**PRE-BIRTH PROCEDURE – SAFEGUARDING PROCESS**

**Contents**

1. Introduction
2. Aim
3. Referrals
4. Pre-Birth Assessment (Social Care)
5. Services and Support Provision
6. Relinquished Babies
7. Chid In Need
8. Pre-Birth Child Protection Planning
9. Legal Planning
10. Presentation at the ARC/LAC Panel
11. Liquid Logic and the Pre-Birth Protocol

 **1.** **Introduction**

Following a two year study of Serious Case Reviews between 2009-2011 "just over a third (36%) of all Serious Case Reviews concerned a baby under one year of age- a drop of more than 10% from the consistent pattern of earlier years. This difference may reflect a change in local decision making about when to undertake a SCR for non-fatal cases, but might also be attributed to the success in spreading awareness among practitioners and community groups of the vulnerability of babies and the risks of harm they face" (Brandon et al. 2012).

Identifying children most at risk to be able to manage their protection effectively involves preventative action at the pre-birth stage. An early warning system is fundamental in ensuring the identification of these vulnerable children, consisting of an agreed multi agency commitment that ensures professionals work together in assessing and managing the risks.

Therefore a referral received about a pregnancy where there are significant concerns for the circumstances of the unborn child's parent(s) and/or extended family must be dealt with in a timely and planned way. This document sets out the practice to be followed in Rutland to ensure appropriate actions are taken at the right time in the life of the unborn child and to avoid unacceptable delay in allocation of resources and critical decision-making.

Examples of when Pre-birth assessments would be required:

* There is domestic abuse and / or honour based abuse;
* There is domestic abuse during pregnancy;
* A parent has significant mental health needs;
* A parent(s) has moderate or severe learning disabilities;
* A parent whose substance misuse is likely to impact on the health and development of the baby;
* A parent has had a child previously removed from their care, contact restricted or voluntary care;
* A parent is 14 or under / concerns around sexual exploitation / abuse;
* A parent who may pose a risk to the child / harmed a child - violent history, sexual offences etc;
* The baby once born maybe living with or have contact with an individual that poses a risk to children;
* A sibling is subject to a Child Protection plan;
* Significant concerns about home conditions;
* Parent’s behaviour indicates that they may be unlikely to care / protect the baby once born- chaotic life style, lack of preparation.

**2.** **Aim**

The aim of this document is to bring forward Social Care involvement to the earlier point of 12 weeks into the pregnancy, and set a clear timeline for case management decisions and social work tasks linked to the stages of risk management that arise.

This document incorporates guidance from Working Together to Safeguard Children 2015 and actions to reflect the learning from the reporting and analysis undertaken from Serious Case Reviews - to act effectively on lessons learned. Partnership working with midwifery is fundamental to this process in promoting the safety of the unborn child. The document sets out clear guidance on the steps to be followed from the point of referral:

* To clarify decision-making regarding thresholds of intervention;
* To clarify the timeline of provision of resources/meetings;
* To set a clear meeting structure;
* To avoid delay and improve the protection of the unborn child;
* To enable expectant parents and their families to be clear from the outset about the process which will be followed and the people who will be involved;
* To ensure that professional colleagues are clear about their roles and responsibilities and the importance of adopting a holistic approach from the outset.

 **3.** **Referrals**

Referrals concerning early pregnancies are made by a wide range of partner agencies, for example, Health professionals, Mental Health services, Substance Misuse Teams, Housing, Locality Teams, and Education.

This referral and assessment process should align with the Early Help Assessment (EHA) which is the assessment of choice if it is deemed that Social Care Threshold is not met and/or to access universal or targeted support in which an EHA would need to be completed. However, if making a referral to Social Care, a referral form will need to be completed. If an EHA has been completed this should be attached with the referral.

Referrals concerning unborn babies will come into the Duty Team [link to contacts and referrals within tri x]

Unborn babies will be recorded under the name of the unborn child (with mother’s family name as the surname and linked in the social network with mother and any other existing family members).

Any professional that has concerns for an unborn that would indicate they may be at risk of significant harm would be expected to follow the LR LSCB safeguarding procedures and make a referral into the Duty Team :

**Tel:** 01572 722577

**Email:** childrensreferrals@rutland.gov.uk

Detail is essential within the referral; history of parents, detailed reason for concern, prospective father, issues around violence, drug and alcohol and relate this to risk of harm to the UBB or child.

Professionals must inform the prospective parents of the referral and gain consent where possible. An exception to this would be if in informing the parents this would place the unborn or the mother at risk.

**Timeline Guide for the Pre-Birth Process:**

**12 weeks – Contact in Duty:**

* At the point of the date scan is an appropriate referral point;
* If referral is due to relinquished baby the case will move straight to the Long Term Team (LTT)
* Where not relinquished but parent has had previous children removed in last 12 months then case will go straight to LTT following an in depth information gathering by Duty to determine any potential changes to family circumstance which will determine who the case should be allocated to, where appropriate and where there are other children open the same case worker will be preferred.
* If it is not going to LTT then Duty will allocate to a Duty social worker for assessment and intervention.

**12 Weeks Allocation:**

* Single Assessment to commence and written with court in mind covering aspects of any parenting assessment. During this process please explore parental consent to share the Child and Family Assessment with midwifery as this helps them in being clear around risks and analysis;
* Consider if it is appropriate to make a referral to Early Help to deliver an appropriate intervention following the assessment, e.g., Children Centre involvement
* Child in Need meeting to be considered to ensure parents and professionals all aware of the concerns.
* During the Single Assessment explore the development of a nurturing relationship with the unborn . Explore parental understanding of the importance of developing a secure attachment. In addition to this, include education and exploration of parent’s ability in developing a dialogue to support the formulation of a secure attachment.

**19/20 weeks (35 days from referral):**

* Single Assessment (SA) MUST be completed by this point and CiN meeting held prior to this to ensure clear plan in place when concerns are identified;
* SA completed with recommendations for ICPC or not;
* Where ICPC is not recommended and agreed and family are to remain open then CiN procedures to be followed as well as transfer procedure where Duty has completed the SA;
* Where ICPC threshold is met then Strategy Discussion/s47 is needed. It is fundamental that professionals and family are notified of the date of conference at the earliest opportunity;
* If there are no concerns then the family would close with appropriate links to other services to be followed as needed.

**21/22 weeks gestation (45 day assessment) (where there are ongoing concerns):**

* Consideration to be given to making a Family Group Conference referral;
* Consider EH support if not already done so;
* Where there are Learning Difficulties consider PAMS assessment
* ICPC/CiN plan will continue to support family;
* Follow transfer process as needed.

**23/24 Weeks ICPCC held (where CP concerns are present):**

* If UBB is to be subject to a CP plan then transfer to LTT at ICPC, Core Group and family need to be aware that proceedings likely if no change evident by birth – this needs to be clear at ICPC and within the CP Plan;
* Ensure contingency plan is in place in case baby is born early and ensure EDT (Emergency Duty Team) aware for out of hours;
* Safety plan should be completed to ensure any eventuality is considered and completed alongside CIN/CP Plan.

**29/30 Weeks:**

* FGC to have been convened (where it is felt likely alternative care arrangements will be needed);
* Any potential kinship viabilities to be completed and if positive referred to the fostering team without delay;
* 2nd Core Group - decision made as to whether Public Law Outline is required. If yes Legal Planning Meeting needs to be held if this is agreed.

**30/31 Weeks:**

* LPM and application to ARC/LAC Panel (At Risk of Care/Looked After Children) (Section 31) for PLO agreement;
* Any positive kinship viabilities progressed to full assessment;
* Final Concurrency decision.

**35/36 Weeks:**

* Review CPC & Panel outcomes for threshold/proceedings if warranted;
* Ensure contingency plan/discharge plan/safety plan is updated and in place in preparation for the birth. Recommended that a date for the discharge planning meeting is arranged prior to the baby being born as this prevents delay in the baby being discharged and the likelihood of more professionals being able to attend;
* Birth possible outcomes - relinquish/proceedings/s20 offer/parents or extended family.

**Possible Outcomes:**

* Possible outcomes when baby is born include:
	+ Relinquish Baby;
	+ Legal Proceedings;
	+ Section 20 offer – Child becomes Looked After (s20 should not be used if appropriate planning has been in place, if s20 is used LPM is needed and proceedings to commence within 2 weeks)
	+ Child to remain with Parents or extended family.

**Concurrency:**

Concurrency needs to be considered at 3 points, conclusion of the Single Assessment, Initial Child Protection Case Conference and ARC/LAC Panel. 30/31 weeks is an ideal time for a final decision on this matter.

EVERY UNBORN CHILD MUST BE NEWLY ASSESSED AND ALL UNBORN BABY REFERRALS WILL BE ALLOCATED AND ASSESSED TO ENSURE OBJECTIVITY.

 **4.** **Pre-Birth Assessment (Social Care Assessment)**

Pre-Birth Assessments must be considered as a separate piece of work from assessments that may have been written for siblings of the expected baby. They should be objective and seen through ‘fresh eyes’. The Courts have been critical in the past of assessments that have been based on work carried out with previous children related to the expected child as they don’t give the parent the best possible chance to demonstrate positive change.

The unborn should not be invisible in the assessment or recording, assessment needs to evidence parental capacity, competency and capability.

Assessing parental capacity - <https://www.nspcc.org.uk/globalassets/documents/information-service/factsheet-assessing-parenting-capacity.pdf>

 **5.** **Service and Support Provision**

Following allocation decisions about which services and support could be involved during the assessment process

* Social Worker;
* Referral to the Early Help for any support identified (targeted support) ;
* Referral to the Family Group Conference - A referral for a Family Group Conference can happen earlier than 13 weeks and it is often better to refer to this service as soon as an unborn baby referral is received. The Family Group Conference Service will meet all the family prior to convening a meeting and can assist the Social Care Team to come up with a plan for keeping a baby within the family
* Adult Services (Drug and Alcohol Services, IDVA’s, MH Team as examples)

 **6.** **Relinquished Babies**

Early involvement is essential as the aim of the work with the parent(s) who remain committed to relinquishing responsibility for the expected child is to place the child with an adoptive family as quickly as possible. This can be achieved within 6 months, or sooner, of the child's birth, if all necessary steps are taken early enough. What is known is that the earlier a child is placed with their permanent carers, the better the chances are that they will form secure attachments. A child placed with permanent carers before they are 18 months old is much less likely to experience adoption breakdown. After 18 months the chances of adoption breakdown rise dramatically. So to place a relinquished baby within a maximum 6 month timescale is particularly essential.

With regard to Referral and Assessment, the timeline applies to relinquished babies also with notification to Fostering and Adoption and to CAFCASS. There may be no need for Section 17 or Section 47 planning and, following a SA, the family will be transferred directly to the Long Term Team (LTT).

If the mother is open to the Social Care team or leaving care service the unborn baby will be allocated to the appropriate service while assessment regarding the baby is carried out.

The relinquished baby process involves, from the outset, the Fostering and Adoption Team and CAFCASS. The guidance is as follows:

At the point of referral, contact the Fostering and Adoption Team to make them aware of the family and discuss the procedures to follow. They will support and offer guidance to practitioners.

'[**Protocol for Children Relinquished for Adoption**](https://www.cafcass.gov.uk/media/126321/good_practice_for_adoption_agencies_and_cafcass_-_children_relinquished_for_adoption.pdf)' - Protocol between Cafcass and Local Authority.

**Adoption**

[**British Association for Adoption and Fostering**](http://corambaaf.org.uk/)

On receipt of a referral about a parent(s) who intends to relinquish their expected child at birth, Social Care must send an advanced notice to CAFCASS giving the expected date of the Adoption Panel. The Fostering and Adoption Team can be consulted at this point also for guidance. CAFCASS need to be informed as soon as possible as they have a duty to provide counselling to the parent(s) and to then report on their work with the family to the Adoption and Fostering service. As there is sometimes a delay in allocating a CAFCASS worker, the sooner they are contacted the better.

Although a parent(s) is not able to consent to their baby being adopted until he/she is 6 weeks old, in some circumstances the baby can be placed with prospective adopters from birth. An adoption application cannot be made until the baby has lived with adopters for 10 weeks so placing early means the adoption stands a good chance of being completed within the first few months of the life of the child.

Some adoption agencies place babies with prospective adopters as soon as the baby is born and offer support to the prospective adopters if the parents then change their minds within the 6 week period. The counselling of the parents, the preparation for matching and booking a place at panel can all happen before the baby is born. In this way, babies can be placed with their adoptive families at just a few weeks old, or even earlier.

 **7.** **Child In Need**

* Initial Child In Need Meeting to be arranged 20 to 30 days after a Single Assessment has been commenced if the family is likely to remain open. A review should be held at least every 6 weeks; Social Worker should record rationale to hold or to not hold Child in Need meeting. Please ensure midwifery are invited to CiN meetings;
* Referral for additional support / services to be completed as appropriate; e.g., Children’s Centre;
* Hospital Discharge Plan to be written at first Child In Need Meeting and updated as appropriate;
* Review Child In Need Meeting to be held within 2 weeks of the birth of the baby.

 **8.** **Pre-Birth Child Protection Planning**

A Child Protection Conference is a multi-agency meeting and is to be held when an enquiry has shown that there are concerns about the safety and welfare of the unborn baby and where it is decided whether the threshold for significant harm has been met and that a Child Protection Plan is therefore required.

A pre-birth conference can be convened after 12 weeks gestation.

Should the unborn baby made subject to a Child Protection Plan then the first Core Group meeting will be within 10 days of the Initial Conference, and then six weekly following this. A review Child Protection Conference will be convened in three months’ time.

 **9.** **Legal Planning**

The Public Law Outline sets out streamlined case management procedures for dealing with public law children's cases. The aim is to identify and focus on the key issues for the child, with the aim of making the best decisions for the child within the timetable set by the Court, and avoiding the need for unnecessary evidence or hearings. This should be considered as part of the Child Protection Conference.

Clear plans need to be in place by 34 - 36 weeks.

See Care and Supervision Proceedings and the Public Law Outline Procedure.

 **10.** **Presentation to the Children Looked After/At Risk of Care (CLA/ARC) Panel**

To be completed in line with the unborn child’s needs.

 **11.** **Liquid Logic and the Pre-Birth Protocol**

All new referrals for Unborn Babies will be recorded under the name of the unborn child (with mother's family name as the surname and linked in the social network with mother and any other existing family members).

**Appendix 1: Consider within the Single Assessment**

Other things to consider:

* Knowledge of a baseline of acceptable parenting is required;
* Family history, parents’ own experiences of being parented;
* Information from other agencies;
* Parents’ view towards previous children that have been removed or where there has been significant concerns:
	+ Do they understand and can provide an explanation around the circumstances of the abuse?
	+ Do they accept responsibility / or do they blame others?
	+ Do they blame the child?
	+ Do they acknowledge the seriousness?
	+ Have they accessed any support / counselling?
	+ What was their response to previous intervention? Disguised compliance / genuine?
	+ What are their feelings towards child now?
	+ What changes have the parents have made/ how would do differently?
* Feelings towards the pregnancy:
	+ Was the baby planned / unplanned?
	+ Is the pregnancy wanted?
	+ Was the pregnancy as a result of a sexual assault?
	+ Is the pregnancy to replace any previous children that have been removed / deceased?
	+ Are there positive foetal representations from the mother and family? Is a bond developing?
* Ability to care:
	+ Has ante natal care been accessed?
	+ What is the parents’ understanding of the needs of an unborn / new-born?
	+ Are the parents plans to care for the baby realistic?
	+ Are parents able to protect the unborn / new-born from the identified risks?
	+ Are the parents able to separate their own needs from those of their unborn/newborn?
* Sexual abuse (where a parent may have a conviction / child likely to be in contact with a known sex offender):
	+ What were the circumstances of the abuse?
	+ Is the perpetrator living in the home or do they have access to children in the home?
	+ Was the non-abusing parent present during the abuse?
	+ Does the non-abusing parent have insight into grooming behaviours?
	+ Were the parents believing of the concerns / abuse?
	+ What is the parent’s attitude towards the abuse now?
	+ Did the perpetrator accept responsibility for the abuse?
* Mental Health:
	+ What support is the parent(s) accessing?
	+ Are they complying with medication and recommended treatment plans or are there concerns around non-compliance?
	+ What has the parent’s historical compliance been like? Can they provide a consistent and stable environment?
	+ Is the parent able to identify their own early warning signs of declining mental health and access support when required?
	+ Is there delusional thinking around the child / blaming of the child?
* Substance Misuse:
	+ What is the parent(s)’ pattern of substance misuse?
	+ Are they accessing support / treatment?
	+ Would they manage their drug use in line with the care needs of a baby?
	+ What is the impact that the drug misuse / treatment may have upon the health and development of the baby?
* Domestic Abuse:
	+ What is the current and / or previous history around domestic abuse?
	+ What is the nature of the incidents?
	+ What are the triggers?
	+ Is the parent able to access support services such as IDVA’s?
	+ Does the perpetrator take responsibility for their actions? Are they willing to demonstrate their commitment to changing?

**References:**

* New learning from Serious Case Reviews: a two year report for 2009-2011- Marion andon, Peter Sidebotham, Sue Bailey, Pippa Belderson, Carol Hawley, Catherine Ellis, Matthew Megson.Dep of Health. July 2012.

**Acronyms:**

ICPC: Initial Child Protection Conference- where it is decided if the child needs to be made subject to a Child Protection Plan.

FGC: Family Group Conference- to explore wider family support and contingency planning should the alternative carers within the family be required

EH: Early Help

LMP: Legal Planning Meeting – when concerns are of the level where threshold for proceeding’s / Private Law Outline is met

S20: Section 20- voluntary agreement gained from parents for baby/child to be placed into foster care

Concurrency: Parallel planning which considers all possible options i.e. CP plan, Removal of Child into Care and subsequent placement planning, or placed with wider family,

CAFCASS: Children and Family Court Advisory Support Services, private family law

IDVA: Independent Domestic Violence Advisor- supporting women who are in or have left an abusive relationship, support around safety planning, work around the impact and risk upon unborn etc

SA: Single Assessment

LTT: Long Term Team

**End**