

Pre-Birth Practice Handbook for Professionals

Guidance for all agencies working with parents of unborn children

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# Introduction

Young babies are particularly vulnerable to abuse. Work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention and support. This practice handbook applies to all professionals who have concerns for an unborn child. It provides a framework within which professionals should respond to safeguarding concerns through practitioners working together with families, to safeguard the baby before, during and following birth.

In the vast majority of situations during a pregnancy, there will be no safeguarding concerns. However, in some cases it will be clear that a coordinated response is required by agencies to ensure that the appropriate support is in place during the pregnancy to best support and protect the baby before and following birth. It may also be necessary to consider the need for particular arrangements to be in place during and immediately following the baby's birth in order to do so.

Where there is a late booking or a concealed pregnancy the health practitioner should complete an immediate assessment in order to identify which agencies need to be involved and make appropriate referrals.

The antenatal period gives a window of opportunity for practitioners and families to work together to:

* Form relationships with a focus on the unborn baby
* Identify risks and vulnerabilities at the earliest stage and understand the impact
* Explore and agree safety and permanence planning options
* Identify if any assessments or referrals are required before birth; for example the use of an Early Help Assessment (or alternative assessments agreed locally) and what actions should be taken next
* Avoid delay for the child where the Public Law Outline threshold is reached.

This guidance should be read in conjunction with local multi-agency safeguarding procedures, including:

[Early Help Guidance](https://www.herefordshire.gov.uk/support-schools-settings/behaviour-support/3)

[Right Help Right Time Levels of Need Framework 2020](https://westmidlands.procedures.org.uk/local-content/2gjN/thresholds-guidance/?b=)

[Multi-Agency Referral Form](https://westmidlands.procedures.org.uk/local-content/zgjN/multi-agency-referral-reporting-concerns-marf/?b=Herefordshire)

[Pre-birth Procedures](https://westmidlands.procedures.org.uk/local-content/0gjN/pre-birth-unborn-tools-and-pathways/?b=Herefordshire)

[Children of Parents Who Misuse Substances](https://westmidlands.procedures.org.uk/pkpzo/regional-safeguarding-guidance/children-of-parents-who-misuse-substances)

[Children of Parents with Mental Health Problems](https://westmidlands.procedures.org.uk/pkpho/regional-safeguarding-guidance/children-of-parents-with-mental-health-problems)

[Domestic Violence and Abuse](https://www.herefordshiresafeguardingboards.org.uk/safeguarding-information/safeguarding-adults-information/domestic-abuse)

# Practice Principles: Adopting the Right Approach

* Early Help should be offered to families at the earliest opportunity to provide them with the help and advice they need and prevent concerns from escalating.

[Being a parent – Herefordshire Council](https://www.herefordshire.gov.uk/family-support/parent) Becoming a parent

[Being a parent – Herefordshire Council](https://www.herefordshire.gov.uk/family-support/parent/5) Early Help in Herefordshire

* Right Help Right Time Level 4 Referrals should ideally be received as early as 12 weeks gestation in order to establish if intervention is needed.
* If Level 4 assessment is needed, **First** **Pre-Birth Panel** attendance should take place at ***14 weeks gestation or 2 weeks after the case has been allocated***, when the family will have been visited and the Team Manager will have provide managerial oversight. A Family and Professionals Assessment Meeting is to be held to outline the assessment process and possible outcomes within 5 working days of initial home visit.
* Plans at all levels of need which build upon family’s existing strengths and networks are more likely to be sustainable in the longer term.
* When there are concerns about the future safety or welfare of an unborn child, child and family assessments should be completed on the **Pre-Birth Assessment Template** utilising the **Pre-Birth Tools and Guidance** ***within 45 working days of the referral date*** and plans should be put in place in a timely way to support the family.
* Timely assessment and support help to mitigate against the anxiety families experience when faced with statutory intervention, which can adversely affect the attachment to the unborn child and in turn exacerbate the strain of caring for a new baby.
* Assessments should be undertaken through effective multi-agency collaboration, with a **Second Pre-Birth Panel** attendance at ***20 weeks gestation or once the assessment has been completed.*** The social worker and Team Manager will sharing information, including relevant historical information, focussing upon the identified risks and answering whether parents are capable of making sufficient changes, with the right support, so that risks can be reduced.
* Every effort should be made towards offering practical support so that the baby can be planned for safely, whilst bearing in mind the sensitivity of the situation.
* Parental engagement and contribution are central to increasing professionals’ understanding of past concerns and current circumstances so that plans are developed which are child centred and focus on the support the family will find most helpful.
* Support should be respectful and convenient for the mother, partner and family to encourage their involvement in the pre-birth process, the focus of which is to support families to stay together wherever possible.
* Family Group Conferences and Family Network Meetings are an important part of developing safety plans and contingency plans to identify and mobilise protective factors, as well as potential alternative care arrangements for the child.
* Decisions in respect of assessment outcomes should be determined by 20 weeks gestation, possible outcomes include Universal Services, Early Help, Child in Need, Child Protection or Child Protection and Public Law Outline combined.
* If the assessment determines level 4 intervention, at 31-32 weeks gestation, a multi-agency birth plan should be created with the family and professionals.

# Risk Factors

The following risk factors should alert professionals to consider a coordinated response. The presence of one or more of these factors does not automatically require a referral for pre-birth assessment (Level 4) and Early Help should be considered. Contextual information about the family’s current circumstances and environmental factors, including strengths from within the wider family network, are critical in determining the level of need. Professionals should refer to the Right Help Right Time Guidance and Appendix 4: Risk Indicators.

**Risk Factors:**

Where mothers, fathers or partners or any other significant member of the household:

* Are involved in risk activities such as substance misuse, including drugs and alcohol or chaotic behaviour
* Have perinatal/mental illness or support needs that may present a risk to the unborn baby or indicate their needs may not be met
* Are victims or perpetrators of domestic abuse (domestic abuse may start or get worse when a woman is pregnant)
* Have been identified as presenting a risk, or potential risk, to children, such as having committed a crime against children
* Have a history of violent behaviours
* Are not able to meet the unborn baby's needs e.g. significant learning difficulties and in some circumstances severe physical or mental disability
* Are known because of historical concerns such as previous neglect or abuse, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care (including in another local authority area)
* Are known because of parental involvement as a child or adult with Children's Social Care
* Are currently 'Looked After' themselves or were looked after as a child or young person
* Are teenage/young parents
* Are living in poor home conditions, homelessness or temporary housing
* Any other circumstances or issues that give rise to concern.

# Working with Fathers and Partners

Fathers and partners play an important role during pregnancy and after. The National Service Framework (2004) states:

“The involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long wellbeing and outcomes of the child regardless of whether the father is resident or not. Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of children.” (NSF, 2004).

It is important that all agencies involved in pre and post birth assessment and support, fully consider the significant role of fathers, partners and wider family members in the care of the baby even if the parents are not living together and where possible involve them in the assessment. This should include the father's attitude towards the pregnancy, the mother and new born child and his thoughts, feelings and expectations about becoming a parent.

Information should also be gathered about fathers and partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified. A failure to do so may mean that practitioners are not able to accurately assess what mothers and other family members might be saying about the father's or partner’s role, the contribution which they may make to the care of the baby and support of the mother, or the risks which they might present to them. Involving fathers in a positive way is important in ensuring a comprehensive assessment can be carried out and any possible risks fully considered.

# Early Intervention and Early Help

The antenatal period is a vital stage in child development and in preparation for parenthood. The 1,001 days from pregnancy to the age of two set the foundations for a child’s cognitive, emotional and physical development. These 1,001 days are a critical time for development, but they are also a time when babies are at their most vulnerable. Babies are completely reliant on their caregivers and later development is heavily influenced by the loving attachment babies have to their parents. It is therefore also important that parents and carers have their own needs met so they can meet the needs of their baby.

[The\_best\_start\_for\_life\_a\_vision\_for\_the\_1\_001\_critical\_days.pdf (publishing.service.gov.uk)](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf)

There are many different services available to support families throughout pregnancy, as their baby is born and in the months that follow. Currently, a small number of services are offered to every new parent or carer – these include midwifery and health visiting services. Other services such as breastfeeding support, mental health support and smoking cessation may be offered on a targeted basis in response to need. Local authorities, working with partner organisations and agencies, have a statutory duty to safeguard and promote the welfare of all children, including babies, in their area. All of these services are vital for ensuring every baby gets the best start.

Prevention, in is simplest terms, can be defined as “the action of stopping something from happening or arising”. Research shows that effective preventative services offer children, young people and families help before any problems arise or when low level problems emerge. From a child or young person’s point of view the earlier they receive help the less likely they are to undergo adverse experiences. (Munro, 2011).

In Herefordshire, Prevention refers to universal and community help being offered at the right time in order to increase the protective factors and decrease the risk factors facing children, young people and families. Preventing problems from occurring or offering help quickly helps to build resilience in families, promotes safety and wellbeing and ultimately reduces the need for involvement more specialist services.

In Herefordshire Children’s Centre Services, alongside health, education and community partners play a pivotal role in supporting families with babies and children aged 0-5 years. A range of universal, preventative and targeted support is offered, in partnership, to help parents/carers to give their child “the best start in life”.

[Children's centres in Herefordshire – Herefordshire Council](https://www.herefordshire.gov.uk/family-support/childrens-centres-herefordshire)

There are many professionals who may have the first contact or be aware that a woman or the partner of a man with whom they are working, is pregnant or about to become a parent. These may be workers in Learning Disability Services, Mental Health Services, Sexual Health Services, Women's Aid, Drug and Alcohol Services, Police, Probation, Leaving Care Teams, Housing and Adult Safeguarding, Education or Health Services.

When any professional becomes aware of pregnancy or impending parenthood and is of the view that there will be a need for additional support they should consider an Early Help Assessment, which includes sharing information with Maternity Services. [Early Help Guidance](https://www.herefordshire.gov.uk/support-schools-settings/behaviour-support/3)

The Early Help Assessment for the unborn child is a holistic assessment that considers the child's developmental needs, parenting capacity and environmental needs to identify and co-ordinate multi-agency service provision and interventions to best support the child and parents to be of all ages. If the parent was under 18 at the point of conception, the young mother may also be offered an Early Help Assessment by her Midwife for the whole family. This would include the offer of the First Steps programme, which offers multi-agency support for all parents to be aged 21 years and younger. The request for First Steps support is submitted by either the allocated Midwife or Social Worker.

Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years. *Working Together to Safeguard Children, 2018.*

# Involvement of Children’s Social Care

Where any professional identifies concerns at Level 4 of the Right Help Right Time Levels of Need Guidance a referral should be made to MASH **from as early as 12 weeks gestation.** Early referral will enable Social Care with other agencies involved to assess the family circumstances and plan any necessary actions and support required in a timely way. This includes whether any actions are required to safeguard the child once born.

In any of the following circumstances a referral **must always** be made to MASH [Multi-Agency Safeguarding Hub]:

* There is a perinatal mental illness that presents a significant risk to the unborn baby
* There has been a previous unexpected or unexplained death of a child whilst in the care of either parent
* A parent or other adult in the household is a person identified as presenting a significant risk, or potential risk, to children
* Factors which may significantly impact on the baby’s safety or development, including domestic abuse, violence, substance/alcohol abuse or mental health
* Children in the household / family currently subject to a child protection plan or previous child protection concerns
* A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order
* Where there are significant concerns about parental ability to self-care or care for the unborn baby, e.g. due to learning disability
* Where there are maternal risk factors e.g. denial of pregnancy, concealed pregnancy, relinquishment, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non-compliance with treatment with potentially detrimental effects for the unborn baby
* The parent is a looked after child or aged under 13
* Any other concerns exist that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child.

There are a number of possible outcomes from a referral to MASH (see also Appendix 1):

1. The threshold for services at Level 4 has not been met however MASH may signpost the family to other appropriate agencies and services. This may include recommending an Early Help Assessment is completed.
2. The unborn child is assessed by MASH to be in need of support or at risk of harm. In such cases the child will be transferred to the Assessment Service and allocated a social worker who will complete a Pre-Birth Assessment to identify the level of need and risk and the service required to address these to support the child and family.
3. If the child is not considered to be at risk of significant harm but in fact in need of support, the assessment may lead to a multi-agency Child in Need plan or a Referral to Early Help, depending on the need. Or if the concerns raised in the referral are not substantiated or if parents refuse to work with agencies under Child in Need or Early Help, the child’s case will be closed.
4. The child is at risk of significant harm. The baby's needs and those of their family will be considered at a Strategy Meeting where a decision will be made as to whether a Child Protection Section 47 investigation is needed and whether the child needs to be presented to an Initial Child Protection Conference. Agency professionals involved with the family will contribute to assessments and interventions.
5. If during Child Protection Planning it is found there are concerns about the safety of the baby returning home with parents when born, the social work team will have a Pre-Legal Gateway Meeting with senior management to discuss presenting the child to Legal Gateway Panel. In Legal Gateway Panel a decision will be made as to whether to instigate the Public Law outline, whether that be Pre-Proceedings and/or issuing Care Proceedings at birth.

# Preventing Drift and Delay in Assessment and Planning

All agencies working with a family have a shared responsibility to safeguard the unborn child and to raise concerns if they identify drift or delay or if they are concerned about decisions that have been made regarding the unborn child. Professionals should use the [Resolution of Professional Disagreements policy](https://westmidlands.procedures.org.uk/local-content/4gjN/escalation-policy-resolution-of-professional-disagreements/?b=Herefordshire) to ensure their concerns are fully documented and resolved.

When a Pre-Birth Assessment is required, in certain circumstances and in order to avoid delay, the case allocation should bypass the children’s social care Assessment Service and be allocated as follows:

|  |  |
| --- | --- |
| Unborn referrals where any child(ren) in the same household are already receiving a service at Level 4 (child in need / child protection / current care proceedings) | Allocated team already working with the family |
| Unborn referrals with significant prior involvement for children of the same household / of either parent previously subject of care proceedings and/or removed from parents care permanently. | Child Protection and Court Service |
| Where older siblings subject to a care order are placed with parents. The unborn referrals should remain in the assessment teams and not transfer to the LAC service, however, it is imperative that we ensure key liaison with the older sibling’s social worker. | Assessment Service |
| In all other cases | Assessment Service |

Where the unborn child requires a child in need / child protection plan, multi-agency safeguarding procedures should be followed in order to progress plans effectively. These plans require consistent collaboration and communication between all professionals with responsibilities for the unborn child, the mother, the father and where relevant the mother’s partner. Where an unborn child will be born into a household where children are already the subject of child protection plans or child in need plans, the midwife must be included in all relevant multi-agency meetings. The unborn child must be progressed through child protection processes in a timely manner, in order to join siblings on the Child Protection plan. The same applies when the unborn child’s siblings are either in pre-proceedings or court proceedings.

Where the threshold for PLO – Pre-Proceedings has been met, the unborn child’s social worker must ensure that all professionals working with the family are aware of the Pre-Proceedings plan and the progress being made. The child in need / child protection plan should be explicitly aligned to the Pre-Proceedings plan.

Where appropriate and particularly when in Pre-Proceedings, a **Family Group Conference** or **Family Network Meeting** should be convened to identify and mobilise protective factors and support from within the family’s wider network, including friends. The social worker should ensure that the outcomes agreed by the family are shared with all relevant professionals and the child in need / child protection / Pre-Proceedings plan updated accordingly.

The Family Group Conference or Family Meeting may also need to identify potential future carers for the child in order to progress viability assessments within Pre-Proceedings. This work should commence as soon as possible in order to prevent delay for the child once born if alternative care arrangements need to be made. Where alternative carers from within the family network are not identified, adoption planning including consideration of ‘**Foster To Adopt’** should commence as soon as possible.

In order to monitor the progress of Unborn Children open to Children’s Social Care, unborn children’s are presented to **Pre-Birth Panel** for scrutiny. MASH notify Panel Business Support when a referral comes in that includes an unborn child. Panel Business Support invite the social work team to attend Pre-Birth Panel 2 weeks after the case has been allocated and include the referral form to complete. It is expected that by the Panel date, the Social Worker will have completed the home visit and the Team Manager will have recorded managerial oversight on the child’s file. At the Panel, Social workers and Team Managers will be asked for a progress report and an update on future planning of the assessment. The panel will then request the case is brought back to Panel once the assessment is completed for oversight. The Panel is chaired by the Head of Service for MASH and Assessment and joined by Service Managers for MASH and Assessment and Child Protection and Court, Case Progression Officer, Named Midwife for Safeguarding, Operational Lead for Health visiting and School Nursing, Service Manager for Children Centres and Panel Business Support.

# Pre-Birth Assessments

A pre-birth assessment is an assessment of the risk to the future safety of an unborn child, to assist in making informed decisions about the child and family’s future. Such assessments may create ethical dilemmas for practitioners undertaking them. The bond between a mother and child is universally revered and practitioners may be reluctant to intervene, feeling that parents must be “given a chance”.

However, the Children Act 1989 is clear that there are grounds for intervention if there is a likelihood of significant harm and that the needs of the child (in these situations unborn) are paramount. Working Together (2018) sets out the requirements to undertake pre-birth assessments and convene pre-birth child protection conferences where those criteria are met. **The West Midlands safeguarding procedures state this should be completed as soon as possible and no later than 30 weeks, or earlier if premature delivery is expected.**

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

* **Identify and safeguard** the babies possibly most likely to suffer future significant harm;
* Ensure that **vulnerable parents** are offered support at the start of their parenting role rather than when difficulties have arisen;
* Establish a working **partnership with parents** before the baby is born;
* **Assist parents** with any problems that may impair their parenting capacity.
* However some potential disadvantages are:
* Parents **may abscond** or a mother may not alert health professionals when she has her baby;
* In some situations, **the stress may have an adverse effect** on the parents’ mental or physical health;
* There may be a risk that a mother could feel **pressured** into harming herself and the unborn baby or terminating her pregnancy;
* The fear of losing the baby may jeopardise the **attachment process** between parent and child.

Hart (2009) indicates that there are **two** fundamental questions when deciding whether a pre-birth assessment is required:

* Will this new-born baby be safe in the care of these parents/carers?
* Is there a realistic prospect of these parents/carers being able to provide adequate care throughout childhood?

Pre-birth trauma for babies needs to be considered also, this includes experiencing high levels of cortisol during the pregnancy as a result of heightened stress from experiencing domestic abuse and/or mental health issues, leaving them stressed which could lead to excessive crying, unable to be soothed effectively, attachment difficulties and the parent struggling to cope with caring for baby. In older children, this could also lead to behaviours linked to ADHD and autism, which are attachment based due to the experiences in the womb. **Glover, V., 2018**

Pre-birth trauma for babies in utero also include maternal drug and alcohol use which can lead to the child experiencing the same drug and alcohol misuse which leads to high cortisol levels, and can possibly lead to the child having Foetal Alcohol Syndrome and or Neo-Natal Abstinence Syndrome, both of which can lead to the child suffering from emotional and behaviour difficulties, anxiety, learning difficulties, sensory processing disorders and attachment difficulties.

# Considerations for Specific Groups

## Recurrent pregnancies

There is increasing national and international concern about birth mothers who are caught in a cycle of repeat public law proceedings. Where birth mothers appear and re-appear before the family court on account of child protection concerns, they face the prospect of multiple losses of children to out-of-home care and their circumstances make exceptional demands on children’s services and the courts. In addition, where siblings enter care or are adopted at different points in time, there are particular complexities in terms of sibling placement and contact that are insufficiently understood.

The findings of a study undertaken by Lancaster University in partnership with The Tavistock and Portman NHS Trust between 2014 -17 have been published and the full report can be found at; [The Vulnerable Birth Mothers and Recurrent Care Proceedings](http://wp.lancs.ac.uk/recurrent-care/overview/)

Key messages from the report include:

1. Scale and pattern

The population of birth mothers who are repeat clients of the family court is sizeable. Reducing care proceedings requires further concerted action to ensure the wider roll-out and evaluation of preventative programmes.

1. Childhood antecedents of women’s complex difficulties

Birth mothers in recurrent care proceedings have experienced significant and multiple adverse experiences in their own childhoods, particularly from their own parents or caregivers.

1. Childhood care experience and adult family justice involvement

Approximately 40% of the women in case file studies had spent a period being formally looked after, with the largest proportion entering care aged 10 years or older. 50% were also found to have experienced multiple placement moves.

1. Contraception, pregnancy planning and intimate partner relationships

64% of recurrent mothers had entered motherhood aged less than 20 years. Many women described pregnancies as unplanned; the reasons behind unplanned pregnancy were varied.

1. Differentiating the population of women in recurrent proceedings

Women differed in regard to their pathways through the family justice system, with some women recording multiple family court appearances and others making marked improvements to their lives, even in the face of very difficult childhoods.

1. Impact of child removal and access to rehabilitative services

Women consistently described an acute phase of grief following child removal, which greatly exacerbated their difficulties. Descriptions of mental health difficulties indicated concerning and enduring levels of mental distress for many women.

1. Positive turning points

The following common factors were associated with positive change: positive changes in intimate partner relationships and kin networks, or effective professionals who were able to form relationships with women to support a process of change; insight and a willingness to learn from experience; and women’s desire to ‘do better’ for children either lost from their care or new-born.

1. Outcomes for children

Recurrent care proceedings impact on children’s lives. A high proportion of infants who appear in subsequent proceedings do so within four weeks of birth. More work needs to be done to better understand the health and placement outcomes for these infants.

## Young people and children in care or care experienced

Teenagers who become parents are known to experience more educational, health, social and economic difficulties than young people who are not parents. Consequently, their children may be exposed to greater social deprivation and disadvantage.

Teenage mothers in leaving care services may experience similar difficulties to those faced by all young mothers. However, they are also less likely to have consistent, positive adult support and more likely to have to move.

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

Regular liaison should take place between the assessing social worker, midwifery and the social worker / personal advisor for the young person who is becoming a parent. If they are looked after, their IRO should be informed of the pregnancy and be kept updated. Advocacy should be considered for young people who are becoming parents.

## Mothers requiring peri-natal support services

Pregnancy and the period after childbirth are times of change and transition in someone’s life. It is common for mothers and partners to experience a range of emotions around this time. Some women experience significant mental health difficulties during pregnancy or after birth, even if they have never experienced mental health difficulties before.

The Herefordshire Perinatal Mental Health Service is a specialist multi-disciplinary service for mothers experiencing moderate to severe mental health difficulties during pregnancy and during the year following childbirth. Health professionals such as a midwife, GP or health visitor can make referrals, or for mothers already working with mental health services, referrals to the specialist perinatal mental health team can also be made.

Mothers may have previously suffered trauma as a result of a pregnancy or birth, had a previous diagnosis of Postnatal Depression or PTSD as a result of their previous births or pregnancies. There are predisposing factors which need to be considered – childhood trauma, sexual abuse and/or previous birth trauma **Speier, D., 2018** these may not meet the level for perinatal mental health team support.

## Parents with a learning difficulty/disability

It is not always clear whether or not a parent or carer has a learning difficulty/disability. Reference to medical and educational records may assist. Close working between children’s social care, adult social care and health services is essential. The GP and midwife may refer for a joint cognitive or capacity assessment of the expectant mother’s needs, capacity for self-care and to provide adequate care for the baby. Subsequent assessment should be in accordance with pre-birth procedures.

Learning disabled parents may also experience additional stressors e.g. having a disabled child, domestic violence, poor physical or mental health, substance misuse, social isolation, poor housing, poverty and a history of growing up in care.

Parents with a learning disability may need positive ‘whole family’ support to develop sufficient understanding, resources, skills and experience to meet the needs of their child with effective, sustained support over time adjusted to meet the child’s changing developmental needs.

It is important to assess needs and provide support for learning disabled parents as early as possible. To ensure that parents are able to understand what is happening and why, and are able to participate meaningfully, advocacy should always be a consideration.

## Concealed Pregnancy

If the pregnancy has been concealed consideration should be given within the assessment to other potential risk factors. Recent research (Murphy-Tighe and Lalor, 2019) has found that women who conceal a pregnancy close to or up to birth may have experienced adverse traumatic life events for example, child sexual abuse, sexual assault, or domestic violence. Concealed pregnancies are more likely to be related to internalised feelings of fear and complex emotions which lead to a coping mechanism of avoidance. Assessments where pregnancy has been concealed should consider the potential existence of pre-pregnancy trauma, complicated attachment or domestic violence. Whilst evidence suggests it is much less likely, mental illness should also be considered as a cause.

One of the key concerns in concealed pregnancies is the failure to access antenatal care and can lead to serious consequences for the mother and/or baby. Women with a history of concealed pregnancy may experience subsequent unresolved trauma following a concealed pregnancy, especially during subsequent pregnancies.

## Support for Vulnerable Parents at Risk of Significant Harm

There are two mechanisms to be instigated where we are concerned about the safety of the parent and baby.

One is [**Complex Adult Risk Management framework – known as CARM**](https://www.herefordshiresafeguardingboards.org.uk/professional-resources/adults-policies-guidance)**.** This is a meeting which called by any professional and is a coordinated multi-agency response to support those who have mental capacity, it is non-prescriptive in terms of actions and who needs to be involved, it focuses on positive outcomes for the adult which builds on strengths and mitigates risks. It is for adults where there is a risk of significant harm and/or complex needs. It is called when risks can’t be managed via other means e.g. Section 9 care assessment or section 42 safeguarding enquiry, agencies are failing to engage the adult and individual agencies unable to achieve resolution in isolation.

The Second one is the Adult Safeguarding Framework. This is the link to the Adult Safeguarding Framework which gives all the information needed as to when, how and who to refer:

<https://www.herefordshiresafeguardingboards.org.uk/safeguarding-adults-board>

Advice and referral forms are located via the professional resources tab, including how to arrange a CARM.

## Surrogacy

The Department for Health and Social Care published very specific and detailed guidance. [“Care in surrogacy: guidance for the care of surrogates and intended parents in surrogate births in England and Wales”](https://www.gov.uk/government/publications/having-a-child-through-surrogacy/care-in-surrogacy-guidance-for-the-care-of-surrogates-and-intended-parents-in-surrogate-births-in-england-and-wales)

The guidance details the legal position of surrogacy in the UK and also the legal aspects of parental responsibility in relation to the surrogate and the intended parents. The guidance also advises that normal child safeguarding processes are applied if concerns arise which may include, for example, mental capacity of the intended parents and/ or surrogate and disputes between the surrogate and the intended parents.

If staff have any concerns about the welfare of the child, they should follow standard procedures for making a risk assessment, involving other appropriate agencies and invoking child protection procedures (if applicable).

# Safeguarding Birth Planning

All unborn children subject to a child in need plan or child protection plan (or child and family assessment if the pregnancy was booked and referred very late) should have a Safeguarding Birth Plan. The plan should detail arrangements for the baby’s protection and welfare leading up to and following the birth so that all relevant professionals, particularly the maternity team and Emergency Duty Team, are aware of the plan.

A Safeguarding Birth Planning meeting should be held **no later than 32 weeks**. Where potential early delivery has been identified, this should be held **no later than 30 weeks**. A date for this meeting should be identified by the Chair at the most recent child in need review / child protection conference.

The Safeguarding Birth Planning meeting should cover **all aspects relating to the birth and plans for discharge post birth**. Specific considerations may be required if a home birth is anticipated and contingency plans should be agreed in the event of an unexpected delivery at home. If following the meeting concerns for the unborn child increase, a review Safeguarding Birth Planning meeting should be held prior to the birth. The plan should be updated and version controlled and redistributed to all parties who received the first plan.

If the plan has been completed comprehensively and distributed accordingly, in most circumstances and subject to unexpected medical needs of the mother or child, there will be no need to convene a separate Discharge Planning meeting. If unexpected medical needs do arise, a Discharge Planning meeting may be required.

As a minimum, the Safeguarding Birth Planning meeting should involve the allocated social worker, midwife and parent(s). The Safeguarding Birth Plan (appendix 4) should be completed in full, agreed by and shared with all relevant parties. It is the responsibility of the Named Midwife to ensure that other health practitioners involved are informed of the plan, for example the obstetrician, paediatrician, GP and health visitors. The social worker is responsible for ensuring other relevant agencies such as EDT and the police are aware of the plan.

All professionals will need to be clear about their role and that of others, which should be clearly detailed in the plan. Midwives have a safeguarding responsibility to all babies and will ensure that any protective action required within the hospital setting is managed following birth of the baby. These arrangements must be included within the safeguarding birth plan, including any protective action that the Police may need to consider. In some circumstances a police OIS incident number may need to be obtained from the Police and recorded in the plan.

In high risk situations, additional security may need to be considered. These measures should only be used in exceptional circumstances and should be agreed between the hospital, police and children’s social care. In this instances a police OIS incident number must be recorded.

If there are evidenced concerns relating to risk of abduction, professionals should agree how this risks will be managed, including alerts to other local authority areas. **Only children subject to child protection plans at the time of the birth will be notified to children’s services by maternity services through the CP-IS national alert system** (see appendix 8). Alternative arrangements may therefore need to be made to alert hospitals in other local authority areas.

Immediately post birth, there may be occasions when either the baby and/or mother will need to stay in hospital for a further period. In such circumstances the birth plan should be reviewed between professionals and amendments agreed as appropriate.

If the mother intends to have a home birth the Ambulance Service Lead should also be invited to the Safeguarding Birth Planning meeting. Particular attention should be given to the roles and responsibilities of all professionals at the time of a home birth, including who should be present with the midwives when the baby is born.

In cases of concealed pregnancy, or where significant concerns have been identified for the first time in hospital when the mother presents in labour or following the birth, the maternity team should immediately refer to MASH. A Discharge Planning Meeting or discussion must take place prior to mother and baby being discharged. If a strategy discussion is required, this must include planning for discharge from hospital.

The maternity team is responsible for co-ordinating the Discharge Planning Meeting and as a minimum should invite children’s social care; a paediatric consultant (or specialist registrar with the consultant’s consent); Named Nurse / Midwife; other relevant hospital staff involved in the care of the baby / family; and health visitor. Other professionals who will contribute to the support to the family post discharge should also be invited.

# Appendix 1: Raising a Safeguarding Concern in Relation to an Unborn Child,

Safeguarding procedures should never be delayed and appropriate actions should be taken as soon as significant concerns are identified. The following timescales are the **latest** that actions should be taken and reflect statutory guidance and regional safeguarding procedures.

|  |  |
| --- | --- |
| What | When |
| All professionals with significant concerns for an unborn child should refer to the **Right Help Right Time Guidance** and make a referral to MASH. | Refer as soon as concerns are identified from 12 weeks gestation. |
| If a decision is taken to progress the referral, MASH will send through for a Pre-Birth Assessment to the Assessment Service [or CP/Court if parents have had children previously permanently removed from their care] and Panel Business Support will be notified of the unborn baby. Panel Business Support will email the allocated Social Worker with the referral form for the Pre-Birth Panel and the proposed date for Panel. ***The Social Worker must email the completed form to Panel Business Support within 5 working days of receiving it.*** | Presentation to Pre-Birth Panel within 2 weeks of allocation. |
| After 2 weeks allocation the child is presented to **Pre-Birth Panel** and the social work team will update on progress and future assessment planning. The initial home visit should have been completed, the child’s file should have managerial oversight recorded on and either the **Family and Professional Assessment Meeting** has already taken place or it is booked in. | Pre-Birth Panel |
| Multi-agency support should begin as soon as needs are identified during the pre-birth assessment. This should include family support services and wider support services in the community. Front loading should be taking place. **The Family Network Assessment Record** needs to be started and names of family and friends who could be candidates for alternative carers, if needed, need to be added so that the Child Protection Court Team know who to approach, should the child’s case progress to them. ***Pre-Birth Assessment should be completed in 45 working days and ideally by week 20 of the pregnancy.*** | Pre-Birth Assessment to be undertaken as soon as possible and ideally completed **before 20 weeks**. |
| If a **Child in Need Plan** is required, the **Initial Child in Need Meeting** should be convened. Decisions to end a child in need plan must be made at a multi-agency child in need review meeting. | Within **10 working days** of assessment completion. |
| If child protection concerns are identified during a pre-birth assessment or child in need plan, a **Strategy Discussion** should take place and child protection procedures followed. | Within **2 working days** of assessment completion. |
| If a **Section 47 Child Protection Investigation** is required and recommends that the unborn child should be made subject to a child protection plan, a **Pre-Birth Child Protection Conference** should be convened. | As soon as significant harm is identified and **no later than 30 weeks.**  If early delivery is likely, no later than 10 weeks before delivery. |
| If the unborn child is made subject to a child protection plan, a **Review Child Protection Conference** should be held. | Within **3 months** of the Pre-Birth child protection conference or within **1 month of the child’s birth,** whichever is sooner. |
| If Social Worker is concerned about the unborn baby returning home with parents when born, a **Pre-Legal Gateway Meeting** needs to be arranged with Team Manager, Service Manager and Case Progression Officer and a decision will be made as to whether the child needs to be presented to the **Legal Gateway Panel** to discuss threshold for initiating the **Public Law Outline**, whether that be **Pre-Proceedings or Issuing Care Proceedings at birth.** | **As soon as** threshold is identified and ideally **before 24 weeks.** |

# Appendix 2: Referral Form to Pre-Birth Panel

**Referral to Pre-Birth Panel**

**Section 1: Referral to Pre-Birth Panel**

This request must be submitted by the social worker or Early Help to Panel Coordinator as soon as possible to allow sufficient time to be convened (at the very least 7 days from case allocation).

Date of referral to Panel by Worker:

Date initial referral received into the service:

Name of Worker making referral and Team:

Name of Team manager and Team:

Unborn child’s detail

Name ID Address DOB/EDD

………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Family Members Details

Name ID Address DOB/EDD

………………………………………………………………………………………………………………………………………….……………………………………………………………………………………

Meeting Type\*

Pre-Birth Panel

Team Manager has approved request\*

Reason for Referral\*

Source of referral

Brief bullet points of referral concerns

Primary Concerns/Problem/History:

Previously known / Background, i.e. siblings open case, subject to CP plan/Court/ first pregnancy.

Current plan

**Section 2: To be completed by Business Support**

Date request received

Name of Co-ordinator dealing with request

Date of Meeting\* Time\* Venue\*

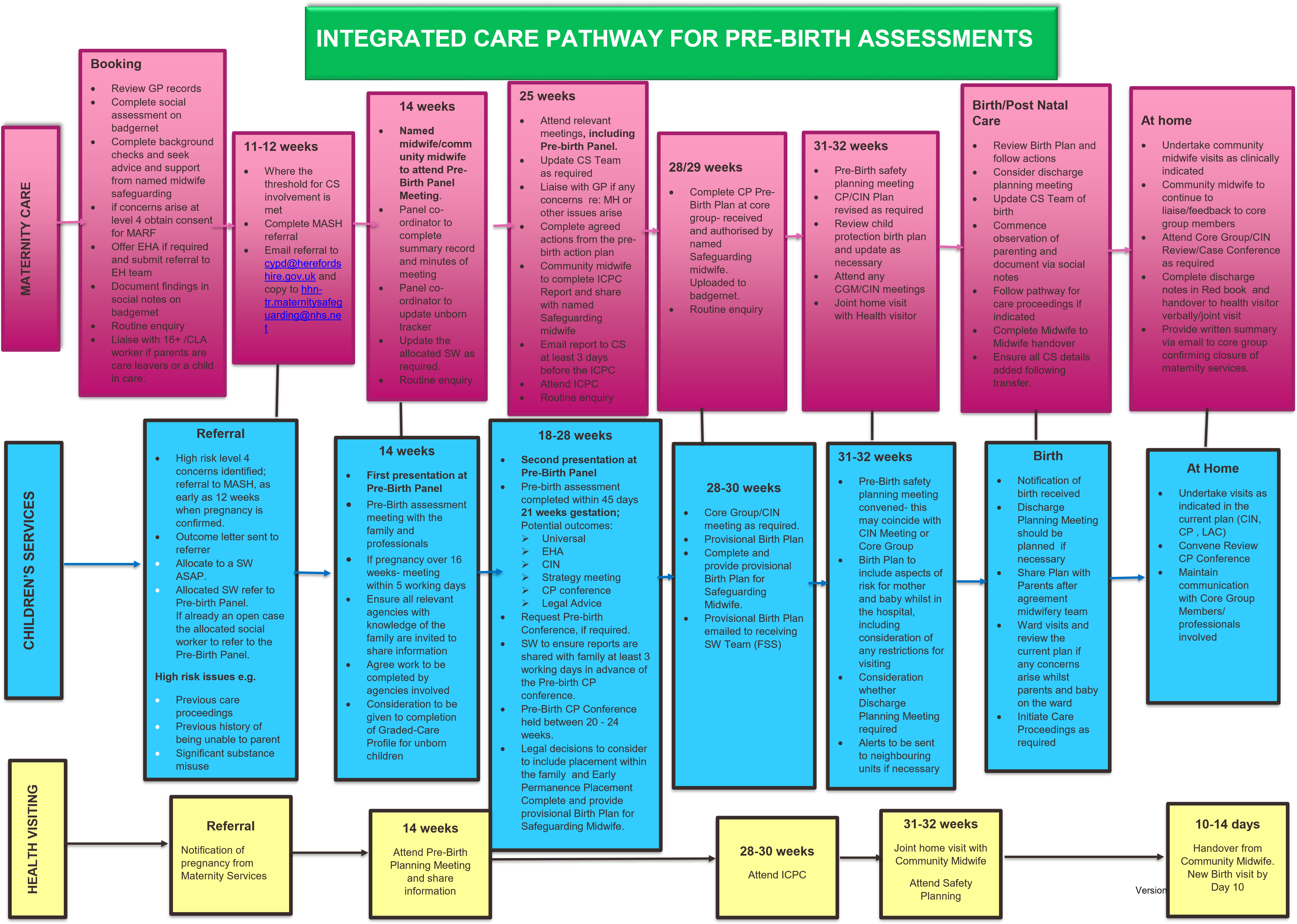
Name of Allocated Chair:

**Section 3: Next Actions/ steps By who Timescales**

…………………………………………………………………………………………………………………………….…………………………………………………………………………………………………

# 

# Appendix 3: Integrated Care Pathway



# Appendix 4: Pre-Birth Assessment Triangle - Unborn Baby's Needs, Parenting Capacity and Family and Environment and Risk Tool

**Baby’s Developmental Needs**

**Parenting Capacity**

**Assessment**

**Framework**

**Unborn Baby Domains**

**Wider Family and Environmental Factors**

(adapted from Barlow *et al*. 2014)

|  |  |  |
| --- | --- | --- |
| **Baby’s Developmental Needs** | **Family and Environment** | **Parenting Capacity** |
| * Foetal development (e.g. impact of smoking, substance dependency, stress, poor parental nutrition, HIV or hepatitis C * Planned / unplanned   pregnancy   * Pregnancy history and antenatal care * Birth planning and preparation * Feeding plans * Maternal relationship with foetus | * Home environment and preparation for birth * Attitude to professional involvement * Employment and childcare plans * Financial problems * Criminal history * History of childhood exposure to domestic abuse, parental substance misuse and parental mental ill health * Experience of childhood sexual abuse or unresolved trauma | * Maternal and paternal pre-natal attachment styles * Attitude towards pregnancy * History of previous pregnancies * Understanding of foetal and infant development * Previous experience of parenting * Impact of current domestic abuse/ substance misuse or mental ill health on future parenting * Ability to manage stress and regulate emotions * Couple relationship * Capacity for reflective parenting style * Family planning * Capacity to change adverse behaviours and to learn new skills * Parent’s medical history |

# Appendix 5: Risk Indicators:

| **Risk Factor** | **Higher Risk** | **Lower Risk** |
| --- | --- | --- |
| Alcohol use | Excessive alcohol use | Occasional/no alcohol use |
| Substance use | Length of time used, types of substances used, no support in place | Ceased use during pregnancy, length of time not used, support in place, triggers for use known |
| Mental health | Chronic mental health issues – long-term, unsupported | Acute/no mental health issues, appropriate support in place |
| Pregnancy | Unplanned. Parent talks about baby as an extension of themselves, cannot picture who baby might be or what life may be like once born | Planned, parent can talk about baby and consider what life may be like once baby is born. Parent is able to identify baby as a person in their own right |
| Parents childhood | Experienced neglect or abuse, physical discipline | No previous social care services warranted, no physical, emotional or sexual harm experienced |
| Domestic abuse | Childhood experience of domestic abuse or in current/previous relationship. No previous or current support received | No experience of domestic abuse or support has been engaged with previously/none with current partner |
| Emotional wellbeing | Parent is not able to regulate emotions, high levels of stress | Parent can regulate emotions appropriately, not too much stress experienced |
| Lifestyle | Chaotic lifestyle, homelessness, unable to budget, associating with people who may pose a risk, poor or unsanitary home conditions | Secure housing, budgeting ability, safe network of people, routine in place – stability, positive home conditions |
| Prioritisation | Cannot prioritise baby over self, partner or others. Is not able to verbalise the need for baby to have routine once born, not prepared for baby – no cot etc. | Prioritise baby over others whilst pregnant and able to understand need to do so once born. Attends all appointments, seeks appropriate advice, prepared for baby – physical items |
| Medical needs | Concealed pregnancy, not seeking medical advice appropriately, missing health appointments for self, baby and older children | Attends medical appointments and follows advice provided, seeks advice as required |

# Appendix 6: Pre-Birth Assessment Tool

Use Part A and Part B of this tool to gather and analyse relevant information for a pre-birth assessment (using the child and family assessment template).

|  |  |
| --- | --- |
| **PART A – INFORMATION GATHERING** | |
| **Intimate Relationships** | * History of relationships for adults * Current relationship status including strengths and risks * Domestic abuse including coercion and control * Who will be main carer for the baby? * What are the parents’ expectations of each other as parents? * Concerns about ‘choosing’ between interests of partner vs child * Parental dependency on each other – is this appropriate? * Anything else about intimate relationships that seems likely to have a significant impact on the child. |
| **Parenting Abilities** | * Physical health needs and potential impact on care * Emotional regulation, resilience and coping strategies * Reflective functioning (capacity to hold the child’s mental states in mind) * Ability to understand and meet the needs of a baby * Ability to understand how children’s needs change and to meet these needs until adulthood * Knowledge and understanding of concerns arising in this assessment * Anything else about parenting abilities that seems likely to have a significant impact on the child. |
| **Parenting Attitudes and Beliefs** | * Context and circumstances of conception * Perception of self and each other in a parenting role * Aspirations for their child’s future * Preparedness and looking forward to baby’s arrival * Ability to access professional advice and support, and apply it appropriately * Antenatal engagement * Capacity to change * Anything else about parenting attitudes and beliefs that seems likely to have a significant impact on the child. |
| **Social history and experience of being parented** | * Experience of being parented as a younger child and adolescent * Experience and understanding of offences against / risks to children within the wider family * Views about these experiences and to what degree this influences their own parenting * Previous involvement with children’s social care as a child (assessment, child protection, looked after, care proceedings, adopted – in any local authority area * Education and employment history * Anything else about social history that seems likely to have a significant impact on the child * Anything else about experiences of being parented that seems likely to have a significant impact on the child. |
| **Parenting behaviours and previous parenting** | * Violence to partners or others – current or previous * Violence to any child – current or previous * Substance misuse and its impact on functioning * Alcohol misuse and its impact on functioning * Chaotic or inappropriate lifestyle * Criminal convictions that may indicate a risk to children * Prior involvement with children’s social care as a parent (assessment, child protection, looked after, care proceedings, adopted – in any local authority area) – ages and genders of children involved, nature and context of concerns * What happened and why? * Parents’ views about previous concerns and the impact on the child/ren concerned * What is different now? * What do previous assessments say? – including expert / independent assessments, and regarding children from previous relationships * Anything else about parental behaviours or previous parenting that seems likely to have an impact on the child * If substances or alcohol are a significant issue more detailed assessment should be sought from professionals with relevant experience. |
| **Perception of risks** | * Are previous convictions or findings, concerns understood and accepted? * Is response to these concerns appropriate? * Is the impact of these risks on the child understood? * How have these concerns been addressed or do they continue to pose a risk? * Anything else about perception of risks that seems likely to have an impact on the child * It may be appropriate to consult with the Police or other professionals with appropriate expertise. |
| **Current circumstances and home conditions** | * Unemployment / employment and its impact * Debt * Criminality or anti-social behaviour * Inadequate housing including overcrowding or homelessness * Chaotic home environment * Significant difficulties within local community * Home conditions unsuitable or hazardous for a child * Social isolation * Anything else about current circumstances or home conditions that seems likely to have an impact on the child. |
| **Mental Health** | * Mental illness and likely impact on parenting * Personality disorder and likely impact on parenting * Engagement with professional advice, support and treatment * History of postnatal mental health concerns * Any other emotional or behavioural issues * Anything else about mental health that seems likely to have an impact on the child. * If mental health is likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise. |
| **Additional Needs** | * Learning disability or difficulties that seem likely to have an impact on the child * Sensory or communication difficulties (e.g. deafness, blindness) that seem likely to have an impact on the child. * If additional needs are likely to be a significant issue, more detailed assessment should be sought from professionals with relevant expertise. |
| **Support network** | * Support now and in the future from extended family or friends * Access to and engagement with support from professionals or other sources * Ability to access local resources including own / public transport is support likely to be available over a meaningful timescale? * Is it likely to enable change? * Will support effectively address any immediate concerns? * Anything else about the support network, or lack of, that seems likely to have an impact on the child. |
| **Engaging with Professionals** | * Access to and engagement with support from professionals or other sources – previously and currently * Understanding of current and previous concerns and willingness to make changes (consult with all involved professionals) * Is support likely to be available over a meaningful timescale? * Is it likely to enable change? * Has support facilitated sustainable change in the past? If not, what has changed to mean it will be sustainable now? * Will support effectively address any immediate concerns? * Anything else about engaging with professionals that seems likely to have an impact on the child. |
| **PART B – ANALYSIS AND CONCLUSIONS**   * Summarise identified risks and concerns * Summarise identified strengths and protective factors * Analyse to what degree protective factors realistically mitigate risks * Analyse to what degree risks are likely to impact on the baby – be explicit about the nature of the risk, from whom, and in what circumstances * Will the risk arise:   + before the baby is born   + at or immediately following the birth   + while still a baby   + as a toddler or pre-school   + as a school age child or teenager * What changes ideally need to be made to optimise the child’s wellbeing * What changes MUST be made to ensure safety and an acceptable level of care for the child * How motivated and capable are the parents to make necessary changes * What is the likelihood of changes being achieved and sustained   Make a recommendation about the Level of Need and next steps for multi-agency support and services. | |

# Appendix 7: Safeguarding Birth Plan and Discharge Template

The information in this plan is required for parents, hospital staff and other relevant agencies where there are safeguarding concerns for an unborn child. This form is to be completed by the allocated social worker and midwife for all unborn babies where concerns are assessed at Level 4 of ***Right Help Right Time.*** (The form can be found on Herefordshire Procedures, under Practice Guidance and Assessment and Planning).

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1. Summary of safeguarding plan** | | | | | | | |
| Date of this plan | | Version number | | | | | |
| Unborn baby (state family name) | | Mosaic ID | | | | | |
| EDD | | Ethnicity | | | | | |
| Unborn baby currently subject to (delete as appropriate)   * Pre-birth assessment * Child in need plan * Child protection plan * Public Law Outline | | | | | | | |
| The plan is (delete as applicable):   * Baby to remain with mother but there are safeguarding concerns * Baby to be separated from mother following birth * Baby to be separated from mother following discharge | | | | | | | |
| Detail actions and timescales to be taken by the local authority to seek legal orders if applicable: | | | | | | | |
| Detail any evidenced concerns re risk of abduction: | | | | | | | |
| **2. Family Information** | | | | | | | |
| Mothers name |  | | | Date of birth |  | | |
| Disability, communication or learning difficulties | | | | | | | |
| Home address | | | | | | | |
| Putative Father’s name |  | | | Date of birth |  | | |
| Disability, communication or learning difficulties | | | | | | | |
| Home address | | | | | | | |
| Will the putative Father have parental responsibility (i.e. married to Mother or intended to be named on birth certificate) | | | | | Yes/No | | |
| **3. Specific information regarding the birth** | | | | | | | |
| Are there any specific observation, assessment or support needs for the mother or father during birth or the post-natal period and how will this information be reviewed? | | | | | | | |
| Agreed birthing partner’s name and status | | | | | | | |
| Who will give consent to screening after the birth? | | | | | | | |
| What is the plan in relation to breast-feeding? | | | | | | | |
| Person(s) who are to be excluded from the maternity unit and reasons why | | | | | | | |
| Names(s) and status of any person(s) who may have access to the maternity unit but whose conduct and behaviour may pose difficulties. State why: | | | | | | | |
| Agreed security arrangements if applicable: | | | | | | | |
| If there are evidenced concerns relating to risk of abduction, what arrangements are agreed to manage this including alerts to other local authority areas? **(NB only children subject to child protection plans at the time of the birth will be notified to children’s services by maternity services through the CP-IS national alert system)** | | | | | | | |
| Are there any other children that need considering within this plan? (please detail names, ages, and nature of concern / consideration) | | | | | | | |
| If the mother is intending to give birth at home who will be present with the midwives at the home? (NB the Ambulance Service must be included in the plan) | | | | | | | |
| What are the agreed contingency plans in the event of an unexpected delivery at home? | | | | | | | |
| **4. Health and social care professionals** | | | | | | |  |
| Name of Hospital and birthing unit | | |  | | | |  |
| Named Midwife  Contact details | | |  | | | |  |
| Named Health Visitor Contact details | | |  | | | |  |
| GP Practice  Contact Details | | |  | | | |  |
| Named Social Worker  Team  Contact details | | |  | | | |  |
| Team Manager  Contact details | | |  | | | |  |
| Any other professionals who may need to be contacted during or after the birth | | | | | | |  |
| Emergency Duty Team contact details | | |  | | | |  |
| Police incident number obtained | | | Yes (state incident number) / Not requi | | | | red |
| **Professionals to be notified (including EDT if required) ON ADMISSION** | | | | | | |  |
| **NAME** | | | **CONTACT DETAILS** | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
| **Professionals to be notified (including EDT if required) FOLLOWING BIRTH** | | | | | | |  |
| NAME | | | **CONTACT DETAILS** | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
|  | | |  | | | |  |
| **5. Contact following birth within hospital** | | | | | | |  |
| For Mother | | | | | | |  |
| Is supervised contact required? | | | | | | | Yes/No |
| If contact is to be supervised please detail the:   * level of supervision required * who will supervise * reason why contact is to be supervised | | | | | | |  |
| For putative Father | | | | | | | |
| Is supervision required? | | | | | | Yes/No | |
| If contact is to be supervised please detail the:   * level of supervision required * who will supervise * reason why contact is to be supervised | | | | | | | |
| For any other person | | | | | | | |
| Is supervision required? | | | | | | Yes/No | |
| If contact is to be supervised please detail the:   * names of those who may have contact and their relationship to the newborn  level of supervision required * who will supervise * reason why contact is to be supervised | | | | | | | |
| Any other restrictions on or information about contact: | | | | | | | |
| **6. Safeguarding birth plan** | | | | | | | |
| Are there any known / likely medical needs for either mother or child following the birth? | | | | | | Yes/No | |
| If yes detail these and how this may impact on the plan:  **(NB if medical needs arise following birth, the discharge plan should be reviewed)** | | | | | | | |
| Is the child to be separated from the mother following birth? | | | | | | Yes/No | |
| If yes: | | | | | | | |
| On delivery suite following birth and transferred to a designated place of safety? | | | | | | Yes/No | |
| On discharge from postnatal ward | | | | | | Yes/No | |
| Will the allocated social worker / duty social worker need to visit the child in hospital? (NB if care proceedings are to be initiated, this should be the same or next working day) | | | | | | Yes/No | |

|  |  |  |  |
| --- | --- | --- | --- |
| Are there any concerns about the mother’s capacity to consent to the plan? If yes, details these concerns e.g. mental health issues, learning disability, due to mother’s young age? If yes, detail here: | | | Yes/No |
| Is the plan agreed by the mother? | | | Yes/No |
| Is the plan agreed by the Father? | | | Yes/No |
| Date plan discussed with parents | | |  |
| **NB: Consent can be withdrawn at any time by any person with parental responsibility** | | | |
| Where the plan is not agreed or consent is withdrawn detail the contingency plan to safeguard the child upon birth. Please include the names of professionals who will be enacting the contingency plan. | | | |
| State how lawful authority for the plan will be obtained: | | | |
| Police Powers of Protection | | | Yes/No |
| Emergency Protection Order | | | Yes/No |
| Interim Care Order application | | | Yes/No |
| **7. Discharge plan** | | | |
| **Arrangements for discharge** | | | |
| How long is it intended the baby will stay in hospital (subject to medical needs)? | |  | |
| How long is it intended the mother will remain on the ward? | |  | |
| Is the baby to be discharged from hospital to an alternative carer? | | Yes/No | |
| If yes: | | | |
| To foster carer? | Yes/No | | |
| Is the foster carers address to remain confidential? | Yes/No | | |
| Address of F/C (if confidential please ensure this is not shared with parents/carers) | | | |
| Discharge to others carers? Please state: | Yes/No | | |
| Name: | | | |
| Relationship to child: | | | |
| Address: | | | |
| If baby and/or mother are being discharged to another area have maternity services been informed?  If not who will do this and when? | Yes/No | | |
| If mother and baby are to be discharged to home address, detail any action and support required, including who is to provides these (professionals and wider family) and timescales | | | |
| If mother and baby are to be discharged to home address, can this happen if they are ready for discharge on the weekend or bank holidays? Yes/No    Detail any additional arrangements required until the following working day: | | | |
| If required is there a working agreement in place setting out the expectations of parents and wider family following discharge? | Yes/Not required | | |
| If yes, when will this be reviewed? |  | | |
| Who should parents and wider family contact if they have any concerns? In working hours:    Outside of working hours: | | | |
| What is the agreed contingency plan and does this include care being provided by a family member who has been assessed as able to provide adequate care? | | | |
| Agreed plan for home visits, announced and unannounced, by who (professionals and wider family) | | | |
| When will the plan for support and visiting be reviewed (date and type of meeting)? |  | | |
| Any other issues to be noted | | | |
| **8. Distribution of notes** | | | |
| Date plan given to: | | | |
| Midwife |  | | |
| Named midwife for safeguarding |  | | |
| Health Visitor |  | | |
| Others (please state) |  | | |
| Date when plan shared with Mother |  | | |
| Date when plan shared with putative Father |  | | |
| If plan not shared with parent/s state reason why |  | | |
| Date copy signed by Social Worker |  | | |

# Appendix 8: Discharge Planning Meeting Agenda

1. Introductions and purpose of meeting.

1. Professionals attending and apologies.

1. Clarify name, DOB, address, ethnicity of child and significant family members including other children.

1. Agency updates in relation to pre-birth, birth and post birth considerations during hospital stay.

1. Discharge plans to include:
   1. when and to whom baby is to be discharged
   2. reasons why this is the proposed plan
   3. confirm parental consent or how consent will be dispensed with
   4. baby’s development and any specific medical needs and how these will be met
   5. who will transport baby and/or parent/s to proposed address
   6. equipment required and who will provide this e.g. car seat, clothing, feeding equipment
   7. when parent/s will be informed of discharge plan and by who
   8. equality and diversity needs for baby and family and how these will be met i. contingency plan

1. Consideration of support needs for siblings, parent/s and significant family members, including how these will be met and by who (professionals and wider family).

1. Contact arrangements with parents and any siblings following discharge, if applicable.

1. Information to be shared or withheld from parent/s and reasons.

1. Arrangements to inform community midwife and health visitor (including who will do this and when).

1. Proposed multi agency visiting arrangements following discharge.

1. Dates for review of arrangements and type of meeting.

# Appendix 9: Reflective Supervision Tool for Social workers, Midwives and Team Managers

This checklist can be used to inform reflective supervision during pre-birth assessment. For social workers this will most likely occur at the 20 day point of a Pre-Birth Assessment. The discussion should conclude with a clear sense of risk and protective factors and the most likely outcome for the child. It can also be used to inform practitioner group supervision and for midwives this tool can be used in safeguarding supervision.

1. The family history of both parents, the fathers of any previous children, the extended family.
2. Any previous court proceedings and any previous expert assessment reports, including parenting assessments.
3. Strengths of, and concerns about, each parent and extended family members.
4. Positive and negative factors in previous parenting, including any assessments made by other local authorities.
5. Strength of wider family support.
6. Parents’ attitude to the new baby and preparedness for its birth.
7. Any concerns about parental mental health and current or previous involvement with mental health services.
8. Possibility of post-natal depression and help available if this arises.
9. The possible need for specialist services for the parents after the birth.
10. Any concerns about parental learning disabilities and history of engagement with adult services.
11. History of and current parental engagement with health professionals and midwifery services and antenatal care, including (if applicable) reasons for poor engagement currently.
12. Involvement with drug and alcohol services.
13. Evidence of previous and current domestic abuse.
14. Previous convictions.
15. Outcome of checks undertaken with the National Probation Service and Community Rehabilitation Company.
16. Engagement with the social worker.
17. Any history of previous children being removed by another local authority. A visit must be made to the other authority to read the case history so that the reasons are fully understood.

# Appendix 10 – National Alerts Process

**The national CPIS (Child Protection Information Sharing) alert system** allows information to be automatically, electronically shared between local authorities and health settings where:

* The child has a child protection plan
* The child is looked after
* The child has had a child protection plan or been looked after in the preceding 12 months.

**Not all health settings are yet signed up to CPIS. An up to date list can be found at:**

[**Implementation progress,** See which local authorities and healthcare organisations are already live with CP-IS.](https://digital.nhs.uk/services/child-protection-information-sharing-project/implementation-progress)

Health settings receive notifications regarding children in one of these categories and children’s services receive notifications from health settings in relevant cases. Notifications from health settings record that the child has attended the health setting. These are received by business support, documented on the child’s case notes and the social worker will be notified by email. It is the responsibility of the allocated social worker to make contact to ascertain the details of this attendance.

Children with a child in need plan are not included in CPIS therefore there will be no automatic notifications between health and children’s services. Where there is a strong possibility of abduction, the unborn child should be made subject of a child protection plan.

# Appendix 11 – Further Reading

[Care in Surrogacy: Guidance for the care of surrogates and intended parents in surrogate births in England & Wales](https://www.gov.uk/government/publications/having-a-child-through-surrogacy/care-in-surrogacy-guidance-for-the-care-of-surrogates-and-intended-parents-in-surrogate-births-in-england-and-wales)



**Research in Practice Resources for Social Workers**

(2019) Working with recurrent care-experienced birth mothers

(2017) Fetal Alcohol Spectrum Disorder (FASD) – identifying and responding in practice with families

(2016) Attachment: understanding and supporting parent/carer bonding before birth and in infancy

(2016) Attachment in children and young people

(2015) Scoring Standardised Measures

(2013) The impact of parental substance misuse on child development

(2013) Assessing parents’ capacity to change

**Additional Reading**

(2019) Murphy-Tighe, S and Lalor, J Regaining agency and autonomy: a grounded typology of concealed pregnancy

(2015) Murphy-Tighe, S and Lalor, J Concealed pregnancy: a concept analysis

(2009) Hart, D in Horwath J The Child’s World: a comprehensive guide to assessing children in need

(1991) Fahlberg, Vera MD A Child’s Journey Through Placement.

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