



Hampshire, Isle of Wight, Portsmouth and Southampton (HIPS) Unborn/New Born Baby Protocol

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1. Introduction

- 1.1 Safeguarding is the action that is taken to promote the welfare of children and protect them from harm; ensuring children grow up with the provision of safe and effective care and taking action to enable all children and young people to have the best outcomes.
- 1.2 Child Protection is part of the safeguarding process. It focuses on protecting individual children identified as suffering or likely to suffer significant harm. This includes child protection procedures which detail how to respond to concerns about a child. Safeguarding children and child protection guidance and legislation applies to all children up to the age of 18.
- 1.3 Section 11 Children Act 2004 places duties on organisations to ensure that they consider the need to safeguard and promote the welfare of children when carrying out their functions. Section 10 of the same Act requires agencies to cooperate with local authorities to promote the well-being of children in each local authority area.
- 1.4 Young babies are particularly vulnerable to abuse and work carried out in the antenatal period can help minimise any potential harm through early assessment, intervention and support (Brandon et al 2016).
- 1.5 The antenatal period provides a window of opportunity for practitioners and families to work together to;
 - Form relationships with a focus on the unborn baby
 - Identify risks and vulnerabilities at an early stage
 - Understand the impact of parental risk factors to the unborn baby when planning for their future;
 - Explore and agree safety planning options;
 - Assess the family's ability to adequately protect the unborn baby and provide appropriate parenting once the baby is born.
 - Identify if any assessments or referrals are required prior to birth
 - Ensure effective communication, liaison and joint working with any services working with the family
 - Agree plans for support which reduce the potential risk of harm to the unborn/new born
 - Support families and children's Social Care where a legal process is likely to be needed such as child protection planning or pre-proceedings.
 - Avoid delay in care for the child where the Public Law Outline threshold is reached.
- 1.6 The National Maternity Review: Better Births (2016) identified that every person, every pregnancy, every baby and every family is different. Therefore, quality services must be personalised to meet the needs of the baby as well as the wider family; adopting a Think Family approach.
- 1.7 The vast majority of situations during pregnancy will have no safeguarding concerns, however in some cases, to ensure that the appropriate support is in place for the pregnant person and wider family members during the perinatal period, a co-ordinated response is required by agencies to best protect the baby, before and following birth.
- 1.8 In these cases, the National Service Framework for Children, Young People and Maternity Services (2004) recommends that Maternity Services and Children's Social Care (CS) adopt joint working arrangements which promote an appropriate multiagency response to concerns regarding the welfare of an unborn baby and his/her future due to the impact of parent's needs and circumstances.

- 1.9 The aim of this protocol is to enable practitioners to work together with families to safeguard unborn/new born babies where risk is identified. The protocol sets out how to respond to concerns for unborn babies, with an emphasis on clear and regular communication between professionals working with the pregnant person and their family. This protocol outlines the agreed process between health agencies, social care and other partner agencies who are working with the pregnant person and their family on the planning, assessment and actions required to safeguard the unborn/new born baby.
- 1.10 It is important that all agencies involved in pre and post birth assessment and support fully consider the significant role of fathers, partners, wider family members or other significant adults in the care of the baby even if the parents are not living together and where possible involve them in any assessment.
- 1.11 Information should be gathered about partners who are not the biological father at the earliest opportunity to ensure any risk factors can be identified.
- 1.12 This protocol should be read alongside the HIPS protocol for the management of actual or suspected bruising in infants who are not independently mobile; ‘Working Together to Safeguard Children 2018’ and other relevant HIPS procedures, available [here](#).

2.0 Scope

2.1 This protocol applies to all professionals who have identified any concerns for an unborn/new born baby.

2.2 In order to remain neutral, this protocol will make reference to “the person who has given birth to the child”, “the pregnant person” or the “person”.

3.0 Purpose

3.1 This protocol provides a robust framework for responding to safeguarding concerns and safe planning by practitioners working together and with families to safeguard the baby before, during and following birth within Hampshire, the Isle of Wight, Portsmouth and Southampton.

4.0 Definitions

Word or Phrase	Definition
Concealed Pregnancy	<p>A concealed pregnancy is where;</p> <ul style="list-style-type: none"> □ A person knows they are pregnant but does not engage with appropriate services; or □ A person appears genuinely unaware that they are pregnant <p>Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.</p> <p>Concealment of pregnancy may be revealed;</p> <ul style="list-style-type: none"> □ Late in pregnancy □ In labour; or

	<ul style="list-style-type: none"> □ Following delivery. The birth may be unassisted and may carry additional risks to the child and pregnant person’s welfare.
Delayed or Late Booking	<p>A late booking is defined as presenting for maternity services after 20 weeks of pregnancy.</p> <ul style="list-style-type: none"> □ The pregnancy may be undetected, where both the pregnant person and their health care providers are unaware that they are pregnant □ It may be a conscious concealment, where the pregnant person is aware of their pregnancy and is emotionally bonded to the unborn baby but does not tell anyone □ The pregnancy may also be denied, this may be a conscious denial where the pregnant person has physical awareness of the pregnancy but lacks emotional attachment to the foetus, or; □ Unconscious denial, where the pregnant person is not subjectively aware of their pregnancy and genuinely does not believe the signs of pregnancy or even the birth of the baby (e.g. Psychotic disorder)
Early Help	<p>A multi-agency team within the local authority who can offer support for those circumstances in which a professional might feel that a child is not at risk of harm at the moment, but the family needs more support to fully meet the child’s needs and prevent any issues from increasing. Please note that this offer is different within each Local Authority.</p>
Multiagency Safeguarding Hub (MASH)	<p>The MASH is a team including Police, Health Children’s Social Care and other agencies (depending on local arrangements). This team receive referrals made to children’s social care and upon receipt, will share information quickly in order to make decisions as to the required level of intervention.</p>
Child Protection Information Sharing (CP-IS)	<p>CP-IS is a nationwide solution that connects Local Authority children’s social care systems with those use by NHS unscheduled care settings. It enables the exchange of key child protection information and episodes of unscheduled NHS care.</p>
Female Genital Mutilation Information System (FGM-IS)	<p>If a person delivers a female child and there is a family history of FGM, a FGM indicator should be added to the NHS Spine Portal Summary Care Record (SCR) of the child. The FGM-IS (FGM – Information System) is a national safeguarding system designed for sharing of information, the FGM-IS tab on the SCR is accessible for girls under the age of 18 years and will be used to identify any female under 18 years who has been identified as at risk of FGM</p>
Local Safeguarding Children Partnership (LSCP)	<p>A Local Safeguarding Children Partnership (LSCP) is independently chaired and consists of three key partners; the Local Authority, the local Clinical</p>

	<p>Commissioning Group and the local Police force. These partners share equal responsibility for developing and leading the partnership arrangements.</p>
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5.0 Information Sharing

5.1 To safeguard children it is essential that practitioners share information and refer to the cross-government guidance on how to share information. The decision and rationale for the decision to share or not to share information must be clearly documented. In practice, consent should always be sought if possible and it is safe to do so, although the individual practitioner needs to take an independent decision on whether sharing information is necessary and permitted by law to address the safety of the individual or individuals.

5.2 To support professionals with identifying how and when to share information, a flowchart and information sharing form have been added to this protocol, see Appendix 2 and Appendix 3.

6.0 Mental Capacity Act Considerations

6.1 In UK law, a person's 18th birthday draws the line between childhood and adulthood (Children Act 1989). In health care matters, an 18 year old enjoys as much autonomy as any other adult.

6.2 However, the Mental Capacity Act applies to 16 and 17 year-olds, who can also take medical decisions independently of their parents.

6.3 Young people aged 16 or 17 are presumed in UK law, like adults, to have the capacity to consent to medical treatment. However, unlike adults, their refusal of treatment can, in some circumstances be overridden by a parent, someone with parental responsibility or a court. This is because we have an overriding duty to act in the best interests of a child. This would include circumstances where refusal would likely lead to death, severe permanent injury or irreversible mental or physical harm.

6.4 A referral must be made to children's social care for any person under the age of 18 where safeguarding concerns are present. Where a young person under the age of 18 is pregnant and safeguarding concerns exist, a referral must be made in the interest of both their safety and the safety of the unborn baby.

7. Roles and Responsibilities

7.1.1 The definition of the roles and responsibilities of those involved, social care, health workers, police and other professionals, are informed by the Children Act 1989 and the statutory guidance as given in 'Working Together to Safeguard Children; 2018'.

7.1.2 It is the responsibility of all professionals to:

- Work to statutory guidance
- Understand and work to the guidance in this document
- Understand and work to their relevant professional guidance
- Share information in an appropriate and timely way
- Refer – not assume that another professional has done so - and escalate issues as necessary
- Engage in 'Early Help' (as applicable in each local authority area) and 'Children in Need' processes for cases below the section 47 threshold
- Respect the view and roles of other involved professionals
- Consider risk of Child Sexual Exploitation (CSE), other Sexual Crime and other forms of exploitation including Child Criminal Exploitation (CCE).

7.1.3. If any professional encounters a person that they believe to be pregnant, and they also believe that person has not sought health advice, they should encourage them to seek support from a Midwife and/or GP.

7.2 Role of Children's Social Care (CSC) and Social Workers

- Accept referrals from other professionals
- Work to the [thresholds](#) published within their LSCP document
- Make enquiries and decide if any action must be taken under section 47 of the Children Act 1989. An unborn child may be subject of section 47 enquiries.
- Decide within one working day the type of response a referral requires
- Give feedback on referrals taken • Lead assessment processes where social work thresholds are met
- Make clear to families how a social work led assessment will be carried out and when they can expect a decision on next steps.
- Ensure assessment is fully informed by the views of other professionals
- Initiate strategy discussions to decide on section 47 thresholds where this is necessary
- Convene an Initial Child Protection Conference for the unborn/new born child if thresholds are met
- A social worker will be the Lead Professional for any case where a Child Protection Plan is in place

7.3 Role of Health Care Staff

Healthcare staff must consider the needs of the unborn baby including whether there could be child protection risks after birth. Within the United Kingdom, the law dictates that there is a difference between an unborn and a new born baby (European Council on Human Rights, 2008) and decisions in regards to the unborn baby therefore also need to take account of the needs and rights of the pregnant person.

This protocol is intended for use by all health professionals and in particular staff who provide care to pregnant person and their families, namely Midwives, GP's, Health Visitors and Family Nurses. However, Midwives have a significant role in identifying risk factors to the unborn/new born baby during pregnancy, birth and the post-natal period both in hospital and the community. Midwives are the primary health professional working with and supporting a person throughout pregnancy. Health Visitors and/or Family Nurse Partnership teams also offer antenatal support. The relationship they foster with the pregnant person provides an opportunity to observe attitudes towards the developing baby and identify potential problems during pregnancy, birth and the child's early care. All pregnant persons will have a named midwife who will:

- Identify pregnant persons where existing risk factors may impact on the wellbeing of the unborn/new born baby and where additional support or protection is required.
- Identify the need for early intervention when planning care by undertaking an early help assessment where appropriate (as applicable dependent on local offer)
- Plan care for the pregnant person and their unborn baby, with the wider maternity team as required, and records the details of this in the person's hand held maternity notes
- Effective inter/intra agency sharing of information, assessment, co-ordinated joint working and care planning for pregnancy and the immediate postnatal period
- Ensure effective notification to Health Visiting and ongoing liaison
- Ensure the views of the parents are sought and are involved and informed in all decisions that affect them.
- Coordinate the health care from confirmation of pregnancy, including the wellbeing concerns for the unborn baby until hand over to the health visitor or family nurse as the named person.
- Consider risk of Child Sexual Exploitation (CSE) and other sexual crime
- Identify Female Genital Mutilation (FGM), record all cases via the FGM-IS and refer according to mandatory processes following discussion with the pregnant person and on a case by case basis, using professional judgement as per [Department of Health guidance](#).

During the childbirth continuum it may be necessary for health professionals to refer to Children's Social Care.

7.4 Midwives

Midwives should risk assess every pregnancy at booking. Social information known to the GP is requested for every pregnant person and hospital records are checked if indicated. If an appointment is made very late for antenatal care (after 20 weeks of pregnancy), the reason for this must be explored. Communication with the GP and Health Visiting colleagues should take place to gather information and if there is a cause for concern, a referral must be made to the relevant Children's Social Care. CP-IS should be checked once it is embedded in maternity services in line with the national roll out. The person must be informed that the referral has been made, unless there are significant child protection concerns that prevent a professional from doing so.

If a person arrives at the hospital in labour or following an unassisted delivery, where a booking has not been made, a referral should always be made to the relevant Children's Social Care Department by the midwife or other appropriate person. CP-IS should also be checked once it is embedded in maternity services for any pregnant person under the age of 18 years. The baby should not be discharged from hospital until a strategy discussion has been held and/or relevant assessments undertaken. *NB Health Professionals have no legal right to stop a person self-discharging along with their baby. The Midwife or appropriate person must immediately contact the Police in these circumstances and subsequently, notify Children's social care.

7.4.1 Health Visitors and Family Nurses (FNP)

If a person refuses all attempts to persuade them to seek health advice from a Midwife or GP in relation to their pregnancy, the reasons should be explored and if safeguarding concerns exist, a referral must be made to children's social care.

If a person refuses all attempts to persuade them to seek health advice from a HV/Family Nurse (FN), the reasons for this should be explored. If the person makes an informed decision not to engage with Health Visiting/Family Nurse services, the organisation in which those services sit should follow their disengagement policy. This should include ensuring that the person's GP is aware of the informed decision to disengage and that information is shared with other professionals as required. This should include a referral to children's social care if required due to safeguarding concerns. From a Think Family perspective, practitioners should consider the needs of the adult person concerned. This may include utilising the HIPS Multi-Agency Risk Management ([MARM](#)) framework or making referrals to relevant Adult Services depending on the needs identified, with the consent of the adult.

It is best practice to discuss the circumstances of the person with the Midwife, GP, FNP Supervisor, School Nurse, as appropriate and the Named Nurse/Midwife for Safeguarding.

Always remember that HV/FNP should ensure they make ante-natal contact with the pregnant person as a priority, particularly where there are safeguarding concerns.

7.4.2 School Nurses

The School Nurse may well be able to help a child who is pregnant to accept that they need support. If possible, having gained consent from the child, the school Nurse should liaise with the G.P and Midwife to consider a way forward. If faced with denial or refusal to seek medical attention the School Nurse should make a referral to Children's Social Care. School staff, parents or others that may become aware that a pupil is pregnant can support the child to liaise with the school nursing service. Accurate record keeping in relation to any such contact by the school nursing service is vital.

7.4.3 General Practitioners (GP's)/Primary Care

It is good practice to signpost/refer all pregnant persons to a midwife as soon as possible, in order that the most appropriate care is given.

Where a GP has significant reason to believe a person is pregnant, but who refuses all attempts to persuade them to undertake further investigations, further action needs to be taken.

This should include discussion with the Midwife, HV/FN or School Nurse (as appropriate). It may also be helpful to discuss the concerns with the Designated Doctor or Named GP for Safeguarding Children. If the person refuses all attempts to persuade them to seek health advice the G.P. should make a referral to children's social care.

7.4.4 Substance Misuse Specialists

If the pregnant person and/or their partner are identified as misusing drugs or alcohol, a referral to substance misuse services should be made. If a pregnant person and/or their partner are known to the local substance misuse service, a referral should be made to the Drug & Alcohol Liaison Team who will follow maternity pathways. Referral to Children's Social Care should be considered using the relevant assessment tool.

7.4.5 Mental Health and Learning Disability Specialists

When working with a pregnant person and/or their partner who has mental ill health or learning disabilities, professionals in these services should encourage these persons to access early ante-natal care and support. Professionals working in Mental Health or with clients with learning difficulties may be well placed to support the person given the therapeutic relationship with them.

It is imperative that Learning Disability or Mental Health specialists support other professionals in their assessments to ensure the needs of the person are fully understood.

Those with learning disabilities must be supported by professionals to access information in a format that they understand.

7.4.6 Role of the Specialist Safeguarding Team in Acute Hospitals

Where the unborn baby is subject to child protection planning, it is the responsibility of the Social Worker, along with core group members, to develop the Child Protection plan and disseminate to agreed partners and relevant birthing units.

The detailed Pre and Post Birth Plan will be developed at 34 weeks gestation or at the earliest opportunity once agencies aware of the pregnancy. The plan will be disseminated to relevant professionals and include contact numbers and names of professionals involved and the agreed discharge arrangements.

7.5 Role of Other Professionals/Agencies

For those professionals not specifically identified within the protocol and where there are concerns regarding an unborn/new born baby, a referral should be made into the local MASH via the appropriate local [referral method](#). Local LSCP's will continue to promote this protocol and signpost professionals to the HIPS procedures website for further guidance.

8. Risks and Risk Assessment

See appendix 4 for risk assessment tool guidance and appendix 5 for the full interactive Risk Assessment Flowcharts.

8.1 Every assessment should reflect the unique characteristics of the unborn/new born child within their family and community context. Family assessments that include all members of the family (including any wider significant adults) should always ensure that the needs of individual children receive distinct consideration.

8.2 Providing early help is more effective in promoting the welfare of children than reacting later when the problems being experienced by the child and family are often more difficult to resolve. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

9. Request for Referral for Children's Social Care (CSC) or Early Help (As applicable by area)

9.1 Referrals to CSC about unborn babies who may need services should be made as soon as concerns have been identified in order to support families as early as possible. Should referrals not be accepted by CSC teams, professionals should either follow advice to re-refer at a later gestation or if this is not deemed appropriate or acceptable, refer to the [HIPS Escalation Policy for the Resolution of Professional Disagreement](#).

9.1.2 Consideration must be given as to the needs of the person and/or any other adult (i.e. partner or the baby's father) and whether a referral to any relevant adult services is required with the adults consent.

9.2 RISK ASSESSMENT can be categorised into 3 main areas (see Appendix 5). Professional judgement and supervision/advice should be used when required. The tool aligns to the LSCP [threshold](#) documents.

9.2.1 Yellow Risks where there is a Consideration for Early Help support; this must be with full consent from either parent. Where there are a number of yellow risks or a mixture and yellow and amber risks a referral to CSC may be required. Professional judgement should be used at all times.

9.2.2 Orange/Amber risks are where there is a Consideration for referral to CSC with medium risk factors or family concerns. Where there are a number of orange/amber risks professional judgement must be used and referral made.

9.2.3 Red risks mean a referral to CSC must be made via the relevant [interagency referral form](#) as these identify situations where there is a significant risk of harm to the unborn baby. It is best practice to inform a person that a referral is to be made to CSC if doing so would not increase the risk to the person or the unborn baby, however gaining consent should not become a barrier to safeguarding children where significant risks exist.

9.3 Referrals should be consistent with the guidance in [Working Together to Safeguarding Children \(2018\)](#) and HIPS [procedures](#) and threshold documents.

10. Outcome of Referral to Children's Social Care (CSC) or Early Help (as applicable by area)

10.1 Following referral CSC information may be gathered from the agencies represented in their respective Multi Agency Safeguarding Hubs to determine an outcome for the referral. The outcome should be one of the following:

- Refer back to Universal Services for extra support.

- Early Help Assessment as per local protocol
- A Single (Pre-Birth) Assessment and planning being completed at Child in Need (Section 17) level.
- A Child Protection Enquiry (Section 47) being completed and Assessment being undertaken if it is suspected that the unborn/new born baby may be likely to suffer significant harm.

10.2 It is the responsibility of CSC to notify the referrer of the outcome of the request for their services. If this is not received within 3 days it is the responsibility of the referring practitioner to check the outcome with CSC. If the referrer feels that the criteria for CSC is reached but has been declined they must follow the HIPS [Joint Working Protocol for the Professional Challenge and Resolution of Professional Disagreement](#).

10.3 In cases where CSC accepts the referral and completes an assessment, whilst the case is open to them they will take the lead responsibility for the coordination of the case. This assessment should be completed by the social worker within 45 days.

10.4 The Social Worker undertaking the assessment is responsible for sharing that assessment with other professionals. CSC may assess that the threshold for their services has not been met; however they may signpost the referrer to other appropriate agencies /services. All CSC decisions should be relayed in writing to the referrer and the family. If the referrer does not feel that CSC decision is appropriate they must seek advice from their named practitioners for safeguarding. Any step down arrangements should be clear and agreed by the family and agencies involved.

10.5 At any point during the course of the Assessment, CSC may decide there is reasonable cause to believe the baby is likely to suffer significant harm and initiate a S.47 inquiry and convene an Initial Child Protection Conference.

10.6 Initial Child Protection Conference (ICPC) The aim of an ICPC is to ensure all the information from the involved agencies for the family is brought together and analysed. An ICPC should be convened between at 24 weeks to 28 weeks of pregnancy or as soon as appropriate once pregnancy is known.

10.7 Professionals should re-refer any case to CSC if they feel that there has been a significant change that increases the risk to the unborn/new born baby including disengagement with Services.

10.8 If there is disagreement regarding decision making at any stage professionals should seek advice and supervision as per their agencies process e.g. Named and Designated Professionals within health services and follow the [Joint Working Protocol for the Professional Challenge and Resolution of Professional Disagreement](#) as required.

10.9 Where these differences cannot be resolved professionals should follow their own escalation process and the HIPS 4LSCP Escalation Policy

11. Multi-agency Pre and Post Birth Plan

11.1 A Multi-Agency Pre & Post Birth Plan must be created by 34 weeks gestation or as soon as appropriate once pregnancy is known. This is the responsibility of the Lead Professional (Social Worker if open to CSC) and should be made in agreement with their manager, the Safeguarding Midwife and any other relevant professional (including the Health Visitor). The plan will include the arrangements for delivery and the immediate post-natal period. Where there are concerns about a family irrespective as to whether the unborn baby is subject to a child protection plan, a multi-agency pre & post birth plan should be agreed. The agreed plan must be kept where practitioners can access its contents in and out of hours to enable midwives and Social Workers to know how to respond. The plan should be shared with parents unless to do so is felt to put the pregnant person/person who has had the baby or the baby at increased risk.

11.2 The multi-agency pre & post birth plan should include contact numbers and names of professionals' involved and clear directions as to where the infant should be cared for following delivery depending on the risk. Where CSC have the lead professional role, it is the responsibility of the allocated social worker to ensure that CSC 'Out of Hours' are made aware of the multi-agency plan. It is the responsibility of the midwife agreeing the multi-agency pre & post birth plan to ensure that other health practitioners involved are informed, for example the obstetrician, neonatologist, GP, HVs, Family Nurse and the safeguarding team within the relevant health agency. All agencies should know what role they have at this time and be clear about their responsibilities.

11.3 Appendix 6 provides guidance for Lead Professional or social workers and midwifery practitioners on the information required for a multi-agency pre & post birth plan and is a useful tool at any other meeting where a safety plan is being developed.

11.4 Plans for discharge for babies identified by this protocol are usually made at the pre-birth planning meeting. Where this has not occurred, there are last minute changes to the plan or new or increasing concerns/risks have emerged, discharge plans should be discussed with CSC and or other involved agencies and a pre-discharge planning meeting arranged.

11.5 The plan should recognise that hospitals are not secure settings. As such the plan should consider contingency plans to include the period between birth and discharge from hospital. It should consider the role of the police in any immediate protection requirements. Where discharge is likely to be complex e.g. discharge to foster placement a pre-discharge planning meeting must be considered.

11.6 It must be recognised by all professionals involved that multi-agency pre & post birth plans can change at short notice and can be fluid. Professionals should exercise their professional judgement to keep the baby and others safe.

11.7 In situations where there is a delay in discharge of the person who has given birth and baby due to social reasons as opposed to medical requirements this needs to be agreed on an individual basis. If a hospital extension is required for social reasons only, risk assessments need to consider the role of the midwife and the risks to the baby. The hospital can, in these situations, charge the Local Authority for the extended stay. It must be remembered however that midwifery units are not a place of safety and supervision may need to be put in place by CSC.

11.8 The pre-birth risk assessment may conclude that the baby would be at risk of significant harm if the infant remains in parent's care following birth. In these circumstances CSC may plan to apply to the courts for an Order to remove the baby to a place of safety following birth. Due to legal reasons applications to court cannot be made prior to birth. It is the responsibility of the attending professional (normally the midwife) to inform CSC and where appropriate the police when labour starts and when the baby is born. It is, however, the decision of the courts whether to grant an Order and alternative care and management of the baby will need to be agreed by all multi-agency partners if this is refused (in this situation a Pre-Discharge Planning Meeting should always be convened to ensure robust plans are in place to keep the infant safe).

11.9 If CSC are applying to court for an Order the court will require a number of days to list a court hearing. There will need to be a safety plan for the new born baby between the application being made and the date of the hearing. Police Protection arrangements may need to be considered as part of the safety arrangements and the police should routinely receive a copy of the multi-agency pre & post birth plan in these circumstances. If Police Powers of Protection are agreed these can last up to 72 hours, but this is not automatic and there should be agreement in place detailing how long this will be required for and recorded as well as contingency plans in case police decide not to exercise their Powers of Police Protection.

12. Management of Emotionally Challenging Cases

12.1 Facilitating Removal of a New Born Baby from Parents' Care.

These are emotionally challenging cases and require sensitivity and effective management. There is no guidance currently available that outlines organisational and professional roles or responsibilities when removing babies from parents care. This may include how and when the removal takes place, by whom, the correct process of doing so and the support mechanisms needed to support the person who has given birth and practitioners afterwards.

12.2 Each case should be individually assessed and where possible should involve the parents in the process. The person who has given birth/parent's wishes should be ascertained and taken into account when deciding how the baby will be removed. There should be clear communication between the Social Worker, the Midwife in charge of the person who has given births' care and the parents (where possible) in order to identify in advance who will facilitate the separation of the baby from the parents and find an appropriate place for the separation to take place, ensuring the needs of the baby are prioritised at all times.

12.3 Support for Parents- Those who have a baby placed in alternative care are noted to have experienced reactions akin to the grief and loss of those whose babies have died. Practitioners should consider a trauma informed approach when supporting these parents and should consider the impact of physical recovery on a person's body post birth and how this may be particularly difficult for a person who has had their child removed from them at birth.

12.4 In each individual case, practitioners caring for both the person who is giving birth to the child and the baby (in discussion with social workers) should consider if offering mementoes such as pictures, handprints, footprints etc. would be appropriate and if copies should be provided for the baby's life story work. The following family support networks are available and should be offered if appropriate:

British Association for Counselling & Psychotherapy http://www.bacp.co.uk/	MATCH http://www.matchmothers.org/
Family Lives: 0808 800 2222 http://www.familylives.org.uk/	National Association of Child Contact Centres http://www.naccc.org.uk/ Feb 2017 FINAL
Woman's Aid: 0808 2000247 www.womensaid.org.uk	Natural Parents Network http://www.n-p-n.co.uk/
Family Rights Group: 0808 801 0366 http://www.frg.org.uk/	CAFCASS: 0300 456 4000 https://www.cafcass.gov.uk/
After Adoption 08008402020 www.afteradoption.org.uk	Grandparents Association 03000337015 http://www.grandparentsplus.org.uk

12.5 Support for Staff- Practitioners who provide care for people who have given birth to a baby and whose babies are removed shortly after birth very often will need support following an emotionally challenging case. Supervision is available from a member of the Safeguarding Children's Team for any staff member to give them the opportunity to reflect on their feelings of engaging with child protection processes which results in the removal of babies at birth.

13.0 Concealed Pregnancy Guidance

13.0.1 The concealment or denial of a pregnancy represents a real challenge for professionals in safeguarding the welfare and the wellbeing of the unborn baby and the parent. Research demonstrates that better outcomes can be achieved by co-coordinating an effective multi-agency approach once the fact of the pregnancy is established. This will also apply to future pregnancies where there has been a previous concealed pregnancy. In some cases, pregnancies may be concealed until labour or following delivery, when particular attention should be given to safeguarding the welfare of the baby and to the well-being of the person giving birth.

13.0.2 A late booking may indicate safeguarding concerns or no concerns at all. This guidance deals with cases where the pregnancy has been identified or suspected to be deliberately concealed.

13.1 Aim

13.1.1 The aim of this guidance is to provide frontline professionals with a knowledge base and action strategy for the assessment, management and referral of persons of child bearing age who are concealing the fact that they are pregnant or where there is a known previous history of concealed or denied pregnancy.

13.2 Definition

13.2.1 This guidance applies to any person of child bearing age.

13.2.2 A concealed pregnancy is when a person knows they are pregnant but does not tell anyone; or a person advises someone about the pregnancy but conceals the fact they are not accessing antenatal care or where a person appears genuinely unaware they are pregnant. A denied pregnancy is when a person is unaware of or unable to accept the existence of their pregnancy.

13.2.3 Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.

13.2.4 This can become apparent at any stage of the pregnancy. Concealment of pregnancy may be revealed late in pregnancy; in labour; or following delivery. The birth may be unassisted and may carry additional risks to the baby and person's welfare.

13.2.5 A late booking is defined as presenting for maternity services after 20 weeks of pregnancy. A booking appointment with a midwife should be around 10 weeks ([NICE 2008](#)). In all cases a person who presents to antenatal care late in their pregnancy should continue to be assessed for any risk factors and any reasons for the delay in presentation should form part of the assessment, regardless of whether there is ongoing engagement with services.

13.2.6 The pregnancy may be undetected where both the person and health care providers are unaware that the person is pregnant (e.g. a peri-menopausal person with an abdominal lump initially suspected to be a tumour). Conscious concealment of pregnancy is where a person is aware of their pregnancy and is emotionally bonded to the unborn baby but does not tell anyone. The pregnancy may also be denied; this may be conscious denial where the person has physical awareness of their pregnancy, but lacks emotional attachment to the foetus, or unconscious denial where the person is not subjectively aware of their pregnancy and genuinely does not believe the signs of pregnancy or even the birth of the baby (e.g. Psychotic delusion).

13.2.7 Migrant pregnant person: professionals should consider the set of circumstances for a person who has presented late in pregnancy and been without access to health care; an interpreter should always be used in such circumstances where a person's language skills would prevent a risk assessment on booking into antenatal care.

13.2.8 Unassisted or free birth is when a person gives birth without medical or professional help. It is a criminal offence for anyone other than a registered midwife or doctor to attend a person during childbirth except in an emergency. ([Article 45 of the Nursing and Midwifery Order](#)). Free birth is a conscious choice and in itself does not require multi-agency involvement. ; however if safeguarding concerns are identified a referral to CSC should be made.

13.3 Risks/Safeguarding Issues.

13.3.1 The reason for any concealment will be a key factor in determining the risk to the unborn/child, the person who has given birth and any other children in the household; in all cases, a holistic risk assessment should be undertaken to ascertain the reason for the concealment.

13.3.2 Where there is concealment, there may be risks for the baby's health and development in utero, especially where alcohol or substance misuse is a factor in the concealment. There may also be risks to the unborn baby from any prescribed medications.

13.3.3 A pregnancy may be deliberately concealed in situations where there is domestic abuse; evidence is clear that domestic abuse is more likely to begin or escalate during pregnancy. It may be due to previous involvement with children's social care, which resulted in the removal of previous child/children. Concealment may also be a result of a person being exploited, subject to trafficking or has suffered FGM.

13.3.4 There may be risks to both person and baby if the person has concealed the pregnancy due to fear of disclosing the paternity of the baby, for example, where the baby has been conceived as the result of sexual abuse. Adolescents may conceal their pregnancy due to fear of recrimination from their parents or peers or professionals.

13.3.5 Late booking can be the result of a person presenting for a termination of pregnancy but unable to have this procedure as the pregnancy is over 24 weeks. Professionals need to consider the reasons for presenting late to termination services, associated risk factors, and level of support needed when the person continues with an unwanted pregnancy including their psychological support needs. Consideration should be given to a completing a Multiagency Safeguarding Hub (MASH) referral,

13.3.6 Implications

13.3.7 The implications of concealment are wide-ranging. Concealment of a pregnancy can lead to a fatal outcome, regardless of the person's intention. Concealment may indicate ambivalence towards the pregnancy, immature coping styles, a tendency to dissociate, or serious mental illness (e.g. psychosis) all of which are likely to have a significant impact on bonding and parenting capacity.

13.4 Recognition and Referral: Action on suspecting concealed pregnancy.

13.4.1 Young People aged under 18 - Whilst it is recognised, at 16 and 17yrs a person is more likely to have the mental capacity to make informed decisions, they are still legally a child.

13.4.2 If a young person under 18 years is thought to be pregnant and denying or concealing the pregnancy, the professional who has the suspicion should ask the young person if they are pregnant.

13.4.3 The young person should be supported in seeking the attention of a medical professional in order to receive appropriate healthcare and investigations; if pregnancy is confirmed there should be a sensitive, confidential discussion regarding choices, ideally guided by what the young person sees as their need. Engaging with the young person at this stage allows the opportunity to explore any safeguarding concerns and what support can be offered by external agencies.

13.4.4 If the young person declines to engage in supportive discussion, and it is suspected they are pregnant, the professional/s involved must refer to children's social care for a pre-birth multi-agency assessment according to HIPS procedures. Please refer to UBB Pathways for ongoing care planning. Please note that in these circumstances, potential safeguarding concerns outweigh the young person's right to confidentiality. We have to advise the young person that we have a duty to share this information with CSC and as a result their parents are likely to be informed. Local teenage pregnancy guidance and pathways should be followed. Social care colleagues should consider, in conjunction and with consent from the young person, notifying the young person's education setting if appropriate.

People aged 18 years and over:

13.4.5 Every effort should be made to confirm whether they are pregnant or not. Although no one can be forced to undergo a pregnancy test, or any other medical examination, in the event of refusal, professionals should proceed on the assumption that the person is pregnant, until or unless it is proved otherwise, and endeavour to make plans to safeguard the baby at birth. A referral should be made to MASH and liaison with other professionals will need to take place.

Pregnant person with a learning disability

13.4.6 Should there be a concern that the person has a learning disability the person can be referred to the Learning Disability Team via the GP. This would only be with consent from the pregnant person and should not be considered as a routine referral, it has to be the individual's choice. Additional support from health professionals, including community nursing and psychology can be provided that may help with enhancing the person's understanding of pregnancy and birth and provide emotional and psychological support before and after the birth of the baby.

Pregnant person with additional mental health needs

13.4.7 Should there be concerns about a person's mental health, the person should be offered a referral to mental health services. This may include perinatal mental health services and may include an assessment of attachment and bonding to their new-born baby. This can be invoked during the antenatal period if discovered in time.

13.4.8 It is unusual for a woman to refuse offers of extra support in these cases; therefore, in any event, if a mental health or perinatal mental health assessment is judged necessary by a clinician and the woman declines to access it, this should increase the clinicians' concerns about the baby's wellbeing and strengthen the need to consider a referral to MASH.

13.5 Planning and Intervention

Children's Social Care

13.5.1 An unborn baby has no legal standing in the UK. Law cannot force an expectant person to have any medical intervention at birth unless they lack capacity, which has been assessed in line with the Mental Capacity Act, and if there is an unassisted delivery; the lack of professional involvement may lead to undiagnosed complications which could have serious outcomes for mother and/or baby where medical

intervention is judged to be necessary and in the person's best interest. It is only possible to make appropriate contingency plans and to ensure that the individual is fully aware of the consequences of their actions. In all cases, legal advice should be sought.

13.5.2 Where a person is in the third trimester (more than 27 weeks pregnant) and there are concerns about late presentation or lack of engagement, a referral to MASH needs to be considered.

13.5.3 In the situations where a person presents during labour then a referral to MASH must be made.

13.5.4 If a person presents following unassisted delivery at the end of a concealed pregnancy then a referral to MASH must be made.

Health Professionals

13.5.5 A wide variety of health professionals may be in contact with people of child bearing age and should consider, where circumstances suggest it, whether a pregnancy is being concealed. This includes those professionals working directly with people who are inpatients, and those in community or primary care settings.

13.5.6 Those professionals working in mental health and learning disability may also be involved with a person who is concealing a pregnancy.

13.5.7 Mental illness, emotional problems, personality problems, a learning disability or substance misuse may all be contributory factors as to why some people conceal the fact that they are pregnant.

13.5.8 The health professional identifying the potential concealment of a pregnancy should inform the person of plans to refer to the MASH, unless to do so would place the unborn baby or the person at significant risk of harm, such as domestic abuse and share the information with health colleagues including midwifery, GP and 0-19 Services to ensure access to appropriate services and support.

13.5.9 Clear contemporaneous documentation of conversations and actions should be added to the person's record.

13.5.10 Given that a previous concealed pregnancy indicates increased risk of further concealment, where this has been the case it should be highlighted in the G.P., midwifery, mental health and health visiting records.

13.5.11 As partner agencies of the LSCPs, health professionals will be expected to participate in, and contribute to, multi-agency assessment of risk and to the provision of additional support to the baby and family as appropriate.

13.5.12 At any stage, professionals should consider involving local specialist services who are experts in working with young people; for example sexual health outreach services or the Family Nurse Partnership.

Staff in Educational Settings

13.5.13 If a member of school staff is concerned that a pupil is attempting to conceal or deny a pregnancy or appears to be unaware that they may be pregnant, the following procedures should be followed:

- Inform the Designated Safeguarding Lead (DSL) or Head Teacher
- Discuss concerns with the pupil, unless in doing so you consider this may increase the risk of harm to the student or to their unborn baby.

- Seek consent from the pupil to share your concerns with their parents or carers. If the pupil is reluctant to consent to their parents or carers being informed this must be treated with sensitivity and respect but the pupil must be informed that a referral will be made to MASH.
- Inform the pupil and their parents of your intention to share your concerns with MASH in the area in which the pupil resides.
- Document conversations with the pupil and their parents or carers contemporaneously and a copy of the written referral to MASH, retained in the child's confidential school record.

13.5.14 As partner agencies of the LSCPs school staff will be expected to participate in, and contribute to, a multi-agency assessment of risk to the child and their unborn baby and to the provision of additional support to the child and family as appropriate.

Police

13.5.15 The Police will be notified of any referral that may require s47 enquiries to be made by Children's Services Social Care following a concealed pregnancy.

13.5.16 Strategy discussions will determine further police involvement.

Other Agencies

13.5.17 All professionals from statutory and voluntary agencies who provide services to people of child bearing age, should be aware of the risk indicators of concealed or denial of pregnancy and how to act on these concerns; for example, contact children's social care, follow local child protection procedures.

13.6 Following delivery of a concealed pregnancy: Immediate Protective Actions, following LSCP child protection procedures.

13.6.1 In some cases, depending on identified risks, babies may need to be placed somewhere else other than with their parents and generally this would be a voluntary agreement; although clearly there could be circumstances in which it might be necessary to consider an application for an emergency protection order or to seek the assistance of the Police, in preventing the child from being removed from the hospital.

13.6.2 In both situations Children's Social Care should consider allocating the assessment to a worker with mental health (MH) expertise or seek advice from a MH professional when undertaking an assessment.

13.6.3 If the baby has been harmed, has died or been abandoned, child protection procedures should be followed.

13.6.4 The discharge summary from maternity services to primary care and health visiting services must record if a pregnancy was concealed or booked late (after 20 weeks). Midwives, 0-19 Service, mental health professionals (where applicable) and GPs should ensure that information regarding the concealed pregnancy is placed on the baby's records, as well as the person's records.

13.6.5 The health visitor must be informed prior to the person being discharged from hospital, to enable the required level of antenatal and postnatal targeted support to be put in place.

13.6.6 Following a concealed pregnancy or unassisted delivery, midwives, health visitors and GPs need to be alert to:

- An enhanced level of professional engagement required for the pregnant person to include a Family Approach

- Difficulties with bonding, attachment and post-natal mental health issues as well as infant mental health
- The receptiveness to future engagement with health professionals
- An awareness of and vigilance for, disguised compliance
- An increase in risk of domestic abuse and sexual violence.

13.7 Future Pregnancies

13.7.1 Following a concealed pregnancy where significant risk has been identified, Children's Social Care should take the lead in developing a multi-agency contingency plan, to address the possibility of a future pregnancy. This will include a clearly defined system for alerting Children's Social Care if a future pregnancy is suspected.

13.7.2 Where it is known there is a history of previous concealed pregnancy, referral must be made to the MASH as soon as any subsequent pregnancy is known. People who have already concealed a pregnancy are at a particular risk of doing so in the future.

13.7.3 Children's Social Care will convene a multi-agency Strategy Meeting and make a plan to address any potential risk within a future pregnancy. Sharing information openly will be a critical factor in safeguarding the unborn baby and professionals will need to accept this may be without the consent of the person concerned.

13.7.4 Only when the underlying reasons for a previous concealed pregnancy are revealed, explored and addressed, can the risk associated with future concealment be substantially reduced.

13.7.5 Where there is a known plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy. The urgency of the meeting will depend on the stage of pregnancy. It is important that all key professionals working with the family are included. At any stage in the process, consideration must be given to the appropriateness of a full psychiatric assessment.

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Appendix 1

Contact Details

Maternity (Hospital) Contact Numbers	
Southampton (Princess Anne Hospital)	Maternity Operation Coordinator available 24 hours a day- Telephone switchboard 023 8077 7222 and ask for Bleep Holder 2872
Portsmouth (Queen Alexandra Hospital)	Maternity Coordinator- Bleep 1333 Labour Ward- 02392 286000 Ext 4500
Winchester (Royal Hampshire County Hospital)	Labour Ward- 01962 824231
Basingstoke (Basingstoke and North Hampshire Hospital)	Delivery Suite-01256 313600
Frimley Park Hospital	Labour ward Matron - Clare Smith-White Labour ward coordinator - 01276 604035 Bleep holder - 01276 604604
Isle of Wight (St Mary's Hospital)	Maternity Coordinator-01983 822099 ext 3210 Labour Ward- 01983 534334

Maternity Safeguarding Children Teams Contact Details	
Southampton (Princess Anne Hospital)	Tel 023 8120 6333 Secure Email uhs.maternitysafeguarding@nhs.net
Portsmouth (Queen Alexandra Hospital)	Tel 02392 286000 Ext 6058 Secure Email pho-tr.safeguardingchildrenteam@nhs.net
Winchester (Royal Hampshire County Hospital)	Tel 07787270233 Secure Email bnh-ft.maternity-safeguarding@nhs.net
Basingstoke (Basingstoke and North Hampshire Hospital)	Tel 07787270233 Secure Email bnh-ft.maternity-safeguarding@nhs.net
Frimley Park Hospital	Tel 07721237435 Secure Email fph-tr.maternitysafeguarding@nhs.net
Isle of Wight (St Mary's Hospital)	Tel 01983 822099 ext 5412 Secure Email iownt.maternity.safeguarding@nhs.net

Children's Services Department Contact Numbers	
Southampton City Council	Children's Resource Service (Formally MASH) Daytime - 023 8083 2300 MASH Email- childrensresourceservice@southampton.gov.uk Out of Hours/Emergency Duty Team- 023 8023 3344 Online referral form
Portsmouth City Council	Daytime MASH- 023 9268 8793 MASH Email- MASH@portsmouthcc.gov.uk Out of Hours/Emergency Duty Team- 0300 555 1373 Early Help and Prevention- 023 9281 5005
Hampshire County Council	Daytime MASH (including Early Help)- 0300 555 1384 MASH Email- childrens.services@hants.gov.uk Online referral form Out of Hours/Emergency Duty Team- 0300 555 1373
Isle of Wight	Daytime MASH (including Early Help)- 0300 300 0117 (running 24 hours a day)

Police Contact Numbers

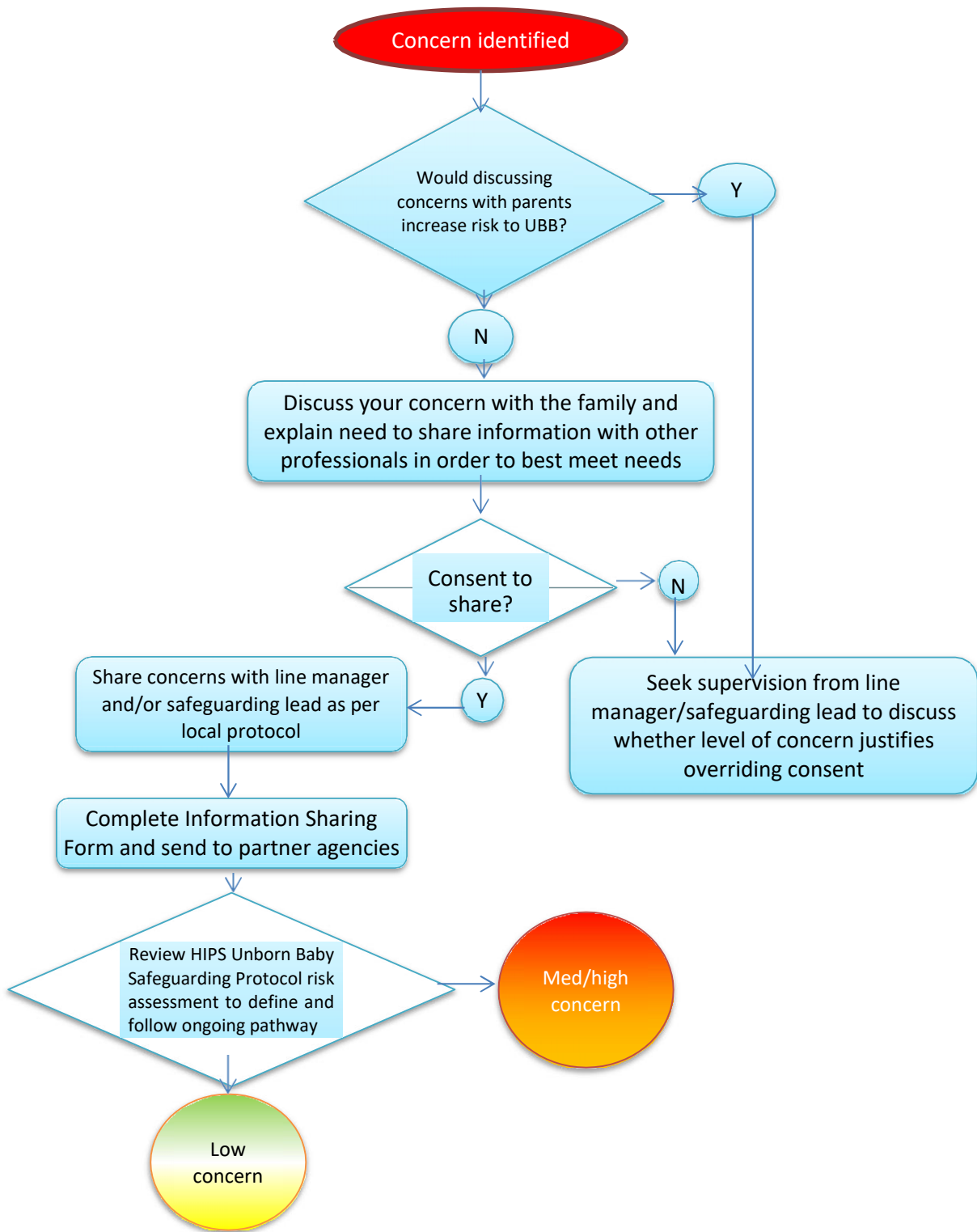
General Police MASH Cover across Hampshire, Southampton and Portsmouth- 0800-1700 Monday to Friday
Hampshire MASH provides contact at the weekends Sat-Sun 0800-2000 and also weekdays until 2000 (from December 2016).

Police will be notified of any concerns that meets threshold following referrals into the MASH.

General Police Contact	999 for emergencies 101 for all other enquiries
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Appendix 2

Safeguarding Information Sharing Flowchart



Appendix 3

Information Sharing Form

This form outlines the minimum information to be shared between agencies/services when there are safeguarding concerns arising for an unborn baby or other children within a family.

This form can be completed at any point during the pregnancy by any professional working with the family, particularly at the Information Sharing points detailed on the full risk assessment in the [HIPS Unborn/New born baby protocol](#). It is to be shared with all significant agencies/professionals involved in the care of a pregnant person (e.g. Midwife, G.P, mental health services, social care).

Please note that this form DOES NOT replace the need for an Interagency or MASH Referral. If there is an allocated social worker then this form is to be shared with them directly. Where there is not an allocated social worker and a MASH referral is indicated following reviewing the risk assessment then follow the MASH process for your area.

Name of professional completing form:	
Agency:	
Contact number:	
Date:	
Unborn Baby of (Pregnant Person's Name) :	
Estimated Due Date:	
Details of concern/information to share (please use bullet points):	
What support has been offered/actions have been taken so far?	
[] I have also completed a MASH referral alongside this form	
I am sharing this information within the consent of the parent or according to the information sharing protocol for my organisation.	

Family Information

Mother	
Name:	Date of Birth:
Home Address:	Telephone Number:
	NHS number (if known):
First language:	Interpreter Required: Y/N
Are there any barriers to communication? (e.g. limited English, hearing or eyesight problems)	
Is the Mother a Looked After Child?	
Partner(Second Parent):	
Name:	Date of Birth:
Home Address:	Tel No:
	Interpreter Required: Y/N
First language:	Interpreter Required: Y/N
Are there any barriers to communication?	
Is the Partner (Second Parent) a Looked After Child?	
Any Other Key Adults:	
Name:	Date of Birth:
Relationship to Unborn Baby:	Tel No:
Home Address:	
First language:	Interpreter Required: Y/N
Are there any barriers to communication?	

Unborn Baby's Siblings or other children that need considering in the family unit:				
Name	DoB	Gender	Address	Primary Carer

Key Professionals' Contact Details:	
Name of Hospital/ Birthing Unit:	
Allocated/Named Community Midwife Contact Details	
Health Visitor or Family Nurse Partnership Contact Details	
GP Name Contact Details	
Named Social Worker Contact Details	
Lead consultant (Obstetrics) Contact Details	
Mental Health Contact details:	
Other support services (Housing, Substance Misuse Team, Domestic Abuse, Probation Service, Specialist Learning Disability Team, etc.) Please specify and provide contact details where known:	

Appendix 4



Safeguarding Children Unborn Baby Risk Assessment Guidance

The Safeguarding Children UBB Risk Assessment tool has been developed as a tool to aid practitioners in decision making regarding the risk of parental behaviours and environment can have on Unborn Babies and their siblings. As previously noted the Antenatal period gives practitioners a window of opportunity to work with families and the work carried out during this period can help reduce the risk of potential harm to children once born if there is early assessment, intervention and support.

UBB Risk Assessment Pathway

This is the overarching pathway and should be consulted if a risk has been identified at any time during the pregnancy; it has been divided into four sections:

Green- No known current risk factors.

Yellow- The family has additional needs that can be met within identified resources through single agency response and partnership working

Amber- Family has been identified as having multiple needs requiring a multi-agency co-ordinated response

Red- Family has high level of unmet needs or UBB is in need of protection

Each section in the tool has information and guidance for practitioners regarding their responsibilities in safeguarding unborn babies and their siblings. Information and resources are included as hyperlinks in the tool along with national and local guidance; practitioners will be able to access this information to further inform their practice.

Please note:

The tool includes guidance on Parental Mental Health, Domestic Abuse (Inc. Honour Based Violence), Drug and Alcohol Misuse, Offending Behaviour, Parents with Learning Disabilities/Difficulties, Previous Intervention with Children's Social Care, Teenage Pregnancy (including CSE), Trafficking and Modern Slavery/Domestic Servitude, Surrogacy, Unplanned or Unwanted Pregnancy/Relinquishment, Sex Working, Communication and Language Barriers, Physical Disabilities, Financial/Housing Issues Inc. No Recourse to Public Funds, Asylum Seekers, Previous unexplained/unexpected death of a child, Fabricated and Induced Illness Inc. Self-Harm, Self-Neglect, Caring Responsibilities, FGM and Radicalisation.

IMPORTANT

Where there is a concern outside of the above, multiple concerns or through robust risk assessment practitioners feel that the tool does not support their views/findings, contact **MUST** be made by the assessing practitioner with their organisation's Safeguarding Children Lead

Appendix 5

Unborn Baby Protocol Risk Assessment Tool

The unborn/new born baby protocol risk assessment pathways can be found [here](#)

Appendix 6

Multi-Agency Pre and Post Birth Safeguarding Plan for Vulnerable Babies

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 <input type="checkbox"/>	Sexual <input type="checkbox"/>	Neglect <input type="checkbox"/>	Emotional <input type="checkbox"/>
Domestic Abuse <input type="checkbox"/>			
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)

2. 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 Social Care (CSC)	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

3. 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

4. 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

5. 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)	
<u>Partner(Second Parent):-</u>	
Name:	Date of Birth:
Home Address:	Ethnicity:
First language:	Interpreter Required: Y/N
Are there any barriers to communication?	
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:	Interpreter Required: Y/N
Are there any barriers to communication?	

Unborn Baby Siblings or other children that need considering in the family unit:-

<u>Name</u>	<u>Date of Birth</u>	<u>Gender</u>	<u>Address</u>	<u>Primary Carer</u>

6. 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:	

Appendix 7

Parenting Observation Tool. NB New Parenting observation tool to be completed for each day whilst on the maternity unit

Baby's Name

Hospital Number Date of Birth..... Mothers name and Hospital Number

This document should be used as recommended by the HIPS Unborn baby protocol and in other appropriate situations as identified by clinical staff. This document is recommended to be shared with Parents/Carers to identify strengths and areas for learning - the information may be shared with relevant professionals. Wherever possible ask parent/ carer(s) to show you and to identify what they understand/are doing. Ensure to provide advice and education if further support is required. Remember to RECORD what you observed and what was said. Observations must be factual, not opinion or subjective interpretation

Aspects of Care		Comments, Signature and Date
What is the current knowledge and understanding of caring for a new born? (E.g. attendance at parenting education classes, previous children, new-borns in the family etc.)		
<u>Infant Feeding</u> To observe parents/carers' ability to appropriately and safely feed their baby	<input type="checkbox"/> Awareness of the signs of baby being hungry/satisfied and responding appropriately <input type="checkbox"/> Appropriate handling during feeding <input type="checkbox"/> Breastfeeding - handwashing, recognising good latch and signs of effective feeding/problems and when to ask for support <input type="checkbox"/> Formula Feeding – handwashing, describes how to make up feeds correctly and safe storage, sterilising of equipment	
<u>Basic Care</u> To observe parent/carers ability to provide basic care for their baby	<input type="checkbox"/> Warmth -providing appropriate clothing/blankets etc. <input type="checkbox"/> Hygiene- nappy changing, bathing, hand-washing <input type="checkbox"/> Appearance of baby - clean, dirty, saturated nappy, skin care <input type="checkbox"/> Appearance of clothes- clean, dirty or wet, appropriate for environment	

<p><u>Ensuring Safety</u> To observe the parent/carers ability to maintain a safe environment for their infant</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Cot sides/cot safety <input type="checkbox"/> Safe and appropriate holding/handling of baby (head support etc.) <input type="checkbox"/> Not swaddled or overwrapped <input type="checkbox"/> Can explain advice re reducing risk of SIDS and safe sleep (including co-sleeping) <input type="checkbox"/> Awareness of advice on ICON <input type="checkbox"/> Car seat safety 	
<p><u>Emotional warmth and Stability</u> To observe the parents/carers ability to provide emotional warmth</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Is there evidence of attachment /bonding? <input type="checkbox"/> Eye contact maintained <input type="checkbox"/> Emotional warmth and availability noted <input type="checkbox"/> Speaks warmly to baby and about baby <input type="checkbox"/> Handling, comforting and cuddling baby 	
<p><u>Guidance and Boundaries</u> To observe if parents/carers demonstrate and model appropriate behaviour, control emotions and interactions with others</p>	<ul style="list-style-type: none"> <input type="checkbox"/> How do they behave to each other? <input type="checkbox"/> How do they behave towards others (including staff and others on the ward?) <input type="checkbox"/> Is there evidence of positive support available? Describe the relationship to visiting siblings, if appropriate. 	
<p>How confident do parents feel in the all aspects of caring for their new-born baby?</p> <p>Are the parents/carers receptive to health advice?</p> <p>How do the parents/carers respond to concerns raised (if any) about baby's health?</p> <p>Have parents/carers recognised any additional support that they require?</p> <p>What additional advice and support would parents like from professionals?</p>		

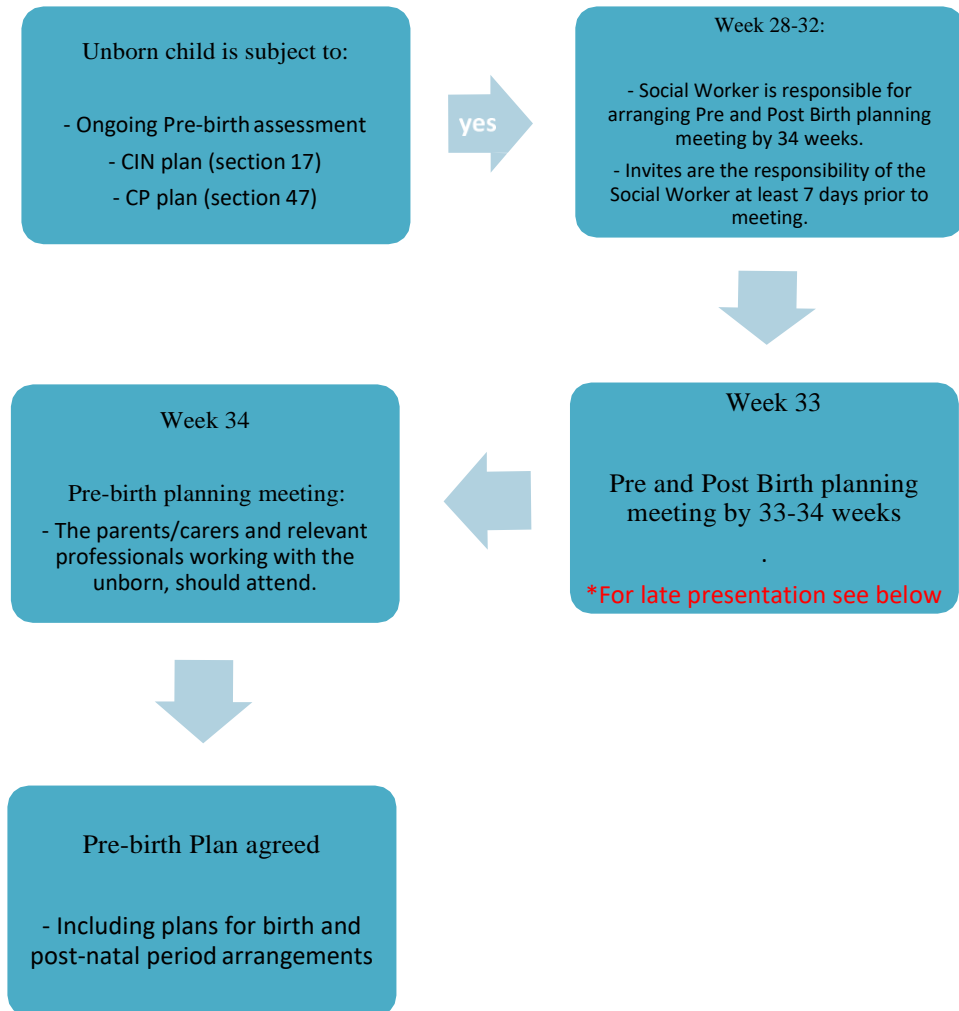
Please outline Midwifery plan (if indicated) following on from above:

Completed by (Full name).....Signed.....Date.....

Appendix 8

Flowchart for Multi-Agency Pre and Post Birth Plan For Vulnerable Babies

This document is a brief outline of the Pre and Post Birth Planning process.



Pre-birth Plan

Each Local Authority (Children Social Care) should have its own agreed internal systems to ensure that Pre and Post Birth Meetings/Plan are held between 33- 34 weeks wherever possible and who will be responsible for sharing the plan once agreed

If Pre-birth plan is not in place by 33-34 weeks the Social Worker should continue to liaise with parents and carers and involved professionals and seek to convene a meeting as soon as possible.

All other agencies involved with the Pre and Post Birth Plan should have agreed internal processes to track and monitor Pre Birth Plans and agreed escalation process if a delay is identified and there has been no communication from Social Worker as to the reason for the delay. If there are ongoing problems consider using: Escalation Policy for the Resolution of Professional Disagreement (HIPS)

*In cases of late presentation/ notification then the above process still needs to be followed in the most timely way possible

Discharge Plans

Discharge Plans should be identified in Pre-birth Plan meeting. Despite this, it must be recognised by ALL professionals that plans can change at short notice and be fluid. Professional judgement is key to keeping the baby and others safe.

If any new or increased risks emerge after agreeing Pre and Post Birth Plan, plans should be reviewed and discussed with CSC and other agencies. As a result, a further pre-discharge planning meeting may need to be arranged.