to better understand the situations of these women, the causes of their deaths, and the quality of the care they received, the study reviewed the UK maternal mortality surveillance data (MBRRACE-UK), looking at all deaths that occurred during pregnancy or up to a year after pregnancy in the UK from 2014-2022. Further insight was then gained through a confidential review of care notes, which looked at anonymised care records of 47 women with CSC involvement.

A note on language
The terms 'pregnant women' and 'mothers' are used throughout this paper, but we recognise not everyone who is pregnant or gives birth will identify as a woman or a mother

* The full research summarised in this Spotlight paper is available at: https://doi.org/10.1136/bmjmed-2025-001464

Context

CSC involvement in pregnancy and early motherhood.

Infants (under one) make-up over a quarter of all children in care proceedings, with newborn babies representing an increasing proportion of these. In 2023 almost 7,000 unborn babies and 16,000 infants under the age of one were considered by children's social care (CSC) to be at risk of harm and required some level of intervention[2]. The number of newborn babies in care proceedings in England increased from 2,425 in 2012/13 to 2,914 in 2019/20; a 20% increase in just seven years[3]. There are marked regional differences in the rates of infants and newborn babies subject to care proceedings, with the North recording far higher rates than London and the South East.

Many of these proceedings happen with little to no notice; in 80%, mothers received seven days or less notice of a court hearing to remove their new baby. Nearly 20% were served notice of a hearing scheduled to take place that same day[4].

The 2022 MBRRACE-UK report on maternal deaths[5] highlighted the fact that many women who died by suicide (11%) or as a result of substance use (58%) had had their baby taken into state care. CSC involvement during pregnancy and the postnatal period has been referred to as one of the most challenging aspects of contemporary clinical maternity practice and is known to be associated with maternal mortality[6,7] and morbidity[8].

It is important to reflect on the role of severe disadvantage and harm in women's lives prior to, and during their CSC involvement. The primary drivers of CSC involvement - mental health need, domestic abuse, and substance use – are for many women linked with histories of trauma and abuse[9]. A high proportion of mothers involved in recurrent care proceedings have themselves experienced multiple adversities in childhood, including abuse and neglect, loss and rejection, either/ both when with their families and when in the care system[10]. Evidence shows that the greatest disadvantage is experienced by those who endure a range of types of extensive abuse across their life-course - and that over 80% of this group are women[11].

Study findings

The circumstances of women who died while known to CSC

The study found that nearly one in three (29%) of the women who died during pregnancy or the postnatal year between 2014 to 2022 were known to CSC. In 2014, the proportion stood at 20%. During this time 420 of the 1,451 women who died (and whose CSC status was known) had CSC involvement for their unborn baby or infant. This proportion is higher than previously reported, as the study included data on maternal deaths in the later postnatal period – from six weeks to a year after birth.

The proportion of maternal deaths that intersect with CSC involvement has been steadily increasing since 2014, with the highest proportion (30.5%) among women who died in 2019-21. The majority of these women's deaths occurred between six weeks and the year after pregnancy (75%), and were more likely to be the result of suicide (20%) or other psychiatric causes including substance use (30%), or homicide (5%), compared to women who died who did not have CSC involvement.

29%

of women who died during pregnancy or the postnatal year between 2014-2022 were known to CSC

Cause of death	No known CSC involvement (n=1031) Frequency (%)**	Known CSC involvement (n=420) Frequency (%)**
Accidental	29 (3)	14 (3)
COVID-19^^	46 (4)	5 (1)
Infection (excl. COVID-19)	61 (6)	23 (5)
Cardiac	171 (17)	44 (10)
Deaths in early pregnancy	12 (1)	2 (<1)
Haemorrhage or AFE	62 (6)	6 (1)
Malignancy	201 (20)	20 (5)
Neurology	91 (9)	23 (5)
Other indirect	87 (8)	22 (5)
Pre-eclampsia & eclampsia	17 (2)	3 (1)
Thrombosis & thromboembolism	89 (9)	34 (8)
Unascertained or other	15 (1)	2 (<1)
Suicide	97 (9)	82 (20)
Other psychiatric causes	36 (3)	125 (30)
Homicide	17 (2)	15 (5)

** calculated rates do not include missing values
^^ only includes women who died in 2020-22

Women known to CSC faced multiple and severe forms of disadvantage. Half were living in the most deprived postcodes in the country, and they were more often unemployed (including both the woman and partner's employment status) than women without CSC involvement (61% versus 10%).

The majority (65%) of women with CSC involvement reported domestic abuse prior or during pregnancy, compared to 3% of women without CSC involvement. Similarly, disclosure of abuse during childhood was much higher among these women (33%, compared to 2% among those without CSC), although this information was missing for a large proportion of women in both groups.

Women aged 20 or younger were almost twice as likely to have CSC involvement as older women.

A higher proportion of women with CSC involvement had pre-existing medical problems (75%, versus 59%), mental health issues (75% versus 27%), smoking during pregnancy (73% versus 21%) and known substance use (55% versus 5%) than women with no CSC involvement.

Women with CSC involvement were predominately White, with those from Black and Asian backgrounds significantly less likely to have CSC involvement in pregnancy or the postnatal year. At first glance, this seemingly contradicts the existing evidence on ethnic disparities in maternal mortality rates[12], and in CSC involvement, which shows disproportionate representation of children from Black and mixed ethnicity in care proceedings[13]. However, recent studies have shown that children from Black and Asian families are referred at older ages than White children[14]. This may mean that among perinatal women, and by extension their infants, such disparities have not yet manifested, but further research is needed. It is important to note that rates in this study are based on the women who died and so may not be reflective of wider representation of those with CSC involvement.

65%

of women **with** CSC involvement reported domestic abuse prior or during pregnancy

33%

of women **with** CSC involvement disclosed abuse during childhood

75%

of women **with** CSC involvement had pre-existing medical problems

3%

of women **without** CSC involvement reported domestic abuse prior or during pregnancy

2%

of women **without** CSC involvement disclosed abuse during childhood

59%

of women **without** CSC involvement had pre-existing medical problems

Study findings

The detailed care records

This part of the study revealed a profound cumulative burden of disadvantage and inequity.

It was clear that there are many barriers to good care, which sit at systemic, organisational and individual levels amidst significant complexity.

In order to understand more about women's needs, circumstances, and the care they received, a detailed review of the care records was conducted for 47 of the women who died. This part of the study revealed a profound cumulative burden of disadvantage and inequity, with almost half of the women (45%) facing five or more 'complex social risk factors'. Evidence of ongoing domestic abuse was found in nearly two thirds of those sampled (60%), with similar levels of substance use (57.5%), homelessness and housing issues (64%), and significant childhood adversity (60%). Among the women whose records were reviewed, referrals to CSC were most often made during the first trimester (in 70% of those sampled). For women who had had previous children, two thirds did not have those children in their care (67%).

While there were some examples of high quality, personalised healthcare in these women's notes, significant issues and gaps were also evident. It was clear that there are many barriers to good care, which sit at systemic, organisational and individual levels amidst significant complexity.

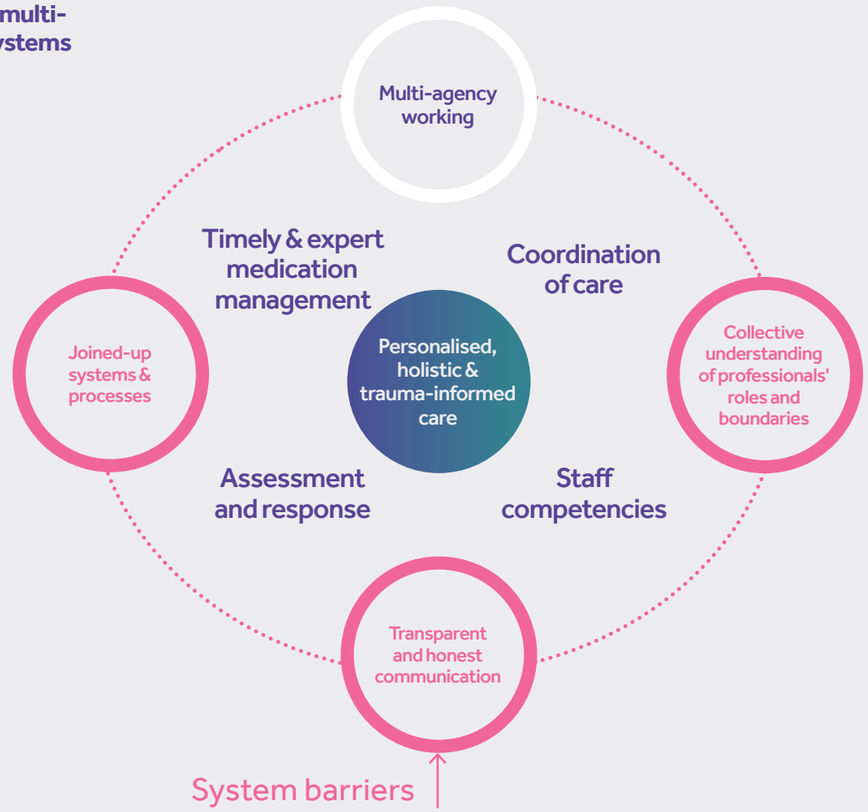
Several themes emerged in the course of the care notes review, linked to the quality of the care women received in light of the significant levels of need and complexity. These themes were discussed at length with a team of women with personal experience of CSC involvement during pregnancy and early motherhood, including infant removal. The reflections provided by these women are included in the thematic summaries below.

Essential requirements of care

Analysis of the care notes allowed the research team to identify four essential aspects that must be considered and addressed in order to provide personalised, holistic and trauma-informed care.

1 Risk assessment and response
2 Medication management
3 Coordination of care
4 Staff competencies and addressing bias

Complex multi-agency systems



Complex adversity

Risk assessment and response

The majority of women presented with a range of pre-existing medical or psychiatric conditions, as well as obstetric risk factors, alongside their wider needs, and yet the interaction between medical and social complexity was often unexplored. Health and social care professionals often focused on one aspect of risk, when a more holistic approach was needed. In some instances, for example, risk management was solely focused on the infant, while disregarding the mother's own need for safeguarding. In other records, professionals focused on women's medical risk factors, with no further exploration of her social circumstances, or women's social risk factors blinded professionals' response to underlying medical conditions, resulting in delayed treatment. In some situations tick-box medical risk assessment tools prevented a more rounded consideration of risk and the social circumstances that impacted on women's engagement with services, their compliance with treatment, or ability to self-monitor for health concerns.

When reflecting on this theme with women who had CSC involvement for their babies, one shared her own experience of medical issues being overlooked.

"The social worker was fully all about the drug and alcohol misuse and not concentrating on the medical issues, to the point she asked for a cocaine test because I was losing weight, when it later turned out I had a pancreas issue."

A common feature in women's records was the absence of information about the identity of the father of the unborn baby and/or (ex-)partner. In the context of domestic abuse or coercive control, detailed information about the potential perpetrator was crucial for safety planning, yet all too often this information was entirely missing in women's clinical notes, creating confusion about the origin of the risks women were exposed to. Assessors felt that concerns around domestic abuse often remained unaddressed, resulting in missed opportunities for adequate signposting and support

Healthcare and social care professionals often focused on one aspect of risk, when a more holistic approach was needed.

Medication management

Despite the number of women who had complex physical and mental health issues, including dependency on substances, there were issues with appropriate and timely medication management. It appears to have been difficult for women to get expert advice or support. Some women were advised against the use of certain medications relating to their mental health, despite these being considered safe to take during pregnancy and breastfeeding.

Women also faced significant obstacles to getting repeat prescriptions, particularly in the postnatal period. Those who were on opiate substitution treatments found it very challenging to collect their daily medication (most commonly methadone or buprenorphine) at their local pharmacy, for a variety of reasons, including the challenge of travelling while heavily pregnant, conflicting commitments including hospital appointments, and during admission to hospital. There was also evidence of professional misunderstanding around substitution therapy and the use of medications prescribed for this purpose. Methadone use was often viewed as a continuation of illicit drug use and an extension of addiction issues, rather than a medically-led treatment for substance dependency. There were several examples of negative attitudes towards methadone, contributing to stigma, judgement and bias.

Some women were advised against the use of certain medications relating to their mental health, despite these being considered safe to take during pregnancy and breastfeeding.

When women were admitted to hospital there were often delays in access to substitution medications. Records suggest this may have been a result of professionals' limited understanding of harm reduction strategies and the importance of the regular intake of these medications.

The risks of a lack of continuity and support around substitution medications were brought into focus in our reflective discussions with women with lived experience.

"Women are self-medicating to calm jitters when they can't get their Subutex/ methodone – it will cause heart problems, and they could end up dead."

"There's a lack of confidence in dealing with drug programmes like methadone and Subutex treatment."

One woman included in the care record review received a referral to an addiction service, despite her methadone treatment being successfully managed by her GP. Rather than acknowledging her efforts in reducing her methadone dose gradually, she now had to engage with an additional service, with whom she did not have a relationship of trust and support. The potential impact of this referral was felt by women with lived experience to have been incredibly negative, with one saying:

"All that woman's hard work – you've made her feel ten times [awful] again."

The coordination and continuity of care

For most women, their complex needs led to a range of referrals and a sudden influx of professionals from various services during pregnancy. As a result, a high number of appointments and meetings were arranged, which the review showed were often uncoordinated. Health and social care professionals had little awareness of the other services involved in a woman's care, which led to multiple appointments being scheduled in different locations on the same day, or in close succession across subsequent days, and added to the burden placed on women at an already challenging time. The records showed most women were going to great lengths to meet this demanding schedule of appointments, which for several exceeded thirty different contacts during their pregnancy. However, for some these schedules became impossible, leading to non-attendance or disengagement. This was then escalated by some professionals to the social workers involved, without regard to the overall levels of engagement that women had displayed throughout their care to date.

Many women were labelled as a 'late booker' or 'poor attender' in clinical documentation, when in fact a retrospective review of their antenatal care demonstrated appointment schedules exceeding national guidance. Handovers with reductive descriptions such as 'poor engagement', 'late booker' or 'poor historian' were copied into subsequent clinical handover notes, even when women had attended multiple appointments since.

Some women were discharged from specialist outpatient clinics and referred back to their GP after a single missed appointment, rather than the reasons for this non-engagement being considered and a new appointment offered. There were also situations where women were discharged from their GP surgery due to persistent non-attendance, creating greater disruption and obstacles.

Health and social care professionals had little awareness of the other services involved in a woman's care.

Rigid systems were not well-equipped to tailor care to the needs of women in such complex circumstances.

On reviewing the study findings, women with lived experience recognised the significant burden of multiple and often conflicting appointments.

"No wonder that she struggles to cope. And then when you don't go to those meetings, you're shown as not engaging."

"Appointments are 'non-negotiable'."

Women's experiences of trauma and past negative contact with services, including the removal of previous children, created significant barriers to engagement, as did their ongoing experiences of domestic abuse, financial destitution, insecure housing, and challenges relating to mental health, neurodiversity, learning disabilities and language needs. Rigid systems were not well-equipped to tailor care to the needs of women in such complex circumstances.

"When you've already had a negative experience with social care, you're extremely reluctant to want to engage for fear they're going to use it against you like they have in the past..."

"...and that's where independent social work assessments are crucial."

Where good care was in place, it was also susceptible to disruption, due to high levels of staff turnover, or provision being abruptly discontinued. Some pregnant women were discharged from mental health teams that had been involved pre-pregnancy, as their mental health or addiction treatment had come to an end, and they were considered 'stable' or 'in recovery'. The consistent care they had received prior to pregnancy suddenly ceased, and with that, opportunities for managing risk or early identification of deteriorating mental health were lost.

Several women were discharged from services once their infant was no longer in their care, including perinatal mental health services, despite the potential for significant escalation in needs.

In other situations, disruption was caused by relocation, incarceration or temporary residence in a refuge, temporary housing, inpatient psychiatric or acute hospital facilities. At transition points in care, handovers between different providers were often incomplete or delayed; something the women with lived experience recognised as common in their own care.

"Bottom line is the social worker and mental health worker should talk to each other."

"You can't please every professional. You get on really well with one, do loads of hard work, then she leaves and someone else comes in and you're clashing heads the whole time. All the hard work you've done with the other one is gone."

"It's about trying to keep the consistency in the pregnancy and afterwards – if one person picks something up, the next person doesn't."

"A lot of this is down to communication, or lack of it, between the professionals and the woman, or between professionals and professionals."

Study findings

Staff competencies and addressing bias

Evidence of routine enquiry about sensitive issues was scant, and signposting to additional support was rarely observed.

Evidence of professional understanding of the impact of trauma and its potential to be reactivated in maternity settings was scant, even though the majority of women disclosed traumatic life events.

Although healthcare professionals from various disciplines were involved in most women's care, proactive safeguarding practice seemed to be solely the responsibility of (specialist) midwives. It was particularly striking that obstetricians rarely documented relevant information about women's social circumstances during their clinical contacts, and provided little to no input in the safeguarding process.

Some records contained clear evidence of professional competency in exploring sensitive issues, such as domestic abuse, substance use, and mental health difficulties, through judgement-free and transparent documentation of conversations, and with signposting to relevant services. However, in most records, evidence of routine enquiry about sensitive issues was scant, and signposting to additional support was rarely observed. Even when maternity staff were aware of ongoing domestic abuse, few women were signposted to, or supported by, relevant services.

Evidence of professional understanding of the impact of trauma and its potential to be reactivated in maternity settings was scant, even though the majority of women disclosed traumatic life events. It is important to note current guidelines to support trauma-informed care were generally not available or adopted during the timeframe of the study cohort (2014-2022). The review also found evidence of professional bias and stigma towards women with CSC involvement, most frequently observed in the use of dehumanising and stigmatising language.

Reflections, priorities and recommendations from Birth Companions

Considering complexity

Complexity is an overarching theme across this study, both in terms of complex systems and service environments, and the complex lives and experiences of the pregnant women and mothers. While virtually every report in health and social care identifies the need for better multi-agency working and improved coordination, the level of complexity and the scale of the barriers faced by women with CSC involvement in pregnancy and early motherhood cannot be overstated. Addressing this level of complexity is highly challenging, but the risks of failing to do so are profound, as we can see in the tragic outcomes for a growing number of women each year.

Priorities and recommendations

This important study highlights the acute need for personalised, holistic and trauma-informed care to be provided to women with CSC involvement, in the face of medical and social complexity. As the findings show, multiple individual and systemic barriers hinder care of this nature being provided.

The evidence drawn from this review makes clear the need for more coordinated national policy across the health and social care systems. It supports the calls made by Birth Companions[15] and others for a national health and social care pathway to help deliver improved, consistent care for all women who have CSC involvement in pregnancy and early motherhood. While this study looks at the care of women who died up to one year after birth, there is clearly huge benefit in extending this pathway to cover the entirety of the 1001 days, from the point of conception up to a child's second birthday, as many of the issues at play in these women's lives will continue far beyond the postnatal year.

Such a pathway must also be supported and scaffolded by a radically improved focus on pre-birth and infant social care involvement in all relevant policies and guidance, in order to establish clarity, consistency and coordination[16].

The evidence drawn from this review makes clear the need for more coordinated national policy across the health and social care systems. It supports the calls made by Birth Companions[15] and others for a national health and social care pathway.

However, there are also several particular priorities for action.

- Changes to perinatal mental health provision, to ensure women are not discharged from specialist mental health services after their baby is removed.
- Prioritisation of, and ring-fenced funding for, the 'loss through removal' pathways in Maternal Mental Health Services.
- Work to embed specialist voluntary sector 'navigator' models of care to ensure personalised, woman-centred support for those with CSC involvement across the 1001 days.
- Investment and reallocation of resource to focus on personalised, holistic models of care, including specialist safeguarding midwives, perinatal mental health, and coordinated multi-agency provision through co-located services.
- An update to NICE CG110 Pregnancy and Complex Social Factors, to include the needs of women with CSC involvement and to ensure all relevant services integrate medical and social risk factors.
- Prioritisation of routine enquiry around domestic abuse, with appropriate action and referral to specialist services, and Independent Domestic Violence Advisors (IDVAs) located in maternity and social care teams.
- Further research to improve understanding of the complex links between ethnicity, CSC involvement, and maternal outcomes.

If we can elevate, embed and deliver against a clear focus on pregnant women and mothers of infants with CSC involvement in the 1001 days, we can address many of the issues this study has highlighted around coordination of care, barriers to engagement, staff competency, bias, and adopting a more holistic approach to assessing and responding to risks as they apply to both mother and baby.

References

1 Knight M, Nair MN, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, et al. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-2014 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2014. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2016.

2 Office for National Statistics. Child in Need Census 2024 [Available from: https://explore-education-statistics.service.gov.uk/find-statistics/children-in-need/2024.

3 Pattinson, R. et al. (2021). Born into care: Newborn babies in urgent care proceedings in England and Wales. Summary. London: Nuffield Family Justice Observatory.

4 Broadhurst K, Mason C, Ward H, Urgent Care Proceedings for New-born Babies in England and Wales – Time for a Fundamental Review, International Journal of Law, Policy and the Family, Volume 36, Issue 1, 2022, ebac008, https://doi.org/10.1093/lawfam/ebac008

5 Knight M, Bunch K, Patel R, Shakespeare J, Kotnis R, Kenyon S, et al. Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2022.

6 Wall-Wieler E, Roos LL, Nickel NC, Chateau D, Brownell M. Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis. Am J Epidemiol. 2018;187(6):1182-8.

7 Wall-Wieler E, Vinnerljung B, Liu C, Roos LL, Hjern A. Avoidable mortality among parents whose children were placed in care in Sweden: a population-based study. J Epidemiol Community Health. 2018;72(12):1091-8.

8 Wall-Wieler E, Roos LL, Brownell M, Nickel NC, Chateau D, Nixon K. Postpartum Depression and Anxiety Among Mothers Whose Child was Placed in Care of Child Protection Services at Birth: A Retrospective Cohort Study Using Linkable Administrative Data. Maternal and Child Health Journal. 2018;22(10):1393-9.

9 Broadhurst, K., Mason, C., Bedston, S., Alrouh, B., Morriss, L., McQuarrie, T. et al. (2017). Vulnerable birth mothers and recurrent care proceedings. Final main report. Available from: www.cfj- lancaster.org.uk/projects/vulnerable-birth- mothers-and-recurrent-care-proceedings

10 Ryan, M. (2021) Recurrent care proceedings: five key areas for reflection from the research. Spotlight series. London: Nuffield Family Justice Observatory.

11 Scott, S. et al (2016) Hidden Hurt: Violence, abuse and disadvantage in the lives of women https://www.agendaalliance.org/our-work/projects-and-campaigns/violence-abuse-poverty-and-multiple-disadvantage/#:~:text=Hidden%20Hurt%20provides%20evidence%20that,%2C%20poor%20housing%2C%20and%20homelessness.

12 Knight M, Bunch K, Vousden N, Banerjee A, Cox P, Cross-Sudworth F, et al. A national cohort study and confidential enquiry to investigate ethnic disparities in maternal mortality. EClinicalMedicine. 2022;43:101237.
Fleszar LG, Bryant AS, Johnson CO, Blacker BF, Aravkin A, Baumann M, et al. Trends in State-Level Maternal Mortality by Racial and Ethnic Group in the United States. JAMA. 2023;330(1):52-61.

13 Webb C, Bywaters P, Scourfield J, Davidson G, Bunting L. Cuts both ways: Ethnicity, poverty, and the social gradient in child welfare interventions. Children and Youth Services Review. 2020;117:105299.
Bywaters P, Scourfield J, Webb C, Morris K, Featherstone B, Brady G, et al. Paradoxical evidence on ethnic inequities in child welfare: Towards a research agenda. Children and Youth Services Review. 2019;96:145-54.

14 Philip M, Luís F, Sarah H, Davara B, Benjamin B. What factors are associated with children being taken into care by the state after initial contact with services? A survival analysis of Children's Social Care data in Liverpool. BMJ Public Health. 2024;2(2):e001130.

15 Birth Companions (2023) The Birth Charter for women with social care involvement https://www.birthcompanions.org.uk/resources/birth-charter-children-social-care

16 Mason, C., Broadhurst, K., Ward, H., Barnett, A. and Holmes, L. (2022a). Born into Care: Developing best practice guidelines for when the state intervenes at birth. Nuffield Family Justice Observatory. http://www.nuffieldfjo.org.uk/resource/born-into-care-developing-best-practice-guidelines-for-whenthe-state-intervenes-at-birth