

Safeguarding Unborn Babies

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[Appendix 1: Calder Practice Guidance](#)

[Appendix 2: Safeguarding Unborn Babies Flowchart](#)

[Appendix 3: References](#)

Contents

1. [Introduction](#)
2. [Multi Agency Responsibilities for Supporting Prospective Parents with Additional Needs](#)
3. [Referral to Children and Families Social Care](#)
4. [Multi-disciplinary Pre-birth Assessment](#)
5. [Initial Multi-disciplinary Planning Meeting](#)
6. [Undertaking the Multi-disciplinary Assessment](#)
7. [Further Multi-disciplinary Planning Meeting](#)
8. [Child Protection Strategy Discussion/Meeting](#)
9. [Child Protection Review Conference](#)

[Appendix 1: Calder Practice Guidance](#)

[Appendix 2: Safeguarding Unborn Babies Flowchart](#)

[Appendix 3: References](#)

1. Introduction

1.1 Pregnancy creates special circumstances/influences on the parent/s, which need to be accommodated

by practitioners. For example, pregnancy has a major impact upon the present lives of the parent/s, which may affect their behaviours as well as their relationships. Pregnant women's health and responses to external factors change during pregnancy.

- 1.2 The physiological, emotional and social influences effecting and affected by this change will determine, to some extent, how representative their behaviours are, their state of health and the functioning of key relationships.
- 1.3 Ante-natal care is usually provided on a shared care basis by Midwives, General Practitioners and Hospital Consultants. Care begins as soon as pregnancy is confirmed and continues until a minimum of 10 days post-partum up to a maximum of 28 days post-partum. The named midwife (geographically attached to a GP) will provide women with choices about the place of birth and the type of care they would like to receive. The midwife is the first point of contact for pregnant women. The first appointment is usually between 6-8 weeks and can take place in either the GP surgery, South Tyneside Antenatal Clinic or very occasionally the woman's own home. This is followed by a full risk assessment at 8-10 weeks. All women must have their Maternity Hand Held Notes by 12 weeks.

2. Multi Agency Responsibilities for Supporting Prospective Parents with Additional Needs

- 2.1 All prospective parents will require help and guidance to maintain a healthy pregnancy and to prepare for caring for their child. For the majority of parents the support provided from universal services, such as ante-natal health services or from family and friends will be all they need. However, some prospective parents may have additional needs and require support either for themselves as adults or in terms of caring for the child in pregnancy and beyond. This may be additional support provided by universal agencies or support from targeted services. These parents / unborn children typically fall within the first two levels of South Tyneside's **Multi-Agency Thresholds Guidance**. Where a practitioner identifies a prospective parent with potential additional needs they must discuss this with the prospective parents and agree the action they will take to provide any necessary support or guidance. Practitioners may be able to arrange the additional support within their own service setting. If this is not possible, the Practitioner should, having secured consent, refer the prospective parents to the Early Help Team, Laygate who will be able to provide further advice on action that can be taken.
- 2.2 **Referral to Children and Families Social Care**
Where a practitioner anticipates that prospective parents may require support services to care for their baby at a level that might warrant the involvement of Children and Families Social Care, including situations where the unborn baby may be at risk of **Significant Harm**, a Referral is to be made to Children and Families Social Care. Where Children and Families Social Care are already working with the family the Team Manager/Social Worker should ensure that this Referral is made.
- 2.3 Wherever possible, the referrer should share their concerns with the prospective parent(s) and seek to obtain agreement to refer to Children and Families Social Care Referral and Assessment Service, unless this action may place the unborn child at risk, for example, through termination of the pregnancy or the parent(s) possibly making their whereabouts unknown.
- 2.4 If the Referral has been made verbally it should be followed up in writing within 48 hours. Children and

Families Social Care Referral and Assessment Service should acknowledge receipt of the Referral and decide on the next course of action within one working day and give verbal feedback to the referrer.

3. Referral to Children and Families Social Care

- 3.1 Referrals to Children and Families Social Care about unborn babies should be made no later than the 12th to 14th week of the pregnancy, unless it has not been possible to meet this timescale, for example, because the pregnancy has been concealed. However, where it is known that a **Looked After** young person is expecting a child, consideration should be given to the timeliness of a Referral to Children's Services Authority.
- 3.2 In the cases of Looked After Children, Referrals should be considered following the first eight weeks of pregnancy in order that the **Key Social Worker** can commence a **Single Assessment** in preparation for the first, multi-agency planning meeting. This earlier assessment should then provide a more rigorous approach to the planning process not only for the unborn baby, but also the young mother, who will, inevitably, require some further thought given to her current and future placement requirements. It should also inform as to whether an early Referral should be made to alert the Placement Officer of a future need for a potential 'mother and baby' Foster Care arrangement.
- 3.3 Referring to Children and Families Social Care by the 12th to 14th week:
- Provides sufficient time for a full and informed assessment;
 - Avoids initial approaches to parents in the latter stages of pregnancy, as this is already an emotionally charged time;
 - Enables parents to have more time to contribute their own ideas and solutions to concerns and increases the likelihood of a positive outcome;
 - Enables the provision of support services so as to facilitate optimum home circumstances prior to the birth;
 - Provides sufficient time to make adequate plans for the baby's protection, where this is necessary. This includes consideration of placement with extended family if appropriate.

4. Multi-disciplinary Pre-birth Assessment

- 4.1 See **Appendix 1: Calder Practice Guidance**
- 4.2 A multi-disciplinary pre-birth assessment must always be undertaken where the following circumstances apply.
- Where previous children in the family have been removed because they have suffered harm or been at risk of Significant Harm;

- Where a person who has been convicted of an offence against a child, or is believed by child protection professionals to have abused a child, has contact with the family;
- Where concerns exist regarding the mother's ability to protect the baby;
- Where there are acute professional concerns regarding parenting capacity, particularly where the parents have either severe mental health problems or learning disabilities. For more information see [Children of Parents with Mental Health Problems Procedure](#) and [Children of Parents with Learning Difficulties Procedure](#);
- Where alcohol or substance abuse is thought to be affecting the health of the expected baby, and is one concern amongst others. For more information see [Children of Parents who Misuse Substances](#) and [Appendix 1: Calder Practice Guidance](#);
- Where the expectant parent(s) are perceived as vulnerable as a consequence of their age, understanding and circumstances and may require an assessment of their own needs as well as their ability to meet the baby's needs;
- Where the child is believed to be at risk of Significant Harm due to Domestic Abuse. For more information see [Domestic Violence and Abuse Procedure](#);
- Where there is concern that the mother may be a victim of child sexual exploitation (see also [Child Sexual Exploitation Procedure](#)).

4.3 The above list is based on the work of Calder (2003) with the addition of the last two bullet points.

4.4 It is essential that professionals and the family address the concerns at an early stage to ensure there is no confusion about why a particular assessment package has been constructed. Workers have a duty to set out clearly for the parents a statement of their concerns, the process and content of the assessment and what the expected child needs to be protected from. They also need to be advised about the potential consequences of non co-operation. This allows the parents to clarify the outcome needed and decide whether they can make the necessary changes in a time-scale commensurate with the expected child's needs. In some cases, this will only become clear as the assessment itself unfolds, but workers should punctuate the work with feedback to accommodate this. It is sometimes useful to assess a parent's motivation to address the concerns at the outset of the assessment and re-gauge these at the end of the formal assessment to see if any change has been noticed.

5. Initial Multi-disciplinary Planning Meeting

5.1 The first multi-disciplinary planning meeting must be held to plan the pre-birth assessment.

5.2 The meeting should be convened by Children's Social Care and arranged at a time when relevant professionals can attend. It should be held during the 14th to 16th week of pregnancy.

5.3 Agencies/professionals who should be invited to, and who should attend the meeting include:

- Children and Families Social Care Team Manager to chair or designated Senior; Practitioner;

- Social Worker;
- Identified Midwife;
- A Health Visitor;
- The family GP (Calder 2003 proposes that it may be more realistic for the Health Visitor to collate any relevant health information and bring it to the meeting);
- A representative of any local children's centre or equivalent, where appropriate;
- Any other professional involved with the family;
- Legal representative as appropriate.

5.4 It is essential that information held by the Police and by the Named Nurse/Midwife for safeguarding children is obtained by the social worker.

5.5 The meeting should specify what type of multi-disciplinary pre-birth assessment is to be undertaken (see [Appendix 1: Calder Practice Guidance](#)).

5.6 A date must be set for a second Multi-disciplinary Planning Meeting to receive the completed multi-disciplinary pre-birth assessment report.

6. Undertaking the Multi-disciplinary Assessment

6.1 A model (Calder 2003) of a multi-disciplinary pre-birth assessment is given in [Appendix 1: Calder Practice Guidance](#). The use of Calder's model is highly recommended.

6.2 Parents should throughout be involved in planning as far as possible.

6.3 The assessment is to be completed within [Single Assessment](#) timescales of 45 working days from being commissioned.

7. Further Multi-disciplinary Planning Meeting

7.1 The completed multi-disciplinary pre-birth assessment report should be considered at the second Multi-disciplinary Planning Meeting. This meeting should be held within 9 weeks of Referral.

7.2 The report should include conclusions and recommendations in relation to support of the baby and family. It should also, where necessary, include recommendations about intervention to protect the baby when born.

7.3 The second Multi-disciplinary Planning Meeting is to consider the assessment report and make plans about next steps in relation to support and any necessary intervention to protect.

8. Child Protection Strategy Discussion/Meeting

- 8.1 If the conclusions of the pre-birth assessment are that the baby, when born, is likely to be at risk of Significant Harm, a **Strategy Meeting** or Strategy Discussion must take place. This must include Child Protection Police and the Named Nurse/Midwife or Nurse Advisor for safeguarding children
- 8.2 The Strategy Discussion/Meeting is to be held during the 28th or 29th week of pregnancy.
- 8.3 If the Strategy Discussion/Meeting concludes that it is likely that an inter-agency protection plan is required to safeguard the baby when born, arrangements are to be made for a Pre-birth **Child Protection Conference** to take place. This applies whether or not Children and Families Social Care intend to take legal proceedings in respect of the child.

8.4 Pre-birth Child Protection Conference

- 8.4.1 A Pre-birth Child Protection Conference is an **Initial Child Protection Conference** concerning an unborn child. It carries the same status and conveys the same purpose as an Initial Child Protection Conference.
- 8.4.2 This Conference is to be held within 15 working days of the Strategy Discussion/ Meeting.
- 8.4.3 It is essential that midwifery services are represented at the Conference.
- 8.4.4 A report from the Social Worker, which should include a summary of the pre-birth assessment process, the conclusions and recommendations for future action, is to be made available to the Conference.

8.5 Pre-birth Conference: Protection and Support Planning

- 8.5.1 If it is decided to make the unborn baby subject of a **Child Protection Plan**, the protection plan is to make explicit the actions to be undertaken, and by whom, immediately following the baby's birth. This is to ensure the baby's protection until the **Child Protection Review Conference** is held. Points to be included in the protection plan are:
- Identification of the **Core Group** members, including Key Social Worker, Co-worker, Midwifery Services, Health Visitor, Parent(s) and others as necessary;
 - Specifications regarding any continuing assessment in terms of what has to be done and by whom;
 - Support services required, including the period mother is in hospital;
 - That if concerns arise at a Core Group meeting, the Core Group should consider the need for an immediate return to a **Review Child Protection Conference**;
 - Contingency arrangements if the protection plan is not succeeding;
 - That legal advice should be sought where necessary;

- The Hospital to have contact details of the **Key Social Worker**/Team Manager;
- The Hospital to inform Children and Families Social Care when the baby is born;
- The expectation that the parent(s) will follow medical advice and midwifery advice regarding discharge of the baby;
- Specific action required to ensure the protection of the child in the period between birth and the Child Protection Conference, including the time the baby is in hospital;
- The name of any identified person who should not have contact with the baby;
- A statement to say whether the baby should go home with parent(s) or not
- Where the plan is that the baby should not go home with the parent(s) the action to be taken should there be any attempt to remove the baby from the hospital, including consideration of Police Protection or **Emergency Protection Order**;
- Where the baby is not to go home with the parent(s), the contact arrangements and whether this is to be supervised and by whom;
- Where appropriate, details of alternative carers;
- That if the baby is transferred or placed in a different hospital, a copy of the Child Protection Plan is to be sent immediately to the new venue via Health.

8.5.2 The Pre-birth Conference must set a date for the Child Protection Review Conference to take place. This must be within the 3 months of the Pre-Birth Conference.

8.5.3 Where a Pre Birth Child Protection Conference is held and the child is made subject to a Child Protection Plan, but it is considered that the child will be **In Need**, the Conference should make recommendations in respect of support for the baby and family.

9. Child Protection Review Conference

9.1 The Child Protection Review Conference should be held within 3 months of the pre birth conference and 6 monthly thereafter. If there are any variations in this timescale the reason for this will be recorded in the conference minutes.

Appendix 1: Calder Practice Guidance

[Click here to view Appendix 1: Calder Practice Guidance.](#)

Appendix 2: Safeguarding Unborn Babies Flowchart

[Click here to view Appendix 2: Safeguarding Unborn Babies Flowchart.](#)

Appendix 3: References

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