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Stoke-on-Trent Safeguarding Children Board

PROCEDURES FOR CHILDREN IN SPECIFIC CIRCUMSTANCES

RESPONDING TO CONCERNS ABOUT UNBORN CHILDREN

Section D 10

Version 7: October 2017
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D 10 Responding to concerns about unborn children

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01 Potential Risk to an Unborn Child

1.1 Working together 2015 states that Assessments for some children – *including unborn children where there are concerns*, will require particular care. Where a child has other assessments it is important that these are coordinated so that the child does not become lost between different agencies involved and their different procedures.

1.2 However the timescale of pregnancy does not readily fit with multi-agency safeguarding procedures duty to investigate (Section 47Children Act 1989) or with the timescales associated with the new Framework for the Assessment of Children in Need.

1.3 In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm to an unborn child. The circumstances, lifestyle and/or personal history of the parents, may indicate sufficient concern that the needs of the baby might not be met.

1.4 The situations that require assessment and pre-birth Child Protection Conferences are listed in Section 4 of the policy.

02 Pre-Birth Referral and Assessment

2.1 The purpose of this procedure is to provide all contributing agencies with clear expectations as to how concerns will be dealt with. All agencies involved with pregnant women should consider the need for an early referral to Children and Family Services, Children's Social Care (CSC) so that assessments are undertaken and family support services provided as early as possible in the pregnancy. It is important that pregnant women receive timely support from the correct service. All agencies must work together with partners to share information and offer a plan of support even if the threshold for specialist safeguarding services has not been met. The Early Help Assessment should be utilised where appropriate.

2.2 Early intervention is essential in ensuring that unborn babies for whom risks are identified are given the best possible chances and to reduce the need for statutory assessment and intervention. This may be achieved through the Early Help Assessment process, which can be instigated by any professional who considered there is an unmet need, or by a direct referral to another service e.g. substance misuse services. Practitioners should always discuss their concerns with the pregnant mother unless to do so would put the unborn child at increased risk of significant harm.

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2.3 All professionals involved with pregnant women where there is concern about the wellbeing of the unborn child or who considers there is an unmet need should give consideration to undertaking an Early Help Assessment. Additional concerns that emerge as part of the assessment process will help practitioners decide whether those additional concerns can be addressed at a lower level or whether the concerns are such that statutory intervention is required.

2.4 Where agencies or individuals anticipate that an unborn baby may be at risk of significant harm, a referral to the Safeguarding Referral Team (SRT) must be made as soon as the concerns are recognised – (See Referrals Procedure).

2.5 Should practitioners be at all unsure as to whether they should make a referral, they should discuss their concerns with their line manager or with their designated or named professional for child protection. Delay must be avoided when making a referral in order to:

- Avoid initial approaches to parents in the last stages of pregnancy at what is already an emotionally charged time;

- Provide sufficient time for a full and informed assessment;

- Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome;

- Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth;

- Provide sufficient time to make adequate plans for the baby's protection.

2.6 Concerns should be shared with prospective parent/s and consent obtained to refer to the Safeguarding Referral Team unless this action in itself may place the welfare of the unborn child at risk e.g. if there are concerns that the mother may be at risk of harm or that the parent/s may move to avoid contact with professionals. For further guidance see the Information Sharing Protocol.

2.7 For any referral for support services, consent must be gained. If such consent is refused then consideration must be made about how this affects the identified risk factors for the unborn child.

2.8 Workers from agencies whose primary responsibility is to the welfare of the prospective parent may feel worried about the impact of making a referral and the parent's continued engagement. This may be of particular concern where engagement with their service will be necessary to reduce risks to child (i.e. Drugs and Alcohol Service, Mental Health Services). **However, the needs of the unborn child should be paramount over all other considerations.**

2.9 Workers from such agencies should discuss their concerns with Children's Social Care to consider the most effective way of constructively engaging the parent(s).

2.10 The Resilience and Risk tool / Guide to Levels of Need documents may help professionals in their decision making process when considering making a referral. This will help you to form your analysis of presenting risk whilst also encouraging the professional to highlight and consider individual resilience in order to avoid delay.

03 Identifying Risks

3.1 Serious Case Reviews and other child death enquiries over many years have identified a range of risk factors which should alert professionals to the possibility that a child may be at risk. Many of these factors can be identified prior to birth and should form the basis for referral. The most significant are:-

- Parents where previous children have been removed from their care. (Including Residence Orders made to other family members).

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- Parents who have offended against children or otherwise are demonstrably a 'Risk to Children.'
- Domestic Abuse.
- Substance misusers not cooperating with treatment.
- Parents with learning or untreated mental health difficulties with limited parenting capacity, particularly where there is inadequate family support.
- Parents with a history of abuse and/or neglect within childhood presenting concerning behaviour/attitude towards pregnancy and support services. (Including those who have 'looked after' by the Local Authority)
- Unstable/chaotic households, unprepared or unsuitable for a baby.
- Young vulnerable parents.
- Young vulnerable parents who are currently looked after by the local authority
- Vulnerable parents expecting twins/triplets etc.
- Where concerns that a pregnancy is being or has been concealed.

3.2 This list is not exhaustive and should not discourage taking action where concerns not listed are identified.

3.3 More than one risk factor should, of course, heighten concerns.

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04 Referral for an unborn child

4.1 All telephone referrals to Children's Social Care, Safeguarding Referral Team (SRT) should be followed up in writing using the Multi-Agency Referral Form (MARF). On receipt of referral and where appropriate, the Children and Family Services will carry out a Pre-birth Assessment in conjunction with information to be provided by either:

- the referrer
- The Community Midwifery Office at the University Hospital of North Midlands.

4.2 The overall aim of the pre-birth assessment is to:

- Gain an understanding of the parents' past history, life style and support networks, and how these factors may impact on the child's welfare;

- Identify risk factors which may indicate a likelihood of the baby suffering significant harm; and

- Identify the parents' needs and whether they have effective support networks.

4.3 The person receiving the referral will ask for the following details:

- prospective parents names and dates of birth

- the expected date of delivery

- Address (es)

- Names of any previous children and dates of birth

- Details of any other family members or significant people connected to the household

- The details of the concerns

- Whether the family is aware that the referral is being made

- Details of any other professionals involved who may have relevant information about the concerns.

- Details of any historical significant events

4.4 Referrals to be made to the Safeguarding Referral Team (SRT).

4.5 Stoke-on-Trent Children's Social Care should acknowledge a written referral **within 24 hours** of receiving it. On completion of the pre-birth assessment one of the following options can be applied:

- No further action
- Step down to Early Intervention Service
- Request targeted services via the local children's centre
- Refer to another service / agency
- Undertake a specialist assessment i.e. parenting assessment
- Provide Child In Need services (Level 4a) a Child In Need Plan will be formulated
- Where there are significant safeguarding concerns, initiate child protection procedures
- Complete a Single Assessment.

4.6 From 28 weeks gestation onwards a decision could be made to convene a pre-birth Initial Child Protection Conference if the pre-birth assessment identifies that the unborn child may be at risk of significant harm.

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05 Referrals Received During the First 20 Weeks of Pregnancy

5.1 Stoke-on-Trent Safeguarding Referral Team (SRT) will accept referrals of unborn children as early as the first booking appointment should concerns arise. SRT will then transfer the referral to a Safeguarding and Support team. If a professional working with the mother has concerns for the unborn child and/or the mother, a referral should be made for additional support at any point during pregnancy.

5.2 Parents are asked to consent to the assessment and to agree to the social worker obtaining information from and sharing information with other agencies. It is essential that full and thorough checks are completed.

5.3 An unwillingness to consent to the assessment or to contact other agencies will lead to the initiation of safeguarding procedures.

5.4 Where case records exist, including those held by other local authorities, either because there have been concerns about a previous child, or because one or both of the parents were previously looked after, or otherwise had significant agency involvement, the social worker should plan to view the information as soon as possible.

06 Referrals Received in the Second Half of Pregnancy

6.1 Clearly at this later stage of pregnancy there is less time to assess the child's needs, including the parents' potential for change before the baby is born. Where there are concerns which identify a potential risk to the unborn child, Section 47 procedures should be initiated, with full and detailed lateral checks and strategy discussion.

6.2 The decision of the strategy discussion is likely to be under 'Section 47 legislation and to convene a further strategy meeting, if time permits before 28 weeks pregnancy.

6.3 The reasons for late referral should be clearly identified as this may be relevant to the assessment.

6.4 A multi-agency strategy meeting should take place no later than **30 weeks into the pregnancy**. This should be chaired by a Principal / Practice manager from Children's Social Care.

6.5 The meeting should consider whether or not an initial child protection conference is required.

6.6 If all professionals attending the meeting agree that this is not required, a service plan should be drawn up with a review planned according to the needs of the family. However should there be disagreement among professionals about potential risks, then an initial child protection conference should be agreed.

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6.7 If the referral is received after 30 weeks pregnancy, there may be insufficient time for a multi-agency strategy meeting. The strategy discussion will make the decision to proceed to an initial child protection conference.

6.8 Except in cases of very late referrals, social workers should aim to convene an initial child protection conference 8 weeks before the expected date of delivery.

07 The Pre-Birth Risk Assessment

7.1 The overall aim of the pre-birth assessment is to:

- Gain an understanding of the parents' past history, lifestyle and previous support networks and how these factors may impact on the child's welfare;
- Identify risk factors which may indicate a likelihood of the child suffering significant harm; and
- Identify the parents' needs and whether they have effective current support networks

7.2 All assessments must be completed within a maximum 45 working days and all relevant agencies informed of the assessment outcome.

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08 The Role of the Father/Partner

8.1 It will be essential to check out at an early stage the role that the father and/or any current partner will play in the child's life and to include them in the assessment as appropriate. Whether or not the father/partner will have Parental Responsibility should not influence the decision about their involvement in the assessment, and full agency checks should be completed on any adults who will have substantial care of the child.

8.2 Social workers should be alert to the possibility of domestic abuse when a partner attends all appointments with professionals with the mother and is reluctant to allow her to be seen alone.

8.3 Where vulnerable young people present as parents, consideration must be given to assessing them as Children in Need in their own right.

09 Multi Agency Strategy Meetings

9.1 Through whichever route the referral has progressed the aim should be to hold a strategy meeting with all relevant professionals to coordinate agency support. Parents do not usually attend strategy meetings. However, given that a strategy meeting about an unborn child is unlikely to involve a criminal offence against a child, it may be reasonable for parents who are fully

cooperative with professionals to attend part or all of such meetings. Where parents are hostile and/or uncooperative the normal procedure for strategy meetings for professional attendance only should apply. Professional agreement should be reached regarding potential parental attendance in advance of the meeting.

9.2 The meeting should explicitly consider the need for an initial child protection conference. If all professionals attending the meeting agree that this is not required, a child in need plan may be drawn up with a review planned according to the needs of the family. However should there be disagreement among professionals about potential risks, then an initial child protection conference should be agreed.

10 Pre-birth Child Protection Conferences

10.1 A pre-birth conference is an Initial Child Protection Conference concerning an unborn child.

11 Thresholds for Conference

11.1 Pre-birth conferences should always be convened where there are concerns that an unborn child may be at risk of Significant Harm and there is a need to consider if a multi-agency Child Protection Plan is required.

11.2 Such a conference should have the same status, and proceed in the same way, as other Initial Child Protection conferences, including decisions about a Child Protection Plan. Child protection review conferences should also proceed in the same way. The involvement of midwifery services is vital in such cases.

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11.3 A pre-birth conference should be held:

- Where a pre-birth assessment gives rise to concerns that an unborn child may be at risk of Significant Harm; or
- A previous child has died or been removed from parent/s as a result of Significant harm; or
- Where a child is to be born into a family or household which already have children who are the subject of a Child Protection Plan.

12 Time of Conference

12.1 The pre-birth Initial Child Protection Conference must be held by 30 weeks gestation or as soon as possible thereafter. This is to allow as much time as possible for planning support for the family.

13 Attendance

13.1 Parents or carers should be invited as they would be to other Child Protection Conferences (See Initial Child Protection Conference procedure C05) and should be fully involved in plans for the child's future. All relevant professionals involved with the family both pre-birth and post-delivery must be invited to attend.

13.2 The social worker must ensure that an invitation is sent to the community midwife, the maternity service at the hospital where the baby will be delivered and health visitor. The invitations must be sent individually as one invitation to midwifery services is insufficient as they are different departments.

13.3 All professionals should give high priority to attendance at pre-birth conferences if requested. Professionals who normally attend a child protection conference must be invited, and any agency involved with the parents (Drugs/ Alcohol Services, Mental Health, Disability Service, Leaving Care).

13.4 If attendance is not possible, they should ensure that another professional from their agency takes the relevant information or that the information is presented to the Chair of the conference in report form. The conference may not be viable if relevant professionals are not present.

13.5 Local authority legal services should be invited where legal action is being considered or where legal advice may be required.

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14 Decision Making

14.1 If a decision is made that the child needs to become the subject of a Child Protection Plan, the category must be determined by the main risk factor. The name included on a Child Protection Plan should be **'baby'**, followed by the mother's family name and the expected date of delivery. The key worker must update the ICS system with the child's name and date of birth as soon as they are notified.

14.2 If the parents have not attended the conference, they should be made aware of the outcome at the earliest opportunity, unless to do so would put the child at further risk of significant harm.

15 Child Protection Plans

15.1 The Child Protection Plan should specifically include details around the birth such as:

- antenatal plans

- admission to hospital and discharge plans
- delivery plans – to include length of stay in hospital taking into account the clinical needs of mother and /or baby and any visiting arrangements for professionals and family in hospital, both in delivery and maternity wards, and at home
- contact arrangements
- discharge arrangements; in particular if the child is to be removed – how this will be done and a plan shared with the hospital
- makes clear recommendations in relation to any legal advice/action to be taken.

15.2 The Core Group must be established and meet within 10 working days of the Conference. Further meetings may be held prior to discharge of the baby and within 14 days of the child's birth. As part of the Child Protection Plan every Initial Child Protection Conference should record a recommendation about whether the child can return home with the parents.

15.3 If it is recommended that the baby should not be discharged to the care of the parent(s), Children's Social Care will seek legal advice. If Children's Social; Care cannot, or decide not to, take action to stop the child being discharged home with the parent(s) a Child Protection Conference must be re-convened within seven working days of this decision.

15.4 If any person is deemed to be a risk to the baby, mother and/or staff, a decision must be taken as to whether or not they can be present at the birth, or visit the child and mother. If it is agreed they can visit, a written statement must include the need for supervision and who will be responsible for this.

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16 Timing of Child Protection Review Conference

16.1 The first Child Protection Review Conference will follow normal Child Protection Review Conference procedures or within one month of the child's birth, whichever is earlier.

17 Child in Need Plans

17.1 In some instances, it may be that while concerns exist, they do not cross the 'significant harm' threshold. In other cases, it may that it appears that there is a good prospect of achieving any necessary changes prior to birth. In such cases, while in the early stages of any intervention, it may be more appropriate to provide a service to the prospective parents that will address need, or to test the potential to make changes (i.e. to test motivation to engage with substance misuse agencies etc.). A Child in Need plan should be

drawn up which details the changes that are required, the services which will be provided to assist, the nature of any on-going monitoring and the consequences should the required changes not be achieved. A date to review the Child in Need Plan should be agreed in accordance with Children's Social Care procedures.

17.2 Where files exist which are held by another Local Authority, either because there have been concerns about a previous child, or because one or both parents were previously looked after, or otherwise significant agency involvement, the social worker should plan to view the information as soon as possible. This should be an agreed action for the service plan.

17.3 The Child in Need plan should be reviewed by a meeting involving all appropriate agencies at around 24 week's pregnancy.

17.4 Where the Child in Need Plan Review identifies safeguarding concerns, either because the required changes have not been made, or because further concerns have come to light, the meeting should agree a way forward with the consideration of further assessment. The tasks and responsibilities for parents and professionals should be set out, with agreed timescales for completion.

18 Pregnant Women Who Are Missing

18.1 The loss of professional contact with a pregnant woman where there are safeguarding concerns for the unborn baby must always be taken seriously. Once loss of contact is established, the police and line manager should be notified and all agencies should be proactive in making efforts to locate the woman. All actions taken must be recorded. The following procedure should be followed:

- The agency identifying the missing woman should inform their relevant line Manager
- Measures should be taken to trace the woman informally through family, friends, neighbours etc. as is considered reasonable and appropriate. Information systems should be checked countrywide
- Enquiries should be made through other local agencies involved with the woman/unborn baby
- In conjunction with the police and family as appropriate, consideration must be given to tracing the woman with the help of the media
- Children's Social Care should initiate a strategy meeting, involving the police, midwife and any other relevant agency to develop a plan to locate the woman and put in place measures to safeguard the baby when born
- Children's Social Care should give consideration to circulating the woman's details and the concerns about the unborn baby to other Local

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Authorities and Hospitals if all other avenues have proved unsuccessful. This should be regarded as a last resort.

18.2 A nominated individual will need to take responsibility for circulating other Local Authorities.

18.3 The social worker must provide the following details:

- Woman's name
- Date of birth
- Description
- Estimated date of delivery
- Name and date of birth of any person the woman may be with
- Reason for concern
- Other information necessary to raise concern upon encounter, or other identifiable features, particularly where names are unlikely to identify
- Enough information necessary to enable an Emergency Duty Worker to react appropriately
- Contact points, including out of hours arrangements
- Scope for circulation, i.e. likely destinations

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18.4 Where there may be reason to believe that the woman has left the country, contact may be made with International Social Services (0207735 8941).

18.5 The progress of plans made at the strategy meeting should be reviewed regularly and the frequency of which should also be agreed at the meeting.

19 Surrogacy

19.1 It is the responsibility of the individual who is providing carer to the host mother to:

- **Ensure good communications with the commissioning couples GP, Local Maternity Unit and Health Visiting Team.**

The Human Fertilisation and Embryology Act (1990) says that no surrogacy arrangement is enforceable by law. The position remains that a local authority needs

to make enquiries when it knows that a baby has been or is about to be born as a result of surrogacy so as to be satisfied that the baby is not, or will not be, at risk as a result of the arrangement. However, local authorities can be assured that when the treatment has been undertaken by a licensed clinic, it will have been undertaken in accordance with the Code of Practice published under Section 25 of the 1990 Act and with regard to Section 13(5) which requires account to be taken of the welfare of any child who may be born as a result of the treatment.

Arrangements may also have been undertaken on an informal basis without referral to a licensed clinic. Where the circumstances of the birth or subsequent arrangements for the baby are not clear, hospital or social work staff may be alerted. Under the Children Act 1989, an emergency protection order will not be available unless Section 44(1)(a) is satisfied. In other situations where the local authority has been unable to satisfy itself that the child is not at risk, the local authority responsibility for checking the wellbeing of the child arise where no licensed treatment centre has been involved.

(Local Authority Circular LAC (94)25) The Human Fertilisation and Embryology Act (1990)

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