4 LOCAL SAFEGUARDING CHILDREN BOARD (LSCB) UNBORN /NEWBORN BABY SAFEGUARDING PROTOCOL
2016

(Replaces 2013 version)

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Hampshire Safeguarding Children Board

ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD

LSCB Southampton Local Safeguarding Children Board

PSCB Portsmouth Safeguarding Children Board
Protecting Portsmouth's Children

4 LOCAL SAFEGUARDING CHILDREN BOARD (4LSCB) Multi-Agency UNBORN /NEWBORN BABY SAFEGUARDING PROTOCOL

1. INTRODUCTION

1.1 The National Maternity Review: Better Births 2016 identified that every woman, every pregnancy, every baby and every family is different. Therefore, quality services must be personalised and meet the needs of the baby as well as the wider family.

1.2 The National Service Framework for Children Young People and Maternity Services (2004) recommends that Maternity Services and Children's Social Care (CSC) have joint working arrangements in place to respond to concerns about the welfare of an unborn baby and his/her future, due to the impact of parents' needs and circumstances.

1.3 Young babies are particularly vulnerable to abuse, and work carried out in the antenatal period can help minimise any potential harm if there is early assessment, intervention and support (Brandon et al 2016). This multi-agency protocol sets out how to respond to concerns for unborn babies, with an emphasis on clear and regular communication between professionals working with the mother and her family.

1.4 The aim of this protocol is to enable practitioners to work together with families to safeguard unborn/newborn babies where risk is identified. The protocol provides an agreed process between health agencies, social care and other agencies working with the mother and her family on the planning, assessment and actions required to safeguard the unborn/newborn baby.

1.5 Unlike many safeguarding situations, the antenatal period gives 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 the earliest stage
- Understand the impact of risk to the unborn/newborn baby when planning for their future.
- Explore and agree safety planning options
- Assess the family's ability to adequately parent and protect the unborn baby and once the baby is born
- Identify if any assessments or referrals are required before birth; for example the Early Help Assessment or Single Assessment Framework or alternative assessments agreed locally.
- Ensure effective communication, liaison and joint working with any adult services that are providing on-going care, treatment and support to a parent
- Plan on-going interventions and support required for the child and parent(s).
- Avoid delay for the child where a legal process is likely to be needed such as pre-proceedings.

2. SCOPE

2.1 The protocol applies to all professionals who have identified any concerns for the unborn/newborn baby.

3. PURPOSE

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

4. DEFINITIONS

Word or Phrase	Definition
Concealed Pregnancy	A concealed pregnancy is when: • A woman knows she is pregnant but does not engage with appropriate services; or • A woman appears genuinely unaware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought. Concealment of pregnancy may be revealed: • Late in pregnancy (after 34 weeks); • In labour; or • Following delivery. The birth may be unassisted and may carry additional risks to the child and mother's welfare.
Delayed or Late Booking	A late booking is defined as presenting for maternity services after **20 weeks** of pregnancy. • The pregnancy may be **undetected** where both the mother and her health care providers are unaware that she is pregnant • It may be a **conscious concealment** where the mother is aware of her 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 mother has physical awareness of her pregnancy, but lacks emotional attachment to the foetus, or • **Unconscious denial** where the mother is not subjectively aware of her pregnancy and genuinely does not believe the signs of pregnancy or even the birth of the baby (e.g. Psychotic delusion).
Multi-Agency Safeguarding Hub (MASH)	The MASH is a team including Police, Health, Children's Social Care and other agencies (depending on local arrangements). The benefit is that they can share information quickly and make decisions as to the required level of intervention
Child Protection-Information Sharing (CP-IS)	CP-IS is a nationwide solution that connects local authority children's social care systems with those used by NHS unscheduled care settings. It enables the exchange of key child protection information and episodes of unscheduled NHS care.

5. ROLES AND RESPONSIBILITIES

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; 2015'.

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 own profession's guidance

And particularly to:

- 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' 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) and other Sexual Crime

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

Accept referrals from other professionals

- Work to the thresholds published within their LSCB 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/newborn child if thresholds are met
- A social worker will be the Lead Professional for any case where a Child Protection Plan is in place

5.2 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 newborn 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 woman.

This protocol is intended for use by all health professionals and in particular staff who provide care to pregnant women and their families, namely Midwives, Health Visitors and Family Nurses. However, Midwives have a significant role in identifying risk factors to the unborn/newborn 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 women throughout pregnancy. The relationship they foster with the pregnant woman 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 women will have a named midwife who will:

- Identify pregnant women where existing risk factors may impact on the wellbeing of the unborn/newborn 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
- Plans care for the woman and her unborn baby, with the wider maternity team as required, and records the details of this in the woman'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 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 and refer according to mandatory processes

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

5.2.1 MIDWIVES

If an appointment is made very late for antenatal care (after 20 weeks of pregnancy), the reason for this must be explored. If there is a cause for concern a referral should be made to the relevant Children's Social Care Department. CP-IS should also be checked once it is embedded in maternity services in line with the national roll out. The woman must be informed that the referral has been made, unless there are significant child protection concerns that prevent you from doing so.

If a woman 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. 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 woman self-discharging along with her baby. The Midwife or appropriate person must immediately contact the Police in these circumstances and subsequently, notify Children's social care.

If the baby has been harmed in any way, or abandoned, as a result of the mother's actions (or non-action) a referral must always be made to the police by the midwife, or appropriate person.

5.2.2 HEALTH VISITORS/FAMILY NURSE

If the Health Visitor (HV) encounters a woman that they believe to be pregnant, and they also believe that woman has not sought health advice they should encourage her to seek support from a Midwife and/or GP.

If the woman refuses all attempts to persuade her to seek health advice the HV/Family Nurse (FN) should make a referral to children's social care.

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

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

5.2.3 SCHOOL NURSES

The School Nurse may well be able to help a child who is pregnant to accept that she needs 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.

5.2.4 GENERAL PRACTITIONERS (GP)

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

Where a G.P has significant reason to believe a woman is pregnant, but she refuses all attempts to persuade her 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 woman refuses all attempts to persuade her to seek health advice the G.P. should make a referral to children's social care (see section 6 and 7)

5.2.5 SUBSTANCE MISUSE SPECIALIST

If a pregnant woman and/or her partner is 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.

5.2.6 MENTAL HEALTH and LEARNING DISABILITY SPECIALISTS

When working with a pregnant woman and/or her partner who has mental ill health or learning disabilities, professionals in these services should encourage these women 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 woman given the therapeutic relationship with her.

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

5.3 ROLE OF SPECIALIST SAFEGUARDING CHILDREN TEAM IN ACUTE HOSPITALS

Where the unborn baby is subject to child protection planning, it is the responsibility of the Social Worker 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 (See section 9).

5.4 ROLE OF OTHER PROFESSIONALS/AGENCIES

For those professionals not specifically identified within the protocol where there are concerns regarding an unborn/newborn baby a referral should be made into the MASH via telephone and followed up in writing using the Inter-Agency Referral Form as per 4LSCB Guidelines.

6. RISKS

See Appendix One for Risk Assessment flowchart.

6.1 Involved professionals along with the family should meet to discuss the strengths, risks and needs of the family and consider completion of an Early Help Assessment or referral to CSC. Reasons for not making a referral or completing an assessment should be recorded and circumstances reviewed regularly to assess risk and consider any further action.

6.2 When it is recognized that parents of an unborn/newborn baby may need the support of services to respond to their babies' needs this can be instigated with their permission prior to birth using the local early help pathway. Please see your local Early help Pathway.

6.3 If any service becomes aware of pregnancy / impending parenthood of one of their clients they must inform maternity services of their involvement and highlight any concerns, as per the 4LSCB Protocol 'Safeguarding Children Whose Parents/Carers have mental health, substance misuse, learning disability and emotional or psychological distress. This contact should be made through the Named Midwife for Safeguarding Children for the area (*See Appendix Three*).

6.4 Referral to maternity services does not negate other agencies responsibility to refer to CSC if there are significant concerns for the safety of the unborn/newborn baby or any other children in the family. If practitioners require advice on safeguarding they should follow their local process.

6.5 Where it is assessed that a referral to CSD is required this should be done in line with Working Together to Safeguard Children 2015 and 4LSCB Procedures.

7. REQUEST FOR REFERRAL TO CHILDRENS SERVICES DEPARTMENT (CSD)

7.1 Referrals to CSD about unborn babies who may need services should be made at 12 weeks gestation or as soon as concerns have been identified after 12 weeks.

7. 2 RISK ASSESSMENT can be categorised into 3 main areas (see Appendix Two). Professional judgement and supervision/advice should be used when required. The tool aligns to the LSCB Threshold documents.

7.2.1 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 CSD may be required. Professional judgement should be used at all times.

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

7.2.3 Red risks mean a Mandatory referral to CSD must be made: These identify situations where there is a significant risk of harm to the unborn baby.

7.3 Referrals should be consistent with the guidance in Working Together to Safeguard Children and 4LSCB procedures and threshold documents.

8. OUTCOME OF THE REFERRAL TO CHILDREN'S SERVICES DEPARTMENT

8.1 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/newborn baby may be likely to suffer significant harm.

8.2 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 need to contact their named practitioners for advice to discuss how to escalate their concerns to CSC.

8.3 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.

8.4 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.

8.5 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.

8.6 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.

8.7 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/newborn baby including disengagement with Services.

8.8 If there is disagreement regarding decision making at any stage professionals should seek advice and supervision as per their agencies process eg Named and Designated Professionals within Health Services.

8.9 Where these differences cannot be resolved professionals should follow their own escalation process and the 4LSCB Escalation Policy

9 MULTI-AGENCY PRE & POST BIRTH PLAN

9.1 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. 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 mother or baby at increased risk.

9.2 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.

9.3 Appendix Three 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.

9.4 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.

9.5 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 – see 9.8 below. Where discharge is likely to be complex e.g. discharge to foster placement a pre-discharge planning meeting must be considered.

9.6 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.

9.7 In situations where there is a delay in discharge of mother 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.

9.8 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).

9.9 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.

10. MANAGEMENT OF EMOTIONALLY CHALLENGING CASES

10.1 Facilitating Removal of Baby from Parent's Care

There is currently no available guidance outlining organisational and professional roles or responsibilities when removing babies from parents care which might include how and when the removal takes place, by whom, the correct process of doing so and the support mechanisms needed to support mothers and practitioners afterwards.

10.2 Each case should be assessed on an individual basis and where possible with involvement from the mother/parents. In particular to ascertain her wishes in how this baby will be removed. There should be clear communication between the social worker, the midwife in charge of the mother's care and where possible the Mother, to identify in advance, an appropriate place and who will facilitate the separation of baby from parents. Ensuring at all times that the needs of the baby are prioritised the parents' wishes should be taken into account.

10.3 Support for Parents

Practitioners should understand that Mothers who have a baby placed in alternative care, experience reactions that are akin to the grief and loss experienced by mothers whose babies have died (Marsh, 2014). Maternity Services should consider in each individual case following discussion with the Mother and Social Worker whether the taking of mementoes such as handprints, footprints etc. would be appropriate. Practitioners should also consider whether copies of mementoes should also be provided for the baby's life story work. The following support networks are available and should be offered if appropriate.

Woman's Aid
www.womensaid.org.uk
0808 2000247

After Adoption
www.afteradoption.org.uk
0800 8402020

Family Lives
http://www.familylives.org.uk/
0808 800 2222

CAFCASS
https://www.cafcass.gov.uk/
0300 456 4000

National Association of Child Contact Centres
http://www.naccc.org.uk/

Natural Parents Network
http://www.n-p-n.co.uk/
NPN Helpline: 0845 4565031

Grandparents Association
http://www.grandparentsplus.org.uk/
0300 033 7015

Family Rights Group
http://www.frg.org.uk/
0808 801 0366

MATCH
http://www.matchmothers.org/

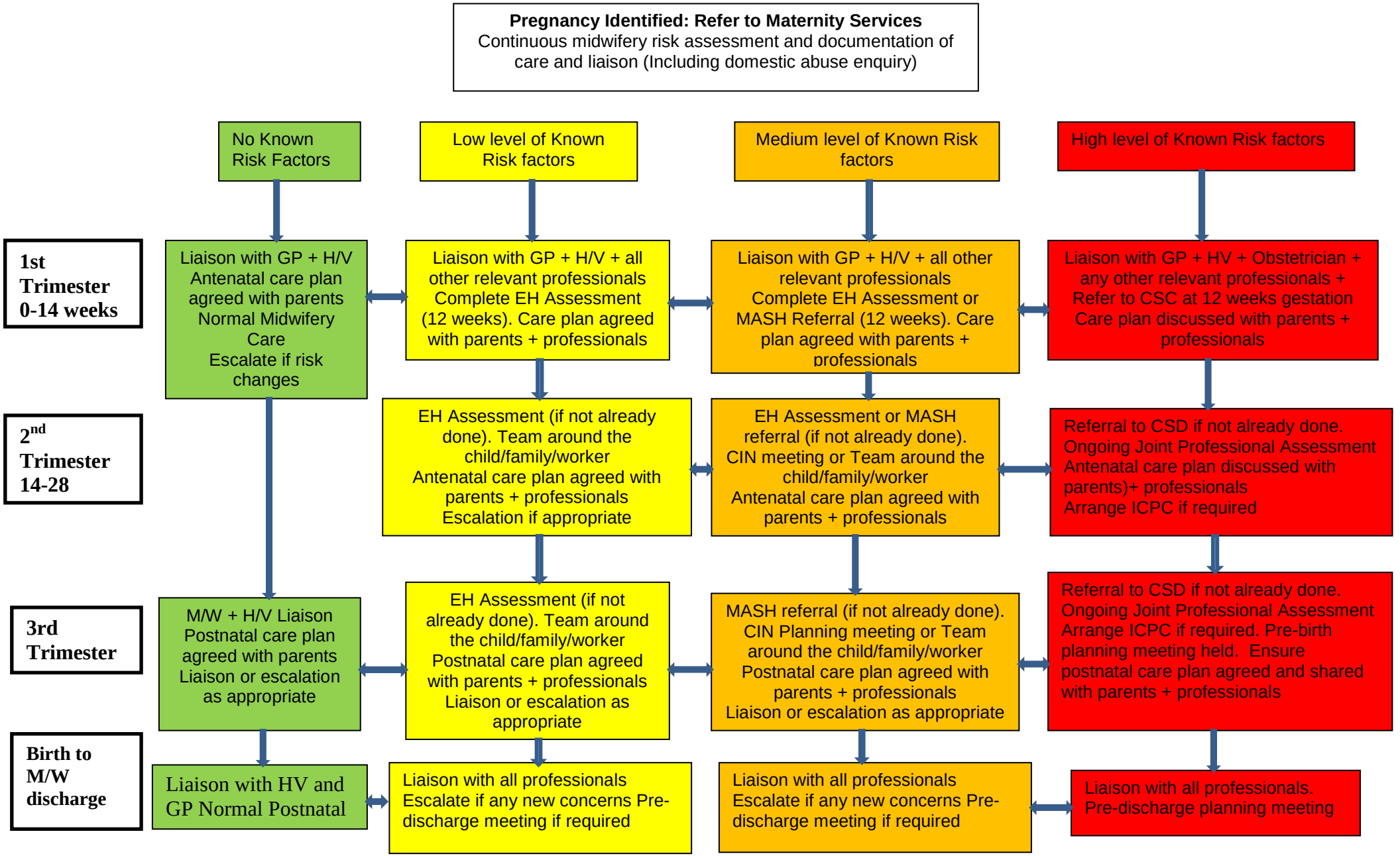
British Association for Counselling & Psychotherapy
http://www.bacp.co.uk/

10.4 Support for Professionals

Professionals who provide care for mothers whose babies are removed at birth or shortly after require education and support to enable them to provide effective care to the families they work with and to enable them to maintain their emotional wellbeing whilst doing so.

Safeguarding supervision has known benefits to staff and should be accessible to them. The receipt of regular formal safeguarding supervision provides individuals with the opportunity to reflect on their feelings when engaging with child protection activities including the removal of babies at birth and has significant benefits to safeguarding practice and emotional wellbeing (Hall, 2007). It is therefore the expectation that all organisations have robust mechanisms in place to ensure that that supervision is available to staff members and is accessible.

APPENDIX 1: Risk Assessment Flowchart (to be used in conjunction with risk assessment tool at Appendix 2)



APPENDIX 2 – Risk Assessment Tool

RISK INDICATOR CHECKLIST

LOW: CONSIDER EARLY HELP OFFER	MEDIUM: CONSIDER REFERRAL TO CSC	HIGH: AUTOMATIC REFERRAL TO CSC
MENTAL HEALTH - Mother, Father, Partner, Significant members of the household		
History of Mental Health difficulties	Significant Mental Illness / Personality Disorder	Chronic and enduring Mental Illness/Personality Disorder
Current mild Mental Health difficulties	Mental Illness / Personality Disorder well managed	Non-compliance with medication/professional treatment recommendations
Engaging / compliant with treatment or medication.	Compliant with medication/ professional treatment	Condition or Treatment significantly impairs functioning
Limited personal / professional support networks	Risk of relapse	
	Condition or Treatment does not impair or has limited impact on functioning	
SUBSTANCE MISUSE - Mother, Father, Partner, Significant members of the household		
History of low-level substance / alcohol misuse	Long-term, stable substance misuse	Intravenous Drug User
Recreational substance misuse	Substance misuse is well managed	Regular street use
Limited personal / professional support network	Compliant with services / medication /professional treatment and screening	Alcohol dependency
	Risk of relapse	Failure to comply with services / treatment plan
	Does not impair ability to function	Alcohol / Substance Misuse impairs functioning
		Substance misuse by both mother and partner
		Drug related debts
DOMESTIC ABUSE, HONOUR BASED VIOLENCE AND FORCED MARRIAGE (complete LSCB risk assessment tool)		
Exposed to domestic abuse as a child	History of domestic abuse (verbal and physical)	Victim / perpetrator of High Risk Domestic Abuse
History of domestic abuse in previous relationship with no indicator of ongoing risk	History of domestic abuse in previous relationship and ongoing risk	Subject to MARAC
	Risk of domestic abuse post-birth and around child contact issues	Honour Based Violence
	Power and control within relationship creates social isolation and absence of support	Pregnancy brings "shame" to the family
	Financial & Economic abuse prevents access to services & ability to provide for basic care needs of mother and child	Forced marriage
		Power and control within relationship prevents access to professionals and services
LEARNING DISABILITIES - Mother, Father, Partner, Significant members of the household		
Moderate Learning Difficulties with good support network who can assist in care	Significant / Severe Learning Disabilities affect ability to function / care for themselves and or others, but where partner is able to provide adequate care for baby	Significant / Severe Learning Disabilities affect ability to function / care for themselves and / or others (both partners)
Mild Learning Disabilities / impairment having limited impact on day-to-day functioning	Moderate Learning Disabilities	
Subject to SEN Statement but educated in mainstream school	Subject to SEN statement and accessing Special Educational Provision as a child	
OFFENDING BEHAVIOUR - Mother, Father, Partner, Significant members of the household		
Previous involvement with Probation / YOS for historical non-violent offences	Current to Probation / YOS for Non-Violent offences	Registered Sex Offender
Previously subject to ASBO, ABC or known for ASB	Previous custodial sentences	Person posing a risk to a child
	Previous conviction for arson	Previous Schedule One status
	Previous conviction for animal cruelty	Subject to current MAPPA
	Previous investigation in relation to violent or sexual offences, where no charge or conviction was successful	History of Violent Offences
	Previously subject to Hospital Order or Custodial Sentence.	Involvement in gang-related activity
		Prolific offending (acquisitive) to fund substance misuse
		Drug dealing / supplying
		Currently subject to Hospital Order / Custodial sentence
CONCEALED PREGNANCY/DELIVERY (including Flight Risk & Late Booking)		
Late booking up to 28 weeks gestation, who engages with care and services with good support network	Late booking up to 28 weeks gestation	Presentation in 3rd trimester or at delivery

Unplanned pregnancy whilst using contraception up to 28 weeks	Multiple transfers of care, sporadic engagement in services and treatment that are unlikely to impact on the health and development of unborn baby	Presentation in labour
		Agency becomes aware of baby of which they were previously unaware
		Multiple transfers of care, failure to engage in services and treatment that are likely to impact on the health and development of unborn baby
PREVIOUS INTERVENTION BY CHILDREN'S SOCIAL CARE - Mother, Father, Partner, Significant members of the household		
Previous intervention at Early Help Level	Current / historic involvement with CSC at Child in Need level	Older siblings / half siblings currently or historically subject to CP planning / Legal proceedings
Either / both parent previously known to CSC at Child in Need / Early Help level	Either / both parent previously LAC / subject to CP planning / legal proceedings	Either / both parent current Looked After Child /Care Leaver
FEMALE GENITAL MUTILATION (Complete LSCB risk assessment tool)		
Mother subjected to FGM, but strong advocate against this	Mother subjected to FGM, but strong advocate against this and:	Mother subject to FGM, current ambivalence to practice, unborn female, existing sibling subject to FGM
No evidence of wider family pressure	Some evidence of coercion / control by partner /within wider family	Coercion / control by partner or wider family
RADICALISATION - Mother, Father, Partner, Significant members of the household		
	Estranged from wider family members who have been radicalised / subject to PREVENT/CHANNEL/Anti-terrorism measures/monitoring	Mother / Father / Partner / Significant family member subject to PREVENT/CHANNEL/ Anti-terrorism measures / monitoring
	Change in behaviour / dress linked to emotional life event	Close relationships with wider family members who have been radicalised / subject to PREVENT/CHANNEL/Anti-terrorism measures / monitoring
		Change in behaviour/dress not linked to emotional life event
TRAFFICKING AND MODERN SLAVERY/DOMESTIC SERVITUDE -Mother, Father, Partner, Significant members of the household		
Engaged in employment - low paid, poor conditions	Unable to provide consistent history or demonstrate stability	Disclosure / Known to have been trafficked (MET) (not exclusively from overseas)
	Accompanied to appointments with unexplained escort (not father / relative to baby / mother	Not working with agencies
	Known to be previously trafficked working with agencies towards achieving stable environment	Ongoing links to traffickers
	Disproportionate level of responsibility for chores	Known to be previously trafficked, but not to be in stable environment - unclear ongoing links to traffickers
CHILD SEXUAL EXPLOITATION (complete LSCB risk assessment tool)		
Significant age difference.	Significant age difference. Evidence of Coercion / Control / Grooming	Known to be at High Risk of CSE (SERAF/MET)
Previous SERAF - low risk of CSE	Previously considered High Risk of CSE (SERAF/MET)	
	Current SERAF - Medium Risk of CSE	
SURROGACY		
Surrogacy Arrangements, seemingly amicable, but where no legal advice has been sought	Ambiguities about handover / care arrangements before, at or after 34 weeks pre-birth handover/arrangements	Enquiries undertaken raise concerns for future care arrangements for child when born
	Ambiguities about post-natal care for mother / baby	Unlawful / Unregulated surrogacy arrangement involving payment / coercion / control
	Surrogate mother showing evidence of ambivalence about handover / not wanting to relinquish baby	Previous CSC involvement with birth mother / proposed surrogate parents
SEX WORKING - Mother, Father, Partner or Significant Member of Household		
Previously engaged in sex working	Where ongoing engagement in sex work is likely to put mother and UBB's health and development at risk	Where engagement in sex working puts mother / child at risk from unsafe adults
Suspends sex-working during pregnancy	Where mother not engaging in regular screening with all services / taking responsibility for own health	Where pregnancy is used as a form of control
Engaging with services / treatment to optimise own / baby's health and development	Intention to resume sex-work post delivery with no safe care arrangements for baby	Where sex-working is believed to be driven by / linked to drug misuse
Intention to resume sex-work post deliver with safe care arrangements for baby.		

RELINQUISHMENT		
Previously relinquished child		Where mother indicates at any stage of pregnancy that they are considering relinquishing baby's care
COMMUNICATION AND LANGUAGE BARRIERS - Mother, Father, Partner or Significant Member of Household		
Limited ability to communicate and limited support	Where communication and language barriers may impact of care of child/engagement in services/treatment	Where this is linked with other risk factors
	Where there is a refusal for the use of any independent interpreters	Where any modifications to the name considered essential to keeping adults /child safe are refused and there is no support to ameliorate for this
	Where any modifications to the name considered essential to keeping adults / child safe are refused and there is support to ameliorate for this	
PHYSICAL DISABILITIES, SIGNIFICANT HEALTH & DEVELOPMENT ISSUES / FOETAL ABNORMALITY - Mother, Father, Partner, Significant members of the household		
All screening declined and baby born with unforeseen illness / disability / abnormality	Where disability / significant health issue will create risk of significant harm to baby / compromise their care - with support	Where disability/significant health issue will create risk of significant harm to baby / compromise their care - no support
Existing child with disability / complex health needs	Life limiting illness / disability with no apparent support network	Lack of engagement with services / refusal to have adaptations significantly compromises health and safety of baby
One or both parents have known disability / genetic condition / life limiting illness	Evidence of rejection / inability to bond with one carer, but not other carer	Where parents are in denial and unwilling to engage with services / treatment
		Evidence of rejection / inability to bond with carers
FINANCIAL / HOUSING ISSUES / NO RECOURSE TO PUBLIC FUNDS - Mother, Father, Partner or Significant Member of Household		
Supported living arrangements	Transient lifestyle - known to services in multiple authorities No CP Concerns	Risk of Homelessness at delivery where housing unable to assist - unable to discharge
Poor employment conditions	Inability to maintain tenancy / provide stability	Transient lifestyle - known to services in multiple authorities and Child Protection concerns
Poor budgeting skills	Accommodation / housing arrangements not suitable post delivery	Gambling / Debt which will compromise ability to meet child's needs
Loss of employment	Gambling / Debt which may compromise ability to meet basic care needs of child	Inability to service debt involves threats of violence - particularly drug debt
	Recognition of risk that accommodation presents and engaging with agencies to address	Unsuitability of accommodation - presents risk to health of mother / baby - housing unable to assist
	Parents have NRPF and unable to meet baby's basic care needs but wider family providing financial support	Poor recognition of parents that accommodation presents a risk. Inability / unwillingness to engage with relevant services to address
	Poor Ante-natal care associated with NRPF	Parents have No Recourse to Public Funds and unable to meet baby's basic care needs
	Asylum seeking status	
TEENAGE PREGNANCY		
Mother 16-18 at point of referral	Mother 13-15 at point of conception	Where mother was under the age of 13 at point of conception
Age difference not more than 2 years	Mother aged 16-18yrs Age difference 2-3 years	No support from family network
No issues of power and control	Mother aged 16-18yrs and issues of power and control	Age difference more than 3 years
Good support from family network	Limited support from family network	
UNPLANNED / UNWANTED PREGNANCY - including TRAUMATIC CONCEPTION / SEXUAL ABUSE		
Unplanned pregnancy where one partner is not fully supportive of pregnancy continuing	Baby conceived via rape - concern about future bonding / attachment	Pregnancy as a result of intra-familial Sexual Abuse
	Concern that pregnancy being used as a form of control	
ASYLUM SEEKER - Mother, Father, Partner or Significant Member of Household		
Temporary leave to remain	Temporary leave to remain linked to employment / education	Presentation after 28 weeks
Stable employment/housing	Unstable housing	No temporary leave to remain
	Other children in country of origin	No Recourse to Public Funds
	Overstayer status not impacting on access to healthcare, services, treatment, housing / ability to meet child's needs	Overstayer status impacting on access to healthcare, services, treatment, housing / ability to meet child's needs
		No support in the UK

PREVIOUS UNEXPLAINED/UNEXPECTED DEATH OF A CHILD - Mother, Father, Partner or Significant Member of Household		
Previous unexplained / unexpected death of a child whilst in the care of mother, father, partner, significant member of household and no indication that death was as a result of failing to follow advice / guidance	Previous unexplained / unexpected death of a child whilst in the care of mother, father, partner, significant member of household and concerns about the impact of unresolved grief / loss and bonding /attachment - one parent	Previous unexplained / unexpected death of a child whilst in the care of mother, father, partner, significant member of household and indication death as a result of failing to follow advice and guidance
Subsequent children all fit/healthy and no parenting concerns		Concerns about the impact of unresolved grief / loss and bonding /attachment - both parents
Well engaged with services		Poor engagement with services
Previous loss of a child (not sudden and unexplained)		
AVOIDANCE OF INVOLVEMENT WITH SERVICES AND TREATMENT - Mother, Father, Partner or Significant Member of Household		
	Not compromising health / development of mother and baby	Compromising health and development of mother and baby
		Coupled with any other concerns e.g. LDS, substance misuse, chaotic lifestyle
FABRICATED / INDUCED ILLNESS / REPEATED ADMISSIONS		
Repeated admissions around genuine health concerns - diagnosed / undiagnosed / in the course of investigation	Repeated admissions / expressions of concerns associated with ongoing anxiety around pregnancy / MH issues	Serious intentional overdose attempt
		Genuine self-harm
		Not associated with anxiety issues
		Compromising own / baby's health, now and once born
		Repeated admissions with injuries associated with undisclosed domestic abuse
		Fabrication of Obstetric history - either having had / not had children
SELF NEGLECT - Mother, Father, Partner or Significant Member of Household		
Poor nutrition	Non-compliance with medication, treatment / services not impacting on own / baby's health	Non-compliance with medication, treatment / services impacting on own / baby's health
Underweight/overweight	Unkempt	
	Poor personal hygiene	
	Poor nutrition	
	Clothes dirty, wrong size/unsuitable for weather	
CRUELTY TO ANIMALS - Mother, Father, Partner or Significant Member of Household		
Low level concerns about care provided to current household pets	Known cruelty to animals	
	Previous animals removed / convictions for animal cruelty	
	Medium / high level of concerns about care provided to current household pets	
CARING RESPONSIBILITIES - Mother, Father, Partner or Significant Member of Household		
Other adult / YP in house with profound difficulties / needs	Young carer	Other adult / young person in house with profound difficulties / needs
Good insight to meet needs and well engaged with services	Other adult / young person in house with profound difficulties / needs	Poor insight / ability to meet needs
Caring responsibilities in and out of home unlikely to impact on ability to meet baby's needs	Limited insight / ability to meet needs	Poor engagement with services
	Erratic engagement with services	Caring responsibilities in / out of home highly likely to compromise ability to meet baby's needs
	Caring responsibilities in / out of home likely to impact on ability to meet baby's needs	Previous care resulted in Child / Adult Safeguarding Enquiry

APPENDIX 3 - Contact Details

Maternity (Hospital) Numbers		
Southampton	Maternity Coordinator Delivery Suite	Tel: 023 8077 7222 Bleep 2872 Tel: 023 8120 8103
Portsmouth	Tel: 023 9228 6000 – Maternity Bleep Holder 1333	
Winchester	Tel: 01962 824231/2 – Labour Ward	
Basingstoke	Tel: 01256 313600 – Delivery Suite	
Frimley Park	Tel: 01276 604035 – Central Delivery Ward	
Isle of Wight	Tel: 01983 534334 – Labour Ward	

Contact Numbers for Maternity Safeguarding Children Teams	
Southampton	Tel 023 8079 6333 –Maternity Safeguarding Team Secure email uhs.maternitysafeguarding @nhs.net
Portsmouth	Phone: 02392 286000 ext. 4315/4314 Secure email: pho-tr.safeguardingchildrenteam@nhs.net
Hampshire Hospitals (Basingstoke and Winchester)	Phone: 07887855142 Secure email: bnh-tr.maternity-safeguarding@nhs.net
Frimley Park	Phone: 01276 522559
St Mary's Isle of Wight	Phone: 01983 822099 ex 5412

Children's Services Department Numbers
Southampton City Council Daytime Tel: MASH 023 8083 3336 Out of hours/ED 023 8023 3344
Portsmouth City Council Daytime Tel: MASH 0845 671 0271 Out of hours: 0300 555 1373
Isle of Wight First Response 01983 814374 (9am-5pm Monday –Friday) Out of Hours Service**:** 01983 821105
Hampshire

Daytime Tel MASH 01329 225379 Out of Hours: 0300 555 1373

POLICE Cover is provided as follows: General MASH hours (across three sites) - Mon-Friday 0800-1700 hrs. Hampshire MASH provides contact at the weekends Sat-Sun 0800-2000 and also weekdays till 2000hrs (from December 2016).
Portsmouth MASH (Police) Portsmouth.mash.admin@hampshire.pnn.police.uk 02380 479840
Southampton MASH (Police) Southampton.mash.admin@hampshire.pnn.police.uk 02380 479250
Hampshire MASH (Police) Hampshire.mash.admin@hampshire.pnn.police.uk 01329 316113
101 for all other enquiries 999 in an emergency

APPENDIX 4 -

PRE AND POST BIRTH PLAN

NAME OF UNBORN BABY: **EDD:** **HOSPITAL NO:**

Mother: -

Name:	**DoB:**	**Hospital No**
Address:		
Ethnicity:	**First Language:**	**Interpreter Required: Y/N**

Father: -

Name:	**DoB:**	
Address:		
Ethnicity:	**First Language:**	**Interpreter Required: Y/N**

Any Other Key Adults: -

Name:	**DoB:**	**Relationship:**
Address:		
Ethnicity:	**First Language:**	**Interpreter Required: Y/N**

Siblings: -

Name	DOB	Gender	Address	Primary Carer

KEY AREAS OF CONCERN: -

	MOTHER	FATHER	KEY ADULT
Mental Health			
Substance Misuse			
Alcohol Misuse			
Domestic Abuse			
Learning Difficulties			
Aggression to Professionals			
Person Posing a Risk to Children			
Registered Sex Offender			
Flight Risk			
Concealment Risk			

SUBJECT TO CP PLANNING: Y / N **Category(ies):**

Key Involved Professionals: -

Name	Organisation	Role	Contact Details
		Community Midwife	
		Social Worker	
		Safeguarding Midwife	
		Health Visitor	
		GP	

LABOUR and DELIVERY

CONSIDERATION	YES / NO	PLAN	PROFESSIONAL RESPONSIBLE
Has Home Birth been agreed?			
Is there a likelihood of a home birth or mother attending a different hospital?		Other Hospitals and Ambulance Service alert to be completed.	Safeguarding Midwife.
Who can and cannot be present during labour and birth?			
Which Agencies should be notified that mother is in established labour?		CSD Out Of Hours Service	Hospital midwife.
Will PPP be required or need to be considered as part of the protection plan for the baby once born? Why?		RMS No:	
Are CSD intending to apply for a Legal Order in relation to the baby, once born? Why?			
Have parents agreed that the baby may be accommodated under S20 of CA 1989 when fit for discharge?			
Does Hospital Security need to be informed that mother is in established labour?			
Can mother and baby be warded together post-delivery?			
Should a Parenting Observation Chart be completed during mother and baby's stay in hospital?			
What arrangements have been made relating to mother and baby's intended stay in hospital after delivery?			

POST-DELIVERY

CONSIDERATION	YES / NO	PLAN	PROFESSIONAL RESPONSIBLE
Is there any restriction on who can / cannot have supervised contact with the baby, once born?		Mother Father Significant Adult / Family member	
Are there restrictions on who can / cannot have unsupervised contact with the baby, once born?		Mother Father Significant Adult / Family member	
Is the baby likely to have withdrawal symptoms? What arrangements have been made for support with this?			
If parents have agreed to S20, what is the contingency if they withdraw consent after birth?			
CSD to be notified of birth / gender and details post-delivery.			
What arrangements have been made for SW to visit post-delivery?			

POST-BIRTH

CONSIDERATION	YES / NO	PLAN	PROFESSIONAL RESPONSIBLE
What arrangements are agreed relating to mother and baby's intended stay in hospital?			
Is a Discharge Planning Meeting required?			
Have any arrangements been made for identified foster carers to visit?			

Have parents been provided with a copy of the birth plan? YES / NO

If not, why not?

Have all agencies been provided with a copy of the birth plan? YES / NO

NAME	ROLE	SIGNATURE	DATE
	Mother		
	Father		
	Safeguarding Midwife		
	Social Worker		
	CSD Out of Hours Service		
	Police		

APPENDIX 5: Example Parenting Observation Charts

Baby's Name: **Date:**

Parenting Capacity		**Comments** **PLEASE ADD EXTRA SHEETS AS REQUIRED**
1) Basic Care **To observe parent's/carer's ability to provide basic care for their infant/child**	• **Responding to baby's cues, appropriate response to baby crying** • **Feeding – appropriate handling during feeds. Record BF assessment in PHCHR- safe storage of Breastmilk** • **Warmth – providing appropriate clothing/blankets etc.** • **Hygiene – nappy changing, disposing of nappy, bathing, sterilisation of equipment, hand washing.**	
2) Ensuring Safety **To observe parent's/carer's ability to maintain a safe environment for their infant/child**	• **Cot sides/cot safety** • **Holding/handling of baby/head support, walking around with baby.** • **Safe sleep advice** • **Who is allowed to visit child/infant? Is this adhered to?** • **How often is baby on ward alone?**	
3) Emotional warmth **To observe parent's/carer's ability to provide emotional warmth.**	• **What is carer/child relationship?** • **Face to face eye contact, appropriate physical contact, comfort and cuddling sufficient to demonstrate warm regard, praise and encouragement**	
4) Stimulation **To observe parent's/carer's ability to promote child's learning and intellectual development.**	• **Are they playing/talking to child? Responding to child's language and questions. Providing toys/books etc.**	
5) Guidance and Boundaries **To observe if parent's/carer's demonstrate and model appropriate behaviour and control of emotions and interaction with others.**	• **How do parents behave towards each other and you?** • **Includes social problem solving, management of anger and Consideration for others.**	

6) <u>Stability</u> **To observe that the family environment is sufficiently stable to enable a child to develop**	• **Is the primary caregiver providing consistency of care, emotional warmth and responding to baby's needs.** • **Following professional instructions there evidence of attachment/bonding being formed**	
REMEMBER TO RECORD	• **What you observed.** • **What you said** • **Distinguish between fact, observation and opinion**	

DO NOT MAKE VALUE BASED/SUBJECTIVE STATEMENTS

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Department for Education (DfE) (2015) Working Together to Safeguard Children. Available at: https://www.gov.uk/government/publications/working-together-to-safeguard-children.

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4 LSCB UNBORN/NEWBORN BABY SAFEGUARDING PROTOCOL 2016

Developed by:

Portsmouth CCG Head of Safeguarding and Patient Safety

Southern Health Foundation Trust

Hampshire Hospitals NHS Foundation Trust

Portsmouth Hospitals NHS Trust

Frimley Park Foundation Trust

University Hospital Southampton Foundation NHS Trust NHS

Hampshire, IOW, Southampton and Portsmouth Local Authorities

Hampshire Police

Solent NHS Trust

APPROVED BY:

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