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| **PRE-PROCEEDINGS PLAN**  **Dated: \*\*\*\*** |

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| The family | |
| The child(ren) | |
| Name: | Date of birth: |
| Name: | Date of birth: |
| Name: | Date of birth: |
| The parents and others with parental responsibility | |
| Mother: | |
| Father: | |

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| The professionals (insert/delete) |
| Child(ren)’s social worker: |
| Team manager: |
| Family support worker: |
| Health Visitor: |
| School: |
| CAMHs / mental health service: |
| We Are With You: |
| Advocate/Intermediary: |
| Insert others or delete |

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| How long will the pre-proceedings process last: **16 weeks maximum** | |
| First pre-proceedings meeting | Week 0 – Date: |
| First review pre-proceedings meeting (if required) | Week 8 – Date: |
| Final review pre-proceedings meeting | Weed 16 – Date: |
| Target finish date | Week 16 – Date: |
| Head of Service - decision to extend (with reasons) | Date:  Reasons: |

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| What needs to happen |
| As agreed, at the first pre-proceedings meeting: |

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| Family Group Conference (FGC) / Family Network Meeting (FNM) |
| An FGC / FNM took place on \*\*\*\*. The plan agreed at the meeting has been circulated (or is to be circulated) |

OR

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| Family Group Conference (FGC) / Family Network Meeting (FNM) |
| An FGC / FNM has not yet taken place. Reason: \*\*\* |
| The social worker will make the referral for an FGC / FNM by \*\*\*. The plan agreed at the meeting will be circulated when available. |

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| Agreed Assessments | | |
| Type of Assessment: Hair strand (and blood) | | |
| To test for [insert substances] for a period of \*\*\* months on a month-by-month basis and PETH testing (if testing for alcohol) | | |
| To be completed by: |  | |
| Type of Assessment: Expert Assessment | | |
| Psychological assessment of \*\*\* / Psychiatric assessment of \*\*\* | | |
| Name of expert agreed: |  | |
| Letter of Instruction by: |  | |
| To be completed by: |  | |
| Type of Assessment: Parenting Assessment | | |
| Name of assessor: |  | |
| First session will take place on: | \*\*\*\* | |
| The last session will take place on: | \*\*\*\* | |
| To be written up by: | \*\*\*\* (Week 12) | |
| Type of Assessment: kinship assessment | | |
| At the first pre-proceedings meeting the child(ren)’s mother/father put forward the following family and friends to be assessed: | | |
| \*\*\* | | |
| \*\*\* | | |
| Initial Screenings to be completed by: | | \*\*\*\* (Week 1) |
| If positive, Viability Assessments to be completed by: | | \*\*\*\* (Week 3) |
| If appropriate/required, Full Assessments to be completed by: | | \*\*\*\* (Week 15) |

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| Help to be provided | |
| Type of help: \*\*\*\* | |
| Parent: |  |
| Referral to be made by: |  |
| Start date: |  |
| Expected completion date: |  |
| Type of help: \*\*\*\* | |
| Parent: |  |
| Referral to be made by: |  |
| Start date: |  |
| Expected completion date: |  |
| Type of help: \*\*\*\* | |
| Parent: |  |
| Referral to be made by: |  |
| Start date: |  |
| Expected completion date: |  |

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| What may lead to care proceedings being issued? |
| 1. If the child(ren)’s safety demands it. 2. If the parents do not work with professionals to make positive changes and there is a need to remove the child(ren) from their care. |

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| Signatures | | |
| Signature | Print name | Date |
|  | Mother: Insert name |  |
|  | Father: Insert name |  |
|  | Social Worker: Insert name |  |
|  | Team Manager: Insert name |  |
|  | Advocate / Intermediary on behalf of \*\*: Insert name |  |

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| Record of outcome of pre-proceedings process | | Date decision made: \*\*\*\* | |
| Pre-proceedings closed: | Yes/No | | Date closed: \*\*\* / N/A |
| Proceedings to be issued: | Yes/No | | |
| Application to be filed by: | | \*\*\* / N/A |
| Details of the outcome of pre-proceedings and the next steps that will be taken: | | | |
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