 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 1 of 12
Approved:	Christine Johnson, Deputy Commissioner	Effective: 10/28/2019

Purpose

To describe the requirements for (1) the ongoing assessment of expectant parents and infants born on open cases and (2) taking appropriate action when needed.

Related Policies

- Family Services [Policy 51](#): Screening Reports of Child Abuse and Neglect
- Family Services [Policy 52](#): Child Safety Interventions – Investigations and Assessments
- Family Services [Policy 55](#): Unaccepted Reports on Open Cases
- Family Services [Policy 61](#): Responding to Domestic Violence in Child Safety Interventions
- Family Services [Policy 65](#): Substance Use Disorder Screening & Drug Testing for Caretakers
- Family Services [Policy 82](#): Juvenile Court Proceedings – CHINS
- Family Services [Policy 84](#): Conditional Custody Orders (CCOs)
- Family Services [Policy 85](#): Minor Guardianships Through the Probate Court

Introduction


Newborns and young children are the most vulnerable population served by the division. Infants are physically vulnerable and rely on a parent or caregiver to meet all of their needs. Prior or current child protection system involvement is one of the most important risk factors of future harm. Young children (those under 3) are at the highest risk for fatality – with heightened urgency for infants under 1. According to the [2016 report findings](#) from the Commission to Eliminate Child Abuse and Neglect Fatalities:

- Children who die from abuse and neglect are overwhelmingly young (approximately 50% are less than 1 year old and 75% are under 3 years old); and
- A call to a child protection hotline is the best predictor of a child’s potential risk of injury death before age 5.

Definitions

Checklist for Assessing Expectant Parents and the Safety of Newborns on Open Cases (FS-78): A checklist, mental map, and supervision tool intended to be used when a parent with an open CF, CS, or CC case is expecting another child. The document is meant to help division staff consider all relevant factors related to safety and planning for newborns. The use of the checklist is intended to support continuous assessment throughout a pregnancy and post-birth. Additionally, the checklist should assist in determining whether a higher level of intervention or additional supports are needed throughout the assessment.

Housing Insecurity: A family is homeless, lacks stable residence, is facing eviction,

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 2 of 12

or is living in an overcrowded residence that presents safety risks to the child(ren).

Plan of Safe Care (POSC): A written plan for a substance-exposed newborn and the infant’s family, focused on meeting health needs and substance disorder treatment needs, and developed in collaboration with the family, the healthcare provider, community agencies, and child welfare when appropriate.

Reproductive Coercion: Behaviors aimed to maintain power and control in a relationship related to reproductive health by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent. More specifically, reproductive coercion is related to behaviors that interfere with contraception use and/or pregnancy. These behaviors may include:

- Explicit attempts to impregnate a partner against her wishes;
- Controlling outcomes of a pregnancy;
- Coercing a partner to have unprotected sex; or
- Interfering with birth control methods.


Policy

The assessment of expectant parents occurs using the *Checklist for Assessing Expectant Parents and the Safety of Newborns on Open Cases* and begins as soon as the division receives information about a pregnancy on any case currently opened due to a child protection matter (CF, CS, CC). Assessment will be ongoing, included in discussions during monthly visits and supplemental contact, and guided by the prompts and sections of the checklist.

As soon as the division receives information about a pregnancy on an open case, this will be documented in case notes. The supervisor and district director should be notified of the pregnancy if the following circumstances are applicable to the family’s case:

- Termination of parental rights (TPR) petition has been filed; or
- Termination of parental rights (TPR) or voluntary relinquishment of rights to another child happened previously; or
- Either parent previously experienced the death of a child which was suspicious for maltreatment or related to an unsafe sleep environment;
- Serious physical injury of a child by a caretaker in the home happened previously; or
- Serious physical injury of a child was substantiated as “perpetrator unknown” and the caretaker was either alleged to have committed the abuse or knew about the abuse and did not take protective action.

The checklist is completed by the assigned family services worker, updated as new

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 3 of 12

information is learned, and shared with their supervisor. Information relied upon to complete the checklist and pertinent updates from the assessment will be documented in case notes.

Prior child protection involvement (within Vermont or in other states), criminal activity by caregivers or household members, substance use, domestic violence/intimate partner violence, residency/housing, and physical and mental health are all areas that should be evaluated initially and throughout pregnancy, at the time of birth, and upon discharge from the hospital. The division’s assessment takes place through observation, interviews with expectant parents and collateral contacts, and through any new reports received. It is critical to assess the circumstances of both parents and not limit the division’s focus to only the mother. If either parent has a new partner or it is known that other friends/relatives are residing in the home or expected to serve in a caretaking role, they should also be included in the division’s overall assessment.

Family services workers, supervisors, and district directors are encouraged to utilize team decision making and consultation with the child safety manager when there are questions or concerns related to the safety of a newborn. If significant safety concerns are revealed about the newborn in the hospital or upon discharge from the hospital, the family services worker will draft an affidavit in support of a request for an emergency care order (ECO) or CHINS petition.


Special Considerations for Cases Closing Prior to the Birth of an Infant

There may be instances where the family’s court case is going to close or the *SDM Risk Reassessment* score is low or moderate, therefore indicating the case should close. Family services workers should complete as much information as possible on the checklist and, in consultation with supervisors, use the information from the checklist to determine whether the case should be closed or remain open until after the birth of the infant. Cases that are low or moderate risk may close in the first or second trimesters of pregnancy. Generally, cases should not close in the third trimester of pregnancy (in recognition of the additional risk that comes with having a newborn in the home) and the division should remain involved to assess for child safety prior to case closure. If a case is closed in the third trimester of pregnancy, the rationale should be documented in case notes.

Assessing Pregnancies and New Babies Born on Open Cases

Upon Learning of the Pregnancy

All Vermonters who become pregnant have access, both online and within local communities, to comprehensive and non-judgmental information about their options (parenting, co-parenting, adoption, or abortion), rights, and responsibilities. Division

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 4 of 12

staff will respect the values, beliefs, and decisions of the expectant parents. It is important to begin planning as soon as the division becomes aware that a client is expecting a new baby. The open case and existing relationship present a unique opportunity to begin planning with the family as early as the first or second trimester of pregnancy. The division should be supportive of parents and jointly engaged in safety planning for their new baby. Family services workers must assess if expectant parents can safely care for their infant and what service referrals parents will need to support them in providing for the safety and well-being of the newborn.

In summary, the checklist includes the following overarching considerations:

- How will a newborn impact the identified dangers or safety concerns that currently exist for other children?
- Do the parents have the ability and willingness to protect the newborn, as well as the other children in the home?
- Is there anyone in the home or any household circumstances that would pose a different or additional threat to a newborn?
- Are the current circumstances different than the known history? Can the differences be articulated?
- If older children are not able to safely live with the parents, have circumstances changed that make it safe for a newborn to remain in this parent’s care?
- Does the family have a safety network comprised of family, friends, or community members who care about the newborn and older children, and are willing to take action to support the family and keep the children safe?
- Is a safety plan needed?
- What has the family done to prepare for the newborn?
- What is the family’s plan for the new baby?
- Has there been prenatal care? Has prenatal care been accessed consistently?
- What community referrals are needed, and has the family accessed them?
- When there are concerns of substance exposure during pregnancy, has the plan of safe care (POSC) been developed?

Prior to Birth

Planning and discussions about the new baby may occur through monthly visits in the home, team meetings, family safety planning meetings (FSPs), pediatric case consultations, or through other local partnerships that exist within communities.

As stated in Family Services [Policy 70](#), contact standards are established by the federal government and one face-to-face contact per month with the child/youth and parents by the assigned family services worker is the contact minimum. When meeting with expectant parents, it is especially important for the visit to occur in the home where the

Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 5 of 12

new baby will reside for the purposes of:

- Assessing the home environment;
- Observing whether the parents are preparing for the new baby;
- Engaging in ongoing dialogue about infant safe sleep and observing the place where the family intends for the infant to sleep; and
- Having ongoing conversations about identified risks.

When possible, it is helpful to have made collateral contacts prior to the home visit to support a comprehensive dialogue with the family. This allows the family services worker the opportunity to address any existing concerns each month during the pregnancy.

Monthly contact, conversations relevant to the pregnancy, and any areas of assessment from the checklist applicable to the expectant parents' circumstances (substance use, DV/IPV, residency/housing, and physical and mental health) should be documented in case notes.

The checklist includes a review and exploration of:

Division History / Prior Child Protection Involvement	<ul style="list-style-type: none"> • A review of prior accepted reports, the dates/timeframes, and a summary of the concerns and outcomes; • Knowledge of child protection history or involvement in other states in addition to Vermont; • Themes or patterns of unaccepted reports or significant events that were not accepted for a child safety intervention (CSI); • Consideration of any new reports, accepted or unaccepted, that were received since the last contact with the family; • The results of the last <i>SDM Safety Assessment</i> and <i>SDM Risk Assessment</i>; and • Particular attention and planning if the following circumstances apply: <ul style="list-style-type: none"> ○ Termination of parental rights (TPR) petition has been filed; or ○ Termination of parental rights (TPR) or voluntary relinquishment of rights to another child has previously occurred; or ○ Either parent has previously experienced the death of a child which was suspicious for maltreatment or related to an unsafe sleep environment; or ○ Serious physical injury of a child by a caretaker in the home happened previously; or
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Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 6 of 12

	<ul style="list-style-type: none"> ○ Serious physical injury of a child was substantiated as “perpetrator unknown” and the caretaker was either alleged to have committed the abuse or knew about the abuse and did not take protective action.
Substance Use	<ul style="list-style-type: none"> • Whether there have been any reports, accepted or unaccepted, or information obtained that alleges use of illegal substances or misuse of prescribed or legal substances in the last six months; • Whether there are concerns about criminal activity associated with substances (drug dealing, trafficking, etc.); • Parent/caregiver’s willingness to engage in a substance use assessment or treatment recommendations; and • If the parent/caregiver is in treatment: <ul style="list-style-type: none"> ○ Having signed and up-to-date releases; ○ Ongoing communication with treatment providers; and ○ Interviews with other collateral contacts (family members, formal and informal supports, etc.).
DV/IPV	<ul style="list-style-type: none"> • Whether there been any reports, accepted or unaccepted, or information obtained regarding DV/IPV in the home; • Whether there are current criminal charges related to DV/IPV or relief from abuse (RFA) orders in place; • Consideration of the impact of DV/IPV on the expectant mother and her pregnancy, including, but not limited to: <ul style="list-style-type: none"> ○ Is the pregnancy the result of sexual assault? ○ Is this a wanted or planned pregnancy by both parents? ○ Is reproductive coercion a factor? ○ Is there violence or threats of violence directed at the expectant mother’s abdomen? ○ Is the partner supportive of the expectant mother receiving prenatal care? • Initial and ongoing consultation with a DV specialist. <p>Additional Resource: Vermont Home Visitation Guide on Screening, Assessment, & Response to Domestic Violence</p>
Residency / Housing	<ul style="list-style-type: none"> • Whether the family is currently homeless or experiencing housing insecurity in the upcoming months; • Whether there are concerns about the infant’s sleeping environment for transient families; • If applicable, discussion of the family’s plan to address housing insecurity and referrals to local housing agencies.

Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 7 of 12

Physical & Mental Health	<ul style="list-style-type: none"> • Whether there have been any reports, accepted or unaccepted, or information obtained regarding concerns about any parent/caregiver’s mental health; • Whether the mother experienced postpartum depression following previous births; • Whether the parents are connected to a medical home or primary care provider; • Whether any parent/caregiver has physical limitations that indicate a need for specialized services and/or planning; and • Ongoing consideration of indicators of concern and healthy functioning, such as: <i>level of consciousness and responses (whether disorientation, heightened irritability, or hallucinations are present), appearance (grooming, hygiene, posture, eye contact), general behavior/presentation, expressions/responses, affect, mood, attitude, insight, attentiveness, comprehension, impulse control, speech/language patterns, and cognitive functioning.</i>
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Contact with the family and planning efforts should include prenatal care, assessing what support or items may be needed, and connecting the family with resources, referrals, and community connections.

A referral to Children’s Integrated Services (CIS) is required for all pregnancies applicable to this policy. The *Strong Families Vermont Nurse Home Visiting Program* is accessed through a CIS referral and can be made anytime throughout pregnancy. Enrollment is encouraged during pregnancy, though participants may enroll prior to the newborn reaching 6 weeks of age.

Division staff will include as many members of the family’s safety network as possible in efforts to plan for the newborn. If the family does not have a strong safety network or support system in place, the division should make efforts to support the family in this exploration, outreach, and dialogue. This may include use of genograms, ecomaps, circles of safety, or other engagement tools with both parents.

Prior to the birth of a new baby, information should be gathered about the mother’s prenatal care, her partner’s support of her receiving prenatal care, and the identity of the prenatal care provider.

If a family lacks items to support preparation for the birth of the baby (i.e., crib, mattress, clothing, blankets, nursing items or formula, diapers, changing pad, approved

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 8 of 12

car seat, stroller, or other identified needs), the local [Vermont Department of Health Office](#) is an excellent resource – specifically the Maternal and Child Health Division. Family services workers should direct specific inquiries to the local maternal child health care coordinators. Families can also be directed to [Vermont 2-1-1](#) for local resources.

Conversations should occur with the parents about their other child(ren) and how their circumstances will change with a newborn. Any gaps in the family’s plan will provide information about the parents’ ability to protect and care for the newborn and may assist the worker in identifying where additional support is needed. Additionally, safe sleeping practices should be continually discussed with the parents and the Vermont Department of Health’s Safe Sleep Brochure ([Keep Your Sleeping Baby Safe: Information for Parents and Caregivers of Infants](#)) should be shared.


In the Hospital

If any of the conversations or assessment described in the section above did not occur in the months leading up to the birth (if the division was unaware of the pregnancy, for instance), this information should be gathered while the newborn and parents are in the hospital. Discussions about safe sleeping practices should continue with the parents.

While the newborn and parents are in the hospital, the division will be in contact with physicians and/or hospital staff to gather information and receive ongoing updates on:

- How the infant is doing post-birth
- Infant-specific vulnerabilities
- Bonding and attachment
- Signs and symptoms of prenatal exposure to and withdrawal from substances, if applicable
- Mother/infant toxicology, if applicable
- Delivery complications and the impact on the mother’s health, if applicable
- Parent or caretaker behaviors while in the hospital
- Parent protective capacities
- Other medical records that could include growth charts, discharge plans, etc.
- Other concerns about the infant’s health or safety

If concerns are shared with the division by medical staff, the family services worker or other district office team member will visit the family in the hospital to address those concerns and assess the newborn’s safety.

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 9 of 12

Division staff, as mandated reporters, are required to make a report to Centralized Intake and Emergency Services (CIES) if they have cause to believe the newborn may have been abused or neglected after the birth or while the family is still in the hospital.

There may be times when division staff gather information which indicates it is not safe to discharge the newborn to the care of the parents. In these instances, the family services worker shall document all information gathered in preparation to request an emergency care order (ECO) or CHINS petition.

Plans of Safe Care for Substance Exposed Newborns


Signs of prenatal exposure to substances and withdrawal include:

- Facial characteristics of fetal alcohol syndrome
- Irritability
- Irregular and rapid changes in states of arousal
- Low birth weight
- Prematurity
- Difficulties with feeding due to poor suck
- Irregular sleep-wake cycles
- Decreased or increased muscle tone
- Seizures or tremors
- Excessive crying or high-pitched crying
- Medical complications, such as those requiring treatment in a Neonatal Intensive Care Unit (NICU)

If these signs are observed by a family services worker, the information should be communicated immediately to the medical provider.

The following tasks are required for cases involving a newborn identified as being affected by legal or illegal substance abuse, withdrawal symptoms, or Fetal Alcohol Spectrum Disorder:

If the newborn is placed in out-of-home care (including DCF custody or CCO with relatives)	A plan of safe care (POSC) will be created with the parent(s) and foster parents/caregivers, and this will be documented in case notes using the phrase “plan of safe care” or “POSC”.
If the newborn can safely remain at home (including CCOs with parents, family support cases, and instances where no further division involvement is needed)	The worker should discuss and review the plan of safe care (POSC) with the child’s primary care provider, and this will be documented in case notes using the phrase “plan of safe care” or “POSC”.

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 10 of 12

The plan of safe care will include the following:

- Information about referrals made to Children’s Integrated Services (CIS) and other services, if necessary;
- The infant’s primary care provider and date of next appointment;
- Identified treatment needs of parent(s) or caregiver(s) and treatment in place; and
- Identified community and family supports for parent(s) or caregivers(s) and the infant.

At Home (Post-Birth)


Family services workers are required to visit the home within three business days of the newborn's discharge from the hospital and will conduct a second subsequent home visit within two weeks of discharge.

The American Academy of Pediatrics (AAP) recommends that babies receive checkups from their pediatric medical home at birth, 3 to 5 days after birth, and then at 1, 2, 4, 6, 9, 12, 15, 18 and 24 months. At least one checkup should have occurred at the time of a post-birth home visit. Discussion with the parents about the checkup and infant’s health should occur.

If any of the conversations or assessment described in the two sections above did not occur in the months leading up to the birth or in the hospital (if the division was unaware of the pregnancy and birth, for instance), this information should be gathered during a home visit after the infant’s birth. Post-birth assessment should include conversation and observation about how the baby is doing since the birth, parental behavior and caretaking, the home environment (including the sleep environment), the dynamics with other children in the home, pediatric visits, and post-birth medical care for the mother.

While in the home, division staff should observe the infant’s sleeping environment. Some of the common concerns identified as unsafe sleeping environments consist of:

- Sleeping on the same mattress, couch, or recliner with a parent, sibling, or pet;
- The presence of blankets, pillows, cushions, bumper pads, toys, or loose clothing that could obstruct breathing;
- The presence of other items, such as laundry or storage items, in a crib or pack and play that would indicate the area is not being used for sleeping;
- Placing an infant on their stomach or side to sleep;
- Cribs that have a drop-down side or a mattress that is not closely fitted to the sides and bottom of the crib; or
- Allowing an infant to regularly sleep in a car seat, baby seat, or swing.

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 11 of 12

Family services workers will address any identified unsafe sleep concern immediately upon observing or learning of the concern.

A new *SDM Safety Assessment* shall be completed on open cases when there are changes in the family or household circumstances. A change in the family or household circumstances includes the birth of a baby. If any dangers are identified, the family safety planning (FSP) framework should be used to develop a safety plan.

Taking Appropriate Action When Needed

While assessing expectant parents and infants born during open cases, family services workers are continually taking action to support the family and connect them to resources and supports throughout the pregnancy.

The assigned worker will make a report to Centralized Intake and Emergency Services (CIES) for consideration of a CHINS (B) family assessment as described in [Family Services Policy 51](#) in the following instances:


- The assigned worker has not been able to locate or engage the expectant parents to assess safety and diligent and documented attempts have been made through monthly home visits, phone calls, outreach to the family’s support network (natural supports, DOC, Economic Services, school, pediatrician, etc.) and it is within 30 days of the expected delivery date; or
- A termination of parental rights (TPR) order has been granted for another child(ren) while the ongoing case is still open.

At the district office’s discretion, the CHINS (B) family assessment may be assigned to the family services worker assigned to the open case or an investigation/assessment family services worker. As stated in Family Services [Policy 52](#), the district’s child safety intervention (CSI) supervisor will supervise all CSIs, even if the worker normally reports to another supervisor.

When a district assigns the CSI to an investigation/assessment worker, the case will be teamed with the worker assigned to the open case. The worker assigned to the open case will provide documentation of information gathered throughout the pregnancy and an overview of the family history with the division as needed for the case disposition and/or a CHINS petition.

Seeking Court Involvement

As stated in Family Services [Policy 85](#), if it is necessary for a child to be in the care of an alternative caretaker on an extended basis through a safety plan to address identified dangers, it is **not** appropriate for division staff to encourage or recommend that the

 VERMONT DEPARTMENT FOR CHILDREN AND FAMILIES Family Services Policy Manual		78
Chapter:	Working with Youth and Families	
Subject:	Assessing Expectant Parents and the Safety of Newborns on Open Cases	Page 12 of 12

family address the concern through the use of probate court for a minor guardianship. If court intervention is needed because the parents are unable to safely care for their child, the case should be referred to the state's attorney for a CHINS petition.

Information about seeking an emergency care order (ECO) or non-emergency CHINS petition is found in Family Services [Policy 82](#).