***GUIDANCE – TO BE COMPLETED BY SOCIAL WORKER DURING MEETING***

**PUBLC LAW OUTLINE – PRE PROCEEDINGS AGENDA/MINUTES**

DATE OF MEETING

MEETING NUMBER (Initial, 1st review, 2nd review)

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| CHILD(REN) |
| Name  |  | DOB |  | N number |  |
| Name |  | DOB |  |  |  |
| Name |  | DOB |  |  |  |
| Name |  | DOB |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Any current legal order |  | Placement Details (Home/*Foster Care/Kinship)* |  |

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| FAMILY COMPOSITION |
| Name |  | Relationship to the child |  | Parental responsibility |  |
| Name |  | Relationship to the child |  | Parental responsibility |  |
| Name |  | Relationship to the child |  | Parental responsibility |  |
| Name |  | Relationship to the child |  | Parental responsibility |  |

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| ATTENDEES (please include contact details – telephone number and email address |
| Social Worker  |  | Legal Representative  |  |
| Team Manager |  |  |  |
| Parent  |  | Legal Representative |  |
| Parent |  | Legal Representative |  |
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| PARENTS |
| DNA testing requiredIf required, is this agreed | YesYes | NoNo | Referral to be made by : |
| Concerns raised re parents’ level of understanding? | Yes | No | Further information on any additional needs and professional involvement to determine the nature of any assessment |

**ATTACH GENOGRAM**

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| Maternal Family / Connected Persons – currently involved ?  | **Name, relationship and current level of support:** |
| Paternal family / Connected Persons – currently involved ?  | **Name, relationship and current level of support:** |
| Family Network Meeting details | **Date and outcome:** |
| Initial Viability Assessments (IVA) completed ? | **Name .................................. Date ……………………………….****Name .................................. Date ……………………………….****Name .................................. Date ……………………………….****Name .................................. Date ……………………………….** |
| Positive IVA referred for full assessment | **Name .................................. Date ……………………………….****Name .................................. Date ……………………………….****Name .................................. Date ……………………………….****Name .................................. Date ……………………………….** |
| Health Professional (eg Paediatrician) | **Details of involvement, referral or report to be requested (inc. dates)** |
| Health Visitor | **Details of involvement, referral or report to be requested (inc. dates)** |
| Drug/Alcohol Services | **Details of involvement, referral or report to be requested (inc. dates)** |
| Domestic Abuse Services | **Details of involvement, referral or report to be requested (inc. dates)** |
| Education | **Details of involvement, referral or report to be requested (inc. dates)** |
| Mental Health | **Details of involvement, referral or report to be requested (inc. dates)** |
| Any other Support Services | **Details of involvement, referral or report to be requested (inc. dates)** |

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| **Duration of the Assessment Phase**The duration should be agreed and set at the first meeting. This is bespoke timeframe for the family and may not last longer than sixteen weeks |
| First PLO meeting |  |
| First PLO review meeting |  |
| Second PLO review |  |
| Target finish date |  |
| Date of decision to extend the PLO process and reasons why (to be complete by Service Manager) |  |

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| **Danger statements**Please clearly state the main concerns that need to be addressed. This should be identify who the concerns relate to.Please ensure that any concern about capacity of cognitive functioning are identified as soon as possible. |

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| **Safety goals** |

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| **PLAN OF WORK – set out below the Actions needed and the detail of each** |

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| **Action 1** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

|  |  |
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| **Action 2** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

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| **Action 3** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

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| **Action 4** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

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| **Action 5** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

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| **Action 6** |  |
| What needs to happen |  |
| Why is it necessary – how does it impact on the child |  |
| Who is responsible for ensuring it happens |  |
| When will it be achieved by |  |
| How will we know the action taken has worked |  |
| update |  |

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| **DISCUSSION** |
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| **OUTCOME** |
| Review PLO to be arranged | Yes | No | Date for Review : |
| Proceed to s31Proceedings | Yes | No | Issued date agreed at : |
| Step down from PLO | Yes | No | Plan to be in place : |

**OBTAIN SIGNATURES AND HAND COPY TO ALL ATTENDEES**

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| **SIGNED BY – FORM TO BE COPIED AND PROVIDED TO ATTENDEES AT THE END OF MEETING** |
| Mother | PRINT |  | Dated |
| Father | PRINT |  | Dated |
| Social Worker | PRINT |  | Dated |
| Team Manager | PRINT |  | Dated |