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| **BIRMINGHAM CHILDREN’S TRUST** **Pre-Proceedings Plan** |
| **Family composition** |
|  **The child(ren)** |
| **Name:**  | **Date of birth:** |
| **Name:** | **Date of birth:** |
| **Name:** | **Date of birth:** |
| **The parents** |
| **Mother:** | **Date of birth:** |
|  **Father:** | **Date of birth:** |
| **Other people who are important** |
| **Name:** | **Relationship to the child(ren):** |
| **Name:**  | **Relationship to the child(ren):** |

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| **Professionals involved with the family** |
| **1. Children’s social worker:** |
| **2. Assistant/Team manager:** |
| **3. Health visitor:** |
| **4. School:** |
| **5. Support workers:** |
| **6. Advocates/intermediary:** |
| **7. CAMHS or mental health service:** |
| **8. Any other relevant professionals/agency:** |

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| **Duration of the Pre-Proceedings process***The duration should be agreed and set at the first meeting. This is bespoke timeframe for the family and ideally should not last longer than 16 weeks* |
| **First Pre-Proceedings meeting** |  |
| **First Pre-Proceedings review meeting** |  |
| **Review Legal Planning Meeting** |  |
| **Second Pre-Proceedings review meeting** |  |
| **Target finish date** |  |
| **Date of decision to extend** **(and reasons)** |  |

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| **Expectations** |
| These were discussed at the first Pre-Proceedingsmeeting and any changes are recorded below*.* |
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| **2.** |  |
| **3.** |  |
| **4.** |  |
| **5.** |  |

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| **Family Group Conference (or similar)** |
| **Has there been FGC (or similar) held prior to starting pre-proceedings:****Yes / No****Outcome:**  |
| **At the first Pre-Proceedings meeting the child(ren)’s mother put forward the following people:** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **At the first Pre-Proceedings meeting the child(ren)’s father put forward the following people:** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **The social worker will make the referral for a FGC (or similar) by:**  |
| **Date of the FGC (or similar):** |
| **Outcome of the FGC (or similar):** |
| **If a FGC (or similar) did not take place, explain the reasons why:** |

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| **Agreed Assessments** |  **Date** |
| **Type of Assessment: Hair strand testing** |  |
| **To be tested for [ *specify substances]* for three months on a month by month basis to include liver function testing if testing for alcohol** |  |
| **To be completed by** |  |

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| **Type of Assessment: Expert assessment** |
|  **Is there a need for an expert assessment?** | **YES / NO** |
| **Name of expert agreed:** |  **Type of expert agreed:** |
| **Letter of Instruction by**  |  **Date:** |
| **To be completed by** |  **Date:** |

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| **Type of Assessment: C&F Assessment (new or update)** |
| **Name of Social Worker** |  |
| **To be completed by** |  **Date:** |

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| **Type of Assessment: Sibling Assessment** |
|  **Is there a need for a sibling assessment?** | **YES / NO** |
| **To be completed by** |  **Date:** |

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| **Type of Assessment: Screening assessments** |
| **Names of family and friends put forward by the parent(s):** |
| **1.** |  |
| **2.** |  |
| **3.** |  |
| **To be completed by** |  **Date:** |
| **Outcome: Positive/negative**  | **Positive** | **Negative** |
| **Referred to connected persons****team on** |  **Date:** |

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| **Supports/ interventions***e.g. therapy, domestic abuse work, drug and alcohol service* | **Date:** |
| **Type of support/ intervention:**  |  |
| **Referral made:** |  |
| **Start date:** |  |
| **Expected completion date:** |  |
| **Who will provide the service:** |  |
| **Which parent will engage:** |  |
| **Supports/ interventions***e.g. therapy, domestic abuse work, drug and alcohol* *service* | **Date:** |
| **Type of support/ intervention:**  |  |
| **Referral made:** |  |
| **Start date:** |  |
| **Expected completion date:** |  |
| **Who will provide the service:** |  |
| **Which parent will engage:** |  |

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| **What may lead to proceedings being issued?** |
| ***Please identify what may lead to the local authority issuing proceedings*** *(e.g.**ineffective/unproductive engagement by a parent or persons being assessed causing**issues of safety with the need to remove the child(ren) from the care of their parents)* |
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| 1. **If the child(ren)’s safety demands it.**
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| 1. **If the parents do not work with professionals to make positive changes and there is a need to remove the child(ren) from the care of their parents.**
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| **Signatures** |
| **Signature** | **Print name** | **Date** |
| **Mother:** |  |  |
| **Father:** |  |  |
| **Social worker:** |  |  |
| **Team manager:** |  |  |
| **Advocate/intermediary:****on behalf of :** |  |  |

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| **Record of the outcome of the Pre-Proceedings** |
| **Court Proceedings to be issued** | **Yes** | **No** |
| **Please record detail of the outcome of Pre-Proceedings and the next steps that will be taken:** |