Newham Pre Birth Protocol

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1. Purpose

1.1 This multi-agency protocol has been developed for professionals working with pregnant women where there is a likelihood of safeguarding concerns. This protocol should be read in conjunction with the latest edition of the London Child Protection Procedures and Working Together to Safeguard Children Guidance (2015). For London Borough of Newham staff, please also refer to local safeguarding polices. For Barts Health staff, please refer to Safeguarding Children's Policy on the intranet.

1.2 This protocol will provide practitioners with a clear pathway when undertaking pre-birth assessments and escalating to S47 enquiries/Child Protection conferences. The aim is to promote early and effective responses to pre-birth referrals and assessments.

1.3 Between 2007 and 2009, 47% of all Serious Case Reviews (SCR) related to babies under the age of one year. Evidence has shown that under one's are eight times more likely to be killed than any other age group (Smith, 2011). The NSPCC highlight that the risk is greatest in the first three months post birth, and perpetrators are most commonly parents (Cuthbert et al 2011).

Learning from SCR's highlight that concealed pregnancy and lack of antenatal care can be indicators of harm.

"Effective child protection work depends on professionals having a framework for thinking which enables them to bring together information from many sources." Beyond Blame, Reder et al 1993.

1.4 Working Together to Safeguard Children 2015:

Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision.

Early sharing of information is the key to providing effective early help where there are emerging problems. At the other end of the continuum, sharing information can be essential to put in place effective child protection services. Serious Case Reviews (SCRs) have shown how poor information sharing has contributed to the deaths or serious injuries of children.

Fears about sharing information cannot be allowed to stand in the way of the need to promote the welfare and protect the safety of children. Please refer to the Working Together to Safeguard Children guidance for agency specific guidance.

2. Background

2.1 Women ideally should be booked for antenatal care at the NHS Trust local to where they live by 12 weeks of pregnancy. However, women have the right to choose where they want to have their maternity care. The initial contact with a midwife (MW) is usually a booking appointment where the mother is asked detailed questions about her medical and social history. The midwife will make assessments of risk based upon the information that the woman provides and other information that may be made available to the midwife at the appointment. The midwife will make necessary referrals at the booking appointment. Referrals to Children Social Care (CSC) will be made at this time should any safeguarding concerns be identified.

2.2 Antenatal appointments are arranged to meet the needs of the mother with plans of care made at the booking appointment, changing if complications arise. Pregnant women with complex social factors may need additional support to use antenatal services (NICE 2010) Appointments are scheduled according to medical/social need with the frequency of appointments increasing in the third trimester.

2.3 Midwives will continue to provide maternity care until the baby is between 10-28 days old, or up to 42 days in some cases, when care is then transferred to the Health Visitors Service. Health visitors will undertake the New Baby review when the baby is between 10-14 days old.

2.4 The Acorn Team midwives provide enhanced maternity care to women with additional vulnerabilities who are booked at NUH. These include significant mental health issues, domestic abuse, learning disabilities, young mums and also women with complex safeguarding concerns. They will see women both in the hospital and at home more frequently than women without additional concerns are seen. They provide postnatal care at the woman's home until the baby is up to 42 days old. They may also provide care in labour.

2.5 Health Visitors (HVs) in Newham are informed of ALL women who are booked for a pregnancy at Newham University Hospital (NUH). Where there are additional vulnerabilities/safeguarding issues raised, the midwives should complete the Midwife to Health Visitor Liaison Form outlining what the additional concerns are and what referrals have been made. Health Visitors/Family Nurses in Newham will arrange an antenatal contact with women from 28-34 weeks of pregnancy or earlier where there are additional vulnerability/safeguarding issues.

2.6 The Family Nurse Partnership (FNP) is a home visiting programme for young mums, aged 19 or under in Newham and having their first child. The FNP is a maternal and early year's public health programme in which local family nurse support mothers and their babies. It replaces the Health Visitor role up until the child reaches two years of age, and provides intensive support and advice during this time. Family nurses work with first time mums with

the aim of enabling them to achieve the best possible health during pregnancy and child development. They also support parents' to build their beliefs and ability to plan and achieve their goals such as employment or returning to education. Referrals to FNP should be made prior to 28 weeks of pregnancy.

2.7 Newham Perinatal Mental Health Team (PMHT) provides specialist mental health assessment, monitoring and treatment to women in perinatal period (women from pre conception up to 1 year post birth) who have moderate to severe mental health illnesses. If mental health is a concern there must be liaison with PMHT and they must be included in all stages of the assessment and child protection process.

2.8 Newham Change, Grow, Live (CGL) is the service that provides support to people who are abusing substances and alcohol. There is a joint fortnightly clinic for pregnant women between CGL and Newham Maternity services.

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2.6 Pregnancies booked at other hospitals should be discussed with the Named Midwife for safeguarding at that Maternity Unit. Local units to Newham are:

Newham University Hospital (Barts Health NHS Trust): 0207 363 8516 / 07799 895 151

Whipps Cross (Barts Health NHS Trust): 0208 539 5522 ext 6733

Royal London Hospital (Barts Health NHS Trust): 0203 594 2547/2547 Mobile: 07824 478 371

Homerton Hospital, Hackney: 0208 510 5759

Queens Hospital, Romford: 01708 503 892 / 2836

3. Principles of a pre-birth single assessment.

3.1 Hart (2000) states that there are 2 fundamental questions when deciding whether a pre-birth assessment is required:

- Will the new born baby be safe in the care of the parents/carer?
- Is there a realistic prospect of the parents/carers being able to provide adequate care throughout childhood?

3.2 Barlow et al (2014) states: *Infants identified as being at significant risk of maltreatment need adequate protection within a time frame consistent with their developmental needs.* This highlights the significance of an early response to pre-birth referrals and the need for a robust plan for support and protection at an early stage, to support secure development in the child's early stages, as well as detection of signs of neglect.

3.2 The main purpose of the pre-birth assessment is to identify:
- What the needs of the new-born are?
- What risks are posed?
- Analysing the capacity of the parent/s to respond appropriately to the baby's needs
- Reducing the risks

3.3 The pre-birth assessment should identify support that the parent/s may need/already have.

3.4 The pre-birth assessment should be undertaken by the allocated social worker but is informed by liaison with the wider multidisciplinary team that are working with family. For

example, midwives, health visitors, GP's, perinatal mental health team, teachers, police, probation, etc.

3.5 The allocated social worker should lead on making appropriate referrals based on identified needs.

3.6 During the pre-birth assessment the social worker will request agency checks; this will include the family general practitioner in addition to specialist services that the family may be known to. It is expected that requests for information are responded to in a timely way so that there are no delays in the pre-birth assessment.

4. Indicators for a pre-birth single assessment

4.1 Pre-birth assessments should be considered on all pre-birth referrals where the following factors are present:

- Parental mental health that may impact on the safe care of the baby
- Domestic Abuse/Violence is disclosed
- Parental substance misuse
- A parent/relative or associate who may represent a risk to children, or who has previously harmed a child. (This would include issues such as a violent history; significant criminal history; sexual offences against adults or children etc)
- Pregnancy to a Looked After Child or Leaving Care young person
- Harmful practices i.e. forced marriage, risk of honour based violence
- Previous children removed from the care of either parent
- Previous CIN/CP plans within families
- Parental criminality
- Concealed pregnancies
- Where the parent/s intend to relinquish baby for adoption at birth
- Pregnancy to an under 16yr old
- Vulnerable young woman where concerns raised regarding Child Sexual Exploitation
- Concerns around sexual abuse within the family
- Learning disability that may impact on the safe care of the baby
- Physical disability in the parent/s that may impact on the safe care of baby
- Risk of Female Genital Mutilation/Cutting

- Sex workers
- Parent/s previously suspected of fabricated induced illness (FII)

This list is not exhaustive; if there are concerns that the baby is at risk of significant harm then a pre-birth assessment should be undertaken.

5 Concealed pregnancies

Findings from SCR tell us that lack of antenatal engagement can increase risk to babies. Women choose to not engage with maternity services and conceal their pregnancy for a range of reasons. It is vital that careful consideration is given when assessing the given reason for concealment. This could include:

- Previous children removed from the parents' care
- Fear that the baby will be taken away
- Domestic abuse
- Mental Health difficulties
- Learning disabilities
- Chaotic lifestyle
- Substance misuse

This list is not exhaustive.

Maternity guidelines state that ALL babies who are born to a mother who has not received antenatal care will be referred to social care. Referrals from maternity should include the reason for concealment, if the mother has made preparations for this baby, etc.

6 Surrogacy

6.1 Surrogacy is legal in the UK, with reasonable expenses only being paid to the surrogate mother. Surrogacy arrangements are not legally enforceable.

6.2 A professional in any agency may become aware of the surrogacy arrangement and have concerns about:

- The suitability of the intended parents to care for the child;
- Conflict between the adults in a surrogacy arrangement e.g. that the surrogate mother is under pressure to relinquish the child against her will;
- The expenses for carrying the child being reasonably incurred, having regard to Section 54(8) of the Human Fertilisation and Embryology Act 2008 or not.

6.3 An unborn or new-born child in these circumstances could be at risk of physical and emotional abuse and / or neglect. In these circumstances, all staff have a responsibility to safeguard and promote the welfare of the unborn or new-born child, and professionals should follow the procedures for referral to children's social care clearly stating the

Safeguarding concern. Children's social care responses should be proportionate to what are likely to be very individual circumstances, and legal advice should be sought.

7 Completing the Assessment

7.1 A pre-birth assessment will be conducted by a social worker within the Neighbourhood Assessment Team in one of the four neighbourhoods in Children Social Care. In families already known to children social care the current social worker will complete the pre-birth assessment. This will be in the form of a pre-birth Single Assessment under Section 17 (Child in Need) or Section 47 (Child in need of protection) of the Children Act 1989.

A Child in Need (CIN) is such that would be unlikely to achieve developmental milestones without a multi-agency approach to intervention.

A Child in need of protection is where the Local Authority has reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm.

7.2 If a *child* is looked after/leaving care and the *mother* becomes pregnant, the allocated social worker will make a referral to Triage for a pre-birth assessment. This will be undertaken by the Neighbourhood Assessment Team.

7.3 If the expecting parent is a Looked After Child (LAC), the allocated social worker will make a referral to Triage for a pre-birth assessment. This will be undertaken by the Neighbourhood Assessment Team.

7.4 If the expecting parent is a Leaving Care young person, the allocated social worker/key worker should liaise with the respective Practice/Team Manager and the Hospital Liaison Practice Manager to discuss the need for referral, and possible support. Should this require a pre-birth assessment, the allocated social worker will make a referral to triage for a pre-birth assessment. This will be undertaken by the Neighbourhood Assessment Team. If the threshold for assessment is not met, the named Key Worker should progress with a family meeting to develop a support/birth plan.

7.5 Where a teenage pregnancy is referred, the mother and unborn child will have different social workers for the single assessment to ensure the needs of each are captured in their own right.

7.6 Pre-birth single assessments can commence as early as six weeks gestation. Pregnancy and Estimated Date of Delivery (EDD) should be confirmed as part of Triage research.

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7.7 Pre-birth referrals made by internal Children's Social Care Teams (Intervention/LAC/Leaving Care) should be at 12 weeks gestation or once the pregnancy is known. A referral/planning meeting should be arranged within one week between the referring and receiving teams to discuss the case and respective responsibilities/joint

planning. Consideration should also be given to referral to the Family Nurse Partnership (FNP) for enhanced health visiting/parenting support. Referrals to FNP must be prior to 27 weeks gestation.

7.8 All pre-birth referrals should have a multi-agency meeting within 14 days of allocation. For pregnancies that are not booked at NUH, the Named Midwife for Safeguarding at NUH should be alerted.

7.9 All pre-birth assessments must incorporate household members including significant others who do not reside in the home e.g. partners and be subject to relevant multiagency checks, including police checks where necessary. Rationale should be given when the father is not involved in an assessment. This is in line with learning from SCR relating to hidden men. Refer to 'Hidden Men – learning from Serious Case Reviews'.

8 Strategy meetings

8.1 In all pre-birth cases where a child protection investigation (Section 47) is considered, the following process must be followed as per the Newham Local Safeguarding Children's Board Multi Agency Strategy Protocol

http://newhamchildcare.proceduresonline.com/pdfs/ch_protect_strat_meet.pdf

- Allocated social worker or the team manager will complete an 87a proforma for discussion with the police

- Police strategy discussion (consider the need for a joint or single agency investigation)

- Within 72 hours of the Police discussion, a multi-agency strategy meeting is to be convened. This meeting must include maternity, and where appropriate professionals involved with any other children. Other agencies include: GP, Mental Health, Substance Misuse, Health Visitor, School, Police, Family Support Worker, Housing, Domestic Violence worker, Probation worker, etc
- The multi-agency strategy meeting will consider the information shared and whether the threshold is met for a child protection investigation, setting actions as necessary. Professionals should consider the need for a Child Protection Conference at this meeting.
- A child protection conference, where decided, must take place within 15 working days from the multi-agency strategy meeting.

8.2 Child Protection concerns should be addressed at an early stage where identified, and the multi-agency network made aware of a multi-agency strategy meeting date in advance within pre-birth timescales.

8.3 Where the assessment is completed prior to 24 weeks, and there are indicators of child protection concerns, the case will transfer to the Neighbourhood Intervention Team under a Child in Need (CIN) Plan. This plan should specify the need for a reviewed assessment prior to the child protection timescales.

9 Initial Child protection conferences (ICPC)

9.1 A pre-birth Child Protection Case Conference acts as an Initial conference. This should take place as early as possible during the pre-birth stage. It is recommended that at 24 weeks of pregnancy, a discussion is held between the social worker and Child Protection Chair to discuss timescales for pre-birth child protection enquiries. The strategy meeting should take place ideally by 27 weeks gestation with a view to presenting to conference by 30 weeks gestation, unless otherwise agreed with the Child Protection Chair.

9.2 Where there are siblings presented to Initial Child Protection Conferences, the unborn child should also be presented unless timescales are otherwise agreed with the Child Protection Chair.

9.3 All pre-birth invites must be sent to the Hospital Liaison Practice Manager, Named Midwife for Safeguarding and community Safeguarding Children's team. If the case is held in the Neighbourhood Assessment Team, the Neighbourhood Intervention Team should be invited to the Initial Conference and must attend to prevent delay and to ensure a seamless transition for the family.

9.4 All professionals must provide a written report to be forwarded to Children's Planning and Review Team and shared with the family prior to the conference. Reports must also include a chronology of agency involvement with the family.

9.5 There are two possible outcomes of a child protection conference: Child in Need Plan or Child Protection Plan. The definition of the categories will be available at conference and consist of: Neglect, Sexual Abuse, Physical abuse, Emotional abuse. Although less frequent, it's also possible for the outcome to be step-down to Early Help.

9.6 The conference will arrange the first Child in Need/core group meeting before the conference ends. The review conference date will also be set if needed.

9.7 The outline child protection plan should, where possible, be circulated within 24-48 hours of the conference.

10 Core group meetings

10.1 If held in the assessment team, the case will transfer to the Neighbourhood Intervention Team at the first Core Group Meeting.

10.2 Core group meetings will take place within 10 days of the initial conference and reconvened every six weeks (maximum) until the review child protection conference. They can be scheduled more frequently if indicated.

10.3 Actions made at the pre-birth conference will be reviewed and updated as necessary.

10.4 Pre-birth conferences are reviewed within three months of the initial conference or within the first month post birth, whichever is sooner.

11 Threshold of care panel (TOC)

11.1 All children in need of or likely to need a Looked After Child placement (full time or regular relief care) will need to be presented to the Threshold of Care Panel prior to the placement being made.

11.2 The panel aims to ensure the best use of available resources to keep the child in the community and out of the care system, giving full consideration to alternatives to Care. This will consider the need for a Legal Planning Meeting and preparation for Local Authority/alternative care for the child. This might include actions such as initiating a Family Group Conference, viability assessments, etc. Where the threshold for care is met, consideration will be given to holding a Legal Planning Meeting if necessary to progress within the Public Law Outline and possible preparation for court.

12 Legal Planning Meetings (LPM)

12.1 Where there is a concern around parenting capacity and significant harm, the Local Authority will consider the need for legal advice and progressing a case under the Public Law Outline. This is separate to the child protection process although the plan will run alongside this. The LPM could lead to the removal of the child. However, The Local Authority will always promote placement within the family if this is seen as a safe option for the child. In the event it is not, placements will be sought with foster and or adoptive carers.

12.2 The Hospital Liaison Practice Manager should be invited to all pre-birth legal planning meetings.

13 Birth of the baby

13.1 A pregnancy is considered to be 'term' after 37 weeks. The EDD is an estimate and is not always the day that the baby will be born. We expect 'term' babies to be born between 37-42 weeks.

13.2 The allocated SW must ensure that plans are shared with Emergency Duty Team where there is high risk and the Local Authority plans to initiate proceedings at birth.

13.3 NUH will inform the allocated Social Worker or the Emergency Duty Team (depending on day and time of birth) when the baby is born

13.4 Where there is a child protection plan in place, the social worker must inform the Child Abuse Investigation Team (CAIT) of the baby's birth and in cases where there is a risk of absconding with the baby and the need for police protection, generate a CAD number to provide the hospital.

13.5 NUH expects that discharges are not delayed due to outstanding actions from CSC. The midwife will contact the social worker in order to plan the discharge planning meeting.

13.6 In cases where Children's Social Care are considering initiating care proceedings, it is expected that court statements and all other relevant documentation is prepared by 36 weeks of the pregnancy (where feasible) to prevent delay in discharge.

14 Discharge planning meeting (DPM)

14.1 Discharge planning meetings will ideally be chaired by the allocated social worker or practice manager who will also minute this meeting and document in the medical records.

14.2 All babies subject to a child protection plan and/or legal proceedings require a DPM prior to the baby's discharge from hospital. In some complex CIN cases or where new safeguarding concerns arise, a DPM should be considered. For additional safeguarding concerns, a multi-agency strategy meeting should be considered.

14.3 The Hospital Liaison Practice Manager and Named Midwife for Safeguarding must be invited to all discharge planning meetings.

15 Step Down

15.1 All pre-birth cases stepped down to Early Help/Universal Services should conclude with a multi-agency step-down meeting with key involved professionals. The step-down plan should be agreed and documented with a named Lead Professional.

16 Missing alerts for unborn babies

16.1 National Local Authority alert to be completed by the allocated social worker and disseminated by Children's Planning and Review Team. This alert will be sent to national Local Authorities, however does not include Health organisations. See Appendix for alert template.

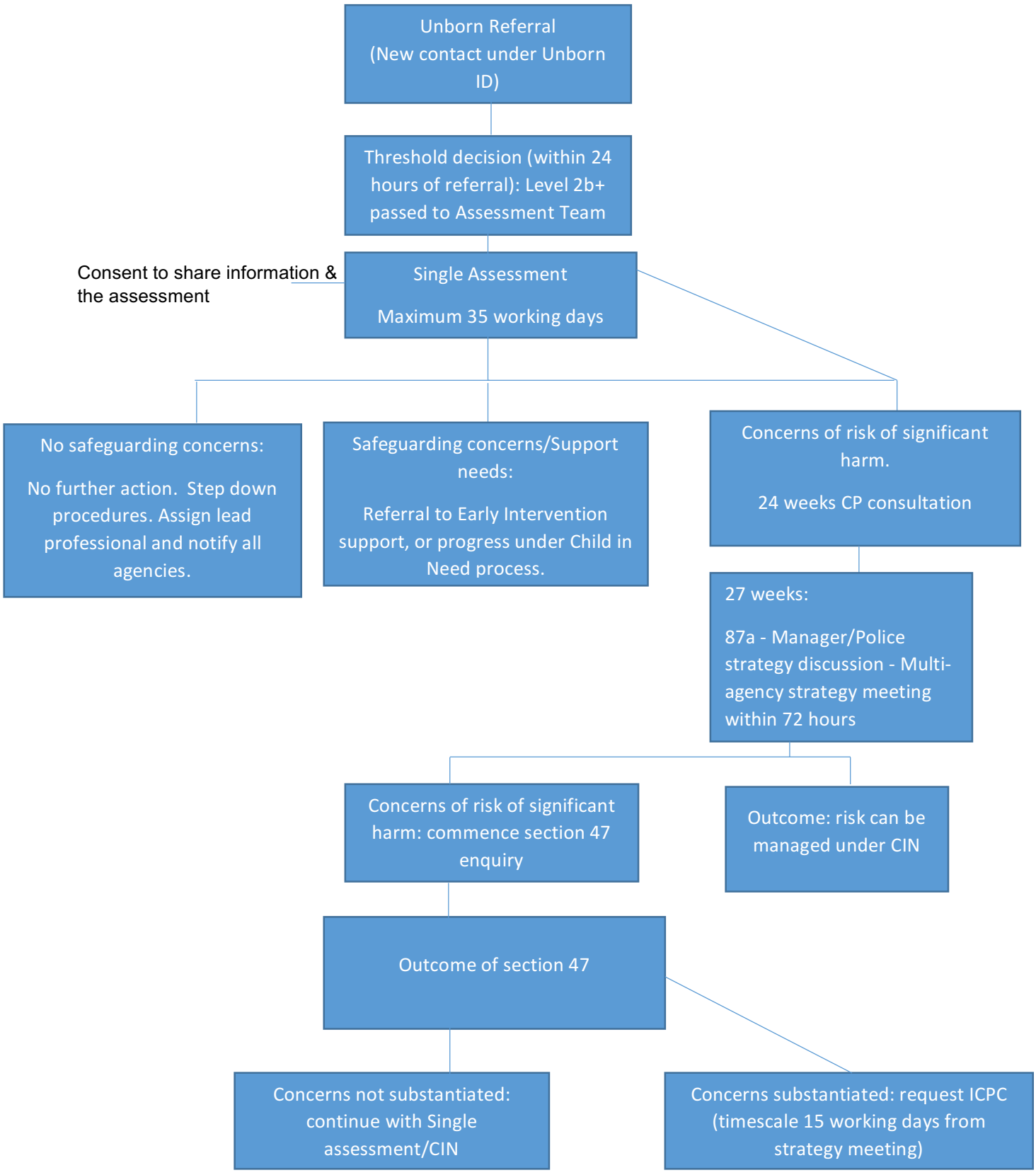
16.2 Individual Hospital alerts to be completed by the allocated social worker.

http://newhamchildcare.proceduresonline.com/chapters/p_missing_from_home.html

17 Newham Safeguarding Children's Board escalation process/Conflict Resolution

If a practitioner remains concerned about a practice issue, and the matter is not resolved, the practitioner should liaise with their line manager and the safeguarding team. They should consider a strategy to attempt to resolve this matter. Please refer to guidelines in link below.

http://www.newhamlscb.org.uk/Areas/Administrator/Content/CkEditerFiles/2e06206b-4663-4be9-918c-1ceb40aa5ea1_NSCB%20Conflict%20Resolution%20Protocol%202015.doc


Unborn Referral
(New contact under Unborn ID)
Threshold decision (within 24 hours of referral): Level 2b+ passed to Assessment Team
Consent to share information & the assessment
Single Assessment
Maximum 35 working days
No safeguarding concerns:
No further action. Step down procedures. Assign lead professional and notify all agencies.
Safeguarding concerns/Support needs:
Referral to Early Intervention support, or progress under Child in Need process.
Concerns of risk of significant harm.
24 weeks CP consultation
27 weeks:
87a - Manager/Police strategy discussion - Multi-agency strategy meeting within 72 hours
Concerns of risk of significant harm: commence section 47 enquiry
Outcome: risk can be managed under CIN
Outcome of section 47
Concerns not substantiated: continue with Single assessment/CIN
Concerns substantiated: request ICPC (timescale 15 working days from strategy meeting)

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Links to useful resources:

- Pan London Child Protection Procedures: http://www.londoncp.co.uk/
- Working Together to Safeguard Children 2015: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf
- https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

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Hart, D. *Assessment Prior to Birth*: in Horwath, J (Ed) (2001) The Child's World: JKP

National Institute of clinical excellence guidelines (2010) *Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors*. www.nice.org.uk/guidance/cg110

Reder, P; Duncan, S; Gray,M (1993) *Beyond Blame; child abuse tragedies revisited* Brunner-Routledge: Hove

Smith, K et al (2011) *Homicides, Firearms offences and intimate violence 2009/2010*; supplementary volume 2 to crime in England and Wales 2009/2010, London, Home Office

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London
E16 2QU

Safeguarding ALERT for Unborn Baby

	Details
Name **CareFirst No:**	Unborn…….. EDD
Family Members (if relevant) **Name** **DOB** **Name** **DOB**	
Home Address	
Child Protection Plan **Date Plan started, category & brief outline of concerns**	YES/NO **CONCERNS:** **CARE PLAN WHEN BABY BORN:**
Special circumstances, e.g. Medical Conditions, Disability or Special Needs	
Brief Description of parent	
Contacts in other authorities	
Police informed	
Who to contact if any information is known about the location of child / young person - PLEASE INCLUDE TELEPHONE NUMBERS **Social Worker:**	

Team Manager: **Emergency Duty Team (out of hours)** **020 8552 9587 IS THIS CORRECT?** **Safeguarding Midwife:**	
Date returned to CP-Co-ordinator	
Date alert sent out	

Email to: Louise Ince; Farah Khan; Helen Mitchell; Abu Taher