Sefton Pre-Birth Protocol

April 2025

1. Introduction

1.1 Research and experience indicate that very young babies are extremely vulnerable and that multi-agency work carried out in the antenatal period to assess risk and to plan intervention will help to minimise harm and improve outcomes for children. A number of Local Child Safeguarding Practice Reviews have been undertaken in respect of babies where key vulnerabilities were evident pre-birth, or in which the pregnancy was initially concealed.

1.2 One review identified an uncoordinated multi-agency response, ill-informed decision-making and planning which was not relevant to the assessed need. In this case, there was a need for a more trauma-informed and assertive approach to working with the family. (no_40_learning_from_review_delilah.pdf.)

1.3 Antenatal assessment is a valuable opportunity to develop a proactive multi-agency approach to families where there is an identified risk of harm. Good practice in antenatal assessment emphasises the importance of all agencies acting as early in pregnancy as possible so they can assess and intervene to keep the unborn baby safe and increase the likelihood of expectant parents being able to provide safe care.

2. Purpose

2.1 The purpose of this protocol is to ensure that clear systems are in place to develop robust plans which address the need for early support and services, and identify any risks to unborn children.

3. Scope

3.1 This joint protocol applies particularly to staff working within Children's Social Care, Health and the Police, but is of relevance to all agencies that work with parents, children and their families.

3.2 The protocol applies to residents of the Sefton area.

3.3 It is essential that all agencies adopt a trauma-informed approach to ensure families receive the specialist support they require during pregnancy, birth and parenthood.

4. Identification of Issues or Concerns in Pregnancy

4.1 If there is a need for non-statutory co-ordinated multi-agency support in order to promote the welfare and meet the additional needs of an unborn child, then Sefton Early Help Procedures should be followed.

4.2 A referral to Children's Social Care must always be completed at the earliest opportunity in the confirmed pregnancy when there is a reasonable cause to suspect that the unborn baby is likely to suffer significant harm before, during or after birth, or where a practitioner

anticipates that prospective parents may require statutory support services to care for their baby. In cases of late presentation and concealed or denied pregnancy, referrals/requests for support should be made as soon as possible and the subsequent process expedited as far as possible to meet the needs of the unborn baby. (Please see pan_merseyside_concealed_pregnancy_protocol.pdf)

4.3 Professionals must gain consent and inform parents or mother in the case of unborn, when professionals wish to seek further information from professionals in other services and share information with them. This should also happen if the professional wishes to refer to another agency for assessment and provision of services.

4.4 If a referral is considered a Child Protection concern (Level 4), it is appropriate and good practice to seek consent. Only in exceptional circumstances can the need for consent be overridden and a rationale for this would need to be documented.

4.5 Examples of concerns about an unborn baby and their parents that may indicate that a multi-agency pre-birth assessment, led by Children's Social Care, should be considered are included in Sefton's Level of Need Guidance, which has a section referencing specific considerations for the unborn child Sefton Safeguarding Children Partnership - Level of Need Guidance (November 2024) (These should be balanced with the strengths evident in the family).

4.6 Professionals should not lose sight of any safeguarding concerns for the parents themselves (either as children or adults) and these should be acted on accordingly.

4.7 **Cared for children and care experienced who are pregnant or going to become a parent:** When it is established that a cared for or care experienced person is pregnant or going to become a parent, the referrer must contact the responsible Local Authority in order to identify the young person's allocated social worker or personal advisor. A decision can then be reached about whether a referral for the unborn child should be made. It should not be an automatic decision to make or accept a referral in relation to the pregnancies of all cared for children and care experienced unless the thresholds are met as outlined above. Where the young person resides in a different local authority area to that which is responsible for them as a cared for child or care experienced, the local authority in which the mother resides is responsible for the pre-birth assessment, although this should be completed in close conjunction with their 'home' local authority.

4.8 Referrals to CHAT should be made by whichever agency has concerns. If CHAT progress to a referral within children's social care, they should check that contact has been made with health visiting and midwifery services, doing so themselves if it has not been. Contact must also be made with the relevant GP.

4.9 It is important that the reasons for the assessment are made clear to the parents at the outset and that there is clarity of understanding between professionals as to the purpose of this assessment process. Care must be given to working collaboratively with parents as a means of drawing together a balanced assessment with due consideration of parental strengths and capacity to change as well as areas of concern. However, it is

critical that the needs of the unborn child remain at the centre of the assessment as opposed to those of the parent/s.

4.10 There needs to be good consistent dialogue between professionals, recognition of the strengths and expertise that individual practitioners bring to the process and constant focus that the needs of the unborn child are paramount.

5. Risk factors relevant to the procedure

The following Risk Factors (but are not limited to) should alert professionals to consider a coordinated response: Where mothers, fathers or partners or any other significant member of the household/family environment:

- Have perinatal/mental illness or support needs that may present a risk to the unborn baby or indicate their needs may not be met;
- Are victims or perpetrators of domestic abuse (domestic abuse may start or get worse when a woman is pregnant);
- Have been identified as presenting a risk, or potential risk, to children, such as having committed a crime against children;
- Have a history of violent behaviours;
- Are currently 'cared for' by the Local Authority themselves or were 'care experienced' as a child or young person;
- Are living in poor home conditions, homelessness or temporary housing, including sofa surfing;
- Where there are concerns that exist regarding the mother's ability to protect.
- Where the development and health of the unborn baby may be affected by maternal substance and/or alcohol abuse.
- Where expectant parents are themselves deemed as children/ young people (under age 18yrs) and there are a number of concerns/complicating factors evident that would need to be considered to ensure the safety of parent/s and unborn. Where expectant parents are under the age of 13 yrs, a referral regarding expectant parent/s and unborn baby MUST be submitted.
- Where the expectant parents are previously known or currently active to Social Care and/or they have children, who are previously known or currently known to Social Care.
- Where previous child/children have experienced neglect, emotional, physical or sexual abuse and these concerns continue to be evident and would impact on the unborn baby in pregnancy and once born by virtue of the child being dependent on their caregiver.
- Where there is maternal ambivalence
- Denial or concealment of pregnancy
- Surrogacy
- Any other circumstances or issues that give rise to concern.

6. Timescales regarding Assessment and planning where there is a need to refer to Children's Social Care for a multi-agency pre-birth assessment

6.1 A referral must be made at the earliest opportunity following a pregnancy being confirmed when there are risk indicators at Level 4 of the SSCP Level of Need, as identified in Sefton's Level of Need document. The referral should be made to CHAT (Children's Help and Advice Team). If a decision has not been made during the conversation between the referrer and CHAT social worker and none received within 3 working days, the referrer should make contact back to children's social care to confirm the outcome. If there is professional disagreement about the outcome of the referral, the Sefton SCP Escalation Procedure should be followed. Please see Sefton Safeguarding Children Partnership - Sefton SCP Escalation Procedure.

6.2 In the case of a late presentation (over 24 weeks) to maternity services or where concerns are identified later in the pregnancy, the referral must be made as soon as possible to allow subsequent processes to be expedited.

6.3 If the referral is accepted by Children's Social Care it is vital that the Child & Family, (C&F) assessment begins in the early antenatal period. Undertaking the assessment during early pregnancy provides parents with the opportunity to show evidence of change. Where there are key risks and vulnerabilities and an evident risk of state intervention at birth if the risks are not addressed during pregnancy, the C&F assessment will be completed within 10 working days. This will lead to a Pre-Birth Assessment which will be more comprehensive and will incorporate multi-agency intervention to address the risks and vulnerabilities identified within the C&F assessment.

6.4 If interventions and support prove to be successful with evidence of change, risk reducing and safety being created, the social care involvement with the baby may end during the antenatal period following pre-birth assessment. If this is the case, a robust safety plan will be coproduced with the family and multi-agency group which clearly sets out what will be place for the baby to reduce risk following the baby's birth. It would also be helpful to clarify what would warrant a re-referral to children's social care.

6.5 A copy of the pre-birth assessment and Child and Family assessment should be shared with the baby's parents and the multi-agency group to ensure sharing of information and risk analysis in order that everyone involved can be aware of the key concerns and provide the right support to the family. Sometimes families share different information with different members of the professional group. If the pre-birth assessment and Child and Family assessment are shared with multiagency partners and the parents, this allows other professionals the ability to see if the information is consistent with their own records in relation to what they have been told by the family. It also provides an opportunity to assure partner agencies that the assessment is based on all known risk factors. If the multiagency partners see that information has been misinterpreted or misrepresented by the family this can allow for effective challenge.

6.6 The specialist pre and post-birth assessment and intervention team within Sefton Children's Social Care, Team Around the Baby, will accept referrals for unborn babies where the following criteria apply:

- Expectant parents with significant vulnerabilities e.g. those who are Care Experienced, have a diagnosis of learning disability or neurodiversity, parents who have lost previous children to care, significant recent substance misuse history, high risk domestic violence

and abuse, significant enduring mental health problems, and where there is risk to children within the wider family.

- Team Around the Baby will only work with parents where the unborn baby (or babies in the case of multiple births) is the only child to consider- i.e. not one of a sibling group where the other children are living at home. (Other referrals for unborn babies who are part of a sibling group will be accepted into the Assessment Teams.)

6.7 When a sibling or other child within the household is already subject to a child in need or child protection plan a referral/ request for support for the unborn child should be made as soon as the referrer becomes aware of the pregnancy. This should be a robust, transparent, trauma informed C&F assessment & pre birth assessment if required. The C&F assessment will gather information from all involved agencies, e.g. General Practitioners/Maternity Services and Health Visitors, and professionals involved with the parent/s themselves. The assessment should draw together the relevant events from the family history.

- Because of the need to intervene as early as possible during pregnancy to address the identified risks, a multi-agency assessment planning meeting must be held 5-10 working days into the C&F assessment. Invites will be sent to all key professionals working with the family within 3 working days of receipt of the referral. Where appropriate, referrals will be sent to the generic safeguarding email accounts for maternity and health visiting services, as opposed to individual practitioners. This will support appropriate attendance at any convened meeting. All professionals must give high priority to attendance at this meeting if requested. If attendance is not possible, they must ensure that their report is taken to the meeting by another appropriately briefed professional from their agency. This meeting will identify the support required to ensure the safety of the baby and ensure multi-agency contributions to the decision of continuing involvement with the baby following the C&F assessment. This meeting will also consider the approach to further pre-birth assessment if this is appropriate, including whether a Parent Assess assessment will be required (i.e. where parental learning disability/serious mental health/neurodiversity are factors). The outcome from this meeting will be: Proceed to Pre-Birth Assessment/Child-in-Need/Early Help/No Further Action (NFA).

- If involvement with the family ends during the antenatal period, the Child and Family Assessment and/or pre-birth assessment should be shared with partners to ensure a shared written understanding of the analysis of risk, interventions delivered as part of the assessment, the rationale for closure and who was involved in the decision making process in order that the multi-agency group can continue to be alive to the risks that were present in their continued involvement with the family.

- If the decision is for a Pre-Birth Assessment, this must be completed within 12 weeks, or within a timescale conducive to determining ongoing planning for the baby (i.e. if the baby's expected date of delivery is earlier, or the risk of state intervention at birth is high, the pre-birth assessment may need to be completed earlier). The unborn baby must remain on a Child-in-Need Plan during this assessment.

- On completion of the Pre-Birth Assessment (or at another point determined by a social work manager), a multi-agency strategy discussion must take place and a decision made whether

to: progress to Initial Child Protection Conference or whether statutory or non-statutory involvement should continue.

- Where a pre-birth Initial Child Protection Conference is required, it will usually be convened at around 30 weeks gestation (no later unless for a concealed pregnancy) and always within 15 days of the strategy discussion. For some unborn babies, it may be advisable to hold the Initial Child Protection Conference earlier in the pregnancy, for instance where there is no engagement from the expectant parents, or where there are concerns about an acute risk to the baby at the birth itself. If the unborn baby is made subject to a Child Protection Plan at that Conference, the first Core Group meeting to agree the plan for the baby will be held within ten working days.

7. Birth Arrangements

7.1 A birth arrangements plan will be completed within a multi-agency meeting (either assessment planning meeting, child in need review, core group meeting or Initial Child Protection Conference) – whichever occurs first between 30 and 34 weeks' gestation. This plan will be completed jointly by midwifery and social care, in collaboration with the family and respecting parental choice, and recorded in midwifery and social care files within 2 working days. The birth plan should include the individual needs of the expectant parents, including learning needs/neurodiversity. This should include the plan for the baby's birth, respecting the parents' choice, including whether birth choices are clinically safe, as well as who will be present, where the baby will be discharged to/the home at which the baby will live after leaving hospital, and any other arrangements which are necessary to safeguard the baby. This might include additional measures such as supervision of parents on the hospital ward, and arrangements for family members to spend time with the baby following discharge. The legal framework for the baby's care planning should be made clear, including where an application to the Family Court is to be made.

7.2 Consideration of any risks to the baby in relation to breastfeeding e.g. HIV status of the mother; medication being taken by the mother which is contraindicated in relation to breastfeeding. Advice should be sought from breastfeeding health practitioners to inform planning.

7.3 Consideration should be given to notifying Northwest Ambulance Service NHS Trust, should there be an indication that future safe transfer to hospital may be required. Information sharing should include an assessment of risk including violence and aggression and Children's Services safeguarding arrangements.

7.4 Contingency plans should also be in place in the event of a sudden change in circumstances.

7.5 Birth arrangements where the baby is to be separated from the person giving birth should be humane, trauma-responsive and holding in mind the importance of the first memories attached to birth. Supervision of parents, particularly the person giving birth to the baby, should be proportionate to the risk.

- The existence of a child protection plan does not remove the parents' choice for the birth to be at home or in another location. In these circumstances, the core group will still agree post birth arrangements including for a discharge planning meeting, which may be in

hospital or at another venue.

- Where separation is likely or planned, the mother is informed in advance, in writing and in person, wherever possible. Please see Birth Charter for women with involvement from children's social care.

- Where there is a high risk of state intervention at birth/a high risk of harm identified to the unborn baby, consideration should be given within children's social care to presenting the baby's circumstances at Legal Gateway panel to consider pre-proceedings processes under the Public Law Outline. This should happen as soon as these factors are identified, i.e. following the 10 day C&F assessment in order to ensure procedural fairness for the expectant parents who would have the benefit of legal advice, to ensure the best opportunity for change during the pre-birth period, and to ensure early permanence planning for the baby. The intention would be that, wherever possible, the baby is discharged from hospital into the care of whoever is likely to be caring for them throughout their childhood and beyond.

- A discharge planning meeting should be held prior to the baby being discharged from hospital, including midwifery, health visiting and any other agencies who will be involved in the post-natal period, ensuring all agencies contribute to the safety plan which will be coproduced with the family.

8. Babies separated from parents

8.1 For a small number of babies, a decision will be taken prior to their birth that their parents will not be able to safely care for them, irrespective of the levels of support with which they are provided. In these circumstances the baby will be placed with extended family members who have been assessed as able to provide safe care, foster carers, or prospective adoptive parents shortly after birth. The following steps should be applied in these circumstances (which would also apply where the decision was made shortly after birth):

- Children's social care should seek legal advice as soon as the possibility arises that the baby may not be able to remain in the parents' care.

- Decision making, once alternatives to keep the family together have been exhausted, should be as early in the pregnancy as possible in order provide the parents with clarity and to begin planning for the baby's longer-term care.

- The parents should continue to be involved in multi-agency planning for the birth and fully understand what to expect following the birth.

- In exceptional circumstances, where children's social care are not able to secure a court order, consideration may be given to the use of police powers of protection.

- The parents should be provided with the opportunity to spend time with their baby following birth and to have a HOPE box for themselves and their baby, dependent on where the baby is delivered. Discussion with the parents regarding the preparation and

development of a HOPE box for mum and her baby can also be discussed earlier in the pregnancy if appropriate to do so. HOPE-(Hold On Pain Eases) aims to minimise the trauma experienced by mothers and babies who are separated close to birth due to safeguarding concerns. The contents of the boxes (teddies & blankets) should be exchanged at each family time. If the maternity provider is supporting HOPE boxes, this should be offered to parents.

- The social worker should consider how the baby's first few days should be captured. for future life story work and include this in both HOPE boxes.

- The parents should continue to be offered multi-agency support. This should involve the named social worker and midwifery. Other services supporting the family should also be invited to participate, particularly mental health services to ensure plans are in place to support mental health and emotional wellbeing (this will support the recommendations from MBBRACE).

- The parents should be supported in attending Court hearings either face to face, or virtually.

- A referral to the Reproductive Trauma Service (RTS) for example, for Merseyside, 'Silver Birch' should be considered at 4 weeks post-partum to reduce any further trauma. Please see Maternal Mental Health Service (Silver Birch Hub) :: Mersey Care NHS Foundation Trust

- Parents must have clear information about their baby's placement and family time (contact) arrangements prior to discharge. This must be discussed at the discharge planning meeting, which would ideally take place within 48 hours of baby's birth, and documented on the discharge information.

- A plan of post-natal visits for mother and baby must be formulated at the discharge meeting. Midwifery visits should be continued up to 28 days post-natal for the mother so that she is fully involved in the planning and timing of these visits and can utilise the support available. Midwives are to complete a safe sleep assessment at the first post-natal visit, which includes viewing day time and night time sleep arrangements. If night time sleeping arrangements cannot be viewed, this should be discussed with other agencies visiting the family to support safe sleep advice (please see Sefton CSPR: Child Delilah).

- A Health Visitor will conduct a home visit between 10-14 days after the birth. This visit will include a safe sleep assessment and an offer to view day and nighttime sleeping arrangements.

- If a baby is to be discharged out of area, the social worker will be required to contact the midwifery safeguarding team in the area where the baby is placed. If this is a mother and baby home, midwifery will liaise with the community midwifery team and health visiting team in the area where they are placed for postnatal care.

- Professionals must check the immediate basic and emotional support needs of the parents prior to them leaving the hospital and consideration must be given to their practical needs such as transport home form hospital.

- Multi-agency professionals should continue to work together to plan for the baby's future through children looked after reviews. Existing child protection (or child in need) plans will cease.

- Parents should be provided with all the available support with the purpose of providing the best start in life and retaining or regaining the care of the baby if possible.

9. Assessments and child protection

9.1 The Pre-Birth Assessment will be a standing item on individual practitioners' supervision sessions. The progression/planning of Pre-birth assessments must be monitored and tracked by both Team and Senior Managers, where appropriate, within all involved agencies.

9.2 Child Protection Conferences re: an unborn baby: all professionals where invited will give high priority to attendance at Child Protection Conferences. If attendance is not possible, they must ensure that their report is taken to the Conference by another appropriately briefed professional from their agency. The conference may not be viable or quorate if professionals are not present. Child Protection Conference Reports will be shared with parents 3 working days prior to the meeting in line with Child Protection Standards.
When an unborn child is made subject to a child protection plan:

- The midwife (or representative for midwifery services) will ensure that the pre-birth plan is filed in the maternity records within two working days of its completion. A copy will also be saved to the baby's case file by the Social Worker and, if necessary, sent directly to the Emergency Duty Team.

- The health visiting service is commissioned to deliver an antenatal contact from 28 weeks gestation or 25 weeks for families who fit the enhanced health visiting criteria in Sefton. Pre-birth assessments completed prior to this, however, should be shared with the health visiting service and filed on the mother's antenatal health visiting record for information. For child protection conferences held earlier than 25 weeks gestation, the health visitor should be invited and will attend wherever possible to gather information.

- Maternity unit staff will inform Children's Social Care of the baby's birth immediately (If out of hours, then the Emergency Duty Team). The named Social Worker will subsequently notify other members of the Core Group.

- For all babies made subject to a child protection plan and/or pre-proceedings prior to their birth, a discharge meeting will be required prior to the baby's discharge from hospital. This meeting will consider where the baby will be living, which professionals will be visiting and when (and the purpose of these visits relating to the plan), and the steps to be taken to ensure safety during the discharge from hospital itself. This meeting will also consider the gathering of important memories from the baby's birth. *At Southport and Ormskirk hospitals, this will include the provision of Hope Boxes.* The multi-agency group might decide that a discharge meeting might be beneficial for a baby subject to a Child in Need plan.

- The named Social Worker will undertake a home visit within 48 hours of the baby's

discharge from hospital, or on the day the baby is placed if the baby is being discharged into foster care.

- The Child Protection Review Conference must be held within four weeks of the birth of the child.

10. Escalations

10.1 Working with children and families is complex. Professional challenge is beneficial and ensures practice is robust in safeguarding children. Good communication and adherence to this procedure are essential. Where this does not occur, there is a responsibility on professionals to escalate the issue in the interests of safeguarding children and supporting families.

10.2 If there is disagreement about the course of action in safeguarding babies at any stage, Sefton's escalation procedure should be followed Sefton Safeguarding Children Partnership - Sefton SCP Escalation Procedure.