Unborn Baby Protocol
Working with Parents to Safeguard the Unborn Baby

First issued by LSCB: 2007
Last revision: January 2022
Date for Review: July 2023

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APPENDICES:

1 INTRODUCTION

The purpose of this protocol is to provide **all professionals** with guidance regarding the safeguarding risks to unborn babies across the 'continuum of need' (The Right Help at the Right Time) to plan appropriate support and intervention. It will also assist with decision making around completing a safeguarding referral to children's social care for an Unborn baby and when undertaking pre-birth assessments.

Pregnancy and the first year of life is a critical life stage – in the first 18 months of life babies experience a period of incredible rapid growth and development. An astonishing 700 connections are created in their brains every second as they constantly interpret and learn from the world that is created around them.
Research and experience indicate that very young babies are extremely vulnerable and that in the ante natal period risk assessment and effective planning and supportive intervention will help to minimise harm to the unborn baby.

This protocol is underpinned by the following national documents:

- Working Together 2018
- NICE guidance Antenatal and postnatal pregnancy and complex social factors (NICE 2010)
- Healthy Child Programme (DOH 2017)
- Hidden Harm (HO 2003)
- Getting maternity services right for pregnant teenagers and young fathers (Public Health England 2015)

and in addition local policies:

- South West Child Protection Procedures http://www.proceduresonline.com/swcpp/
- The Right Help at the Right Time guidance (Threshold document)
- Safeguarding Discharge Planning protocol

This revision of the protocol takes in to consideration the learning from several local Serious Case Reviews since 2016 and in addition a Multi-agency Unborn baby audit undertaken in 2020.

This protocol also considers the importance of the fathers and that it is essential to involve them in all aspects of assessments but also in the support required.

In 2021, the independent Child Safeguarding Practice Review Panel reviewed serious child safeguarding cases and this latest review looks at the lives of babies who were known or suspected to have been seriously harmed or killed by their father, step-father or male carer. The key findings show that while maternal health and wellbeing are, and should be, the main focus of maternity services, insufficient attention to men means that support for them to be active and engaged fathers is limited. The Panel has called for universal, antenatal and

perinatal services to work with fathers so significant risk factors, such as domestic abuse, substance misuse, and mental health problems, are addressed and the fathers are offered support before the additional stressor of a baby's birth.

Antenatal assessment provides a valuable opportunity to develop a multi-agency approach to supporting families where there are acknowledged vulnerabilities or an identified risk of potential harm to the unborn baby.

- During the antenatal period there is the opportunity for professionals in all agencies across the partnership to:
- Assess **both** parents and their family's ability to protect the unborn baby
- Identify risk factors relating to **both** mother and father.
- Identify positive engagement and strengths
- Identify, explore and assess the impact of the risk to the unborn baby & the baby once born.
- Explore the safety planning options
- Plan on-going supportive interventions during pregnancy
- Ensure that the continuum of need as identified in 'The Right Help at the Right Time' is considered and assessed.
- Avoid delay for the baby where a legal process is likely to be needed such as pre-proceedings.
- Be clear about the discharge arrangements from maternity care

2 EARLY IDENTIFICATION AND ASSESSMENT

It is important that all professionals are aware of indicators that may suggest a baby could be at risk of harm either before or following birth, or that the family will require a higher level of support in order to parent the child safely and meet all their needs.

It is vital that all assessments, including agency specific assessments are started as early as possible and that information is shared so that the child and family have the necessary support and best start to family life, thereby minimising the need for child protection intervention

If any service becomes aware of pregnancy or impending parenthood and has a concern for the unborn baby of one of their service users they must inform maternity services of their involvement and highlight any concerns and risks. Agencies should use their own agency specific consent pathways.

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 baby(or baby once born) or any other children in the family.

Where it is considered that additional needs exist for an unborn baby then that practitioner is required to assess any risks, discuss the concerns and options with the parents and have a

clear plan to achieve positive and sustainable outcomes for the baby once born. It is important to assist the parents throughout the pregnancy and in making arrangements to enable them to be prepared for the birth and the parenting of their new baby.

Signposting early to the appropriate service is important so that the right support is in place and there is time for the parents to address any risks and show positive and sustainable improvement before the baby is born.

If new concerns are raised or outcomes not achieved then the practitioner will need to consider the appropriate level of support which includes universal, early help or statutory (Child in Need/Child Protection) support.

Throughout the engagement with the parents, all discussions, decisions and actions must be clearly documented in the appropriate agency record. Circumstances must be reviewed regularly to assess risk against the strengths and weaknesses and consider any further action or changes to any safety plan.

If the mother books late in her pregnancy there will be limited time to assess positive and sustainable improvement against the identified risks so this must be considered within any agency assessment or intervention or Children's Social Care 'Pre-birth assessment'.

3 FACTORS WHEN CONSIDERING THE RISK TO AN UNBORN BABY

Below is a list of potential risk factors. Remember 'Multiples Matters', so several risk factors are likely to increase the risk to the unborn baby and increase the level of support needed.

Unborn Baby	
Unwanted pregnancy Emotional detachment from pregnancy Poor antenatal care Concealed pregnancy/ Late Booking *see appendix 3. Lack of awareness of the baby's needs inappropriate parenting plans	Inability to prioritise baby's needs No preparation for baby's needs Premature birth Foetal abnormality Traumatic birth

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 (adult needs be referred for assessment)	Known offender against children Parents < 20years/Immaturity Communication difficulties Mental health (current or previous, including post natal depression) Personality disorder Learning difficulties Lack of engagement with professionals Homelessness/asylum seekers

Learning difficulties	No recourse to public funds

Family and Environmental Factors	
Domestic abuse Unsupportive relationship Frequent moves of home Inappropriate home environment Unemployment Change of partner Flight risk	Relationship disharmony Multiple relationships Lack of support networks Financial difficulties Inappropriate associates Uncontrolled or potentially dangerous animals in the house Mistreated animals

These are examples and not an exhaustive list. Further research in to high risk factors can be seen in appendix 3.

3.1 Pregnancy in a young person under the age of 19 years:

The young age of a parent should not automatically be seen as an indicator of risk. However, there are occasions when the young person may have needs which require a further assessment. All young people under the age of 19 will be referred to the Family Nurse Partnership by the midwife.

If the mother is aged 19 to 24 years with a first baby and was a Looked After child or has a Learning Disability, Family Nurse Partnership should be notified to consider support. There are also some other criteria in relation to the mother's presenting history that the FNP team will consider supporting.

Remember, any referral to Family Nurse Partnership service needs to be done with the parents consent.

3.2 Pregnancy in a young person under the age of 16 years:

Professionals working with a young person under 16 must give consideration to a referral to Children's services as sexual activity under the age of legal consent should always give rise to the consideration of whether the child is suffering or likely to suffer significant harm or has been exploited. Professional should also consider whether the child, when born, may be a child in need due to their mother's inability to access some services and benefits in her own right as a result of her age and that mother may need support to prepare for the child and therefore a referral would continue to be appropriate . These children should always be discussed with the safeguarding lead in the agency. Under the Sexual Offences Act 2003 penetrative sex with a child under 13 is classified as rape, these cases will **always** need to be referred to Children's Social Care and a strategy discussion held.

3.3 Fathers & Partners:

Fathers and partners play an important role during pregnancy and after. The National Service Framework (2004) states *'The involvement of prospective and new fathers in a child's life is extremely important for maximising the life-long wellbeing and outcomes of the child regardless of whether the father is resident or not. Pregnancy and birth are the first major opportunities to engage fathers in appropriate care and upbringing of children'.*

Serious Case Reviews and CSPR's in Swindon have identified that professionals in all agencies do not consider the fathers in the same way they consider the mother and often there is very little information known about the fathers past or current situation.

Fathers and partners and extended family members must be included as appropriate in the assessment. Messages from Serious Case Reviews both locally and nationally have informed us of the importance of gaining information about fathers and partners who are not the biological father and that at the earliest opportunity to ensure any risks and support can be identified.

It is important to include as a minimum, name, date of birth, address where different from the mother's, relationship to the baby and GP details. Where adult services i.e. mental

health, substance misuse, are involved contact details of professionals and consent to contact should be sought.

Any safety/action plan MUST identify the fathers' role and any partner (non biological father or same sex partner) and expectations and any specific support that is required.

Where consent to contact services has not been given but the risk to the mother has been identified as potentially high, professionals should consult their named or specialist safeguarding lead and consideration must be given to sharing information in the best interest of the child.

The South West Child Protection procedures provide useful information and advice for professionals about working and involving fathers:

http://www.online-procedures.co.uk/swcpp/parenting-capacity-families/working-with-men/

A source of information for fathers is the Dad Pad, whilst this is not customised within Swindon you can get further information from:

https://thedadpad.co.uk/

4 SAFEGUARDING & THE CONTINUUM OF NEED (RIGHT HELP AT THE RIGHT TIME GUIDANCE)

Level 1:

This level of care is where there are no additional needs and the baby's health and developmental needs will be met by good parental care and the universal services that are available to all children. (See Appendix 1 for the routine appointment schedule for maternity care)

1) The **aims of antenatal care** are to optimise maternal and fetal health, to offer women maternal and fetal screening, to make medical or social interventions available to women where indicated, to improve women's experience of pregnancy and birth and to prepare women for motherhood whatever their risk status (NICE Quality Standard QS22)

2) Initial contact should be between 8-12 weeks but may occur at any time.

3) The majority of women and their partners will have an uncomplicated pregnancy and present no risk factors.

4) Midwives will throughout pregnancy be alert to the factors in section 3 and if circumstances change or any new risks identified will consider the need for additional support and intervention.

Level 2 (Early Help):

This level of care is where the professional or parent identifies a requirement for additional support above that provided by universal services to ensure that the baby's needs are met particularly in relation to their health and development. It is likely that the main concern lies with the parent and it may be that the needs of the baby are not clear or not known.

5) If during the initial booking assessment the Community Midwife has some level of safeguarding or vulnerability concern (considering the risk factors in section 3) the family should be informed that there is a need to liaise and possibly refer to other professionals for support. For example, if the mother discloses drug use then a discussion should be had with the specialist substance misuse midwife and a consideration about referral to the Substance Misuse Service.

6) The Community Midwife will complete a Safeguarding Mother & Baby Risk Assessment Notification which must be then sent to the safeguarding midwifery team for review and decision making.

7) If there is a safeguarding concern identified and further information is required to inform the assessment, the Great Western Hospital Maternity Team will make an enquiry to Swindon MASH (Multi Agency Safeguarding Hub). This will be done using the 'Midwifery Request for Information relating to Unborn Baby' form to ascertain whether there are any children in the family who are receiving support from Children's Social Care or if there have been any other concerns that require a formal referral to be made. If there are clear risk indicators for a formal safeguarding referral then this can be done directly without the safeguarding team completing the above form.

8) Following their 'booking-in' appointment and assessment the midwife may refer the mother/father/partner to other support services such as the Family Nurse Partnership, Health Visitor, Pregnancy in Mind, Perinatal mental health team, sexual health support, the SARC (Sexual Assault Referral Centre), Substance Misuse Services or the Early Help Hub.

9) If at any time there are considered to be adults safeguarding factors and that they are in need of care and support then the practitioner should consider a separate Adult Safeguarding referral

10) Any agency making a safeguarding referral must send the referral (RF1) to the MASH.

11) When concerns have been raised by someone other than the midwife, the early help worker or social care worker involved must (to seek consent from the parent – although consent is not needed to share safeguarding concerns) bring them to the attention of the Safeguarding midwife at Great Western Hospital who will liaise with the appropriate community midwife to ensure that the mother is booked as soon as possible. This enables the midwife to continue to monitor and support the family.

12) If consent is not given then the practitioner raising the concern should be advised to speak with their line manager to decide if information about the concerns should be shared.

Level 3 (Social Care):

This level of concern relates to when there are concerns that an unborn baby may be a 'Child in Need' (section 17 Children Act 1989) or 'in need of protection' (section 47 Children Act 1989) which means that their basic physical and/or psychological needs will not be met and is likely to impair the child's health or development.

Follow step 1-12 as above:-

13) If after the above steps the Community midwife assesses the need for a safeguarding referral to MASH, they must inform the Safeguarding Midwife and GP/Consultant Obstetrician if appropriate.

NB: **It is the responsibility of the practitioner making the referral to follow up the referral at 72 hours if there is no response in that timeframe**

14) Initial contact with the pregnant mother is made by professionals primarily working with the adult family members e.g. Police, Probation, Housing or Voluntary Agency, Mental Health, Substance Misuse and Learning Difficulties professionals. If there is concern at Level 3 then Children's Social Care referral made in respect the unborn baby.

15) Any practitioner who has concerns for the welfare of the unborn child must ensure that the midwifery service is aware of the concerns and that any further safeguarding information is passed on in writing to the maternity safeguarding team and recorded on the maternity electronic records by the midwife/maternity safeguarding team.

16) Once a referral (RF1) to Children's Social Care has been made, the processes are exactly the same as for any Child in Need/Child Protection referral. A statutory assessment will be undertaken dependant on the outcome of the MASH decision.

17) Should the assessment identify risks of significant harm to the unborn baby or likely significant harm post birth a multi-agency strategy meeting will be held.

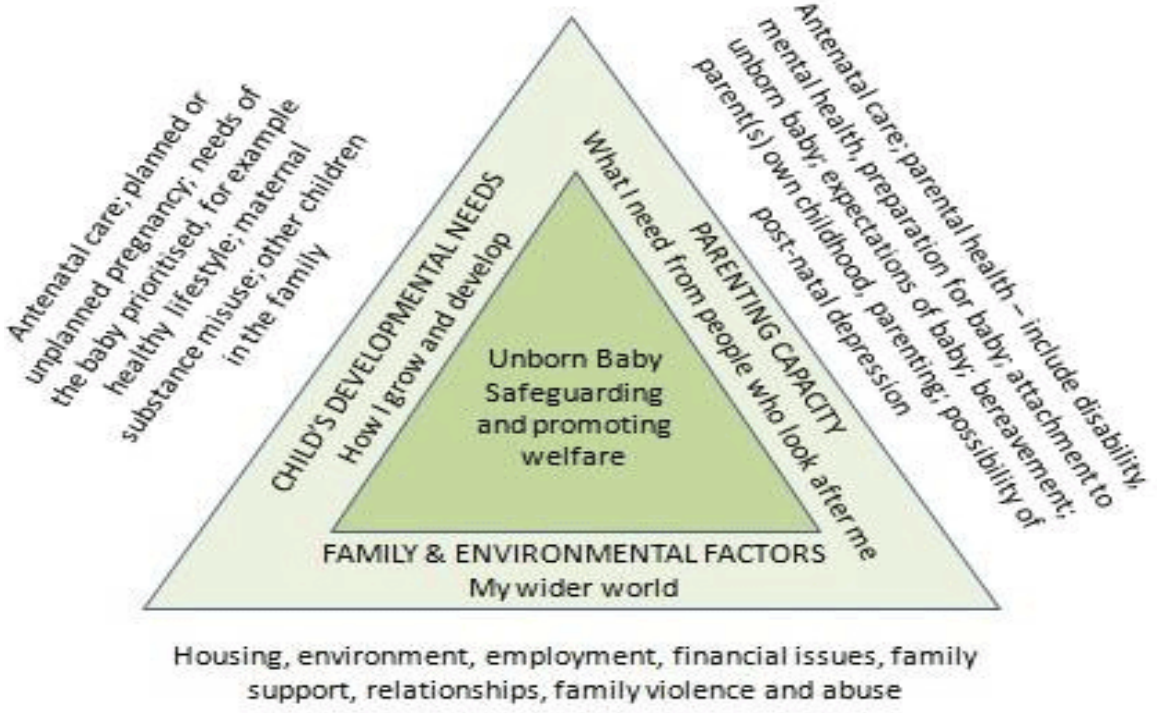
18) Any assessment will consider both parents and mothers partner if not the father of the unborn baby, the assessment will also consider wider social and family history, environmental factors as well as the obstetric history.

5 REFERRALS TO CHILDRENS SOCIAL CARE (CSC)

Referrals to Children's Social Care about unborn babies who may need services should be made early in the pregnancy as soon as concerns have been identified. This can be done as soon as the practitioner becomes aware of concerns but it may be that concerns are not known until later on in the pregnancy. Early referral enables Children's Social Care to assess and plan in a timely way and make a decision as to whether a child is in need, requires protection from significant harm and/or that legal process will need to be initiated.

In any of the following circumstances a referral **must** always be made (and as detailed in The Right Help at the Right Time guidance) if:-

- 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 serious concerns about parental ability to care for the unborn baby or other children.
- 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.
- Risk of 'flight' during pregnancy



It is important when making a referral to MASH for an Unborn baby that the following is considered.

What is the impact of the risk to the unborn baby when planning for their future?

Are the identified risks going to impact on the baby's emotional and physical development and safety once born?

and

The baby must always remain the focus of the assessment

If professionals require any advice on safeguarding they should contact their line manager and/or named professional for safeguarding. Advice and guidance is also available from

http://www.proceduresonline.com/swcpp/swindon/index.html

6 OUTCOMES OF THE REFERRAL TO CHILDREN'S SOCIAL CARE

If the decision is made by MASH that the level of need does not require a social care statutory assessment to be completed then a decision must be taken as to whether there should be future support through an early help assessment and the referrer must be informed within 72 hours of contact reaching MASH.

It is the responsibility of Children's Social Care 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 Children's Social Care. If the referrer feels that the criteria for Children's Social Care is reached but has been declined they need to contact their named safeguarding professionals for advice to discuss how to escalate their concerns to Children's Social Care.

If an assessment is deemed necessary by Children's Social Care this must be completed within 45 working days (in line with the statutory assessment framework).

The outcome of the assessment would be one of the following:

a) Referral to Early Help or another agency for support.
b) Child in Need Plan
c) Strategy Discussion
d) Request for legal advice
e) No further Action

In cases where Children's Social Care accepts the referral and completes a statutory assessment to determine whether the unborn baby is a child in need (s17) or is a child in need of protection (s47), whilst the case is open to Children's Social Care, they will take the lead responsibility for the coordination of the case and will involve close working with and input from all relevant professionals involved with the family.

In cases of highest risk where it is believed that an Initial Child Protection Case Conference or Pre Proceedings are required the statutory assessment must be completed at the earliest possible stage to ensure timely planning for the baby's birth.

Throughout pregnancy the midwife and any other practitioner supporting the parents will continue to monitor and support the family. If at any time new concerns are identified or previous concerns resurface then Children's Social Care must be contacted with the new information.

Postnatally, the Midwife will again monitor and offer support until handover to the Health Visitor at around 10 days.

The Health Visitor will maintain contact with the family and as for all families will take a lead role in assessment and intervention unless the parents are receiving support from the Family Nurse Partnership service or a more appropriate health professional to meet the needs of child. (E.g. Community children's nurse for complex medical needs)
There could be other health professionals involved with a lead role for assessment and intervention to meet the needs of the parent/adults

7 PRE BIRTH ASSESSMENT

A Pre-Birth assessment must be undertaken by the Social Worker when there is evidence to indicate the unborn baby may be at risk of Significant Harm.

It is important that Social Workers do not conduct assessments in isolation. The Social Worker will liaise with the community midwife and other agencies to complete the Pre Birth Assessment and the Safeguarding Birth Plan Proforma (see section 10 & Appendix 2). All agencies have a common shared duty to engage with this Pre-Birth assessment.

The importance of compiling a full chronology and family history, including a clear history from the parents about their own previous experiences, is particularly important in assessing the risks and likely outcome for the child. Where there have been previous children in the family removed, the previous Court documents should be accessed at an early stage. Background Police and other checks should be made at an early stage to ascertain any potential risk factors.

Serious consideration needs to be given as to when during the pregnancy the child protection procedures are implemented. This is to ensure that appropriate support and monitoring can be put in place sufficiently early to enable appropriate preventative action in cases such as:

- The mother is identified as at risk of sexual exploitation or there is evidence of Domestic abuse.
- If the mother has significant mental health issues that may impact on their ability to provide 24hour care for the baby.
- The lifestyle of the mother is putting the foetus at risk of harm e.g.: misuse of alcohol and/or other substances, particularly where there has been no response to brief interventions or engagement in specialist treatment services. (This may include third party information, observed presentation of intoxication, smelling of alcohol, or signs of withdrawal).
- Planning protection for after the birth - if it is assessed that there is a need to provide particular support services or a change of living accommodation when the child is born.

During mother's pregnancy, there may be a number of occasions when either the baby and/or mother will need to stay in hospital, for example where there are medical risks to the mother or baby. It is important that during these times that the Social Worker is informed of any admission.

If the mother is under the care of the perinatal mental health team it is essential that they are involved in any Pre-Birth assessment and that the Perinatal Mental Health pathway is adhered to.

If the Pre-Birth assessment concludes that the baby would be at significant risk of harm to stay within the family following birth then Children's Social Care may plan to apply to the courts for an order to remove the baby following birth and this should be conveyed to the mother and father. 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.

Where there is a possibility of Children's Social Care applying for a court order at birth, police should be invited to the pre-birth planning meeting.

In a High Court judgment (Nottingham City Council v LW & Ors [2016] EWHC 11(Fam) (19 February 2016)) Keehan J set out five points of basic and fundamental good practice steps with respect to public law proceedings regarding pre-birth and newly born children and particularly where Children's Services are aware at a relatively early stage of the pregnancy.

In respect of Assessment, these were:

- A risk assessment of the parent(s) should 'commence immediately upon the social workers being made aware of the mother's pregnancy';
- Any Assessment should be completed at least 4 weeks before the mother's expected delivery date;
- The Assessment should be updated to take into account relevant events pre - and post delivery where these events could affect an initial conclusion in respect of risk and care planning of the child;
- The Assessment should be disclosed upon initial completion to the parents and, if instructed, to their solicitor, to give them the opportunity to challenge the proposed Care Plan and assessment of the risk factors.

8 ESCALATION

Recent Case Reviews have highlighted a lack of awareness and use of escalation within agencies and it seems that for various reasons professionals have tended not to refer to the Escalation policy. This has led to drift and delay in individual cases and means that

professionals have not been able to satisfactorily resolve professional disagreements, resulting in potential risk to the child

Specifically in relation to unborn babies there is no time to permit drift in either support or action planning and so all professionals must ensure that timescales are adhered to and any concerns escalated as per the Escalation policy.

Learning from the multi-agency unborn baby audit undertaken in 2020 identified that unborn babies should not be stepped down or closed prior to birth by Children's Social Care.

9 LEGAL PLANNING

Where safeguarding concerns have been identified, the Local Authority will consider the need for legal advice. If the referral (RF1) is made after 16 weeks of the pregnancy, consideration should be given to seeking legal advice prior to the completion of the statutory pre-birth assessment.

A case discussion will be had with the allocated social worker's Head of Service and agreement sought to present the case, based on the risk of significant harm and any evidenced based social work practice, to the weekly Legal Gateway Panel.

If at the Legal Gateway Panel it is agreed that threshold has been met then a Legal Planning Meeting will be held within 5 working days to consider the pre-birth planning such as assessments of the parents, family members and any specialist assessments.

In all cases where there is a unborn baby, there should be a pre proceedings meeting with the parents, regardless of how late in the pregnancy legal are notified and there should be as little delay as possible in sending out a 'Letters before Proceedings' and holding the Pre Proceedings meeting.

Prospective parents have a right to full information about the concerns professionals hold about their ability to parent a child, and a clear understanding of the action the Local Authority intends to take in regard to their child. Entering the Pre Proceedings Process ensures that prospective parents have access to free independent legal advice.

When there is a risk of flight, consideration should be taken to whether a 'Letter before Proceedings' will heighten the risk and if an alternative legal plan is needed.

Good practice guidance set out by Keehan J in Nottingham City Council v LM

(1) The period of time for which a hospital is prepared to keep a new born baby may be a material consideration for a local authority in relation to the timing of an Interim Care Order

(ICO) application – but one must not place too great a reliance on these indications, particularly as:

(i) a hospital may not detain a baby in hospital against the wishes of parents with parental responsibility;

(ii) the capability of a maternity unit or hospital to accommodate a new born baby may change within hours;

(iii) police protection orders and emergency protection orders are emergency remedies – but they do not afford the parents nor the child with the same degree of participation, representation and protection as an on-notice ICO application and should therefore be avoided if possible;

(iv) the indication of a maternity unit as to date of discharge should not normally set or lead the time for an ICO application.

(2) The social work team should provide all relevant documentation to the legal department no less than 7 days before the expected date of delivery and this should be shared with the parents and their solicitors if instructed, prior to the birth of the baby. Cafcass should also be notified of the intention to issue proceedings;

(3) It is "essential and best practice" that the Local Authority issue the application on the day of birth (date of notification of the birth).

(4) "The message must go out loud and clear that, save in the most exceptional and unusual of circumstances, local authorities must make applications for public law proceedings in respect of new born babies timeously and, especially where the circumstances arguable require the removal of the child from its parent(s), within at most 5 days of the child's birth"

(4) The availability of additional evidence from the maternity unit or elsewhere must not cause delay in the issue of care proceedings – rather "the provision of additional evidence may be envisaged in the application and/ or provided subsequently".

There cannot be an application to court for any order until after the baby has been born and an application will be dealt with by the Court as soon as necessary based on the facts of the case. The Local Authority does not have any control over the listing of the case.

10 SAFEGUARDING BIRTH PLAN

It is important to have a Safeguarding Birth Plan, accepting that some babies will be born prematurely and so this may not always be possible. However for most babies the Social Worker must complete a detailed Safeguarding Birth Plan using the Swindon Safeguarding

Birth Plan proforma (see appendix 2). This Safeguarding Birth Plan will detail the planning for delivery and immediate post natal period.

This must be completed by 36 weeks and done in consultation with the chronologies from professionals and other agencies and updated as required. It could be that following the Initial Child Protection Conference that this is done at the first core group.

The Safeguarding Birth Plan must be shared with parents unless to do so is felt to put the mother or baby at increased risk. An agreement must be reached as to how the plan will be shared with parents and this must be documented in both the midwifery and social care records.

Parents will be encouraged to have their babies delivered in a hospital setting if there are safeguarding concerns. Consideration should be given by the Social Worker and other professionals in reviewing what support parents require to attend hospital.

All agencies must know what role they have at the time of the birth so they are clear about their responsibilities.

Most parents now take their babies home after 6 hours if a normal birth and the post natal baby check has been performed so it is essential there is a clear safety plan for the birth and this plan will need to ensure it covers out of hours and weekend births.

The allocated social worker must ensure that children's social care 'Out of Hours service' is made aware of the Safeguarding Birth Plan.

It is the responsibility of the ward midwife to inform the Social Worker and the Safeguarding maternity team when the mother presents in labour and then again when the baby has been born. If there are further safeguarding concerns identified during the admission then the Social Worker and the Safeguarding maternity team must be informed accordingly.

It is the responsibility of the Community Midwife to ensure that other health professionals involved are also informed of the birth such as the GP and the Family Nurse Partnership/Health Visitor. They should also inform the police if this is an agreed action.

A Safeguarding Discharge Planning meeting must be held in line with the Swindon Safeguarding Partnership 'Safeguarding Discharge Planning protocol'. (See section 11)

11 SAFEGUARDING DISCHARGE PLANNING MEETINGS

All professionals must follow the Swindon Safeguarding Partnership's Safeguarding Discharge Planning Protocol: Discharge of Children and Young People from Hospital Settings.

The Safeguarding discharge planning process must be initiated as soon as the mother presents for delivery and all Midwives caring for the mother and baby should have full access to and knowledge of the Safeguarding Birth Plan.

A Safeguarding Discharge Planning meeting must be agreed between the social worker and the relevant senior midwife. The Safeguarding Midwife must always be consulted.

The relevant senior midwife on the ward will be responsible for arranging the discharge planning meeting alongside the Social Worker, during normal working hours as soon as the baby is born. If the baby is born prematurely it is reasonable to plan the discharge planning meeting for 7-10 days prior to the earliest likely discharge date.

The relevant senior midwife needs to ensure that all relevant professionals involved with the child are involved in the discharge planning process, for example, the Community Midwife, the Health Visitor, the Consultant Paediatrician, the Social Worker and the General Practitioner and any other key professionals that are in a position to support the safeguarding of the newborn. Safeguarding Midwife must always be consulted and in the more complex cases may attend.

The relevant senior midwife will ensure that the parents and any support person they choose will be informed when and where the meeting will take place.

The Social Work team will lead the Safeguarding Discharge Planning meeting as per the protocol.

If a baby is subject to a Child protection plan they must not be discharged unless a Safeguarding Discharge Planning meeting has been held or there is written agreement by the Social Worker that it is safe to discharge.

The newborn baby should not be discharged at weekends or on bank holidays unless there is a consensus of opinion that it is safe and reasonable to do so. If discharge is agreed it must be documented in the child's medical record and the Discharge Planning meeting minutes.

All agencies must aim to agree the baby's discharge as soon as safely and practicably possible, which should be no longer than two working days of the baby being medically fit for discharge.

12 REFERENCES AND USEFUL INFORMATION

Common Assessment Framework DH (2002)

http://www.education.gov.uk/childrenandyoungpeople/strategy/integratedworking/caf

The National Service Framework for Children Young People and Maternity Services (2004) DH

https://www.gov.uk/government/publications/national-service-framework-children-young-people-and-maternity-services

NICE Quality Standard on Antenatal Care. QS22. (2012 & updated 2016)

https://www.nice.org.uk/guidance/qs22/chapter/introduction-and-overview#:~:text=The%20aims%20of%20antenatal%20care,motherhood%20whatever%20their%20risk%20status.

South West Safeguarding Procedures

http://www.online-procedures.co.uk/swcpp/

Working Together to Safeguard Children (2018) DH

https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors (2010)

https://www.nice.org.uk/guidance/cg110

Right Help at the Right Time (Swindon Threshold guidance 2020)

https://safeguardingpartnership.swindon.gov.uk/downloads/file/381/right_help_right_time_2020

Swindon Integrated Perinatal Mental Health Pathway

Prevention in mind: All Babies Count: Spotlight on Perinatal Mental Health
https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf

Swindon Escalation policy (Policy on Resolution of Professional Disagreements Relating to the Safeguarding & Protection of Children)

https://safeguardingpartnership.swindon.gov.uk/downloads/file/303/escalation_policy

Getting maternity services right for pregnant teenagers and young fathers

https://www.rcm.org.uk/sites/default/files/Getting%20maternity%20services%20right%20for%20pregnant%20teenagers%20and%20young%20fathers%20pdf.pdf

Adults Safeguarding & Domestic Abuse - A guide to support professionals and managers

https://safeguardingpartnership.swindon.gov.uk/downloads/file/445/adults_safeguarding_and_domestic_abuse_-_a_guide_to_support___and managers

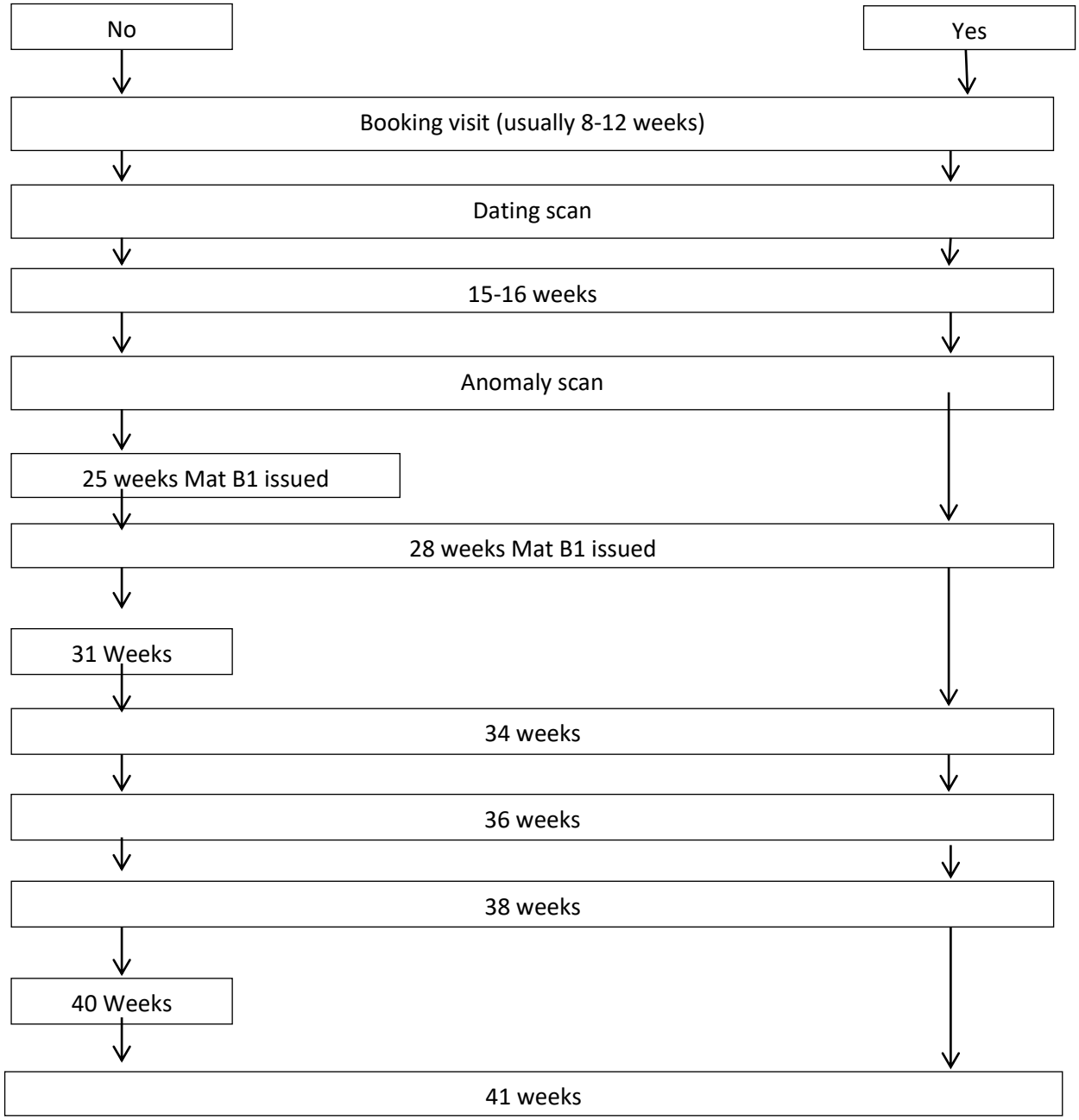
APPENDIX 1:- SUMMARY OF YOUR ROUTINE APPOINTMENTS DURING PREGNANCY

Each appointment will have a specific purpose and the aim of these antenatal appointments is to check on you and your baby's wellbeing and to provide you with clear information to plan your care accordingly.

As well as face-to-face information you should have access to antenatal classes and written information that is based on the best research evidence available.

Schedule of appointments discussed……(sign and date)

Have you had a baby before?



Total appointments if this is your first baby: **10 plus scans**

Total appointments if you have had a baby before: **7 plus scans**

APPENDIX 2:- SWINDON SAFEGUARDING BIRTH PLAN

Swindon Safeguarding Birth Plan

This form is to be completed for all unborn babies who are;

- Subject to a child protection plan
- Subject to a pre-birth assessment (Children's Social Care)
- Subject to pre-proceedings processes (Children's Social Care)

1. **Summary of safeguarding plan**	
Unborn baby (state family name)	Care First Reference
	Ethnicity
Delete as applicable: • Baby to remain with mother but there are safeguarding concerns • Baby to be separated from mother following discharge – if courts agrees to this	

2. **Family Information**	
Mothers name	
Home address	
Partner's name /Biological fathers name	
Home address	
Will the Father have parental responsibility (i.e. married to Mother or likely to be named on birth certificate)	
Are there any barriers to communication e.g. language understanding	

Are there any specific observation, assessment or support needs for the mother and partner during birth or the post-natal period?
Are there any other children that need considering within this plan? (please detail names, ages, and nature of concern/consideration)

Agreed birthing partner's name and status
Person(s) who are to be excluded from the maternity unit and reasons why
Names(s) and status of any person(s) who may have access to the maternity unit but whose conduct and behaviour may pose difficulties. State why:
NB: Any difficult or disruptive behaviour within the hospital will automatically involve the hospital's security and police and those persons will be removed as per hospital policy.

3. **Health and social care professionals**	
Name of Hospital and birthing unit	
Named Midwife Team Contact details	
Named Midwife Team Contact details	
Named Health Visitor Contact details	
Family Nurse Practitioner (if applicable)	
GP/Practice Contact Details	

Named Social Worker Team Contact details	
Team Manager Contact details	
EDS contact details	
Child Protection Plan	
Category (tick as applicable) Physical ☐ Sexual ☐ Neglect ☐ Emotional ☐	
Date of CP plan	
Pre-birth assessment completed?	
Recommendations of completed pre-birth assessment	
Public Law Outline meeting	Date of next meeting
Details of parents lawyers to include their telephone numbers and names	
Outline the plan for the baby and the time frame for issuing proceedings and drafting of paperwork.	

Professionals to be notified – including EDS if required	
On admission to hospital NAME	**CONTACT DETAILS**
Following birth NAME	**CONTACT DETAILS**

4. **Contact following birth within Hospital**	
For Mother	
Is mother's care to be supervised? If yes, by who?	
Date of discussion with Safeguarding Midwifery team	
Outcome of discussion. If contact is to be supervised please detail the: • reason why mother's care is to be supervised • level of supervision required (please consider if this is constant supervision / open ward observations / only during caring tasks/ other level) • who will supervise (are their assessed family members who could do so / has consent or funding agreement been agreed / has a placement search request been made)	
For Father/Partner (where partner may not be the biological father)	
Is supervision required?	
Date of discussion with Safeguarding Midwifery team	
Outcome of discussion. If contact is to be supervised please detail the: • is father in a relationship with mother and is he likely to be on ward post birth • reason why contact / care is to be supervised • level of supervision required(please consider if this is constant supervision / open ward observations / only during caring tasks/ other level) • who will supervise (are their assessed family members who could do so i.e mother or other family / has consent or funding agreement been agreed / has a placement search request been made)	

Contact for any other person who may visit on the ward (detail names and relationship)	
Is supervision required? If so, by who?	
Date of discussion with Safeguarding Midwifery team	
Outcome of discussion. If contact is to be supervised please detail the: • reason why contact is to be supervised and if supervision is needed why does this person have to be on ward • level of supervision required • who will supervise	

5. The Safeguarding Plan	
Is the plan of the Local Authority for the child to be separated from the mother following birth?	
If yes	
On delivery suite following birth and transferred to a designated place of safety (please consult legal before answering yes to this question)	Yes/No
On discharge from post-natal ward	Yes/No
Are there any concerns about the mother's capacity? E.g. mental health issues, learning disability, due to mother's young age? Has a capacity assessment been undertaken? What decisions has mother consented / not consented to? **NB: Consent can be withdrawn at any time, by any person with parental responsibility and is time and decision specific. A midwife or doctor can consider consent if there is a concern postnatally about capacity.**	
Is the plan agreed by the mother?	
Is the plan agreed by the Father and where relevant, Partner?	
If possible ask parents to sign and date this plan at this stage to evidence agreement or set out when and how the plan was shared with parents and any comments that they made **NB: Remember that the father will not have Parental Responsibility until baby's birth is registered unless he is married to the baby's mother.**	
Where the plan is not agreed (post birth) or consent is withdrawn, detail the contingency plan to safeguard the child upon birth. Please include the names of professionals who will be enacting the contingency plan.	

6. DISCHARGE PLANNING	
A Safeguarding Discharge Planning Meeting is required in almost all instances. If you believe one is not needed please set the reasons	
Detail the planned date of the meeting and who will participate:	
Arrangements for discharge	
If the baby is to be discharged from hospital to an alternative carer please give details below	

To foster carer?	Yes/No
Is the foster carer identified?	Yes/No
Address of F/C (if confidential please state this is not to be shared with parents)	
Discharge to others carers? Please state:	Yes/No
Name	
Relationship to child	
Address	
If baby and/or mother are being discharged to another area have maternity services been informed? If not when will this happen?	Yes/No
Where mother and baby are to be discharged to home address, detail any action and support required, including who is to provides these and the timescales for doing so.	
Any other issues to be noted	

6. Distribution of Safeguarding Birth Plan	
Date plan given to:	
Community Midwife	
Safeguarding Midwifery team (gwh.safeguardingmaternity@nhs.net)	
Health Visitor	

Others (please state)	
Date when plan shared with Mother	
Date when plan shared with putative Father	
If plan not shared with parent/s state reason why	
Date copy signed by Social Worker	

APPENDIX 3:- SUPPLEMENTARY INFORMATION

Late Booking, concealed/unknown pregnancy:

Pregnant women with complex social factors are known to book later on average, than other women and late booking is known to be associated with poor obstetric and neonatal outcomes (NICE 2010)

A late booking is defined as presenting for maternity services after 20 weeks of pregnancy (Wessel, 2002).

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone; or a woman appears genuinely to not be aware she is pregnant. 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 should be made to Children's Social Care.

The concealment of a pregnancy represents a challenge for professionals in safeguarding the welfare and the wellbeing of the foetus (unborn child) and the mother. There is no national agreed definition of what constitutes a concealed pregnancy, however a coordinated multi-agency approach is required once the fact of a pregnancy has been established; this will also apply to future pregnancies where there has been a previous concealed pregnancy. Concealment of pregnancy may be revealed late in pregnancy, in labour or following delivery. The birth may be unassisted (no midwife) whereby there might be additional risks to the child and mother's welfare and long-term outcomes.

A concealed pregnancy is when:

- An expectant mother knows she is pregnant but does not tell any professional; or
- An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care; or
- A pregnant woman tells another person or persons and they conceal the fact from all health agencies.

For the purpose of this guidance the phrase concealed pregnancy is used for both denied and concealed pregnancies. A denied pregnancy is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases a woman may be in denial of her pregnancy due to mental illness, substance misuse or as a result of a history of loss of a child or children.

A pregnancy will not be considered to be concealed or denied for the purpose of this procedure until it is confirmed to be at least 24 weeks; this is the point of viability.

In some cases a woman may be unaware that she is pregnant until late in the pregnancy due to a learning disability. Concealment may occur as a result of stigma, shame or fear because the pregnancy may be the result of incest, sexual abuse, rape or as part of a violent relationship.

Possible implications:

- Concealment of a pregnancy can lead to a fatal outcome (for both mother and/or child), regardless of the mother's intention;
- Concealment may indicate uncertainty towards the pregnancy, immature coping styles and a tendency to dissociate, all of which are likely to have a significant impact on bonding and parenting capacity;
- Lack of antenatal care can mean that any potential risks to mother and child may not be detected. It may also lead to inappropriate advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy;
- The health and development of the baby during pregnancy and labour may not have been monitored and foetal abnormalities not detected;
- Underlying medical conditions and obstetric problems will not be revealed;
- An unassisted delivery can be dangerous for both mother and baby, due to complications that can occur during labour and the delivery;
- Lack of maternal willingness/ability to consider the baby's health needs, or lack of emotional attachment to the child following birth;
- Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently;
- There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community;
- Risks to the unborn baby from prescribed medications.

References:

National Institute for Health and Care Excellence (NICE). Clinical guideline [CG110] - Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors. Sept 2010.

Wessel, J. Buscher, U. (2002) Denial of pregnancy: Population based study. British Medical Journal (International Edition) February 23rd.Volume 324, Issue 7335 p. 458.

Domestic Abuse:

During pregnancy, domestic violence and abuse can pose a threat to an unborn child as assaults on pregnant women often involve punches or kicks directed at the abdomen, risking injury to both the mother and the foetus.

In almost a third of cases, domestic violence and abuse begins or escalates during pregnancy and it is associated with increased rates of miscarriage, premature birth, foetal injury and foetal death.

The mother may be prevented from seeking or receiving antenatal care or post-natal care. In addition if the mother is being abused this can affect her attachment to her child, more so if the pregnancy is a result of rape by her partner.

Young mothers are at greater risk of experiencing domestic abuse especially where there are a range of complicating factors including mental health issues, substance abuse, and a lack of wider support or housing problems. It is often harder for them to ask for help.

Children under the age of 12 months are particularly vulnerable so incidents of domestic abuse after the baby has been born are very concerning.

Alcohol & Substance Misuse

Use of alcohol, illicit drugs and other psychoactive substances during pregnancy can lead to multiple health and social problems for both mother and child, including miscarriage, stillbirth, low birth weight, prematurity, physical malformations and neurological damage.

Dependence on alcohol and other drugs can also severely impair an individual's functioning as a parent, spouse or partner, and instigate and trigger gender-based and domestic violence, thus significantly affecting the physical, mental and emotional development of children.

Pregnancy may be an opportunity for women, their partners and other people living in their household to change their patterns of alcohol and other substance use. Health workers providing care for women with substance use disorders during pregnancy need to understand the complexity of the woman's social, mental and physical problems in order to provide appropriate advice and support throughout pregnancy and the postpartum period.
Common risks for drugs, alcohol and tobacco include:

- complications in pregnancy and labour
- maternal death
- miscarriage
- premature birth
- stillbirth
- infant death
- low birth weight
- Sudden Infant Death Syndrome

Where drug or alcohol misuse occurs:

- withdrawal symptoms in infants
- physical and neurological damage to the baby
- Foetal Alcohol Spectrum Disorder

Women who inject drugs who share injecting equipment risk infection with Blood Borne Viruses, which may be passed to the baby.

Children born to smokers are more likely to suffer from asthma, chest, inner ear and other infections, and to become a smoker in later life

https://researchbriefings.files.parliament.uk/documents/POST-PN-0570/POST-PN-0570.pdf

Impact of Poor mental health in parents

Mental illness during pregnancy, whether anxiety, depression or more severe psychiatric disorders can have a significant negative impact on a mother and her baby. Poor psychological health has been associated with low birth weight, premature birth, perinatal and infant deaths, postnatal depression, as well as longer term behavioural and psychological impacts on the child.

Maternal antenatal anxiety and/or depression have been shown to predict increased risk for neurodevelopmental disorders in children, and to confer risk for future mental illness. The impact of women's anxiety (and/or depression) during pregnancy has been found to extend into childhood and adolescence, as well as to affect the hypothalamic-pituitary-adrenal (HPA) axis, predicting attention deficit hyperactivity disorder (ADHD) symptoms in 8–9 year old children.

Parental Learning Disability

30-50% of **children** whose mothers have a **learning disability** are at risk of poorer development, compared to **children** from similar socio-economic groups. They are no more likely to be born with a **learning disability**, but they are more likely to have developmental delays, lower IQ and behavioural problems.

Many parents with a learning disability live under conditions that may contribute to poorer parenting, including poverty, low literacy, poor health, poor mental health, domestic abuse, having grown up in care, and social isolation. In particular, social support (such as living with relatives) contributes to successful parenting.

Early intervention improves outcomes. Parents with a learning disability can improve their parenting skills with additional support tailored to their needs. For example childcare skills can be taught through behavioural modelling, using visual manuals and audiotaped instructions, and using simple behavioural instructions. Parents learn more effectively where they are given praise and feedback, and where complex tasks are broken down into simpler parts.

Parents with a learning disability may be reluctant to ask for support with parenting issues because of fears that this will raise child protection concerns. Many will have already had a previous child removed into care. Some parents will not be eligible for support from adult learning disabilities teams because their learning disability is not severe enough to qualify.

https://www.bestbeginnings.org.uk

https://www.bristol.ac.uk/media-library/sites/sps/documents/wtpn/2016%20WTPN%20UPDATE%20OF%20THE%20GPG%20-%20finalised%20with%20cover.pdf