

**Dudley Pre-birth Protocol**

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**Glossary of terms:**

DSPP – Dudley Safeguarding People Partnership

PLO – Public Law Outline

UBN – Unborn Baby Network

GCP2A – Graded Care Profile 2 Antenatal

LMP – Legal planning meeting

ICPC – Initial Child Protection Conference

CP – Child Protection

# 1. Introduction

Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention, and support.

Unlike many safeguarding situations, 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
* Understand the impact of risk to the unborn baby when planning for their future; Explore and agree safety planning options
* Assess the family's ability to adequately parent and protect the unborn baby and once the baby is born
* Identify if any assessments or referrals are required before birth. This should include those pertaining to parental mental health and the need for referral to specialist mental health services.
* Ensure effective communication, liaison, and joint working with all involved and relevant professionals that are working with the family
* Plan on-going interventions and support required for the child and parent(s)
* Avoid delay for the child where the Public Law Outline threshold is reached

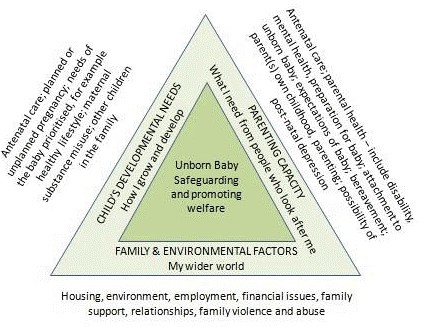
Where risks have been identified, it is important that practitioners do not assume that Midwifery or other Health services are aware of the pregnancy. It is critical that all professionals work together and share information to provide a coordinated response, and appropriate interventions and planning at the earliest opportunity to optimise the outcomes and support for the child and their family.

This procedure sets out how Dudley Safeguarding People Partnership (DSPP) responds to concerns for unborn babies where vulnerability and risk factors are identified. Further information and guidance on multi-agency roles and responsibilities can be found on the [West Midlands Regional Procedures website](https://westmidlands.procedures.org.uk/)

Where there is a late booking or a concealed pregnancy, the health practitioner must complete an immediate assessment to identify which agencies need to be involved and make appropriate referrals. Where there is evidence of a concealed pregnancy a referral to Children’s Social Care must be made. This must include consideration of the holistic needs of the parent.

# 2. Identification of Need and Risk During Pregnancy

**Parents or carers Who May Require Additional Support**



**Parents with learning disabilities who may need help to manage caring for a young child** - The UK legislative framework dictates that parents with learning difficulties have a right to have children and to be supported in bringing them up. However, it is recognised that such parents or carers will face a particular set of problems and challenges, including accessing antenatal care, understanding information about their pregnancy and birth choices or medical information about their baby. Parents or carers may also be anxious about asking for or accepting professional help as they may believe that this will result in their child being removed from their care.

If the parents or carers of the unborn child are already accessing support via adult services, the lead worker must be involved in any pre-birth assessment. If adult services are not involved this should be explored with the parents or carers and, with consent, a referral could be made for additional support.

**Young and/or unsupported parents or carers** - A report from Public Health England, 2019 advised ‘like all parents, young mothers and fathers want to do the best for their children. Whilst a good proportion of young parents manage very well, many young parents’ health, education and economic outcomes remain disproportionately poor, affecting the life chances for both them and their children. While every young parent has their own individual story, the risk factors for early pregnancy highlight the vulnerabilities with which some enter parenthood, including family poverty, persistent school absence, slower than expected school attainment and being looked after or a care leaver.’ This same report concluded that poor outcomes for the children of young parents or carers can be mitigated by early coordinated and sustained support.

**Parents or carers who are Looked After or Care Leavers** - Some of the key risk factors associated with teenage pregnancy are particularly pertinent for young people who are looked after or care leavers. Pregnant teenagers who are looked after/care leavers will need support and guidance to enable them to make informed choices about their future and should be put in contact with relevant health professionals at the earliest opportunity (including specialist teenage pregnancy services where these are available and appropriate). For young people who are looked after by the local authority, the Social Worker will have primary responsibility for ensuring access to services and the coordination and updating of the Care Plan in relation to either or both young parents or carers.

**Parents or carers with significant physical health problems or disabilities which may make it difficult for them to care for a young child** - There are around 1.7 million disabled parents or carers in the UK, mostly with physical and sensory impairments. A report on a UK study on physically disabled parents or carers' experiences of maternity services reveals that physically disabled people embarking on parenthood face a number of challenges in getting appropriate information and support, including negative attitudes from some health professionals, a lack of knowledge and information available for parents or carers and professionals, as well as poor communication between disabled parents or carers and professionals.

**Asylum seekers and families where English is not a first language** - There is a five-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds and an almost two-fold difference amongst women from Asian Ethnic backgrounds compared to white women (Knight et al, 2018). There are also significant adverse pregnancy outcomes for babies. Migrants, refugees and asylum seeking women who have recently arrived into the UK bring new challenges for services. The key issues include poor overall health status, language difficulties as many do not speak English, underlying and possible unrecognised medical conditions and HIV/AIDS and TB.

**Families who are homeless** - Women who are pregnant and homeless constitute a unique group at significant risk of adverse foetal and maternal outcomes. Women often become homeless due to family breakdown, debt, poor mental health and substance misuse problems which add to their vulnerability and those of the unborn infant. Robust collaborative working is needed by all who provide social and healthcare services to homeless pregnant women, to improve the health outcomes for these women and babies.

**Parental Behaviours Which *May* Pose A Risk To The Child**

**Domestic abuse** -pregnancy can be both a trigger and risk factor for domestic abuse (DH, 2016) with domestic abuse starting or intensifying in pregnancy. Between 4% and 9% of women are abused during pregnancy and/or after the birth (Taft 2002).

Domestic abuse is associated with an increased risk of miscarriage, still birth and premature birth (NHS 2018). It can also be linked to mental health concerns and substance usage (DH, 2010). Domestic abuse also directly affects the unborn baby: by 18 weeks gestation the unborn baby can hear and by 24-26 weeks gestation the unborn will be startled by very loud noises outside the womb which can cause a stress response in the baby. If a pregnant woman is stressed or scared over a significant period of time, which often occurs where there is domestic abuse, increased levels of the stress hormone, cortisol, will be shared with the unborn baby. Cortisol affects the brain development of the unborn baby and has been associated with mental health concerns later in life as well as affecting the growth of the unborn baby.

**Current use of drugs or alcohol** - substance misuse by parents or carers does not on its own automatically indicate that children are at risk of abuse or neglect. However where substance misuse is causing physical, psychological, social, interpersonal, financial and or legal problems, the implications for children and families must be thoroughly assessed. Drug and alcohol misuse during pregnancy, dependent on frequency and severity, can adversely impact the developing foetus, particularly during the first twelve weeks of gestation. There is an increased risk of miscarriage, likelihood of premature delivery, reduced birthweight and head circumference, and an increased risk of sudden unexpected death in infancy. The infant exposed to drug or alcohol use during pregnancy may also experience additional long-term cognitive and development problems.

**Parental mental illness** - during pregnancy and in the year after birth, women can be affected by a range of mental health problems, including anxiety, depression and postnatal psychotic disorders. These are collectively called perinatal mental illnesses. Perinatal mental illnesses affect at least 10% of women (O’Hara, Swain, 1996) and between a quarter and half of fathers with a partner with a perinatal mental illness are depressed themselves (Goodman 2004). Some women are at an increased risk of experiencing mental illness in the perinatal period, particularly those who have had a previous history of mental illness. A small group of women are known to be at significant risk of developing severe perinatal mental illness. Women who have experienced postpartum psychosis, severe depression in the past or have a diagnosis of Bi-polar disorder have around a 50% chance of becoming unwell in the perinatal period (Oates, M, 2001; Jones, 2019).

Most families where there is perinatal mental illness manage very well and are able to give their children safe and loving care. However, without the right support, perinatal mental illness can have an adverse effect on the baby’s brain development and long-term outcomes for the child (Centre on the Developing Child at Harvard University 2009). Interactions with caregivers are the most important element of a baby’s early experience and help build secure and stable attachments. The nature of this early attachment sets the template for future relationships and can predict a number of physical, social, emotional and cognitive outcomes (Cuthbert et al 2011).

In more serious cases, parental mental illness increases the risk that a baby could be abused or neglected. Babies are particularly at risk if:

* Parents or carers experience psychotic beliefs about the baby
* Parental Perinatal mental illness results in conflict or isolation
* Parental Perinatal mental illness significantly impairs parent’s ability to function. (Manning, Gregoire 2008)

‘Red Flag’ presentations which should prompt urgent senior psychiatric assessment (MBRRACE-UK – Saving Lives, Improving Mothers’ Care 2018)

* Recent significant change in mental state or emergence of new symptoms
* New thoughts or acts of violent self-harm
* New and persistent expressions of incompetency as a mother or estrangement from the infant

Much of the negative impact that parental perinatal mental health could have on the family and baby’s lives can be prevented. The quality of parent’s or carer’s interactions with babies and the development of secure and stable attachment relationships can be improved through effective interventions (Hogg 2013).

For information on Dudley and Sandwell Perinatal Mental Health service visit <https://www.blackcountryhealthcare.nhs.uk/our-services/perinatal-services> or call 01384 314455.

**Maternal ambivalence** - an analysis of Serious Case Reviews (DfE, 2016) recognised that maternal ambivalence towards the child (both during and after pregnancy) was highlighted in many reviews as a potential indicator of a child’s vulnerability. At its extreme, this may present with a concealed or denied pregnancy. Whilst such cases are rare, other presentations including delayed antenatal booking or uncertainty about keeping the pregnancy are far more common.’ The report concluded that such presentations offer professionals (particularly in primary care and maternity services) opportunities to explore parental concerns and feelings towards the pregnancy and the unborn infant.

**Denial or concealment of pregnancy** - the concealment and denial of pregnancy will present a significant challenge to professionals in safeguarding the welfare and wellbeing of the unborn infant and the mother. Lack of antenatal care in concealed or denied pregnancies can mean that potential risks to mother and child are not detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy. The potential risks to a child through the concealment of a pregnancy are difficult to predict and are wide-ranging.

While concealment and denial, by their very nature, limit the scope of professional help, better outcomes can be achieved by coordinating an effective multi-agency approach.

**Surrogacy** - government guidance in respect of surrogacy (2018) advises: ‘Altruistic surrogacy is an established and legal way of creating a family in the UK. Surrogacy agreements are not legally enforceable and the IPs (intended parents) need to apply for a parental order after their child is born in order to become the legal parents of the child. The legal framework allows for a surrogate to receive reasonable pregnancy-related expenses from IPs, as assessed by the family court. Surrogacy through commercial means, however, is illegal in the UK (Surrogacy Arrangements Act 1985) and therefore it is an offence for an individual or agency to act on a profit-making basis to organise or facilitate surrogacy for another person. Any persons or organisations that organise or facilitate surrogacy must do so on a non-commercial basis.’

When any professional is made aware of a pregnancy as a result of a surrogacy arrangement they should seek advice from their Designated Officer for Safeguarding Children or the Designated/Named Doctor or Nurse with responsibility for safeguarding children, to enable them to make the necessary enquiries to satisfy themselves of the legitimacy of the arrangement.

If professionals, following such consultation, are satisfied that the relevant Code of Practice (HFEA, 2017) has been followed, the local authority need not be informed unless there are other concerns being expressed that might indicate that the child may be at risk.

Where the circumstances of the conception and subsequent arrangements for the baby are not clear the parents or carers should be informed of the need for a referral to Children’s Social Care to allow for further enquiries to be made.

**Current or previous history of safeguarding concerns:**

* Previous unexpected death of a child whilst in the care of either parent where abuse or neglect is/was suspected;
* A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children;
* Children in the household / family currently subject to a Child Protection Plan or previous child protection concerns;
* Sibling (or a child in the household of either parent) has previously been removed from the household either temporarily or by court order;
* Parent previously suspected of fabricating or inducing illness in a child;
* Families where there is a history of FGM, Honour-based Violence, Forced Marriage or suspected Trafficking.

**Working with fathers and partners**

Fathers or 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).

The Child Safeguarding Practice Review Panel published a national review called “The Myth of Invisible Men” and is available to view [here](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf)[[1]](#footnote-1)

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

Information should also be gathered, and checks completed in relation to fathers and partners who are not biologically related to the child at the earliest opportunity to ensure any risk and protective 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 their 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.

# 3. Early Intervention and Early Help

Where there are additional support needs identified during the pregnancy, an Early Help Assessment should be completed at the earliest opportunity, helping to identify support and intervention best suited to the family and their needs.

A referral to the Unborn Baby Network may also be considered (see Appendix 4).

The Unborn Baby Network is a meeting monthly in Dudley to discuss high risk pregnancies. The aims include:

* To promote working together with partner agencies and support the over sight of cases being managed within the universal and early help services, and monitor the progress of pregnancies during this time.
* To implement an early help pre-birth pathway which will provide information and advice to professionals, to ensure that pregnant women are enabled to access support services at the right stage in pregnancy.
* Through multi-agency discussion and information sharing early detection of safeguarding concerns leading to early intervention will improve the emotional and physical outcome for unborn children.

Please refer to the [Early Help guidance and strategy](https://dudleysafeguarding.org.uk/children/professionals-working-with-children/dudley-early-help/) for further information around the completion of assessments.

# 4. Involvement of Children's Social Care

Referrals are to be made as early in the pregnancy as possible and as soon as concerns have been identified which indicate that the unborn is at risk of harm. It may be that concerns are not known until later in the pregnancy at which point a referral should be made.

In any of the following circumstances a referral must always be made:

* A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children. This may be due to domestic abuse, violence, substance/alcohol abuse, mental health or learning difficulties
* A sibling (or child in the household of either parent) has previously been removed from parental care/previous PLO and/or Court Proceedings
* Children in the household / family currently subject to statutory planning (Child in Need/Child Protection Plan/Looked After child);
* Where there are serious concerns about parental ability to care for the unborn baby or other children (for example, teenage/young parents or carers who have been/are Looked After and/or with limited support)
* There is a perinatal mental illness that presents a risk to the unborn baby please ensure referral to Peri-Natal Mental Health Team.
* Where there are maternal risk factors e.g., denial of pregnancy, concealed pregnancy, avoidance of antenatal care (failed appointments), non-engagement with necessary services and/or with treatment with potentially detrimental effects for the unborn baby
* Any other concern exists that indicate the baby may be at risk of significant harm.

See the referrals procedure for advice and guidance regarding the process to follow where a professional has concerns about a child/ren. The [DSPP Support Level Guidance and Framework document](http://dudleysafeguarding.org.uk/wp-content/uploads/2023/03/DSPP-Support-Level-Guidance-and-Framework-March-2023.pdf) also provides important information and safeguarding guidance to consider.

# 5. Outcome of Referral to Children's Social Care

There are several possible outcomes from a referral to Children’s Social Care:

1. The unborn baby is deemed to be at risk of significant harm. The unborn baby's needs and those of their family will be considered within the Child Protection process, inviting multi-agency pre-birth assessment and planning
2. The unborn baby is deemed to be a Child in Need under Section 17. In these circumstances, a multi-agency pre-birth assessment will be completed, led by a social worker to identify the level of need and risk, and the service required to support the child and family
3. It may be that threshold is not considered met for Social Care involvement, but that the family would benefit from support via Multi Agency Early Help Services (see Section 2 for detail)
4. It may be that threshold is not considered to be met for either Children’s Social Care involvement or Multi Agency Early Help Services. In these instances, the referrer should be signposted to other appropriate agencies /services. This may include recommending an Early Help Assessment is completed and/or a referral to the Unborn Baby Network (UBN).
5. If the referrer disagrees with the outcome of a referral, they can utilise the [DSPP Professional Challenge and Resolution procedure](https://dudleysafeguarding.org.uk/children/professionals-working-with-children/safeguarding-children-procedures/) as appropriate.

**Notifying the referrer of the outcome of a referral**

Children’s Social Care should notify the referrer about the outcome of their referral, and this would normally be within 72 hours. If the referrer does not receive the information within this timeframe, they can contact Children’s Social Care directly.

Any child can be re-referred at any point if there are any changes that increase the risk to the unborn baby.

# 6. Child Protection Concerns

**Strategy Discussion**

If there is reasonable cause to suspect an unborn baby is likely to suffer significant harm, a Strategy Discussion will be convened. Best practice is for this meeting to take place no later than Day 25 of the Pre-Birth Assessment. However, a strategy meeting can be convened at any point during the assessment.

This will be coordinated and chaired by Children’s Social Care who will involve all other professionals involved with the family. For further information on Strategy Discussions and the Child Protection process please refer to Child Protection enquiries. A midwife (preferably the assigned named midwife) should always be invited to a Strategy Discussion involving an unborn baby.

The Strategy Discussion will determine if there is evidence/risk of significant harm. If this is the case, then a Section 47 enquiry will be initiated either jointly with Police, or as single agency enquiry, led by Children’s Social Care to ascertain the level and source of risk to the unborn baby and any others. It will include seeing the parents or carers and any other significant adults as well as seeing and speaking to other children in the family/household.

**Outcome of Section 47 Enquiry Child in Need of Protection**

A possible outcome of the Section 47 enquiry may be that there is evidence that the unborn baby is suffering or at risk of suffering significant harm. In these circumstances Children’s Social Care will convene an Initial Child Protection Conference and will need to consider the most appropriate timing for this to be held. It may be that, where the pregnancy is in the early stages there is sufficient time for assessments including a GCP2A if there are neglect concerns and interventions to be provided to address the identified risks prior to birth. In such situations Children’s Social Care may decide, in consultation with other agencies, to undertake this work and hold a further strategy discussion at a later point in the pregnancy to consider whether the risk of significant harm is still evident. In such circumstances, the unborn child will be subject to a Child in Need plan. This approach must also consider the likelihood of premature birth.

Planning arising from the Strategy Discussion must also include timescales for the completion of the Pre-Birth Assessment, including GCP2A whether attendance at Legal Gateway Panel is required to consider entering Public Law Outline (PLO) and contingency planning around alternative support and care.

Whether the decision following the Section 47 enquiry is to proceed to an Initial Child Protection Conference or hold a strategy discussion later in the pregnancy, the Initial Child Protection Conference must take place within 15 working days of the date of the strategy discussion where the decision to proceed to Conference is taken.

The first Review Conference should be scheduled to take place within 1 month of the child's birth or within 3 months of the pre-birth conference whichever is the sooner.

**Child in Need**

It may be that the unborn child has not been assessed to be at risk of significant harm, but the family would benefit from support to prevent escalation. In such circumstances, Children’s Social Care would need to determine if threshold is met for Child in Need planning, to work with the family and other agencies to develop an outcome focused Child in Need plan to address identified risk and need. Regular Child in Need multi-agency meetings would be held with the family to review progress with achieving the outcomes. These should happen on at least a 4-6 weekly basis.

On occasion, the Section 47 enquiry and subsequent Pre-Birth Assessment may result in no further action being taken by Children’s Social Care. It is important that if this is the case, that decision making is clear, defendable and evidence based. Whilst there may be no further action being taken by Children’s Social Care, it would be expected that as part of the outcome, that there are considerations and discussions with the family around Early Help and UBN, as well as clear analysis around the decision making.

The GCP2A assessment should be included in any concerns related to an un-born, professionals can get more information on training and assessments at <https://learning.nspcc.org.uk/services-children-families/scale-up/graded-care-antenatal-gcp2a>

# 7. **Pre-Birth Assessment**

The importance of conducting pre-birth assessments has been highlighted by numerous research studies and Child Safeguarding Practice Reviews (previously known as Serious Case Reviews) which have shown that children are most at risk of fatal and severe assaults in the first year of life, usually inflicted by their carers.

Pre-Birth Assessment is a sensitive and complex area of work. It is important to undertake the assessment during early pregnancy so that the parents or carers are given the opportunity to demonstrate the capacity to change. If the outcome of the assessment suggests that parenting capacity is of concern, there is an opportunity to make clear and structured plans for the baby’s future together with support for the parents or carers.

Where threshold has been determined that a Pre-Birth Assessment is required, Children’s Social Care is the lead agency, and this is a Social Work led activity. However, it is imperative that social workers do not conduct assessments in isolation, and work in partnership with the parents or carers and relevant and involved professionals to inform assessments and outcomes for children and families. Professional obligations to participate in and contribute to assessments is set out within [Working Together to Safeguard Children](https://assets.publishing.service.gov.uk/media/65cb4349a7ded0000c79e4e1/Working_together_to_safeguard_children_2023_-_statutory_guidance.pdf) literature.

To inform any assessment, it is important to compile a clear history from the parents or carers about their own experiences of being parented and a clear understanding of the family system/network, traditions, culture, and identity, mindful of social graces. It is imperative that appropriate measures and support are in place for parents or carers where there are communication difficulties/barriers; ensuring that they can fully participate within assessment and planning activities and that there is assurance of their understanding. It is important to record all parents or carers details and also other adults who are around a baby in documentation. View the Child Safeguarding Practice Review Panel’s publication “[The Myth of Invisible Men](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf)” for more information.

If the parent/s have experienced social care involvement, it is important that this is explored and understood. If applicable, their views about any previous children who have been removed from their care must be discussed and whether they have demonstrated sufficient insight and capacity to change in this respect requires robust and evidence-based assessment. In these situations, previous Court documentation, Judgements and completed assessments should be accessed and considered at an early stage. Consultation with previous and/or current social workers is essential, and they should be invited to relevant meetings.

Working with extended families is crucial to the assessment process and achieving positive outcomes for unborn children. A Family Group Conference should be offered and convened for each family, especially where there is a possibility that the parent/s may be unable to meet the needs of the unborn child. Family Group Conferences can enable the families to be brought together to make alternative plans for the care of the child thus avoiding the need for Care Proceedings for that child. Parallel planning and assessment of alternative family carers can prevent delays in Care Planning for the child.

Pre-Birth assessments should be completed within 35 working days and must include a three generational and cultural genogram, demonstrating a robust understanding of the family and networks. A detailed chronology must also be completed, as an effective way of reviewing history, identifying patterns and issues, and supporting good risk analysis of likely harm. It is important to not only assess and consider the concerns identified, but also strengths and how the risks can be mitigated.

The Graded Care Profile Antenatal (GCP2A) - An evidence-informed assessment tool to help professionals understand potential risks and support parents or carers.

The antenatal period and early years of a child’s life can have a profound impact on their future physical and emotional safety and wellbeing. It’s important that parents or carers are given support to provide the best care for their developing baby and newborn infant. Support is available from the specialist perinatal mental health service, for those identified as having moderate to severe mental health concerns. The team can work with birthing people from conception to up to 2 years post-natal and will provide a range on interventions optimising the mental health of the birthing person, the unborn/ infant and the partner. The team will also assess and signpost if it is felt intervention is best met elsewhere.

Graded Care Antenatal (GCP2A) helps a range of professionals working with expectant parents or carers to identify areas of strength and areas where they may benefit from support.

Please also see Appendix 1. This is a Process Map to be followed and used in conjunction with this guidance.

<https://westmidlands.procedures.org.uk/page/contents>

# 8. Safeguarding Birth Plan

All unborn babies who are subject to Public Law Outline and/or Child Protection planning will require a Safeguarding Birth Plan.

It is the responsibility of all core group members, including the social worker and community midwife, to contribute to the development of the Safeguarding Birth Plan.  This should begin as early as the first Core Group and be updated as required.  The Social Worker should ensure the Safeguarding Birth Plan is disseminated to agreed partners, the community midwife and relevant birthing units.

This will detail the planning for delivery and the immediate post-natal period, including who should be notified upon the birth of the baby.

The detailed Safeguarding Birth Plan must be completed and disseminated to relevant professionals including the Emergency Duty Service (EDS) no later than week 35 of the pregnancy. Where a Birth Plan is needed, the mother should be encouraged to give birth within a hospital setting however, if a home birth is the desired choice, a pre-birth planning meeting should invite additional consideration around the level of risk and how this will be managed; as well as identifying who can be present.

Every Birth Plan should include roles and responsibilities, contact numbers and names of professionals involved and the agreed arrangements for where the baby is to be discharged to.

It is the responsibility of the Social Worker to ensure that other health practitioners involved are informed, such as the obstetrician, neonatologist, GP, Health Visitors. The Social Worker is responsible for ensuring other relevant agencies such as EDS and the police are aware of the detail within the plan. All professionals will need to be clear about their role and that of others.

The Safeguarding Birth Plan should be shared with parents or carers unless to do so is felt to put the mother or baby at increased risk of harm. Professionals will need to agree how the plan will be shared with parents or carers and who will lead this conversation.

**Additional Considerations**

* Immediately post birth, there may be occasions when either the baby and/or mother will need to stay in hospital for a further period, for example where there are medical needs in relation to the baby. In such circumstance’s professionals will need to assess the baby and mother's needs and risks during this period and how these will be met and managed during this period.
* In situations where the mother has been discharged from the birthing unit/hospital and there are safeguarding concerns for the baby, a multi-agency risk assessment and safety plan may need to be made with the parents or carers about family time with their baby in the hospital setting. This will include whether unsupervised contact between parents or carers, other relatives and the baby is allowed.
* For some unborn babies, the pre-birth assessment and planning activities conclude that the baby would be at significant risk of harm if they were discharged home to the immediate family following birth. In these circumstances Children’s Social Care will consider the best way to safeguard the baby including whether to apply to the Courts for an Order to remove the baby following birth.
* Where the plan is to apply for a Court Order, this will be conveyed to the parent/s at the earliest and most appropriate opportunity. It is however the decision of the Courts whether to grant an Order and so there should be an alternative agreed care and management plan following discharge of the baby by all partners if this situation arises. Where Children’s Social Care plan to apply for a Court Order at birth, the Police should be invited to the discharge planning meeting to consider any immediate protective action required. The discharge plan will set out where the baby is to be discharged to if not to parental care.
* It is important Midwifery services 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, and where the circumstances require, including any protective action that the Police may need to consider.

# 9. Discharge Planning Meeting

For all babies who are subject to Public Law Outline and/or Child Protection planning, the discharge planning process should be initiated as soon as the mother is admitted/ presents for delivery and all Midwives caring for her should have full access to and knowledge of the Safeguarding Birth Plan.

Following birth, a Discharge Planning Meeting will be required for all babies (including those babies born at home). This meeting should take place ideally 48 hours ahead of the proposed discharge, but certainly no less than 24 hours before. All involved agencies must be invited to attend and should be represented for the meeting to proceed. The convening and timing of the Discharge Planning Meeting and alerting all those required to attend should be a shared responsibility between Health and Children’s Social Care. The Social Worker will lead the discharge planning meeting.

Professionals that need to be represented:

* Dudley Council Team Manager/Social Worker
* Paediatric Consultant (or specialist registrar with consultants’ consent)
* Midwife
* Other relevant hospital staff involved in the care of the child/family
* Health Visitor
* Other agencies and wider attendance should be considered such as Family Hub, Young Parents Service, School Nurse if there are other school aged children in the family, Police, Mental Health colleagues, Learning Disability colleagues, GP, Family Nurse Partnership and any other key professionals that are able to support the safeguarding of the new-born.

An agreed multi-agency discharge plan will set out arrangements for the care and safety of the child following discharge from hospital into the community and will include SMART actions, to include:

* Details of the child's GP. If they are not registered this should be organised before the child leaves hospital
* Additional medical investigations requested including timescales for completion
* Multi-Agency support and monitoring
* Documentation of any legal orders arising from the admission.

The Social Worker will ensure that the parents or carers and any support person they choose will be informed when and where the meeting will take place. Parents or carers will always be invited unless to do so would present a risk of harm to the child. If this is the case the meeting will need to discuss how and when parents or carers will be informed of the outcome of the meeting.

Where a baby is born prematurely it is reasonable to plan the discharge meeting 7-10 days prior to the earliest likely discharge date. All agencies should aim to agree the baby's discharge as soon as safely and practicably possible.

The new born baby should not be discharged at weekends or on bank holidays unless there is a consensus that it is safe and reasonable to do so. This should be documented in the child's medical record and discharge plan. **Please ensure that the child's GP is aware of the discharge plan and the safeguarding concerns because if the baby is not yet registered at a GP the notes will not be added to the child's records as there is no record as yet**

**A copy of the Discharge Planning meeting must be placed in the child’s social care file, medical notes and shared with the baby’s GP. See Appendix 2 for suggested template.**

# Appendix 1: Pre-Birth Pathway - Process

Contact received requesting pre-birth assessment.

Progress to Family Safeguarding Service chronology must be completed.

Threshold met – pre-birth Assessment is required – Children & Families assessment opened to include a GCP2A.

Passed to Front Door for thresholding decision.

Threshold for Strategy Discussion met.

Team Manager convenes Strategy Discussion no later than **day 25** of Children & Families Assessment.

Legal bundles from previous proceedings should be read.

If Head of Service agrees, LPM should be held following ICPC, and PLO process commenced.

Threshold for Strategy Discussion not met.

Continue under S.17 with Children & Families assessment.

Ensure that at least 1 visit is undertaken with Midwife and/or Health Visitor.

Ensure any specialist support is utilised including GCP2A assessment.

Permanency Planning Meeting should be held.

Birth Plan should be in place for CP and PLO cases.

**Late Presentations**

Risk of immediate and significant harm threshold met then progress straight to Strategy Discussion.

If baby is due within 3 months of referral and safeguarding concerns are high, case should be raised with Head of Service as LPM decision will need to be made.

If no significant safeguarding concerns, then Children & Families assessment under S.17 should be progressed, GCP2A at this point.

ICPC should be convened.

Threshold not met – referrer notified of outcome – advise a GCP2A at this point.

Viable pregnancy confirmation not received (pre 12 weeks) – passed to Early Help.

# Appendix 2: Discharge Planning Meeting Template

**DISCHARGE PLANNING MEETING PROFORMA**

|  |  |  |  |
| --- | --- | --- | --- |
| **Child Name** | **Date of the meeting:** | **NHS number** | **Date of proposed discharge aimed for:** |

**Use your threshold document (LSCP) to assess the layers of need to determine what course of action is needed to support the family.**

|  |  |  |  |
| --- | --- | --- | --- |
| Universal Need | Universal Plus | Additional Needs | Complex and Significant Needs |
|  |  |  |  |
| Could the needs of the family most appropriately be described as:  Requiring no additional support.  **Standard information sharing – GP only.** | A single universal service or two services are likely to be involved; these services should work together on a plan with the child and family by completing and registering a plan.  **Additional information sharing – HV/ SN.** | A child and their family have needs that require a multi-disciplinary approach. Engage the family and other professionals to co-ordinate support for the family by completing and registering a plan.  **Clear plan at discharge.**  **Clear information sharing at discharge.**  **Consider discharge planning meeting/ virtual DPM** | A child or their family have needs that are so complex or significant that they need an immediate statutory social work assessment and intervention or other specialist services to prevent significant harm or serious risks to their health or welfare.  **Discharge plan must be agreed.**  **Discharge planning meeting must take place.** |

|  |  |
| --- | --- |
| Universal Needs | Information only: NFA  Date…………………… |
| Universal Plus | Information shared with:  Date: |
| Additional Needs | Early Help completed – Yes/ No  Discharge plan discussed with…………………………………….. ………………………………………………  Date: ………………….. |
| Complex and Significant Needs | Request for Support submitted by:  ……………………………………  DPM held:………Date: ……………… |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical requirements on discharge: include medication, home visits, monitoring** | | | | | | | | | | |
| **Persons present at the meeting** | | | | | **Agency** | | | | | |
| **Status of the Case** | **Early Help** | | **Open SW assessment** | | | | **CIN plan in place** | | **S47 investigation** | |
| **ICPC pending** | | **CP Plan in place** | | | | **GCP2A** | | **Other (specify)** | |
| **Outcome to be achieved:** | **Child is safe Child’s needs are met fully Family supported appropriately and know how to access support ** | | | | | | | | | |
| **Concerns for the child’s safety related to family’s needs (please tick and add)** | **Issue**  Parental issues with substances  Parental mental health problems  Domestic abuse  Concerns with parenting capacity  High level of need for the child due to prematurity/ complications  Stability Housing issues  Previous children removed or requiring social care involvement | | | **Tick**  ****  ****  ****  ****  ****  ****  **** | | | **Other details** | | | |
| **If child is with parents is supervision of them required and if so who will provide this:** | | | | | | |  | | | |
| **Concerns related to the child’s safety related to their own needs** | **Risk due to factors external to the family – exploitation ** | | | | | | | | | |
| **Beyond parental control/ family breakdown ** | | | | | | | | | |
| **Mental health related harming behaviours ** | | | | | | | | | |
| **Disability ** | | | | | | | | | |
| **Complex needs ** | | | | | | | | | |
| **Separation from parent (NNU) and concerns re attachment ** | | | | | | | | | |
| **Other ** | | | | | | | | | |
| **Intervention plan post discharge to include:**  **How often will the child be seen?** **Who will be visiting the home and how frequently?** **When is the next review to ensure the plan is working and the child is safe?** **Do the parents/ child feel that the plan will support them sufficiently well?** | | | | | | | | | | |
| **Proposed intervention** | | | | | | | | **Professional to deliver this** | | **Proposed review date** |
| **Do the parents/ child feel that the plan will support them sufficiently well?** | | **Yes  No  Unsure **  **Comments** | | | | | | | | |
| **Lead agency** | | **Lead/ Trusted Professional** | | | | | | | | |
| **All attendees in agreement with the plan** | | **Yes  No  If no what action is being taken** | | | | | | | | |
| **Is a further DPM required** | | **Yes  No  If yes state reason why** | | | | | | | | |
| **Is escalation necessary** | | **Yes  No  State who this is escalated to and when:** | | | | | | | | |
| **Date of discharge:** | | **Place of discharge/ Address of discharge:** | | | | | | | | |
| **Name of carer at discharge:** | | Parent | | | | Kinship carer | | | Foster Carer | |
| **Copies of plans CP/CIN or court order requested/ filed in child’s records** | | Yes  No  NA  | | | | | | | | |
| **HV/ SN notification to be completed by:** | |  | | | | | | | | |
| **GP notification to be completed by:** | |  | | | | | | | | |

**Discharge Planning Safeguarding/Complex Cases Guidance**

At the point of admission all staff should consider the needs that the child presents with in line with the relevant local threshold document. The DSPP threshold document can be found here <https://dudleysafeguarding.org.uk/wp-content/uploads/2023/03/DSPP-Support-Level-Guidance-and-Framework-March-2023.pdf>

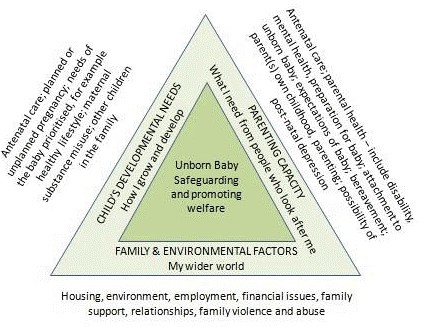
It is good practice to record the level of need, as per the local threshold document, on admission documentation for all children under 18 years of age.

At the point that the child is medically fit for discharge the level of need should be reassessed and documented.

The discharge plan should be developed based on the assessed level of need and should be multi-disciplinary/multi agency if required.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Level of need** | **Universal** | **Universal plus** | **Additional** | **Complex** |
| **Work with children, young people, and families at all levels in developing the discharge plan**  **On-going review of need is required throughout admission- the level of need may change** | | | | |
| **Description of need** | All children have a right to a range of universal services; professionals will assess families to make sure that their general needs are met | When a child and their family have needs that require support and interventions above and beyond normal universal services | Additional Needs: when a child and their family have needs that may require an intensive or substantial package of support, but the concerns can be managed without the need for statutory social work intervention.  Examples- children with complex health needs, children with Early Help assessments in place | When the child and their family have needs that are so significant that they need immediate statutory social work intervention, or highly specialist services to prevent significant harm or serious risks to their health, or welfare.  This includes all children who are on a child protection, child in need or child in care plan-**additionally those children referred to children’s social care during admission.** |
| **Discharge planning action required** | Notification to GP and other relevant health professionals at point of discharge.  Discharge plan will be shared with parents and carers, including information about follow up required. | **Consider need for discharge planning meeting,** that might be multi-disciplinary, for information sharing and to develop a clear action plan if required | Ensure all relevant professionals are aware of admission and a plan is in place for safe discharge.  **Discharge planning meeting (DPM) required, to include all relevant multi agency professionals and disciplines.**  Consider identifying a lead professional known to the family, to coordinate the multi-agency approach  Written discharge plan required. | **Discharge planning meeting (DPM) required, to include all relevant multi agency professionals and disciplines.**  Written discharge plan required using the ‘Safeguarding/Complex Cases Discharge Planning Meeting’ template.  Safeguarding team will attend DPM. |

# Appendix 3: Assessment Triangle



# Appendix 4: Unborn Network Referral Form

**Unborn Baby Network**

|  |  |
| --- | --- |
| **Referrer details** | |
| **Name** |  |
| **Designation** |  |
| **Organisation** |  |
| **Contact number** |  |
| **Contact email** |  |
| **Date of referral** |  |
| **Consent obtained?** |  |
| **If overriding consent have you informed the parent(s) you are making this referral?** |  |
| NB: If you do not have consent and/or have not informed the parent(s) please do not make this referral. Discuss this referral with the parent(s) first. | |
| **Parent details** | |
| **Name of mother** |  |
| **DOB** |  |
| **NHS Number** |  |
| **Address** |  |
| **Contact details** |  |
| **Name of father** |  |
| **DOB** |  |
| **NHS Number** |  |
| **Address** |  |
| **Contact details** |  |
| **Do you know if parents are in a relationship?** | . |
| **Unborn Details** | |
| **EDD** |  |
| **Hospital** |  |
| **Midwife** |  |
| **GP of Mother** |  |
| **Family members / Significant others** | |
|  | |
| **Reason for referral / Nature of concern(s)** | |
|  | |
| **INFORMATION RECEIVED FOLLOWING PRO FORMAS SENT TO PROFESSIONALS** | |
| *Updates received via email:* | |
| **DISCUSSION AT MEETING** | |
| *Information reported at meeting:* | |
| **ACTIONS** | |
| ***Identified during meeting:*** | |
| **UPDATES POST MEETING** | |
|  | |

**Referrals to be submitted to the Unborn Baby Network at** [**dgft.safeguardingteam@nhs.net**](mailto:dgft.safeguardingteam@nhs.net)

# Appendix 5: Roles and responsibilities around a pregnancy and new born

|  |  |
| --- | --- |
| Role | Responsibilities |
| Specialist Midwife | Specialist Midwives provide expert midwifery care to groups of women with additional support needs in Dudley we have a range of roles and support available |
| Named Midwife for Safeguarding | Works within the Safeguarding Team and is able to offer advice, escalation, support, to community and in patient midwives, this is not a case holder. |
| Specialist Midwife for vulnerable women | Works with women who have adult vulnerabilities such as homelessness, women seeking asylum, mental health, teenage pregnancy, substance misuse. |
| Specialist Midwife for Equality, Diversity and inclusion | This role’s aim is to improve service provisions to reduce inequalities and poor outcomes for those with protected characteristics and from inclusion groups as well as addressing workforce inequality issues whilst improving representation and diversity. |
| Community Midwife | Individual women’s case holder will attend meetings related to the women on their case load. Hands over to Health Visitor around day 10 - 14 if baby and mum are well. They should be invited to meetings related to the unborn such as pre-birth proceedings, ICPC, Strategy discussions. |
| Bereavement Midwife | The role of the bereavement midwife is to provide immediate and long-term sensitive care and support for families in Dudley, following late foetal loss, stillbirth and neonatal death. |
| Obstetrician | A medical professional who provides ante natal clinical care. Not a Paediatrician (child specialist doctor). |
| Paediatrician | A medical professional - Most babies delivered will see a Paediatrician who will carry out an examination before the baby is discharged. Many babies are now also seen by a midwife trained in this examination. |
| Neonatologist | A medical professional who will care for a baby with a medical condition requiring an in-patient stay in a Neonatal unit, will be involved with medical conditions such as heart issues, substance withdrawal, extreme prematurity. |
| Specialist Midwife for long term conditions | Attends clinic and sees women who have long term medical conditions which need management throughout pregnancy such as Diabetes, VTE, epilepsy, cardiac issues. |
| Inpatient and outpatient department midwives | Work in labour ward, inpatient wards and outpatients providing clinical support to women and babies. |
| Midwifery Support Workers (inpatient and community) | Support women with additional needs and support the Community Midwife in delivering care ante natal |
| Healthy pregnancy support service | Support women who are pregnant with healthy lifestyle advice and support. |
| GP | A GP will refer their patient to maternity services. The GP will be involved with the whole family around a pregnancy/baby and so needs to be informed of any issues during pregnancy whether they are clinical or safeguarding. They should also inform any pre-birth plan due to the fact that they hold information on all of the family. All GP surgeries have a Safeguarding Lead GP. |
| Health Visitor | Health visitors are specialist community public health nurses, (SCPHN) and are registered midwives or nurses. They specialise in working with families with a child aged 0 to five to identify health needs as early as possible and improve health and wellbeing by promoting health, preventing ill health and reducing inequalities. The Health Visitors are involved in the ante natal period with an ante natal visit and then up to the age of 5 years. They will attend meetings related to babies and children such as ICPC and core groups. |
| Family Nurse | Family Nurse Partnership (FNP) has three aims: to improve pregnancy outcomes, improve child health and development and improve parents or carers’ economic self-sufficiency. A Family Nurse works with a pregnant woman throughout the ante natal period and is the child’s Health Visitor following birth. They will attend meetings related to their clients such as ICPC, Core groups and should be involved in a pre-birth plan if the mother is their client. |
| Social Worker | The Social Worker acts as the lead professional for multi-professional assessments and plans at child in need or child protection level. They work directly with families and significant members of their network to assess whether changes are needed to ensure children are cared for safely, and will lead and take part in a multi-agency plan to bring about the changes. |
| Family Support Worker | Family Support workers are part of the social care team. They may lead an early help plan or contribute to a child in need or child protection plan undertaking work with children, parents and carers which enable children's needs to be met within their family. |
| Perinatal Mental Health Team | The Perinatal Mental Health Teams specialise in the assessment, diagnosis and short-term treatment of those affected by a moderate to severe mental health illness in the preconception, antenatal and postnatal period. The team promotes wellbeing during pregnancy, prevention of relapse and assists with birth planning. The team works with those who have a previous history of serious mental health difficulties and those who are experiencing mental health difficulties for the first time during the perinatal period.  They provide support for a range of mental health difficulties, including bipolar disorder, puerperal psychosis, depression, anxiety, OCD and bonding difficulties.  The Perinatal Mental Health Team is a secondary mental health service and therefore supports those who are antenatal and postnatal whose needs cannot be met by primary care professionals, such as GPs, specialist midwives, health visitors or primary care psychological services. |

1. DSPP acknowledge the same learning can be applied to missing or invisible parents in same sex relationships [↑](#footnote-ref-1)