**This form should be completed by 34 weeks or at the earliest opportunity for all unborn babies subject to the following criteria;**

* Subject to a child protection plan or Child in Need Plan
* Subject to a pre-birth assessment (Children’s Social Care)
* Subject to pre-proceedings processes (Children’s Social Care)
* Where there are vulnerabilities and/or concerns about a family

1. **Summary of Safeguarding Plan**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Unborn Baby (Mother’s Surname) :** | | | |
| **Estimated Due Date:**  **Gestation of Pregnancy (at time of Multi-Agency Birth Plan Meeting):** | | | |
| **Hospital Number:**  **NHS Number:** | | | |
| **Subject to a Child In Need (CIN) Plan? Y/N Date of commencement :**  **Subject to a Child Protection (CP) Plan? Y/N Date of commencement :**  **No children’s services involvement ? Y/N** | | | |
| **Category(ies) (Please tick as applicable)**  **Physical Sexual Neglect Emotional Domestic Abuse** | | | |
| **Areas of Concern** | **Mother** | **Partner (Second Parent)** | **Key Adult** |
| Mental Health |  |  |  |
| Substance Misuse |  |  |  |
| Alcohol Misuse |  |  |  |
| Domestic Abuse |  |  |  |
| Learning Difficulties |  |  |  |
| Aggression to Professionals |  |  |  |
| Person Posing a Risk to Children (previous offence against a child) |  |  |  |
| Previous Child(ren) in care |  |  |  |
| Registered Sex Offender |  |  |  |
| Flight Risk |  |  |  |
| Concealment Risk |  |  |  |
| Adverse Childhood Experiences (ACES) |  |  |  |
| Other (Please Expand): |  |  |  |
| **Is a Discharge Planning Meeting required? Yes / No** | | | |
| **Children’s Services Department to be notified of birth/sex and details post-delivery** ?**Yes / No** | | | |
| **Parenting Observation Chart and/or withdrawal observations to be completed during mother and baby’s stay in hospital? Y/N** | | | |
| **Mother’s agreed birthing partner (s) (name and status):**  **Do key professionals need to be notified if this changes ? Y/N** | | | |
| **Name(s) and status of any person(s) who may have access to the maternity unit but whose conduct and behaviour may pose difficulties. State why:**  **(Any difficult, aggressive or disruptive behaviours towards any members of staff or other patients will result in security and Police being called immediately)** | | | |

1. **Professionals to be notified about admission in labour/birth**

|  |  |  |
| --- | --- | --- |
| **On Admission to Hospital (e.g. Children’s Services Department, Hospital security)** | **Contact Details (phone and/or email)** | **Professional Responsible** |
|  |  |  |
|  |  |  |
|  |  |  |
| **Following Birth (add additional as required)** | **Contact Details** | **Professional Responsible** |
| Children’s Services Department (CSD) | In Hours:  Out of Hours: | Hospital Midwife |
| Health Visitor and/or Family Nurse Partnership | In Hours:  Out of Hours: | Children’s Services Department |
| Perinatal Mental Health (If applicable) | In Hours:  Out of Hours: | Hospital Midwife |

1. **Labour and Delivery**

|  |  |  |  |
| --- | --- | --- | --- |
| CONSIDERATION | YES / NO | PLAN | PROFESSIONAL RESPONSIBLE |
| Is a Home Birth being considered? Is there a plan in the event of a Birth before arrival (BBA)? |  |  |  |
| Is there a likelihood of a home birth or mother attending a different hospital? |  | Local Hospitals and Ambulance Service alert to be completed. | Safeguarding Midwife |
| Are Children’s Services Department intending to apply for a Legal Order in relation to the baby, once born? Why? |  |  |  |
| Will Police support be required or need to be considered as part of the protection plan for the baby once born? Why? |  | RMS No: |  |
| Is supervised contact required?  (e.g. Level of supervision, who will supervise, reasons why contact is supervised) |  |  |  |
| Agreed contact arrangements; is there a working agreement in place? |  | Mother  Father  Significant Adult / Family member |  |
| Have alternative arrangements been considered if circumstances change at the time of birth or following birth |  |  |  |
| What arrangements have been made for the Social Worker to visit the ward post-delivery? |  |  |  |
| **Delete as Applicable:**   * Mother and baby to return home with no court needed * Mother and baby to go to a voluntary Mother and Baby Placement without a court order * The Local Authority are planning to make an application to court with a view to obtain an interim care order, with a care plan proposing: * Mother and Baby return home * Mother and Baby Placement * The Baby to be placed in foster care | | | |

1. **Post-Birth Hospital Stay**

|  |  |  |  |
| --- | --- | --- | --- |
| **CONSIDERATION** | **YES / NO** | **PLAN** | **PROFESSIONAL RESPONSIBLE** |
| Arrangements have been agreed relating to mother and baby’s intended stay in hospital? (if Mother and Baby clinically well) |  |  | Safeguarding Midwife and Social Worker |
| Is the baby to be discharged from hospital to an alternative carer? |  | The alternative address is to remain confidential? Y/N | Hospital Midwife |
| Have any arrangements been made for identified foster carers to visit? |  |  | Safeguarding Midwife and Social Worker |

1. **Family Information**

|  |  |  |
| --- | --- | --- |
| **Mother:-** | | |
| Name: | | Date of Birth: |
| Home Address: | | Ethnicity: |
| First language:  Are there any barriers to communication ?(e.g. limited English, learning difficulties, hearing or eyesight problems ) | | Interpreter Required: Y/N |
| Is the Mother a Looked After Child Y/N | | |
| At this current time the Social Worker is satisfied that Mother understands the plan and its implications. Y/N  If No please add additional info:    **Consent can be withdrawn at any time by any person with parental responsibility and escalated to social care (if relevant)** | | |
| **Partner(Second Parent):-** | | |
| Name: | Date of Birth: | |
| Home Address: | Ethnicity: | |
| First language:  Are there any barriers to communication? | Interpreter Required: Y/N | |
| Is the Partner (Second Parent) a Looked After Child? Y/N | | |
| At this current time, the Social Worker is satisfied that the Partner (Second Parent) understands the plan and its implications. Y/N. If No please add additional info:  **Consent can be withdrawn at any time by any person with parental responsibility and escalated to social care (if relevant)** | | |
| **Any Other Key Adults:-** | | |
| Name: | Date of Birth: | |
| Relationship to Unborn Baby:  Home Address: | Ethnicity: | |
| First language:  Are there any barriers to communication? | Interpreter Required: Y/N | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Unborn Baby Siblings or other children that need considering in the family unit:-** | | | | |
| **Name** | **Date of Birth** | **Gender** | **Address** | **Primary Carer** |
|  |  |  |  |  |
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|  |  |  |  |  |

1. **Distribution of the plan - Social worker is responsible for distributing the plan:**

|  |  |  |
| --- | --- | --- |
| **Plan discussed and shared with:** | **Yes/ No/ Not Applicable** | **Date** |
| Mother | If No, Why? | Date shared: |
| Partner (Second parent) | If No, Why? | Date shared: |
| Social Worker/Children’s Services Department |  | Date shared: |
| Allocated/Named Community Midwife |  | Date shared: |
| Safeguarding Midwife |  | Date shared: |
| South Central Ambulance Service (SCAS) |  | Date shared: |
| Health Visitor |  | Date shared: |
| Family Nurse Partnership |  | Date shared: |
| Police |  | Date shared: |
| Perinatal Mental Health Team/AMHT |  | Date shared: |
| Primary Care (GP’s) |  | Date shared: |

**Appendix One- Key Professionals Contact Details:-**

|  |  |
| --- | --- |
| **Key Professionals** | |
| Name of Hospital/ Birthing Unit |  |
| Allocated/Named Community Midwife  Team  Contact Details |  |
| Named Health Visitor or Family Nurse Partnership  Organisation  Contact Details |  |
| GP Name  Practice  Contact Details |  |
| Named Social Worker  Team  Contact Details |  |
| Lead consultant (Obstetrics)  Contact Details |  |
| Perinatal Mental Health Team and/or Mental Health Services involvement? Y/N  **If Yes, please elaborate and provide contact details:** | |
| Other support services (Housing, Substance Misuse Team, Domestic Abuse, Probation Service, Specialist Learning Disability Team, etc. **Please specify:** | |