**West Sussex Multi-Agency Joint Pre-Birth Safeguarding Protocol**

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**1 Purpose and Scope**

Very young babies are extremely vulnerable to abuse, and work carried out in the pre-birth period to assess risk, plan intervention and provide support will help to minimise harm (Brandon et al 2016). Unlike many safeguarding situations, the antenatal period creates a window of opportunity for professionals and families to work together not only to safeguard the child but to ensure that parents who are vulnerable receive the kind of support and services they need in order to be able to parent effectively.

The National Service Framework for Children, Young People and Maternity Services (2004) recommends that Maternity Services and Children's Social Care have in place joint working arrangements to respond to concerns about the welfare of an unborn baby and his/her future, due to the impact of the parents' needs and circumstances.

This protocol provides a framework for multi-agency working where there are concerns about the welfare of an unborn child and/or there may be concerns following their birth, to ensure that there is a shared response which supports and safeguards the child with timely and proportionate intervention; and also ensures that families have the most appropriate support available to them during their pregnancy and once their baby is born. It sets out the roles and responsibilities of agencies in referring expectant parents to the most appropriate service for support, including referral to Children’s Social Care; as well as professional responsibilities in contributing to assessment and implementing any agreed plan of action.

Although Children’s Social Care can take no legal action under the Children Act 1989 until a child has been born, where there are safeguarding concerns regarding an unborn child local authorities and related agencies can intervene during pregnancy for example by undertaking a pre-birth assessment and offering intervention and support. During the antenatal period, all professionals have a role in identifying and assessing those families in need of additional support and in sharing information where there are safeguarding concerns. Any concerns should be identified and addressed as early as possible to maximise time for full assessment, to enable a healthy pregnancy and to support parents so that where possible they can provide safe care to their baby.

This protocol should be followed by all relevant agencies in West Sussex, alongside each agency’s own internal safeguarding procedures. This protocol should be read together with information from the Local Safeguarding Children Partnership (LSCP), relevant legislation including Working Together 2018, and the Pan-Sussex child protection procedures.

1. **Multi-Agency Recognition of Risks for Unborn Children**

Agencies in the community play a key role in identifying risks and providing support through advice or referral for vulnerable expectant parents and their unborn child. All professionals play a role in safeguarding the unborn child and should be confident in sharing information appropriately in line with Early Help, Child in Need and Child Protection processes. It is the responsibility of all professionals to understand and work to statutory guidance, as well as the guidance in this document and their own agency’s procedures. All professionals should respect the views and roles of others involved.

If any professional becomes aware of a service user’s pregnancy or the pregnancy of a service user’s partner, they should seek consent from their service user to inform maternity services of their involvement and highlight any concerns. This contact should be made through the [named safeguarding midwife](#_Safeguarding_Midwives:) for their area.

Referral to maternity services does not negate other agencies responsibility to refer to Children’s Social Care if there are significant concerns for the safety of the unborn or new-born baby. Where professionals become aware that a person is pregnant and there are concerns for the parents or the unborn baby’s welfare, they should not assume that a referral to social care has been completed by another professional. It is essential in safeguarding children that practitioners share information, and they should refer to the [cross-government guidance](https://www.gov.uk/government/publications/safeguarding-practitioners-information-sharing-advice) and Pan-Sussex guidance on how to share information and discuss any concerns in the first instance with their safeguarding lead.

The [West Sussex Continuum of Need](https://www.westsussexscb.org.uk/wp-content/uploads/WS1953-Threshold-Guidance-2018-September-180917.pdf) provides a framework for professionals who are working with children, young people and their families. It aims to help professionals identify when a child may need additional support to achieve their full potential through a graduated response from universal, early help, targeted early help or specialist services. The Continuum of Need document and risk assessment tools at Appendix 1 and 2 should be used alongside this protocol and guidance to consider what level of assessment and support is most appropriate for the family.

Where an unborn baby is considered to be at risk of significant harm or likely to be in need of services from Children’s Social Care now or when born, partners should make an immediate, timely referral to Children’s Social Care so that a pre-birth assessment can be considered. Where there are concerns about the safety and welfare of an unborn child, it is vital that pre-birth assessment is carried out as early as possible so that professionals can recognise potential and future risk of harm to the child and plan effectively to promote their welfare following birth.

* 1. **Health Professionals**

Health professionals have a key role and specific responsibilities in safeguarding and promoting the welfare of unborn children. Professionals must be alert to the needs of the unborn baby including whether there could be any child protection risks after birth, whilst taking into account the needs and rights of the pregnant person.

West Sussex works with four main health trusts; Western Sussex Hospitals NHS Trust, Surrey and Sussex Healthcare NHS Trust (SASH), Brighton and Sussex University Hospitals NHS Trust (BSUH) and Sussex Community NHS Trust which provides the Healthy Child Programme, Family Nurse Partnership and other community services. Each trust has its own maternity pathway and safeguarding policy which should be followed by health professionals alongside this protocol.

* + 1. **Midwives**

Maternity staff are the primary health professionals likely to be working with and supporting pregnant people and their families throughout pregnancy. This relationship provides a key opportunity to observe the attitudes towards the unborn and identify any potential concerns during pregnancy, birth and the child’s early care. Midwives are responsible for planning and providing midwifery care to pregnant people and their babies during the antenatal, intrapartum and postnatal periods. They have a duty to ensure that the needs of the parent and baby are the primary focus of their practice. Throughout this time, they have a responsibility to work with other professionals in order to safeguard a baby from harm.

At booking interview, midwives must undertake an assessment of the pregnant person’s individual needs including a social history to ensure that they receive appropriate care. At this time the person’s partner/father of the unborn’s details must be obtained where possible, as well as details for any other children or adults living in the home. Parents should be spoken to alone to allow screening for domestic abuse. If vulnerabilities or risk factors are identified at booking, midwives must consider offering the pregnant person an enhanced midwifery/continuity of care service, and they will signpost to the appropriate care pathway within their own health Trust.

If maternity staff conclude that a referral to Children’s Social Care is required, they should discuss this with parents unless this is likely to put the unborn child/children at immediate risk. Referrals should be made to Children’s Social Care in line with the Trust Safeguarding Policy. Midwives should ensure that the estimated date of delivery (EDD) and father and/or partner’s details are included in referral.

Midwives will share information as appropriate with the GP, health visiting service and other agencies. Expectant parents receiving an enhanced midwifery service will be discussed at a monthly multi-agency antenatal safeguarding meeting in SASH or Western Hospitals, where consent has been given, to ensure that a joined-up approach is taken to the expectant parent’s care and to safeguard the unborn child.

Assessment of any family’s needs should be on-going. If new concerns arise or if concerns escalate, professionals should complete a new referral to Children’s Social Care; this includes if a family disengages from support offered or has poor attendance at appointments. If concerns decrease, cases can be stepped down to a lower level of support.

Midwives should offer targeted postnatal care to parents where there are safeguarding concerns or vulnerabilities. Throughout the perinatal period, maternity services and health visitors can help to identify emerging mental health problems and refer to appropriate mental health interventions. Where there are safeguarding concerns for a child, midwives must ensure attendance at multi-agency meetings for example child protection conferences, recognising that they are experts in the unborn child’s health and development and are often well-placed to build relationships with parents.

1. **Concealed pregnancy, late booking or non-engagement with antenatal care**

Where there is a **late booking or a concealed pregnancy** the health practitioner should complete an immediate assessment in order to identify which agencies need to be involved and make appropriate referrals. In the case of a concealed pregnancy a referral must be made to Children's Social Care.

Professionals should adhere to the Pan-Sussex procedures in relation to concealed pregnancy or late booking of pregnancy, found online [here](http://sussexchildprotection.procedures.org.uk/tklz/children-in-specific-circumstances/concealed-pregnancy/#top). All professionals are responsible for supporting a pregnant person to access and attend antenatal care at the point that a concealed pregnancy is disclosed or suspected.

Concealment may be an active act or a form of denial where support from relevant health professionals is not sought. A **concealed pregnancy** is when:

* A person knows they are pregnant but does not tell anyone or;
* A person appears genuinely unaware that they are pregnant.

If a professional has a concern that a young person (under 18 years old) could be pregnant and not accessing antenatal care, they should make a referral to Children’s Social Care and an assessment will be carried out.

Where the expected pregnant parent is over 18, every effort should be made to resolve the issue of whether they are pregnant or not. No person can be forced to undergo a pregnancy test or other medical examination, but in the event of refusal with clear reason to suspect that the person is pregnant, professionals should proceed on the assumption that they are pregnant unless it is proven otherwise. A referral to Children’s Social Care will be required for multi-agency decision and assessment to make plans to safeguard the baby’s welfare at birth. All professional referrals should include an assessment of risk.

A **late booking** is defined as presenting for maternity services **after 20 weeks**. It is important to remember that unless the expectant parent has genuinely not been aware that they are pregnant, they have still concealed their pregnancy up until the point they have accessed antenatal care. A booking appointment with a midwife should ideally be by 10 weeks ([NICE 2008](https://www.nice.org.uk/guidance/cg62)).

A person who presents to antenatal care late in their pregnancy should be assessed by maternity services at the booking appointment and potential risks highlighted and considered in relation to safeguarding the unborn baby and any other children within the household or family, as well as the young person themselves if the expectant parent is under 18 years old. This will inform the decision as to whether to refer to Children’s Social Care and/or whether other services could support the family e.g. Early Help. CP-IS should also be checked once it is embedded in maternity services in line with the national roll out. The parent must be informed that the referral has been made, unless there are significant immediate child protection concerns that prevent this.

Late booking can be the result of a person presenting for a termination of pregnancy but unable to have this procedure because the pregnancy is over 24 weeks, or because of ambivalence about whether to go ahead with the procedure. When these parents continue with the pregnancy, professionals need to be alert to the impact of any missed antenatal care. Professionals must consider the reasons for presenting late to termination services, associated risk factors, and level of support needed when the parent continues with an unwanted pregnancy including their psychological support needs.

Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. In all cases where a person arrives at hospital in labour or following an unassisted delivery as a result of a concealed pregnancy, **an immediate referral** must be made to Children’s Social Care. The baby should not be discharged until a Strategy Discussion has been held and appropriate assessments undertaken. The Strategy Discussion must consider the initiation of a psychiatric assessment; mental health representation should be included in this meeting.

Where the referral to Children’s Social Care is received out of hours in relation to a baby born as the result of a concealed pregnancy, the Out of Hours Service will take steps to prevent the baby being discharged from hospital until Children’s Social Care have given their approval for discharge; most instances this would be after a Strategy Discussion has been undertaken. The baby should not be discharged out of hours.

1. **Female genital mutilation (FGM)**

Female genital mutilation is illegal in this country by the Female Genital Mutilation Act 2003, except on specific physical and mental health grounds. Professionals working with women during pregnancy have a role in identifying the risk of FGM to unborn children as well as children already living in the home, and should consult the Pan-Sussex guidance available [here](http://sussexchildprotection.procedures.org.uk/tktq/children-in-specific-circumstances/female-genital-mutilation/#s317) which includes the risk assessment to be used with pregnant women.

Any suspicion of **intended or actual** female genital mutilation must be referred to Children’s Social Care. Health professionals have a specific responsibility in that NHS hospitals are required to record if a patient has had FGM, if there is a family history of FGM or if an FGM-related procedure has been carried out on a patient.

* + 1. **Health Visitors**

The health visitor should ensure that there is contact from the West Sussex Healthy Child Programme during the antenatal period. Health visiting teams should prioritise making antenatal contact with parents where there are safeguarding concerns or vulnerabilities and the Universal Plus offer should be considered.

Where there are safeguarding concerns for a child, health visitors should ensure attendance at multi-agency meetings for example child protection conferences, recognising that they are experts in that child’s health and development and are often well-placed to build relationships with parents.

If a health visitor encounters a person that they believe to be pregnant who has not sought health advice, they should encourage them to access health advice and care from a midwife and/or GP. If the person refuses to seek health advice, then a referral should be made to the Integrated Front Door (IFD).

* + 1. **GP’s**

It is good practice that all pregnant people are referred to a midwife as soon as possible, so that the most appropriate care can be given. Where a GP has significant reason to believe a person is pregnant, but they refuse all attempts to persuade them to undertake further investigations or referral, further action needs to be taken including a referral to the Integrated Front Door (IFD).

The GP should be alert to factors that may affect an expectant parent’s parenting capacity or which may pose a risk to an unborn child (for example mental illness, domestic violence, alcohol or other drug use), and must share information appropriately with the midwife, health visitor and colleagues from other agencies to ensure that any pre-birth assessment is fully informed; this includes sharing relevant medical information regarding putative fathers.

**Professionals Working with Parents in Specific Circumstances**

* 1. **Young Parents**

We know that young women who become pregnant as teenagers are often vulnerable, and teenage fathers are often excluded from support or involvement with their unborn child. Teenagers who become parents may have more difficulty accessing education and training or social activities than young people who are not parents. Consequently, their children may be exposed to greater social deprivation and disadvantage. Professionals need to offer coordinated support to these young parents in order to help them become the best parents that they can be.

All expectant young parents in West Sussex should be offered support through the [**Young Parents Pathway**](#_Links_to_related). The specific criteria for the pathway are:

* + All those that are a pregnant mother with an expected date of delivery before she is 20 years old;
  + All fathers whose baby is due before he is 20 years old;
  + All Care Leavers living in West Sussex up to the age of 25 years old.

The pathway will provide support to expectant young parents at all levels of the West Sussex Continuum of Need. By the time of their child’s birth all young parents will have received information and support about four key areas, alongside any respective Early Help or Children’s Social Care plans:

1. Five to Thrive (attachment parenting strategy)
2. Healthy relationships
3. Safe feeding, bathing, washing, dressing
4. Safe sleep advice and guidance
5. Coping with crying

In West Sussex Family Nurse Partnership (FNP) offer a voluntary home visiting programme to first time vulnerable young parents. Family Nurses are Health Visitors/midwives that have undergone further training to deliver the Licenced FNP programme alongside delivering the Healthy Child Programme.

Young Parents are allocated a named Family Nurse who visits regularly from the early stages of pregnancy and if needed until the first child reaches their 2nd birthday.

Through a psycho-educational approach, focusing on positive behaviour change, Family Nurses deliver a highly personalised intervention based around the specific strengths and needs of each client.

Family Nurse Partnership enables young parents to:

* + Build positive relationships and understand their baby’s needs.
  + Make positive lifestyle choices that will give their child the best possible start in life.
  + Build their self-efficacy, helping them to get back into employment or training.
  + Build positive relationships with others, modelled by the family nurse, helping clients to access and engage with other local services.

The programme addresses the six Early Years high impact areas:

* + Transition to parenthood.
  + Maternal mental health,
  + Breastfeeding,
  + Healthy birthweight and nutrition,
  + Managing minor illness and reducing accidents, and
  + Supporting child development.

Eligibility factors for Family Nurse Partnership include:

* + First pregnancy;
  + Mother must be aged under 19 years OR aged 24 years or under with a statement of special educational needs OR aged 21 years or under if a care leaver;
  + Under 28 weeks in pregnancy unless concealed.

Other factors that would be taken into consideration in addition to those above when establishing eligibility and priority for the program: Father aged 16 or under; father with a statement of special educational needs; father a care leaver or looked after child; either parent with police or social service involvement; either parent using drugs or alcohol; either parent with mental health problems.

Family Nurse Practitioners receive regular safeguarding supervision and are responsible for escalating any concerns about an unborn or new-born child to Children’s Social Care or Early Help.

Most young parents will be able to safely care for their child with the support of their naturally connected network or with the support of agencies in the community. However, in some circumstances, professionals may be concerned that there are factors specific to young parents which indicate that they may have difficulties in meeting their unborn child’s needs or ensuring their safety and may consider that a referral to Children’s Social Care is required. These factors may include the below:

* + A young parent who is isolated or unlikely to be provided with adequate family support;
  + A young parent who has become pregnant as a result of exploitation;
  + A young parent who has additional issues that make them more vulnerable for example mental health difficulties, learning difficulties or substance use problems;
  + A young parent of a particularly young age e.g. under 16 who is reliant on their carers;
  + A young parent who is currently open to Children’s Social Care on a Child in Need, Child Protection or Child Looked After status.

Where a young person is under the age of 13, a referral must be made to the Integrated Front Door (IFD) as all sexual activity with a child under 13 is illegal. Where a young person is under the age of 16, a referral to the Integrated Front Door (IFD) should be considered by professionals as the legal age of consent in the UK is 16. Professionals can use the Pan-Sussex [guidance](http://sussexchildprotection.procedures.org.uk/tkyyl/children-in-specific-circumstances/sexually-active-children) for sexually active children to support decision-making. Children’s Social Care will contact the police where this is necessary.

* 1. **Care Leavers**

Young parents in Leaving Care Services are likely to experience similar challenges to those faced by all parents, however they may be less likely to have consistent positive adult support and more likely to have to move. Young people who have been in local authority care may have experienced trauma or adverse childhood experiences which, if unresolved, could impact their ability to provide safe care.

If either expectant parent is or has been eligible for Leaving Care Services, the unborn baby should be referred to the Integrated Front Door (IFD) early in pregnancy for the case to be reviewed. This will not lead to a pre-birth assessment being recommended in all cases; a pre-birth assessment will be carried out where there are recent or current issues which could impact on the parents’ parenting capacity. For example, complex attachment or emotional difficulties, placement instability or homelessness, substance use or alcohol problems, mental health difficulties, criminal offending, exploitation or any other factors which could impact their ability to provide safe care. The decision about how to proceed will be made by MASH and recorded on the unborn’s file. MASH will inform the referrer of the outcome.

It is recognised that Personal Advisors play a key part in the support of young people leaving local authority care, and they are responsible for encouraging and supporting the young people with whom they are working to access antenatal care and other support services.

* 1. **Alcohol and drug use**

Drug and Alcohol Services in the community can play a key role in supporting expectant mothers, such as identifying drug and alcohol use in pregnancy at an early stage, referring on to appropriate help and support, and providing advice and intervention. Drug and Alcohol Service professionals should consider whether a referral to Children’s Social Care is required using relevant risk assessment tools.

Within the bounds of their usual consent and confidential policies, Drug and Alcohol Service professionals are responsible for sharing relevant information with midwives, GPs, health visitors, social workers and other relevant professionals about how the expectant parents’ alcohol and other drug and accompanying treatment may affect parenting capacity or development of the foetus to support in assessing risk to the unborn child. Professionals should also support service users to engage with maternity services.

Whilst drug or alcohol use does not in itself indicate that a parent will be unable to care safely for a child, excessive parental alcohol and/or other drug use is likely to have a detrimental impact on an unborn or new-born child and professionals should consider certain factors, including:

* + Patterns of alcohol and/or other drug use;
  + The potential consequences for the unborn baby of continued alcohol and/or drug use during pregnancy, or withdrawal during pregnancy;
  + Whether parents’ alcohol and/or drug use can be managed alongside caring for a baby;
  + Whether parents are appropriate for and willing to attend treatment;
  + any dual diagnosis (alcohol and drug use coupled with mental health problems).

In West Sussex, the alcohol and drug service provided by Change, Grow, Live (CGL) offers a specific service covering the perinatal period (pregnancy and the first year of the child’s life). Family workers are closely aligned with maternity services to ensure that the pathway does not leave pregnant or expectant parents feeling stigmatised if they needed help. Where alcohol and/or drug use is identified by maternity staff, parents should be offered a referral to CGL.

Maternity staff working in Brighton and Sussex University Hospitals Trust (BSUH) should refer to their specialist service, One Stop Clinic. One Stop Clinic offers a multi-agency approach to providing the best possible pregnancy care to women and their babies where there are alcohol and/or drug use issues.

Social workers and other professionals should use the expertise of community alcohol and drug use teams when considering the implications of drug and alcohol use on the unborn child and the potential impact on parenting capacity.

Professionals should be alert to the elevated risks to children where there are concerns about a combination of parental alcohol and drug use, parental mental illness and domestic abuse. Cases involving multiple complex problems such as these cannot be effectively worked by a single agency and cooperative working with other professionals is vital to capturing a full picture of the risks for the unborn baby.

* 1. **Mental Health**

Professionals should be aware that although most parents with mental health problems are able to provide an acceptable standard of care to their child, there is a link between parental mental ill-health and risk of harm to children. Parents with multiple or complex problems are particularly likely to find the parenting role more difficult to adapt to, for example those with substance use issues, learning difficulties or unsupportive relationships in addition to their mental health problems. In these cases, a referral should be made to Children’s Social Care for a pre-birth assessment; this will ensure that the unborn child is safeguarded and will allow for robust multi-agency planning of support for parents during the pregnancy and postnatal period. Further guidance about risk factors and circumstances in which a referral to Children’s Social Care should be considered is available in the Pan-Sussex guidance for Parental Mental Health [here](http://sussexchildprotection.procedures.org.uk/tkyxo/children-in-specific-circumstances/parental-mental-health/).

Mental health professionals will follow all relevant advice in liaising with multi-agency services such as midwifery, GP’s and Children’s Social Care where they have concerns.

Sussex Partnership NHS Trust provides a community-based Specialist Perinatal Mental Health Service (SPNMHS) for mothers with severe mental health difficulties either now or in the past, during pregnancy or up to one year after birth. The team comprises four teams of perinatal mental health professionals from a range of different disciplines; including psychiatrists, mental health nurses and psychologists. They are all highly trained and specialise in perinatal adult and infant mental health. Referrals to the service are most commonly made by midwives or GP’s but can come from any professional. For women where there is already involvement from a community mental health service, consultation and support can be offered by the SPMHS to those workers with existing relationships with parents.

* 1. **Parents with Learning Disabilities**

Parents with a learning disability may require additional support in order to understand and access antenatal care. When any professional working with an adult with a learning disability becomes aware that a service user is pregnant, they should encourage the expectant parents to engage with antenatal services and should seek consent to contact the named midwife and GP to share information. Even in the absence of a diagnosed learning disability, if any professional has concerns about a parents’ level of understanding or their cognitive capacity, they will need to adjust their approach and ensure they are working in line with the good practice guidance available [here](#_Links_to_related), in order to enable parents to engage with the process.

Midwives who believe that an expectant parent may have a learning disability should check health records and seek consent to contact Adult Social Care to confirm if they are known to the Community Learning Disability Team service and should consider alongside other professionals whether additional support is required. Where there are significant concerns about the impact of an expectant parents’ learning needs on their parenting capacity, a referral must be made to Children’s Social Care. An early referral will allow for a pre-birth assessment to be undertaken to ensure that professionals have a clear understanding of the expectant parents’ needs and how best to support them to safely care for the child where possible.

A pre-birth assessment will focus on how the learning disability may impact on the adults’ ability to parent and the provision of appropriately tailored services and support that may assist them to do so; it should also consider the level of family support available to the parents. Social workers can refer parents for further assessment, for example from the West Sussex Learning Disabilities Parenting Service, particularly if there is no confirmed learning disability but professionals have identified a concern about a parents’ cognitive ability. Social workers can also access specialist parenting assessments such as PAMS in order to ensure that parents are prepared for their baby.

* 1. **Domestic Abuse**

Women’s Aid indicates that domestic abuse can either begin, or increase, when women are pregnant. The stress of caring for a new-born baby can also trigger domestic abuse or violence within the home. Domestic abuse in pregnancy can pose serious physical and emotional risks to the health of both mother and child. There may also be an indirect impact on women’s attendance at antenatal care, or increased difficulties with their mental health which could impact on their ability to bond with and care for their child (Cleaver et al 2011). Continued exposure to domestic abuse once the child is born can impact on his or her emotional and cognitive development. The extent to which the violent partner also poses a direct physical threat to the child will need to be considered.

It is important that the risks associated with domestic abuse are identified early in pregnancy. Midwives must see women alone in order to allow screening for domestic abuse. Sussex Police should ensure that when attending domestic abuse callouts, they are asking about and aware of any expectant mothers in the household and sharing this information with Children’s Social Care. Domestic abuse services and refuges in West Sussex providing a service for an expectant mother should support her to access and engage with midwifery services.

Where there are concerns about domestic abuse and violence, the victim, which could be either parent, can be referred to Domestic Abuse Hub/Worth Services for advice and support, contact details are available [here](#_Domestic_Abuse_Hub:). Where there are significant concerns about the effect of domestic abuse on the unborn child, a referral should be made to Children’s Social Care.

* 1. **Housing and Homelessness**

While homelessness is an issue for children of all ages, it is a factor of special importance for young babies (Ofsted 2014). The quality of housing itself can be an additional stressor for new parents and frequent moves between different temporary accommodation can make it more difficult for services such as midwifery and health visiting to provide a consistent service and monitoring of baby’s development at a crucial time in their lives. Professionals should take into account the additional stress of homelessness or inadequate support when undertaking a risk assessment for an unborn baby.

Housing professionals should ensure that they communicate with other involved professionals to share any relevant information. For families open to Children’s Social Care or under Early Help plans, Housing Officers should ensure that the professional network is kept up to date with any changes of address for a vulnerable family.

* 1. **Police and Probation**

Probation professionals should make a referral to Children’s Social Care if they become aware that a service user, or the partner of a service user, is expecting a baby where the criminal history is likely to impact on the child. For example, if a violent or sexual offence has been committed, or any offence against a child; if there has been domestic abuse; or if drug and alcohol use or mental health are factors in offending. Professionals should ensure a referral for pre-birth assessment is made if there is any likelihood of an expectant mother receiving a custodial sentence for a crime committed.

Sussex Police should ensure that they ask about expectant parents when attending incidents and make a referral to Children’s Social Care if there are concerns about the unborn child. Police must be involved in Strategy Discussions regarding unborn children, particularly in respect of birth and discharge planning where there are significant concerns about the immediate safety of a baby once they are born.

1. **Making a Referral to Children’s Social Care**

All referrals should be made to the [Integrated Front Door (IFD)](https://www.westsussexscp.org.uk/professionals/working-together/making-a-referral) once the pregnancy is confirmed. Consent to the referral should be obtained from the parent unless this is likely to provoke immediate safety concerns for an expectant parent or child. Where the family normally resides outside of West Sussex, a referral should be made to the relevant local authority.

In most cases the most appropriate and proportionate point to make a referral is at 12 weeks gestation, once the pregnancy has been confirmed through an ultrasound scan. However, there will be circumstances in which earlier referral is appropriate if a pregnancy is confirmed or suspected, given the importance of early assessment and intervention particularly in the most complex situations. In these circumstances, professionals should make the referral upon confirmation of a pregnancy and the MASH should accept and triage the referral at this point. If a referral is received very early in pregnancy, particularly where risks are not substantiated or the pregnancy is not confirmed, MASH may request that partner agencies for example health or Early Help Services monitor and support the expectant parents until an appropriate point of referral (e.g. 12 weeks gestation).

If a pregnancy is suspected by professionals but not confirmed, efforts should be made by professionals to confirm the pregnancy and EDD, however it is recognised that this is not always possible. If the clear professional view following observation is that mother is pregnant, the referral must be accepted. It may be that concerns are not known until later in the pregnancy, at which point an immediate referral should be made.

Professionals should familiarise themselves with their own agency policies on referring to and consulting with Children’s Social Care where there are concerns about a child. Professionals may wish to discuss concerns with their own safeguarding lead prior to referral. If professionals have any queries relating to the referral or need advice on whether to make a referral or in relation to consent, they should contact the Integrated Front Door (IFD) on 01403 229900.

In the following circumstances, a referral must be made, and Children’s Social Care **should always undertake a pre-birth assessment:**

* + if a previous child/young person has died unexpectedly, and the cause of death is a result of anything other than ‘natural causes’, or has suffered a serious unexplained injury in the care of one or both expectant parents;
  + if a previous child has been removed via Care Proceedings due to abuse or neglect or other risk of significant harm, or if they have a current child who is the subject of Care Proceedings or within the Public Law Outline (pre-proceedings) process;
  + if the parents have a child living with them who is currently the subject of a Child Protection Plan;
  + where a person who has been convicted of an offence against a child or is believed by professionals to have abused a child, has joined the family;
  + if either parent has requested to relinquish the child upon birth;
  + where there are concerns about parental ability to self-care and/or to care for the child;
  + if for any reason (in addition to the above) it is possible that the mother and new-born will need to be separated at birth.

In the following circumstances, Children’s Social Care should always **consider** a pre-birth assessment:

* + if the pregnancy has been concealed or denied, or if there has been an avoidance of antenatal care or non-cooperation with healthcare with a potentially detrimental effect on the unborn baby;
  + if either parent is under 16 years of age; in these circumstances’ consideration should always be given to whether a dual assessment of parents’ own needs is required as well as an assessment of their ability to meet their baby’s needs;
  + if either parent is currently a Child Looked After;
  + if either parent is a care-leaver (former Child Looked After up to 25 years old) the unborn child should be referred to the Integrated Front Door (IFD) for the case to be reviewed, however with the acknowledgement that this may not lead to a pre-birth assessment in all cases. A pre-birth assessment will be carried out in circumstances whereby there are recent or current issues which could impact on the parents’ parenting capacity for example complex attachment or emotional difficulties, placement instability or homelessness, drug or alcohol use problems, mental health difficulties, criminal offending, exploitation or any other factors which could impact their ability to provide safe care. The decision about how to proceed will be held by the MASH;
  + where there are concerns about domestic abuse in either the present or previous relationship(s) of either expectant parent;
  + where the degree of parental mental ill-health is likely to have a significant impact on the baby’s safety or development;
  + if either parents’ alcohol or substance use is likely to have a significant impact on the baby’s safety and development, either directly or as a result of the impact of this substance use on parenting capacity;
  + where the degree of parental learning disability is likely to have a significant impact on their parenting capacity and baby’s safety or care received;
  + where there are concerns about the expectant parents’ capacity to adequately care for their child because of a physical disability or illness;
  + if either parent has previously been suspected of fabricating or inducing illness in a child;
  + if either parent or members of their network have convictions or have been subject of criminal investigation for offences of either a violent or sexual nature;
  + where there are any other concerns which indicate that the baby may be likely to suffer significant harm in their parents’ care.

The presence of one or more of these factors does not automatically require assessment but they highlight the need to consider the known predisposing factors to child abuse or neglect.

1. **Children’s Social Care Responses**

The MASH manager will make a decision on the referral within 72 hours and will notify the referrer of the outcome. If the referrer does not receive confirmation of the outcome of their referral, it is their responsibility to follow this up. If the referrer feels that the criteria for Children’s Social Care is reached but has been declined, they should contact their safeguarding lead to consider whether there is a need to escalate their concerns.

If the expectant parents are young parents, MASH should confirm that they have been offered the Young Parents Pathway as this is a service available to any young parent in West Sussex.

If the case meets the threshold for a social work service from Children’s Social Care because it is thought that the unborn child may be a child in need or at risk of significant harm, the case will be passed to a social work team for a Pre-Birth Child and Family Assessment, or a multi-agency Strategy Discussion may be convened.

If the case does not meet the threshold for a social work service but further support is required, the MASH manager will transfer the case to Early Help who will consider what level of response is appropriate from them, if any.

If the family does not appear to require a service from Children’s Social Care or Early Help Services, the case may be referred back to Universal Services to provide support.

In cases where Children’s Social Care accepts the referral and completes an assessment, they will act as lead professional with responsibility for the coordination of the case whilst it remains open to them. A Pre-Birth Child and Family Assessment should be completed by the social worker within 45 working days. The social worker undertaking this assessment is responsible for sharing the outcome of their assessment with other professionals.

At any point during the course of the assessment, Children’s Social Care may conclude there is reasonable cause to believe the baby is likely to suffer significant harm. In this case, a Strategy Discussion will be convened at which a decision may be made to initiate a Section 47 enquiry and convene an Initial Child Protection Conference (ICPC).

The purpose of an ICPC is to ensure that relevant information from all involved agencies for the family is shared and analysed, and a multi-agency plan is developed in order to safeguard the unborn child. An ICPC should normally be convened between 25 and 28 weeks of pregnancy or as soon as appropriate once the pregnancy is known. All involved professionals must prioritise attendance at an ICPC.

The Children’s Social Care assessment may conclude that the baby would not be safe in the care of their parents once they are born, and the local authority may seek legal advice regarding potential action to protect the child. The social worker should inform professionals about these steps.

Assessment of any family’s needs should be on-going and professionals should re-refer any case to Children’s Social Care if they feel that there has been a significant change in circumstances which increases risks to the unborn or new-born baby; this includes disengagement from services which were supporting the family.

1. **Legal Planning**

In cases where pre-birth assessment has concluded that the baby would not be safe in the care of their parents once they are born, the local authority will seek legal advice regarding potential action to protect the child. The social worker should inform the parents and professionals about these steps.

In some circumstances, it will be agreed that work should be undertaken under the Public Law Outline. Parents will be invited to a Meeting Before Proceedings where they will have independent legal advice, and the local authority will endeavour to work with the family to explore all options in order to avoid initiating Care Proceedings.

In cases where there is a high level of concern about the safety and welfare of a new-born baby, the local authority may decide that Care Proceedings are required to seek a court order to keep the child safe; this could involve seeking to separate the child from their parents and removing them into foster care. In these cases, the local authority will issue an application to the court upon the child’s birth. Although the local authority will make an application to the court, it is the decision of the courts whether to grant an order.

As part of care proceedings, professionals may be asked to provide information or a report to the court. Midwives in relevant health trusts should consider the use of Postnatal Parenting Observation Notes.

1. **Safeguarding Birth Plans**

Children’s Social Care guidance is that all unborn children open to the service should have a Safeguarding Birth Plan on file and shared with health colleagues prior to the expected date of delivery. Where there are safeguarding concerns, this should be developed and shared **by 32 weeks gestation**. The parents should be aware of and, wherever possible, involved in the development of this plan unless it is felt that this would put the mother or baby at an increased risk of harm. It is the responsibility of the social worker to share the plan with the parents, unless there is prior agreement that another professional is best placed to do this.

The birth plan should follow the template found [here](#_Links_to_related), which has been agreed by safeguarding midwifery services across all three of the health trusts covered by West Sussex (SASH Surrey and Sussex Healthcare NHS Trust, Western Sussex Hospitals NHS Trust and Brighton and Sussex University Hospitals NHS Trust). The plan should detail the planning for delivery and the immediate post-natal period, including who should be notified upon the birth of the baby.

For children made subject to a Child Protection Plan, good practice would be for this plan to be devised and agreed at the first Core Group meeting. The plan should be uploaded to the social care recording system and clearly case noted so that information can be accessed by the Emergency Duty Team (Out of Hours Service) and shared with, at a minimum, the relevant safeguarding midwife for the hospital where the mother plans to deliver.

The plan must recognise that hospitals should not be considered a place of safety and are not secure settings; therefore if the risks to the child are so high that they would be at immediate risk of harm from their parents once born, contingency plans must be put in place by Children’s Social Care including consideration of the role of police in taking Police Protection. Planning must take place including clear guidance about who maternity staff should contact if the parents try to remove the baby from the ward, for example the police. If 24/7 supervision is required of the parents with their baby on the ward, specific arrangements will need to be made as it is unlikely that this will be provided by midwives on the unit.

It is the responsibility of the named safeguarding midwife to ensure that other health practitioners involved are informed of the detail of the Safeguarding Birth Plan, for example the obstetrician, neonatologist, GP and Health Visitors (HVs). The social worker is responsible for ensuring other relevant agencies such as Out of Hours (Emergency Duty Service) and the police are aware of the detail of the plan. All professionals will need to be clear about their role and that of others, which should be set out in the plan.

1. **Children Who May be Born at Home or in Other Areas**

Expectant parents can be fearful of social care intervention and may try to conceal the birth of their baby from professionals either by giving birth at home or by moving to another local authority. If the social worker considers that this may be a risk, the social worker and relevant safeguarding midwife should agree to complete a ‘[Safeguard Alert’](#_Links_to_related) which can be distributed internally within the health trust, to bordering maternity units, to the South East Coast Ambulance Service or to other health trusts regionally or nationally, in line with the Trust policy. Information must be provided detailing if it is suspected that the child may suffer or be likely to suffer Significant Harm (i.e. is subject of a Child Protection Plan), is currently subject to a s47 enquiry or if the local authority intends to apply to the courts to remove the baby at birth.

It may be necessary for a Strategy Discussion to be held in order to ensure that all relevant agencies are aware of the risk of a family moving area prior to the birth of the child, or of removing the baby from hospital in an unplanned way once born. In the event of the pregnant parent going missing once an unborn child is subject of a Child Protection Plan, consideration should be given to making a missing person report to the police.

1. **Discharge Planning**

It is expected that a discharge planning meeting will normally take place for all children subject of a Child Protection Plan prior to their discharge from hospital. In some circumstances a clear discharge plan may have been agreed in advance between the social worker and hospital. A child subject to a Child Protection or Child In Need Plan should not be discharged from hospital without consultation with the social work team and a plan being in place. A newborn 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 must be documented in the Safeguarding Birth Plan and child’s discharge plan.

If a discharge planning meeting takes place, this should be attended by Children’s Social Care, safeguarding midwife, health visitor, and any other relevant agencies. An agreed multi-agency discharge plan will set out arrangements for the care and safety of the baby following discharge from hospital into the community and should include details of where the baby will be living, and which professionals and family members will be visiting and when. Where a baby is born prematurely it is reasonable to plan the discharge meeting 5-7 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.

If a baby is moving to a foster placement or to a placement in a different area, the midwife will be responsible for ensuring that the relevant health visiting team are notified of the child in their area.

1. **Infant Removal at Birth and Management of Emotionally Challenging Cases**

There is currently no guidance outlining roles and responsibilities when removing infants from parents’ care, however it is widely accepted that in addition to having an inevitable impact on attachment and bonding, the experience of separating an infant at birth from their mother, father and wider family is an acutely distressing and traumatic experience for all concerned, including involved professionals. Available literature recognises that mothers who experience the removal of a baby at birth experience deep-felt grief, guilt and shame; and there are similarities drawn between the experiences of women who have an infant removed at birth and those whose babies have died (Mason et al 2019).

Every situation should be assessed on an individual basis, however at a minimum there must be clear communication between the social worker, the midwife in charge of the mother’s care and where possible the mother and/or father, to identify in advance an appropriate place and who will facilitate the separation of baby from their parents. Where possible, parents should be given the opportunity to have some choice in who they will hand the baby to at the point of separation and whether they leave the hospital before or after the baby is removed. Where possible, photographs should be taken of the mother/father and baby together and mementoes from hospital provided both for the baby’s life story work and for the parents.

* 1. **Support for Parents**

Women in West Sussex who have experienced recurrent care proceedings (more than one child removed from their care) can receive support from PAUSE. PAUSE aims to give women the opportunity to pause and take control of their lives, breaking a destructive cycle that causes both them and their children deep trauma. Further information is available online [here.](https://www.pause.org.uk/practice/west-sussex/)

* 1. **Support for Professionals**

Professionals who provide care for parents whose babies are removed at birth or shortly after require education and support to enable them to provide effective care to the families they work with and to enable them to maintain their emotional wellbeing whilst doing so. Research has demonstrated the significant emotional impact that this work has on professionals, with studies noting that the tension between balancing the safety of the new-born baby and the rights of the birth parents is felt particularly acutely by midwives given the centrality of the woman’s needs in their work (Mason et al 2019).

Safeguarding supervision has known benefits to staff and should be accessible to them. The receipt of regular formal safeguarding supervision provides individuals with the opportunity to reflect on their feelings when engaging with child protection activities including the removal of babies at birth and has significant benefits to safeguarding practice and emotional wellbeing (Hall, 2007). It is therefore the expectation that all organisations have robust mechanisms in place to ensure that that supervision is available to staff members and is accessible.

1. **Resolving Professional Differences**

If there is disagreement regarding decision making at any stage professionals should seek advice and supervision as per their own agency’s process. Where these differences cannot be resolved professionals should follow their own escalation process and the Local Safeguarding Children Partnership (LSCP) policy.

1. **Useful Contacts**

**West Sussex Integrated Front Door (IFD):** 01403 229900 or [WSChildrenservices@WestSussex.gov.uk](file:///C:\Users\dcr90830\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\5EURZKRC\WSChildrenservices@WestSussex.gov.uk)

**Emergency Duty Team (Out of Hours Service): 0330 222 6664**

# **Domestic Abuse Hub:** 0330 222 8181 / 07834968539 or [DomesticAbuseServicesCentral@westsussex.gov.uk](mailto:DomesticAbuseServicesCentral@westsussex.gov.uk)

# **Safeguarding Midwives:**

Surrey and Sussex Trust (East Surrey Hospital - Crawley and Horsham areas): Safeguarding midwife Salli Alihodzic ([s.alihodzic@nhs.net](mailto:s.alihodzic@nhs.net))

Brighton and Sussex University Hospitals (Princess Royal Hospital – Haywards Heath and Burgess Hill areas): Safeguarding midwife Fiona Rose ([f.rose@nhs.net](mailto:f.rose@nhs.net))

Western NHS Trust (Worthing and St Richards Hospitals – covering Worthing, Shoreham, Littlehampton, Chichester and Bognor areas): Safeguarding midwives [wshnt.safeguardingmidwives@nhs.net](mailto:wshnt.safeguardingmidwives@nhs.net)

F**amily Nurse Partnership:** Contact from referrers is welcomed by the FNP Supervisor Sue Mercer who can be contacted on 07780 224204 / 01273 696011 x 8195 [sc-tr.fnp@nhs.net](mailto:sc-tr.fnp@nhs.net)

**Change, Grow, Live :** 0300 303 8677 option 1 or [Familyteam.wsxdawn@cgl.org.uk](mailto:Familyteam.wsxdawn@cgl.org.uk)

**Specialist Perinatal Mental Health Service:** Referral form available [online](http://www.sussexpartnership.nhs.uk/perinatal) or email spnt.perinatalreferrals@nhs.net

Coastal West Sussex: 0300 304 0214

Northwest Sussex and Surrey: 0300 304 0213

1. **References**

National Maternity Review (2016) Better Births: Improving Outcomes of Maternity Services in England.

Available at <https://www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-review/>

Brandon et al (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014; Final report. Department of education

Broadhurst, K. Mason, C., and Robertson, L. (2019) Pre-birth assessment and infant removal at birth: experiences and challenges. A literature review

Available at:

<https://www.nuffieldfjo.org.uk/app/nuffield/files-module/local/documents/Executive%20summary_Born%20into%20care%20literature%20review_December%202019.pdf>

Department for Education (2018) *Working Together to Safeguard Children*

Hall, C. (2007) ‘Health Visitors and School Nurses perspectives on child protection supervision. Community Practitioner, 80(10), pp.26-31.

NICE Guidance (2008) <https://www.nice.org.uk/guidance/cg62/chapter/Appendix-D-Antenatal-appointments-schedule-and-content>

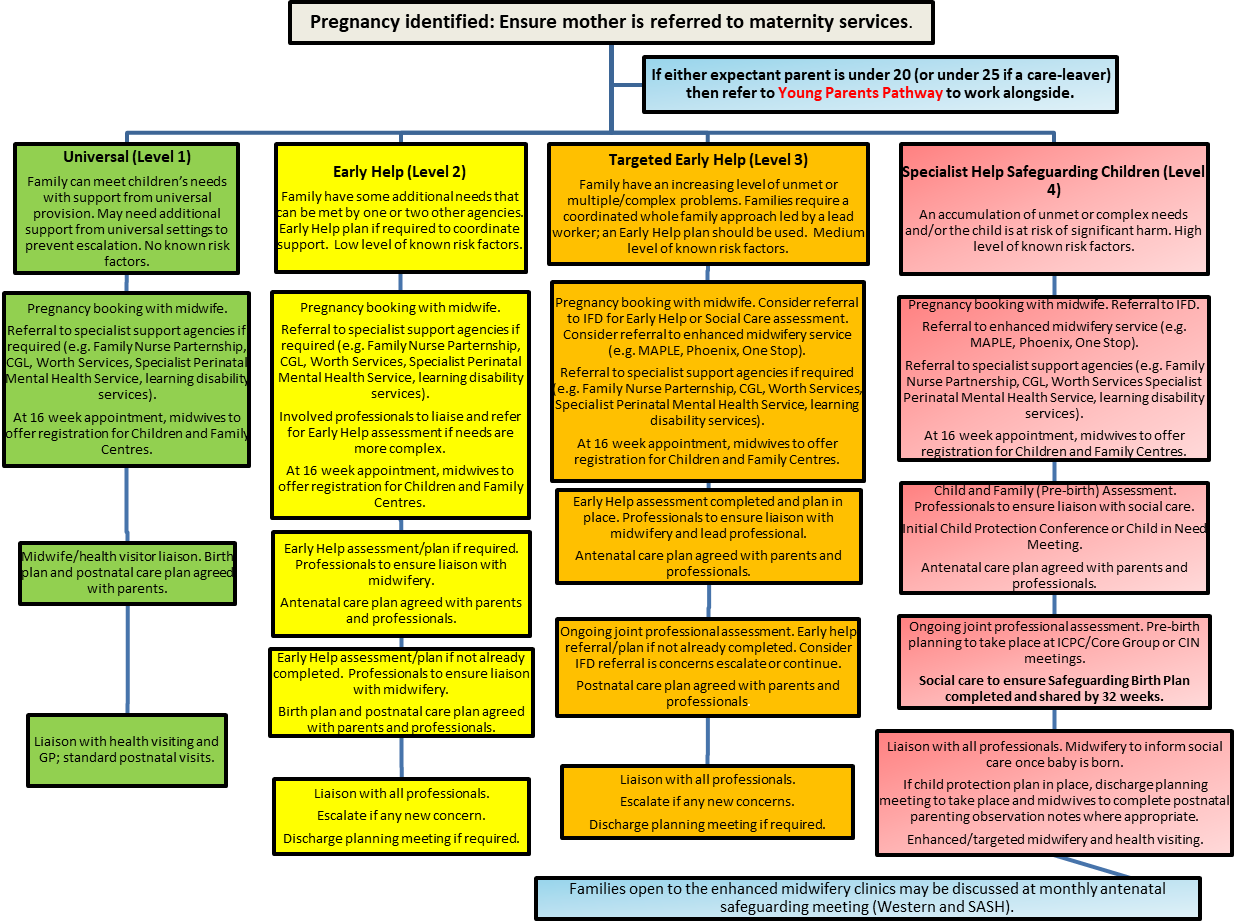
## Links to related documents:

1. **APPENDICES**
   1. **APPENDIX 1: MULTI-AGENCY FLOWCHART** See page 22

Assessment of any family’s needs should be on-going. If new concerns arise or if concerns escalate, professionals should complete a new referral to IFD. If concerns decrease, cases can be stepped down to a lower level of support.

In cases of late booking or concealed pregnancy, professionals should seek safeguarding supervision regarding next steps as the below processes may need to be completed in a shorter timescale.



* 1. **Appendix 2: RISK ASSESSMENT TOOL**

|  |  |  |
| --- | --- | --- |
| **LOW: CONSIDER EARLY HELP OFFER** | **MEDIUM: CONSIDER REFERRAL TO IFD** | **HIGH: AUTOMATIC REFERRAL TO IFD** |
| **CURRENT OR PREVIOUS INTERVENTION FROM CHILDREN'S SOCIAL CARE** | | |
| * Previous intervention at Early Help Level * Older siblings or half-siblings currently receiving support through Early Help * Either parent previously known to CSC at Child in Need / Early Help level * Older siblings or half siblings historically subject to a Child in Need Plan | * Older siblings or half-siblings historically subject to a Child Protection Plan or legal proceedings * Either parent was previously a Child Looked After (but not currently open to Leaving Care Services) * Either parent previously subject to a Child Protection Plan or legal proceedings | * Either parent has had a child previously removed from their care * Either parent is a current Child Looked After or Care Leaver * Either parent is currently on a Child in Need/Child Protection Plan * Older siblings or half-siblings are currently subject to a Child Protection Plan or legal proceedings * Older siblings or half-siblings are currently subject to a Child in Need Plan |
| **PREVIOUS UNEXPLAINED/UNEXPECTED DEATH OF A CHILD** | | |
| * Previous unexplained / unexpected death of a child whilst in the care of either parent or significant member of household, and no indication that death was as a result of failing to follow advice or guidance * Subsequent children all fit and healthy and no parenting concerns * Well engaged with services | * Previous unexplained / unexpected death of a child whilst in the care of either parent or significant member of household, and concerns about the impact of unresolved grief / loss on one parents’ bonding with new baby | * Previous unexplained / unexpected death of a child whilst in the care of either parent or significant member of household, and indication death was as a result of failing to follow advice and guidance or direct harm caused by parents * Concerns about the impact of unresolved grief / loss on both parents * Poor engagement with services |
| **RELINQUISHMENT** | | |
|  | * Either parent has previously relinquished a child for adoption | * Where expectant parent indicates at any stage of pregnancy that they are considering relinquishing baby's care |
| **MENTAL HEALTH** | | |
| * History of mild mental ill-health but currently well * History of mental ill-health and current mild low mood or anxiety * Current mild mental health difficulties e.g. mild low mood/anxiety/stress relating to pregnancy, * Engaging / compliant with treatment or medication * Condition or treatment has limited impact on functioning | * Significant mental illness including personality disorder * Mental illness is well-managed * Parent is compliant with medication and professional treatment * Limited personal or professional support network | * Chronic and enduring mental illness including personality disorder * Non-compliance with medication/professional treatment recommendations * Condition or treatment significantly impairs functioning * High risk of relapse * Limited or no personal or professional support network * Dual diagnosis (mental health and alcohol or drug use) |

|  |  |  |
| --- | --- | --- |
| **ALCOHOL AND OTHER DRUG USE** | | |
| * History of low-level drug or alcohol misuse * Current recreational drug or alcohol use * Does not impair ability to function | * Substance use is well managed * Compliant with services / medication /professional treatment and screening * History of significant substance use but currently stable or abstinent * Risk of relapse * Limited support network | * Alcohol or other drug use impairs functioning * Alcohol or other drug use is by both mother and partner * Intravenous drug user * Alcohol dependency * Drug related debts or known to be involved with drug dealing * Not engaging or compliant with support services |
| **DOMESTIC ABUSE** | | |
| * Exposed to domestic abuse as a child * History of domestic abuse in previous relationship with no indicator of ongoing risk | * History of domestic abuse in previous relationship and ongoing risk * Risk of domestic abuse post-birth and around child contact issues * Power and control within relationship creates social isolation and absence of support | * Victim or perpetrator of high-risk domestic abuse * Subject to MARAC * Risk of honour-based violence * Forced marriage * Power and control within relationship prevents access to professionals and services * Financial abuse prevents access to services & ability to provide for basic care needs of mother and child |
| **LEARNING DISABILITIES** | | |
| * Mild learning disabilities which have limited impact on day-to-day functioning * Moderate learning difficulties with good support network who can assist in care of the child * Subject to SEN Statement but educated in mainstream school | * Significant or severe learning disability which affects ability to function / care for themselves and/or others, but where partner can provide adequate care for the child * Moderate learning disabilities and limited support network, or both parents with moderate difficulties * Subject to SEN statement and educated in Special Educational Provision as a child | * Significant or severe learning disabilities which affect both parents’ ability to function / care for themselves and/or others * Limited or no support network |
| **OFFENDING BEHAVIOUR** | | |
| * Previous involvement with police / probation / youth offending for historical non-violent offences including anti-social behaviour | * Currently under probation / youth offending for non-violent offences * Previous custodial sentences * Previous conviction for arson * Previous conviction for animal cruelty * Previous investigation in relation to violent or sexual offences, where no charge or conviction was successful * Previously subject to Hospital Order or Custodial Sentence | * Registered Sex Offender (e.g. VISOR subject) * Historic or recent violent offences * Person posing a risk to a child * Subject to current MAPPA * Involvement in gang-related activity * Prolific offending to fund drug or alcohol use * Drug dealing / supplying * Currently subject to Hospital Order / Custodial sentence |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **YOUNG PARENTS (including risk of Child Sexual Exploitation – professionals should use LSCB risk assessment tool)** | | | | | |
| * Mother 16-18 at point of referral * Age difference not more than 2 years * No issues of power and control * Good support from family network * Previously considered low risk of CSE | | * Mother aged 16-18yrs and age difference 2-3 years or issues of power and control * Limited/no support network from family network * Previously considered high risk of CSE | | * Mother 13-15 at point of conception * Where mother was under the age of 13 at point of conception * No support from family network * Known to be at high risk of CSE * Significant age difference in relationship (more than 3 years) * Evidence of grooming or coercion and control | |
| **AVOIDANCE OR NON-ENGAGEMENT WITH SERVICES AND TREATMENT** | | | | | |
|  | | * Not compromising health or development of mother and baby | | * Compromising health and development of mother and/or baby * Coupled with any other concerns e.g. learning disabilities, drug or alcohol use, chaotic lifestyle | |
| **CONCEALED PREGNANCY/DELIVERY (including late booking and flight risk)** | | | | | |
| * Late booking (after 20 weeks) up to 28 weeks gestation, who engages with care and services with good support network * Unplanned pregnancy whilst using contraception (up to 28 weeks) | | * Late booking of pregnancy (after 20 weeks) and no clear explanation for this or ambivalence about pregnancy * Multiple transfers of care, sporadic engagement in services and treatment but these are unlikely to impact on the health and development of unborn baby | | * Very late booking (3rd trimester) and ambivalence about pregnancy or no clear explanation of lateness of booking * Presentation in labour or following an unassisted birth * Multiple transfers of care, failure to engage in services and treatment that are likely to impact on the health and development of unborn baby * Concern that expectant parent may not present in labour due to fear about involvement of services | |
| **FEMALE GENITAL MUTILATION (FGM) – Professionals to complete LSCB risk assessment tool** | | | | | |
| * Mother subjected to FGM, but strong advocate against this * No evidence of wider family pressure | | * Mother subjected to FGM, but strong advocate against this, however some evidence of coercion / control by partner or within wider family | | * Mother subject to FGM, current ambivalence to practice, unborn is female * Existing sibling subject to FGM * Coercion or control by partner or wider family | |
| **FINANCIAL / HOUSING ISSUES / NO RECOURSE TO PUBLIC FUNDS (NRPF)** | | | | | |
| * Supported living arrangements * Poor employment conditions * Poor budgeting skills * Loss of employment | | * Transient lifestyle - known to services in multiple authorities but no child protection concerns * Inability to maintain tenancy / provide stability * Accommodation / housing arrangements not suitable post delivery * Gambling / debt which may compromise ability to meet basic care needs of child * Recognition of risk that accommodation presents and engaging with agencies to address * Parents have NRPF and unable to meet baby's basic care needs but wider family providing financial support * Poor ante-natal care associated with NRPF * Asylum seeking status | | * Transient lifestyle - known to services in multiple authorities and child protection concerns * Unsuitability of accommodation - presents risk to health of mother / baby and housing unable to assist. Especially if parents do not recognise that accommodation could present a risk or are not working with services to address issues * Risk of homelessness at delivery where housing unable to assist - **unable to discharge** * Parents have NRPF and are unable to meet baby's basic care needs * Debts pose a potential risk or are indicative or wider issue e.g. drug debts or gambling addiction | |
| **ASYLUM SEEKER - Mother, Father, Partner or Significant Member of Household** | | | | | |
| * Temporary leave to remain * Stable employment/housing * Other children in country of origin * Overstayer status not impacting on access to healthcare, services, treatment, housing / ability to meet child's needs | | * Temporary leave to remain linked to employment / education * Unstable housing | | * Presentation after 28 weeks * No temporary leave to remain * Overstayer status impacting on access to healthcare, services, treatment, housing / ability to meet child's needs | |
| **FABRICATED / INDUCED ILLNESS / REPEATED ADMISSIONS** | | | | | |
| * Repeated admissions around genuine health concerns - diagnosed / undiagnosed / in the course of investigation | | * Repeated admissions / expressions of concerns associated with ongoing anxiety around pregnancy / mental health issues | | * Serious intentional overdose attempt or genuine self-harm * Repeated admissions not associated with anxiety issues * Compromising own or baby's health, now and once born * Repeated admissions with injuries associated with undisclosed domestic abuse * Lying about obstetric history - having had / not had children | |
| **SELF NEGLECT** | | | | | |
| * Poor nutrition * Poor personal hygiene | | * Non-compliance with medication, treatment / services not impacting on own / baby's health | | * Non-compliance with medication, treatment / services impacting on own / baby's health | |
| **SIGNIFICANT HEALTH & DEVELOPMENT ISSUES OR FOETAL ABNORMALITY** | | | | | |
| * All screening declined and baby born with unforeseen illness / disability / abnormality * Existing child with disability / complex health needs * One or both parents have known disability / genetic condition / life limiting illness | | * Where disability / significant health issue will create risk of significant harm to baby / compromise their care - with support network * Life limiting illness / disability with no apparent support network | | * Where disability/significant health issue will create risk of significant harm to baby / compromise their care - no support network * Lack of engagement with services significantly compromises health and safety of baby * Where parents are in denial and unwilling to engage with services / treatment | |
| **UNPLANNED / UNWANTED PREGNANCY - including TRAUMATIC CONCEPTION / SEXUAL ABUSE** | | | | | |
| * Unplanned pregnancy where one partner is not fully supportive of pregnancy continuing | | * Baby conceived via rape - concern about future bonding or attachment * Concern that pregnancy being used as a form of control | | * Pregnancy as a result of intra-familial sexual abuse | |
| **SURROGACY** | | | | | |
| * Surrogacy arrangements, seemingly amicable, but where no legal advice has been sought | | * Ambiguities about handover / care arrangements before, at or after 34 weeks pre-birth handover/arrangements * Ambiguities about post-natal care for mother / baby * Surrogate mother showing evidence of ambivalence about handover / not wanting to relinquish baby | | * Enquiries undertaken raise concerns for future care arrangements for child when born including previous CSC involvement with birth mother/proposed surrogate parents * Unlawful surrogacy arrangement involving payment / coercion / control | |
| **SEX WORKING** | | | | | |
| * Previously engaged in sex working * Suspends sex working during pregnancy * Engaging with services / treatment to optimise own / baby's health and development * Intention to resume sex work post-delivery with safe care arrangements for baby. | | * Where ongoing engagement in sex work is likely to put mother and UBB's health and development at risk * Where mother not engaging in regular screening with all services / taking responsibility for own health * Intention to resume sex work post-delivery with no safe care arrangements for baby | | * Where engagement in sex working puts mother / child at risk from unsafe adults * Where pregnancy is used as a form of control * Where sex-working is believed to be driven by / linked to drug misuse | |
| **RADICALISATION** | | | | | |
|  | | * Estranged from wider family members who have been radicalised / subject to PREVENT/CHANNEL/Anti-terrorism measures/monitoring | | * Parent or significant family member is subject to PREVENT/ CHANNEL/ Anti-terrorism measures / monitoring, or parents have close links to wider family members who are subject to measure/monitoring | |
| **TRAFFICKING AND MODERN SLAVERY** | | | | | |
| * Engaged in employment - low paid, poor conditions | | * Disproportionate level of responsibility for chores * Known to be previously trafficked but working with agencies towards achieving stable environment * Unable to provide consistent history or demonstrate stability * Accompanied to appointments with unexplained escort (not father / relative to baby / mother | | * Known to be previously trafficked, and not in stable environment - unclear ongoing links to traffickers * Disclosure or known to have been trafficked (not exclusively from overseas) * Not working with agencies * Ongoing links to traffickers | |
| **Review / Contacts / References** | |  | |
| Document title: | | Multi Agency Pre-Birth Protocol | |
| Date approved: | | 6 April | |
| Approving body: | | Policy, Practice and QA Steering Group | |
| Last review date: | | 24 March 2020 | |
| Next review date: | | March 2021 | |
| Related internal policies, procedures, guidance: | |  | |
| Document owner: | | Sally Allen | |
| Lead contact / author: | | Lauren Thompson, Pre-birth Specialist  Jenny Brickell, Service Development Manager | |