Pan-Dorset Safeguarding Children Partnership

Pan-Dorset Protocol for the Protection of the Unborn Child January 2020

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1. Scope

This joint protocol particularly applies to Health, Social Care staff, Children's and Adult Services and Police across Dorset. It should be read following reference to the Pan-Dorset Policy onSafeguarding Newborn or Unborn babies (and where relevant, the Policy on Concealed / Denied pregnancy).

2. Introduction

Research indicates that young babies are particularly vulnerable to abuse but that work carried out by professionals in the antenatal period can help minimise harm if there is early assessment, intervention and support. Working Together to Safeguard Children (2018) specifically identifies the need of the Unborn Child.

3. Purpose

The purpose of this protocol is to ensure that a clear system is in place for multi-agency response to concerns for the welfare of an unborn child and to maintain timely, clear and regular communication. The agencies most often involved in these responses will be Midwifery, Children's Services, Adult Services and Health Visiting Services.

4. Risks

SCRs tell us that babies are the highest risk group for serious injuries from physical or other harm. It is important for professionals to identify factors which will increase the risk of harm to the unborn child. The Pan-Dorset Policies referenced above set out the range of risks related to the unborn child.

5. Fathers / Partners and risk of domestic abuse

It is essential to capture information about partners and other males in the household or in in a relationship with the mother. This will include any risk factors (historic or current), which may present risks to the unborn child, eg history of violent behaviour, history of harm to children in previous or current relationships, drug or alcohol misuse, mental health problems, care leaver or poor experience of childhood and other risk that could cause harm.

Any assessment must include demographic (to include date of birth and GP details) and medical details of the mother's partner, wider social and family history and environmental factors as well as the obstetric and social history of the mother.

6. Screening for domestic abuse

The National Service Framework for Children, Young People and Maternity Services (DH 2004) states that *'all pregnant women must be offered a supportive environment and the opportunity to disclose Domestic Violence and those local services are trained to respond appropriately'*. This means that on initial booking if the partner is not present, or at another appropriate time, the midwife will raise the issue of domestic abuse and again when appropriate throughout the pregnancy.

If the partner attends each appointment, the risk of Domestic Abuse should be taken into consideration and the midwife should do her utmost to speak with the woman alone, for example taking the woman out of the room to be weighed. Research informs us that 30% of domestic abuse starts in pregnancy and that domestic abuse is a prime cause of miscarriage or still birth (Why Mothers Die, Department of Health, 2001). A significant number of pregnant women will need referral to other services.

7. Pregnant Teenagers

Where a young person is 17 or under and pregnant they are a child in their own right and good practice is to undertake an early help assessment to understand their own needs as well as those of the unborn child.

The practitioner who takes the lead for this early help assessment will be identified depending on agencies involved for the young person at the time. The named midwife should inform the HV of the pregnant teenager for additional support at 28 weeks.

Agencies will have to agree to whether the needs of the parent and the unborn needs can be met with one lead professional or whether separate allocation will be more effective in meeting both the parent's and the unborn babies' differing needs.

8. Pan Dorset Continuum of Need

The Pan Dorset Continuum of Need will be used by agencies undertaking assessments to understand the level of need and continuum of support for a family who is expecting a baby.

A concealed or denied pregnancy will meet Level 3 or Level 4 of the level of need and sections 9 and 10 of this document will be used.

9. Early Identification

All professionals working with families need to be alert to the factors that may indicate a potential risk to the child either before or after birth. They will also be vigilant to parental need that can be addressed or commenced before birth.

Where an agency (eg. Midwifery, Health Visiting, Children's Services, Children's Centres, Adult Services, etc.) working with a family becomes aware of a pregnancy, and they have concerns, they must ensure that the midwifery service is aware of the concerns and that any relevant information is passed on in writing / secure email, this will include current plans and work with the family members.

Professionals primarily working with the adult family members (e.g. Police, GP, probation, housing or voluntary agencies, mental health, substance misuse and learning difficulty services) who are aware of concerns related to the protection of the unborn baby are integral to this early identification.

Where a care experienced young person is going to become a parent their social worker or pathways advisor will discuss and record with their manager any known vulnerabilities and whether a referral for a pre-birth assessment or request for early help assessment is warranted. It will also set a time frame for their Pathway Plan review,

considering changes in their circumstances and the different professionals who will be involved. There will not be an assumption of risk to the unborn

See Section 18, Contact Details

10. Early Help Assessment / Midwifery Social Risk Assessment

It is vital that assessments are started early and that information is shared so that the family have the necessary support and best start to family life, thereby reducing the need for greater levels of intervention.

Practitioners across multi-agency Children's Services are trained to use the early help assessment. Once they have liaised with midwifery service about the concerns, they should agree on who is best placed to undertake the early help assessment. Midwifery will undertake a social risk assessment with every pregnant mother using their local tool and guidelines, but in some cases more information may be known by another agency in order to complete an early help assessment. Where risks are already clearly identified that meet Level 4 Statutory Services a referral should be made to Children's Social Care rather than undertaking an early help assessment (see section 14 responses to level 4).

If the family already have an allocated social worker or Lead Professional, then the midwifery team will join the team around the child working with the family. Children's Social Care should inform Health Visiting, Midwifery Services, Children's Centres and other services of their involvement, but these services have responsibility to be proactive in seeking joint working too.

Midwives will undertake a social risk assessment with the mother alone (to enable disclosure of any domestic abuse) and record this in the booking forms.

Following the booking appointment, the midwifery department will notify the GP and the Health Visiting Service that the woman is pregnant and is in the care of the midwifery service via their local arrangements for communication. Within this notification the midwifery service will seek relevant information from the GP and Health Visiting Service about risk factors. The social risk assessment will be shared with the GP and Health Visitor and Children's Centre.

If concerns are identified by the Social Risk Assessment screening or by the midwife, GP or Health Visitor, the specialist midwife for safeguarding will be involved to ensure all appropriate actions are agreed. The level of need will be established by gauging the information in the assessment against the relevant LSCB Threshold / Levels of Need and Continuum of Support (see Section 8). Good practice is that the family should be informed that there is a need to liaise and possibly refer to other professionals.

Health professionals should make an enquiry to the appropriate Social Care (Children's Services) office or Early Help Assessment Coordinator to confirm the status of the case and ascertain whether there are any children from the family who are subject to a child protection plan or to identify any Lead Professional already allocated.

The Social Risk Assessment for any family where concerns are identified at level 3 or 4 will be sent securely to the Early Help Assessment Co-ordinator to be logged as an Early Help Assessment.

See Section 18, Contact Details

11. Responses to parents / unborn assessed as at Level 1 - Universal Level of Need

Services expected for this group include GP, Midwifery, Health Visiting and Children's Centres. Obstetric Care will be offered based on medical need and the parent and unborn will be supported by Universal Services.

All Women with identified vulnerability e.g. maternal mental health, learning disability, foetal development issues, domestic abuse etc. will be considered at an antenatal meeting with the Midwifery, Health Visitor and Children's Centre to agree a joint risk assessment and plan that will meet early help requirements to ensure a plan is in place.

12. Responses to parents / unborn assessed as at Level 2 - Universal Plus Level of Need

Where needs identified in the early help assessment meets Level 2 Universal Plus – children with additional needs a Lead Professional should be identified. There are a number of approaches which can be used. These include:

- an enhanced pattern of contacts including visits to the home to assess the home environment and to identify and document any concerns;
- involving services within the area who provide lower levels of support to families, related to the presenting issues;
- Contact with other professionals involved with the family such as G.P. health visitor, adult services workers, schools, children centres etc. to ensure they have a full picture of the family's social context and identify any outstanding concerns. Previous assessments should be accessed, where available. Good practice is that the permission of the mother should be sought.

13. Responses to parents / unborn assessed as at Level 3 - Partnership Plus

At Partnership Plus level the unborn will be assessed as vulnerable with high level additional needs requiring co-ordinated services. The following approaches are needed:

- the early help assessment / social risk assessment will be logged with the Local Authority Early Help Assessment co-ordinator;
- a lead professional will be identified from those working with the parent/s and unborn;
- assessment should lead to a multiagency support plan overseen by the Lead Professional using Team Around the Child / Family meetings as needed. Pre-birth planning meetings may be needed to draw together a multi-agency plan;
- a midwifery appointment will be offered in the home by 16 weeks and a further offered at 34 weeks if deemed necessary, with priority given to those who are considered vulnerable.

14. Responses to parents / unborn assessed as at Level 4 –Specialist / Statutory

Level 4, Specialist Services will be required where assessment indicates that an unborn baby may be “in need” (section 17) or at risk of significant harm (section 47) and is unlikely to achieve and maintain a reasonable standard of health and development without the provision of services. At this level the midwife or another professional will make a referral to CSC and the following will be expected.

i. The referring health or other professional must confirm the referral in writing, either by letter or confidential fax, within 48 hours. This should be completed using the LA inter-agency referral form.
ii. The early help assessment / social risk assessment will be logged with the Local Authority Early Help Assessment co-ordinator.
iii. The midwife must inform the named midwife for their Trust and the specialist safeguarding midwife for their organisation, G.P, Health Visitor & Consultant Obstetrician if appropriate.
iv. Throughout pregnancy the midwife will continue to support the family, update Children’s Social Care and share any new or developing concerns and document all of this in the relevant health care record.
v. Children’s Social Care will consider referrals regarding unborn babies, including the viability of the pregnancy and the need for a statutory plan to consider whether there is a need for a social care assessment. Management decisions / actions will need to consider the urgency and timescales for assessment to enable planning to be made in time for birth.
vi. Children’s Social Care will acknowledge receipt of the referral and communicate their decision on the next course of action within one working day to the referring professional. It is the responsibility of the professional making the referral to follow up if there is no response from social care within 10 working days.
vii. If CSC do not agree that Level 4 has been reached, they should discuss this with the referrer and agree the appropriate level and next steps together. The Continuum of Need should be used. If a consensus cannot be reached, the LSCB Escalation should be used.
viii. Whenever there is reasonable cause to suspect that a child is suffering or is likely to suffer significant harm there should be a strategy discussion involving LA CSC, Police, health and other parties such as the referring agency to determine the child’s welfare and plan timely future action, including whether to commence s47 enquiries. If the unborn is part of a sibling group the strategy discussion will consider which children will be subjects of any s47 enquiries.
ix. When concerns about an unborn have been raised by someone other than the midwife the social care worker involved must bring them to the attention of the named or specialist midwife or named nurse for the appropriate Acute Health Trust. This enables the midwife to be part of the Team around the Child / Family and to continue to monitor and support the family effectively and share this with the GP and Health Visitor.
x. If an assessment is deemed necessary, the single assessment framework allows up to 45 days for completion of the assessment. A pre-birth assessment should include areas identified by the DoH Assessment Framework for the unborn, which is underpinned by ‘Unborn Children: A Framework for Assessment and Intervention in ‘Assessment in Child Care: Using and Developing Frameworks for Practice’ (Eds Calder M.C. and Hackett S. 2003) Russell House Publishing’.

xi. The assessment needs to be proportionate and timely and review of the progress of assessments must bear in mind the need for multi-agency planning for the birth.

xii. It is important for any assessment to include details of the father (DOB and GP), mother's partner where different from the father, wider social and family history and environmental factors (as can be found in the core assessment) as well as the obstetric history to ensure all risks are adequately considered.

xiii. Unless there are exceptional circumstances, i.e. late referral, the initial child protection conference (if required) should take place by 30 weeks. This enables agencies to have a plan in place ahead of the birth even if there is an early delivery. Timing should be arranged so that work commences as soon as possible, but in a way that the first Review Child Protection Conference (RCPC) is following baby's birth. Midwives, health visitors and children's centres should always be invited and attend CP conferences for unborn babies.

xiv. Pre-birth planning meetings may be needed to draw together a multi-agency plan. These may be held in the Core Groups or a Child in Need meeting.

xv. The records of pre-birth planning should be shared with any agency who may need to be involved in implementing them (eg. Police and Out of Hours Social Services).

xvi. Where assessments indicate the need for court action, specific guidance is available in Local Authority pre-birth assessment policies about the issues which need to be considered.

15. Discharge Planning from hospital

In a small number of level 3 and 4 cases there will need to be very clear discharge planning arrangements to allow a safe transition from hospital care to home care. In a very small number of cases new-borns will be removed from parental care after birth once the relevant legal agreement is in place (Emergency Protection Order or Section 20).

The Lead Professional is responsible for agreeing these plans in advance of birth and sharing this information with all of those involved, including the parents in all but exceptional cases. It is essential that each agency identifies, understands and agrees their role in this plan. This may be as part of a child protection or child in need plan, or require a multi-agency meeting to coordinate the care the family need.

For those cases where a plan has been agreed pre-birth, in the period between birth and discharge there should be a review of these arrangements to ensure that circumstances / risks have not changed and that the plan is still fit for purpose.

Health Visitor involvement is key alongside midwifery colleagues and in some cases Police and Out of Hours Social Services will need to be involved to support the implementation of the plan.

16. Discharge from midwifery services

Postnatally the midwife will provide services until handover to the Health Visitor at day 11-14. The Health Visitor will maintain contact with the family and as for all families will take a lead role in assessment and intervention. The transfer from midwifery care to health visitor is agreed based on levels of need.

The involvement of the Health Visitor from an early stage in the planning at Levels 2 to 4 will ensure that transition is smooth.

Children's Centre involvement should be promoted strongly with families and the discharge from midwifery is another point to check the families' engagement with services.

It is the responsibility of the midwife to inform the Health Visitor involved when the midwife will leave the team around the child / family.

Where midwifery has been lead professional a new lead professional will be identified to progress the early help plan.

17. Escalation Policy

If at any point a there is professional disagreement about the best way to safeguard a child, the front line practitioner should seek to discuss and negotiate a resolution. If this is not resolved the professional should use the Escalation Policy to support them in reaching an agreed position. These escalations should be logged with safeguarding leads in agencies as evidence of appropriate challenge.

18. Contact Details

See the Health section of the Local Directory for midwifery leads for the Acute Trusts and Local Authority Early Help Co-ordinators.

19. Further Information

NICE Guidance 62 Antenatal Care (March 2008)
NICE Guidance 110 Pregnancy and Complex Social Factors; a model for service provision for pregnant women with complex social factors (Sept 2010)
The National Service Framework for Children, Young People and Maternity Services (DoH, 2004)
DoH "Why Mothers Die"
NICE Guidance Domestic violence and abuse: multi-agency working