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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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