Hampshire, Isle of Wight, Portsmouth & Southampton 4LSCB Maternity and Childrens Services Unborn Babies Safeguarding Protocol

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Hampshire Safeguarding Children Board

ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD

PSCB Portsmouth Safeguarding Children Board Protecting Portsmouth's Children

LSCB Southampton Local Safeguarding Children Board

1. INTRODUCTION

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

1.2 The aim of this protocol is to enable practitioners to work together with families to safeguard unborn babies where risk is identified. The protocol provides an agreed process between Health and Children's Service's Department (CSD) on the planning, assessment and actions required to safeguard the unborn child.

1.3 Unlike many safeguarding situations, the antenatal period gives a window of opportunity for practitioners and families to work together to:-

- Form relationships with a focus on the unborn baby
- Identify risks
- Understand the impact of risk to the unborn child
- Explore safety planning options
- Assess the families ability to protect the unborn baby
- Identify if any assessments or referrals are required before delivery; for example the use of Common Assessment Framework (CAF) or alternative assessments agreed locally, including the need for statutory intervention for a child in need/in need of protection.
- Plan ongoing interventions.

1.4 When risks have been identified, it is important that practitioners offer early help and engage in planning to optimise the outcomes and support for the family. It is essential in safeguarding children that practitioners share information and they should refer to the cross-government guidance on how to share information: *Information Sharing: Guidance for practitioners and managers* 2008.

1.5 Any disagreements about thresholds or disputes should be discussed with your supervisor, if these remain unresolved the 4LSCB dispute resolution process should be followed.

2. SCOPE

2.1 The protocol applies to any practitioner working in Health or CSD planning for the safety of the unborn child and other practitioners as identified. The protocol sets out a process of safe planning by practitioners working together with families to safeguard the baby at birth. However where there are immediate risks to the unborn baby, an urgent referral to CSD must be made**.**

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

3. PURPOSE

3.1 This Joint Working Protocol provides a robust framework for responding to safeguarding concerns for unborn babies within Hampshire, the Isle of Wight, Portsmouth and Southampton.

4. RISKS

4.1 Below are examples of concerns that may trigger this protocol:

- Mothers and/or partners or other significant members of the household involved in risk activities such as substance misuse including drugs and alcohol.
- Mothers, fathers or other carers/significant members in the household with significant contact who have mental health support needs.
- Known domestic abuse by any member of the family living in the household (this includes control and power in relationships that may prevent the ability of others to care for and protect children) or disclosed through routine antenatal enquiry that a parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children.
- The ability of the parents or carers to meet the unborn baby's needs e.g. significant learning difficulties and in some circumstances severe physical disability.
- Historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care.
- Parental involvement as a child or adult with CSD.
- Parents or other carers who have been convicted of a crime against children or are deemed to be a risk to children.
- Any other circumstances or issues that give rise for concern.

See **Appendix One for Risk Assessment flowchart.**

4.2 Involved professionals along with the family should meet to discuss the strengths, risks and needs of the family and consider completion of a CAF (or other locally agreed assessment) or referral to CSD. Reasons for not making a referral or completing an assessment would be recorded and circumstances reviewed regularly to assess risk and consider any further action.

4.3 A CAF is an assessment that can be used to identify early help for families. It is a four-step process whereby practitioners can identify a child's or young person's needs early, assess those needs holistically, deliver coordinated services and review progress. When it is recognized that parents of an unborn baby may need the support of early services to respond to their babies needs this can be instigated with their permission prior to birth. When a CAF or Team Around the Child (TAC) meetings are held and there is a high level of concern which has not yet reached the threshold for a referral to CSD, consideration should be given to inviting CSD to the meeting. CSD can then advise on any appropriate actions to support the family or make need to consider a referral.

4.4 Other agencies may have the first contact or be aware that a woman (or their partner) they are working with, is pregnant or about to become a principal carer. These will be workers in Learning Disabilities, Mental Health, Women's Aid, Drug and Alcohol Services, Police, Leaving Care Teams, Housing and Adult Safeguarding. If any service becomes aware of pregnancy / impending parenthood of one of their clients they must inform maternity services of their involvement and highlight any concerns, as per the 4LSCB Protocol 'Safeguarding Children Whose Parents/Carers have mental health, substance misuse, learning disability and emotional or psychological distress. This contact should be made through the named midwife for the area via the Health Care Trust. (See Appendix Two).

4.5 Referral to maternity services does not negate other agencies responsibility to refer to CSD if there are significant concerns for the safety of the unborn or any other children in the family. If practitioners require advice on safeguarding they should contact their manager and/or their named practitioner for safeguarding.

4.6 Where it is assessed that a referral to CSD is required this should be done in line with Working Together to Safeguard Children 2013: 64 and 4LSCB procedures.

5. REQUEST FOR REFERRAL TO CHILDRENS SERVICES DEPARTMENT (CSD)

5.1 Referrals to CSD about unborn babies who may need services should be made early in the pregnancy as soon as concerns have been identified. This enables CSD to assess and plan in a timely way and make a decision as to whether an Initial Child Protection Conference (ICPC) is required.

5. 2 A referral should always be made if:-:

- There has been a previous unexpected or unexplained death of a child whilst in the care of either parent. A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children. This may be due to domestic abuse, substance/alcohol abuse, mental health or learning difficulties.
- Children in the household / family currently subject to a child protection plan or previous child protection concerns.
- A sibling (or child in the household of either parent) has previously been removed from the household temporarily or by court order.
- Where there are concerns about parental ability to self care and/or to care for the child e.g. unsupported young or learning disabled mother.
- Where there are maternal risk factors e.g. denial of pregnancy, avoidance of antenatal care (failed appointments), non-co-operation with necessary services, non compliance with treatment with potentially detrimental effects for the unborn baby.
- Any other concern exists that the baby may be at risk of significant harm.

5.3 Factors **that may need to** be considered when undertaking a pre-birth risk assessment. These are examples of indicators and not an exhaustive list. Professional judgement will need to be exercised and supervision taking where necessary.

Unborn baby

Unwanted pregnancy
Emotional detachment from pregnancy
Concealed pregnancy
Lack of awareness of the baby's needs
Exhibit inappropriate parenting plans
Cultural issues
Inability to prioritise baby's needs
Poor engagement with ante natal services
No preparation for baby's needs
Premature birth
Foetal abnormality
Gender issues

Parenting Capacity

Negative childhood experiences
Experience of being in care
Abuse in childhood, denial of abuse
Drug/alcohol misuse
Violence/abuse of others
Abuse/neglect of previous children
Previous care proceedings
Learning disability (4LSCB adult needs be referred for assessment)
Known offender against children
Age-very young/teenager/immaturity
Communication difficulties
Mental health/personality health issues
Learning difficulties
Lack of engagement with practitioners
Postnatal depression
Homelessness/asylum seekers
No recourse to public funds

Family and Environment

Domestic abuse	Relationship disharmony
Unsupportive relationship	Multiple relationships
Frequent moves of home	Lack of support networks
Inappropriate home environment	Financial difficulties
Unemployment	Inappropriate associates
Change of partner	

5.4 Referrals should be consistent with the guidance in Working Together to Safeguard Children 2013 :64 and 4LSCB procedures.

5.5 It is important for practitioners to remember that a CAF or alternative assessment is not required where it has been identified that the unborn child has already met the threshold of being at significant risk of harm.

6 OUTCOME OF THE REFERRAL TO CHILDRENS SERVICES DEPARTMENT

6.1 CSD may assess that the threshold for their services has not been met, however they may signpost the referrer to other appropriate agencies /services all CSD decisions should be relayed in writing to the referrer and the family, . If the referrer does not feel that CSD decision is appropriate they must seek advice from their named practitioners for safeguarding.

6.2 Health practitioners can re-refer any case if they feel that there has been significant change that increases the risk to the unborn baby.

6.3 It is the responsibility of CSD to notify the referrer of the outcome of the request for their services. If this is not received within 3 days it is the responsibility of the referring practitioner to check the outcome with CSD. If the referrer feels that the criteria for CSD is reached but has been declined they need to contact their named practitioners for advice to discuss how to escalate their concerns to CSD.

6.4 In case's where CSD accepts the referral and completes an initial assessment, whilst the case is open to them they will take the lead responsibility for the coordination of the case. If there is reasonable cause to suspect a baby is likely to suffer significant harm, there should be a strategy discussion, where emergency action may be needed. This will be led by CSD, and involve other professionals, such as maternity services and GPs. The strategy discussion will normally be in the form of a face to face meeting. CSD will Chair this meeting and ensure that a copy of meeting minutes with clear actions is circulated to those attending. A core assessment is the means by which a section 47 enquiry is carried out. One of the possible outcomes of the section 47 may be to convene a child protection conference. The aim of the conference is to ensure all the information is brought together

and analysed, and should be held within 15 days of the strategy discussion/meeting. If the child protection conference decides that the child is likely to suffer significant harm in the future, a child protection plan will be agreed. It is the responsibility of the midwifery practitioner who attends the initial child protection conference to ensure that a safeguarding birth plan is agreed.

6.5 CSD may decide to complete a Core Assessment to get more information about the family's situation. At any point during this they may decide there is reasonable cause to believe the baby is likely to suffer significant harm and initiate a S.47 inquiry.

6.6 The optimum time for an Initial Child Protection Conference for an unborn baby is between 28-32 weeks.

7 SAFEGUARDING HOSPITAL BIRTH PLAN

7.1 A safeguarding hospital birth plan must be created by 34 weeks gestation, *(If a decision for a home delivery is taken a safety plan would need to be agreed for delivery in the home)*. This will detail the planning for delivery and immediate post natal period. Where there are concerns about a family irrespective as to whether the unborn baby is subject to a child protection plan, a safeguarding birth plan should be agreed. The detailed safeguarding birth plan must be kept where practitioners can access its contents in and out of hours to enable midwives to know how to respond during and post delivery. The birth plan should be shared with parents unless to do so is felt to put the mother or baby at increased risk.

7.2 The safeguarding hospital birth plan should include contact numbers and names of professionals involved and clear directions as to where the child should go post delivery depending on the risk. Where CSD have the lead professional role, it is the responsibility of the allocated social worker to ensure that CSD 'Out of Hours' are made aware of the safeguarding plan. It is the responsibility of the midwife agreeing the birth plan to ensure that other health practitioners involved are informed, for example the obstetrician, neonatologist, GP, HVs and the safeguarding team. All agencies should know what role they have at this time and be clear about their responsibilities.

7.3 Appendix Three provides guidance for midwifery practitioners on the information required for a safeguarding birth plan and is a useful tool at any other meeting where a safety plan is being developed.

7.4. Plans for discharge for babies identified by this protocol are usually made at the birth planning meeting. Where this is has not occurred discharge plans should be discussed with CSD and or other involved agencies and a pre birth discharge meeting arranged if required. It should be recognised that hospitals are not secure settings. Any safeguarding hospital birth plan should consider

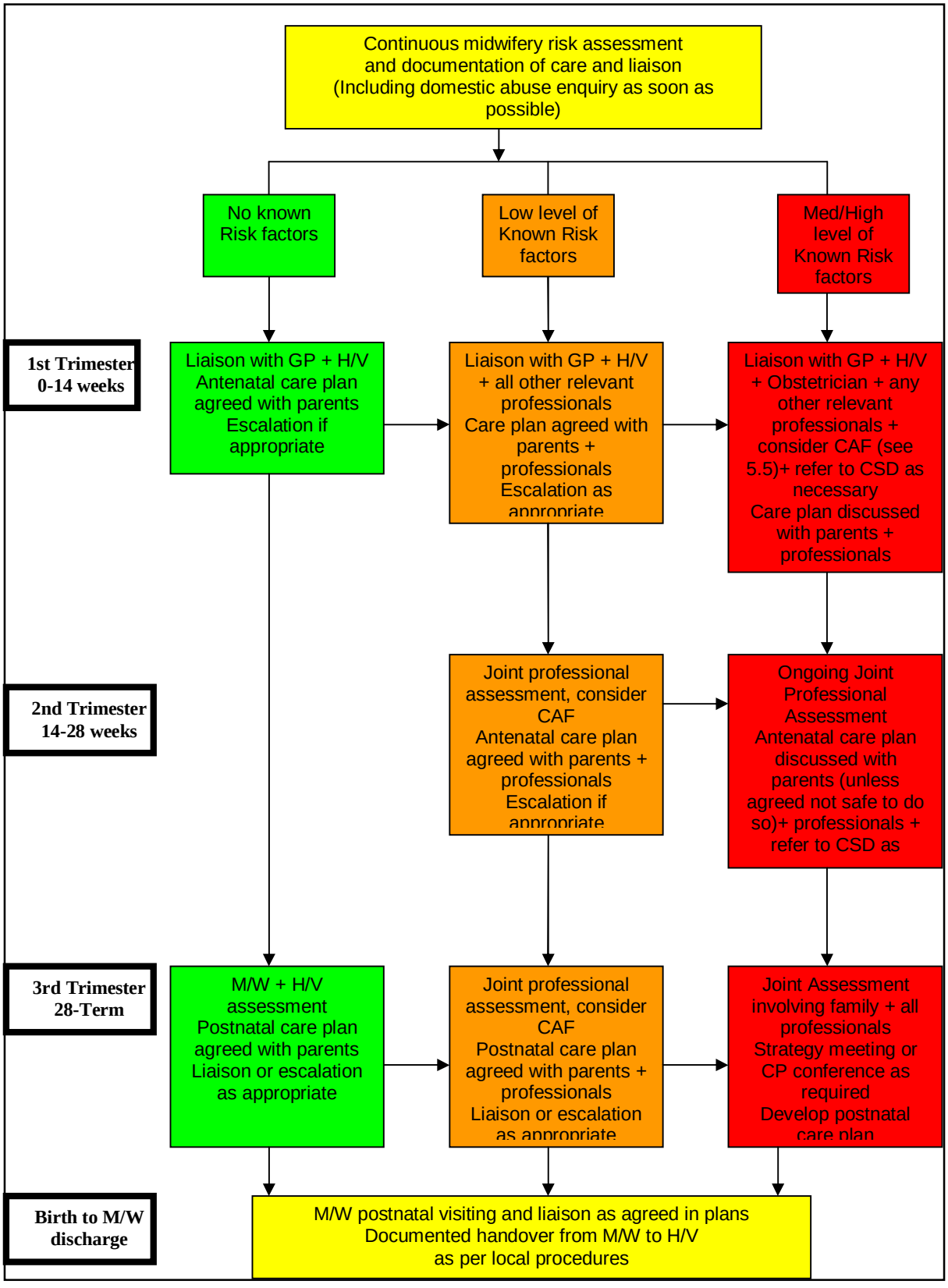
discharge in line with any existing child protection plan or other orders that CSD may have taken.

7.5 In situations where there is a delay in discharge of mother and baby due to social reasons as opposed to medical requirements this needs to be agreed on an individual basis. If a hospital extension is required for social reasons only, risk assessments need to consider the role of the midwife and the risks to the baby. The hospital can in these situations charge the Local Authority for the extended stay. It must be remembered however that midwifery units are not a place of safety and supervision may need to be put in place by CSD

7.6 The pre birth risk assessment may conclude that the baby would be at significant risk of harm to stay within the family following birth. In these circumstances CSD may plan to apply to the courts for an order to remove the baby following birth as applications cannot be made prior to birth and this should be conveyed to the mother and father/partner. It is however the decision of the courts whether to grant an order and alternative care and management of the baby will need to be agreed by all partners if this is refused. If CSD are applying to court for an order the court will require a number of days to list a courts hearing. There will need to be a safety plan for the new born baby between the application being made and the date of the hearing. Police protection arrangements may need to be considered as part of the safety arrangements and the police should routinely receive a copy of the safety plan. If police protection is agreed this can last up to 72 hours but this is not automatic and there should be an agreement in place how long this will be required for and recorded.

APPENDIX ONE: Risk assessment flow chart

Abbreviations: GP General Practitioner, HV Health Visitor, MW Midwife, CAF Common Assessment Framework, CSD Children's Services Department, CP Child Protection * Relevant practitioner your safeguarding lead, A common assessment process will also refer to any other locally agreed assessment



APPENDIX TWO: Contact numbers for Midwifery Services

Maternity (Hospital) numbers

Southampton Tel 023 8079 6333 – Named Midwife

Portsmouth Tel: 023 9228 6000 – Maternity Bleep Holder 1333

Winchester Tel: 01962 824231/2 – Labour Ward

Basingstoke Tel: 01256 313351 – Triage Suite

Frimley Park Tel: 01276 604035 – Central Delivery Ward

St Mary's Isle of Wight Tel: 01983 534334 – Labour Ward

APPENDIX THREE
Generic Check List for Safeguarding Birth Planning –

CONSIDERATION	YES/NO	PLAN	IF ACTION REQUIRED WHO IS RESPONSIBLE?
Can mother have unsupervised contact with the baby once born?			
Intended stay in hospital after delivery			
Is there anybody who cannot have unsupervised contact?			
Is there anybody who should not be present at the birth?			
Are there any reasons why the mother should not have contact with the baby at birth?			
Are there any concerns about the partner?			
Are there any mental health concerns?			
Does mother or partner have a Learning Difficulty/Disability?			
Are there any issues regarding drug or alcohol abuse?			
Is the baby likely to have withdrawal symptoms?			
Are there any barriers to communication? i.e. language, literacy, learning disability etc. (consider both parents)			
Is there a likelihood of a home birth or mother attending a different			

hospital? If the answer is Yes – Alert other hospitals and ambulance service.			
Will Police Protection be required or need to be considered?			
Are the Local Authority planning to apply for and Emergency Protection Order/Interim Care order?			
Is the Local Authority planning to accommodate under Section 20 of the Children Act 1989?			
If parents have agreed to Section 20, what is the contingency if they withdraw consent after birth?			
When will the Emergency Duty Team be advised of the plan and who will do this?			
Does hospital security need to be informed of plan- if so who will do this?			
Have parents been provided with a copy of the birth plan, if not when will they be?			
If the birth plan cannot be shared, why not and who has agreed this? (usually via legal advice)			
Have all agencies been advised of the plan?			
Arrangement/s for the Named Social Worker to visit mother and baby in the post natal period if being placed before the court?			

Any other information?			

Date completed _____

Social Worker – Name _____

Signature_____

Midwife – Name _____

Signature_____

Team Manager/Senior Practitioner – Name _____

Signature_____