

**Interagency Protocol for Unborn Children and Babies**

**1.0 Introduction**

1.0 This Pathway has been developed in response to a Serious Case Review in respect of Daniel Jones, as a result of learning from Daniel’s death in 2013. The Protocol seeks to offer advice to professionals to the action they should take to support parents and safeguard unborn children and young babies.

The protocol should be used in conjunction with [Wolverhampton’s Threshold document.](https://www.wolverhamptonsafeguarding.org.uk/images/Final_Threshold_Doc.)

Young babies are particularly vulnerable to abuse and work carried out in the antenatal period can help minimise harm if there is Early Help. This multi-agency protocol sets out how to respond to concerns for unborn children, emphasising clear and regular T

1.2 Professionals should be concerned and should take action:

* Worries about either parent’s current behaviour, e.g. known mental health concern or substance misuse
* Worries that either parent/carer may not be able to care for the baby to an acceptable standard, e.g. significant learning difficulty, previous neglect or other children subject to child protection plans/taken into care
* Behaviours by others (including fathers), that may pose a threat to the unborn baby, e.g. domestic abuse or known allegation or conviction for offences against children under 18 years of age
* Parental behaviours towards each other may be reducing their ability to care for the baby to an acceptable standard
* Concerns because the mother is unable, or unwilling to say who the father of the child is

These concerns do not automatically require a referral to Children’s Social Care but they do need further exploration in line with Wolverhampton Threshold document and discussion with your line-manager, or safeguarding lead professional.

1.3 Sharing information early gives the best chance to children and parents. It means services can be put in place, parents have a chance to reach their potential, and there is a chance to see progress made. Early Help minimises the need for child protection intervention

**COMMUNICATION IS KEY. ACT EARLY - DO NOT WASTE VALUABLE TIME**

**2.0 Early Help**

2.1 Identification of the need for Early Help is an on-going process before and after birth. The following should be considered during ongoing pre and post birth assessment:

* Details of the mother’s partner(s)
* Wider social and family history (Inc. previous agency involvement, obstetric history etc.)
* Think Family

2.2 Awareness and exploration of:

* Domestic abuse
* Adult mental health issues
* Substance misuse

2.3 Remember, as a professional, you are considering the impact of social complexity on the unborn child and young infant.

2.4 **IINFORMATION GATHERING / GOOD PRACTICE**

* Where possible the mother should be seen alone, without partner or extended family members.
* Include information about fathers/partners.
* Provide an interpreter for any families where English is not their first language,
* Ask about domestic abuse, alcohol/substance use and mental wellbeing.
* If concerns have been identified, refer to Strengthening Families Pathway.

**3.0 NEXT STEPS**

3.1 Add Threshold document to determine the level of support and action required to be taken.

Consider other support also available to the family (application to charities, housing support, food banks, citizens advice, debt management, substance misuse services, mental health support etc)

3.2 **Planning for the birth where there are significant concerns**

Pregnancy can be an anxious time for all parents. These anxieties are heightened where there are safeguarding concerns. If threshold has been met a Child Protection Conference will be held, or a Child in Need Plan must be in place as soon as possible. *The Child Protection Conference should be held no later than by week 24 of the pregnancy unless there is a late referral where plans must be agreed as soon as possible following identification of concerns to avoid any delay.*

It is essential, for good communication and practice to have a plan and where the unborn baby is subject of a Child Protection plan a ‘CP Checklist’ *(see Appendix 2)* is completed by the core group.

Think Family-father of the unborn and extended family must be considered and included in meetings and planning for birth

3.3 **Escalation/resolution policy**

Where there is a dispute between professionals, [WST escalation](https://www.wolverhamptonsafeguarding.org.uk/images/WST_Escalation_Policy_Apr2021.pdf) policy can be implemented.

3.4 **Concealed / Late booking/Denied Pregnancy**

**Definition -**pregnancy beyond 20 weeks gestation

**Concealed Pregnancy**

There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women may have a variety of reasons for their behaviour.

A woman may repeat concealment on a second or third pregnancy.

Concealment of pregnancy takes 3 different forms:

1. It may be conscious and deliberate by the mother, with or without the collusion of others.
2. The pregnancy may be denied by the mother
3. The mother may genuinely not know she is pregnant.

In each case the pregnancy will be unknown to professionals.

3.5 **Reasons for Concealment**

There are a variety of reasons why women deliberately conceal their pregnancy. These include:

* Denial
* Fear
* Stigma
* Sexual abuse
* Previous safeguarding issues/ child protection
* Ignorance/poor education/lack of PHSE
* Cultural
* Domestic abuse
* Unknown

**Implications of concealed pregnancy**

* Health implications for mother
* Potential poor outcomes for baby
* Lack of bonding
* Undiagnosed health care requirements
* Death of mother/ baby or both
* Increased risk of harm to child
* Future mental health of mother. Increased risk of depression

Consideration should be given to:

* Collusion of partner/ family in concealment and their reasons for doing so
* Woman’s drug/ alcohol misuse
* Paternity worries
* Partner abuse
* Trafficking
* Benefit fraud
* Mental capacity/ learning disability

Each case is individual, and should focus around the needs of the woman and unborn baby on an individual basis.

3.6 **Late booking**

After 20 weeks of pregnancy if a woman presents for ‘booking’ it is treated as an obstetric high-risk pregnancy.

If any professional becomes aware of a pregnancy and there are safeguarding concerns, they should not assume Midwifery, or other health services, are aware of the pregnancy or concerns held.

Consider

* Safeguarding referral/MARF
* Safeguarding Adult Referral
* MARAC referral
* Mental health referral
* Midwifery services
* Family support
* Health Visitor involvement as early as possible
* Discharge planning
* Future pregnancies

It is the duty of all agencies to consider the safety of the mother and the unborn child (and any other children in her care). Any safeguarding concerns that meet the threshold must be referred to Multi-Agency Safeguarding Hub (MASH) in accordance with the Wolverhampton Safeguarding Together Threshold Document.

3.7 **Free birthing**

Free or unassisted birth (often referred to as ‘free birthing’) refers to a woman giving birth without medical or professional help.

‘Free birthing’ should not be confused with ‘natural childbirth’ or with a birth attended by a self-employed independent midwife.

If a woman chooses not to contact or engage a midwife it is her right to do so. Women are not obliged to accept any midwifery or medical care or treatment during childbirth and cannot be compelled to accept care unless they lack mental capacity.

3.8 **Attendance by unqualified persons at childbirth**

The Nursing and Midwifery Order (Amendment) 2018, Part 9 Article 44 explains that it is illegal for an unqualified person to undertake the role of a registered midwife. Article 45 further explains that no person other than a registered midwife or a registered medical practitioner shall attend a woman in childbirth (assume responsibility) unless in an emergency or in supported recognised training.

An ‘unqualified’ person is an individual who gives medical or midwifery care but may not lawfully do so. This ‘unqualified’ person may include a non-registered midwife, a doula (also sometimes known as a ‘labour coach’, a ‘doula’ is a non-medical person who assists a woman before, during and after childbirth by providing information, physical assistance and emotional support), a nurse, the woman’s partner, a relative or a friend who is not a registered midwife or registered doctor.

An unqualified person may be present during childbirth but must not assume responsibility, assist or assume the role of the medical practitioner or registered midwife or give midwifery or medical care in childbirth. This is unlawful and may incur sanctions and a conviction. If it is suspected that an ‘unqualified person’ has acted illegally the local maternity unit must be informed specifically the Head of Midwifery and Named Midwife for Safeguarding.

3.9 **Notification of births**

It is a legal requirement to notify all births and deaths in the UK. The duty of notifying a birth

to the appropriate medical officer within 36 hours rests with the father or any other person

present at the birth or within six hours of the birth. If a midwife is in attendance at a birth this

is normally undertaken by the midwife. The relevant form can be obtained from

the relevant Clinical Commissioning Group.

3.10 **Registration of births**

The father or mother must give the Registrar of Births and Deaths information about the birth within 42 days of the birth taking place. If the father or mother does not do this, it falls to any other person including the midwife who was present at the birth.

3.11 **The Role of the Midwife when Summoned to Attend a Freebirth**

If a woman decides to plan and implement a free birth event, she will assume full responsibility for the birth of her child and will decide not to call or be attended by a qualified person. The midwife must respect the woman’s choice to have an unassisted birth and if called prior to, during or after completion of the birth, the midwife should adhere to The Code: Standards of Conduct, Performance and Ethics for Nurses and Midwives (NMC 2015 and the Standards of Proficiency for Midwives (NMC 2019).

If a midwife is summoned to attend for whatever reason and the birth has not occurred, any benefits, risks or concerns should be discussed with the woman and documented. It is possible that the woman and her family may or may not have previously engaged with maternity services and whilst this service should be offered the woman may choose to decline and her decision should be respected. Any concerns in relation to the mother’s physical or psychological wellbeing, mental capacity or safety should be discussed with the Senior Midwife on call, Professional Midwifery Advocate and Named Midwife for Safeguarding informed.

If a midwife is summoned during labour or birth, all remaining care should be performed, findings documented and emergency help requested if needed, also informing senior midwives as above.

**4.0 GUIDANCE FOR PROFESSIONALS**

4.1 **Schools & Colleges**

In many instances staff in educational settings may be the professionals who know a young woman best. Supportive, caring and non-judgmental pastoral support systems within schools can be extremely valuable in resolving problems at an early stage. It may be appropriate to engage the assistance of the Designated Safeguarding lead for Child Protection in addressing these concerns.

Where there is significant evidence that a girl is pregnant despite repeated denial, such as:

* increased weight or attempts to lose weight
* wearing uncharacteristically baggy clothing
* concerns expressed by friends
* repeated rumours around school
* uncharacteristically withdrawn or moody behaviour

Staff working in educational settings should try to encourage the pupil to discuss her situation, through normal pastoral support systems, as they would any other sensitive problem. However, where they still face total denial further action should be considered. Negotiating the early assistance of or referral to the School Nurse may be appropriate in these circumstances

Education staff may often feel the matter can be resolved through discussion with the parent of the young woman or girl. However, this must be discussed and the Designated Child Protection Lead.

Professionals who are in contact with girls not attending school should consider the possibility that pregnancy may be a cause for non-attendance.

It will be beneficial to convene a multi-agency meeting to include the Designated Safeguarding Lead, Education Welfare Officer, School Nurse and other appropriate professionals and undertake an Early Help Assessment. As a result of the Early Help Assessment, it may be necessary to make a referral to the MASH.

As with any referral to the relevant MASH, the parents and the young woman should be informed, unless in so doing there would be significant concern for the young woman’s welfare, or that of the unborn child.

4.2 **Health Care Professionals**

All health professionals have a duty to use Wolverhampton Threshold document guidance and the Strengthening Families Pathway to safeguard the unborn/baby.

Good communication between health professionals is key to ensure positive outcomes for the women and children of Wolverhampton. All health professionals have a duty to consider an Early Help Assessment and work with other professionals to support the unborn/baby/young child. . As a result of the Early Help Assessment, it may be necessary to make a referral to Children Social Care.

4.2.1 **Midwives**

If booking for antenatal care is after 20 weeks gestation, the reason for this must be explored by the midwife and the Named Midwife for Safeguarding informed

If there is a cause for concern a referral should be made to the relevant Children’s Social Care. The young girl / woman must be informed that the referral has been made, unless there are significant child protection concerns.

If a woman arrives at the hospital in labour or following an unassisted delivery, where pregnancy is unbooked, a referral should always be made to the relevant Children’s Social Care by the midwife or other appropriate medical practitioner. The baby should not be discharged from hospital until a strategy discussion has been held and relevant assessments undertaken.

**\*NB** Health Professionals have no legal right to stop a woman self-discharging along with her baby. The Midwife or appropriate medical practitioner 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 medical practitioner.

(Please note the section on Concealed Pregnancies)

4.2.2 **Health Visitors**

If the Health Visitor encounters a woman that they believe to 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 she refuses all attempts to persuade her to seek health advice the Health Visitor should make a referral to children’s social care.

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

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

(Please note the section on Concealed Pregnancies)

4.2.3 **School Nurses**

The School Nurse may well be able to help a girl who is pregnant to accept that she needs support. If possible, having gained consent from the young person, it may be helpful to liaise with the G.P and Midwife to consider a way forward.

If faced with denial, the School Nurse should seek advice from the Named Nurse to determine whether a referral to the relevant Children’s Social Care Departmemt is appropriate.

4.2.4 **General Practitioners**

It is good practice to refer all pregnant women to your 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, Health Visitor or School Nurse (as appropriate). It may also be helpful to discuss the concerns with the Designated Doctor for Child Protection. As a result, it may be necessary to make a referral to Children Social Care.

4.2.5 **Addiction Specialist**

If mother is known to the specialist addiction service a referral should be made to the Drug & Alcohol Liaison Team who will follow maternity pathways. If there are concerns these will be referred into the MASH using the MARF.

4.2.6 **Mental Health and Learning Disability Specialists**

When working with a pregnant woman 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.

There are occasions when women with learning difficulties and mental ill health may be unaware they are pregnant.

4.3 **Social Workers**

On receipt of Multi Agency Referral Form (E-Marf) from a professional seeking advice regarding an unborn child, for whom there are potential safeguarding concerns, the social worker has a duty to:

1. Check relevant electronic systems.
2. Share any relevant information held
3. Record the contact
4. Determine, from the information shared, where it meets the threshold for a referral to children’s social care or Early Help support

On receipt of a referral in respect of an unborn/new born baby who is considered to be at risk of significant harm or a Child in Need an Assessment will be considered to assess the needs of the unborn/newborn baby and their family.

Where a young person under 16 is pregnant, the referral is received in the name of the young mother and unborn child. In such circumstances there may be a criminal or child protection investigation to consider.

If the expectant mother is over 16, the referral will be received in the name of the unborn/new born baby.

In the case of **Concealed pregnancies**:

Where the expectant mother is **under 16**, initial contact should be confidential with the young woman to discuss concerns regarding the unborn child. She should be provided with the opportunity to satisfy social workers she is not pregnant, by undertaking appropriate medical examination or investigation, or to begin to make realistic plans for the baby.

In the event the young woman refuses to engage in constructive discussion, and where parental involvement is considered necessary to address risk, the expectant mother’s parents or carers should be informed and plans made wherever possible to protect the unborn baby’s welfare. Potential risks to the unborn child or to the health of the young woman would outweigh the young woman’s right to confidentiality.

Where the expectant mother is **over 16**, every effort should be made to resolve the issue of whether she is pregnant or not. Clearly no woman can be forced to undergo a pregnancy test, nor any other medical examination, but in the event of refusal, social workers should proceed on the assumption that the woman is pregnant, until or unless it is proved otherwise, and endeavor to make plans to safeguard the baby’s welfare at birth.

A multi-agency meeting should be convened, to share information and to construct a plan. It may be appropriate to invite a representative from Mental Health Services (child or adult as appropriate) so that support, advice and/or consultation is available at an early stage.

Where there are additional concerns, e.g. lack of engagement, possibility of sexual abuse, or substance misuse, the referral should be dealt with under WST child protection procedures (Section 47 investigation). It may be appropriate to convene a pre-birth child protection conference.

In undertaking an assessment, the social worker will need to focus on the facts leading to the pregnancy, reasons why the pregnancy was concealed and gain some understanding of what outcome the mother intended for the child, as well as all the other aspects of the Assessment Framework, as these will be one of the key factors in determining risk.

Expectant care leavers (mothers and fathers) also have access to a mandatory offer around early intervention and parent champions which will provide them with support as a corporate parent.

4.4 **Police**

The police will be notified of any Child Protection inquiries made to the relevant MASH.

Consideration will be given to whether a joint investigation is needed. This will be dependent upon whether an offence may have been committed or if the child is at serious risk of significant harm.

If the child has been found to have been harmed, died /or deemed to have been still born, child protection procedures will apply, and a joint investigation will be conducted with the relevant Children’s Social Care Department.

## 4.5 Other Professionals

## For those professionals not specifically identified within the protocol where there are concerns regarding an unborn baby a referral should be made into the Multi-agency Safeguarding Hub via telephone and supported by a Multi-agency Referral Form.

## 4.6 Future pregnancies

Where it is known that there is history of previous concealed pregnancy, consideration must be given to the risk factors and discussion must take place with the designated child protection professional. Where this discussion highlights risks or additional concerns a referral must be made to the relevant children’s social care department. Sharing information openly will be a critical factor in safeguarding the unborn child and professionals will need to accept this may be without the consent of the mother concerned.

Following a concealed pregnancy where significant risk has been identified, the relevant children’s social care department 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 the relevant children’s social care department if a future pregnancy is suspected.

Where there is a known plan in place, it should be activated as soon as professionals become aware of a subsequent pregnancy.

**References**

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*Appendix 2*

[cid:image003.gif@01CC3A41.332FD600](http://www.royalwolverhamptonhospitals.nhs.uk/)

**CHILD PROTECTION CHECKLIST AT PRE-BIRTH CHILD PROTECTION CONFERENCE/STRATEGY MEETING**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mother’s Name** |  | | | |  | | | **GP** | | | |  | | | | |
| **Address** |  | | | |  | | | **CMW** | | | |  | | | | |
| **Social Worker number** | | | |  | | | | |
| **DOB** |  | | | |  | | | |  | | | | |
| **EDD** |  | | | |
| **Social worker to be informed** | | **Yes** | | | **No** | | | |
| On admission | |  | | |  | | | |
| At delivery | |  | | |  | | | |
| Day of Delivery | |  | | |  | | | |
| Prior to Transfer home | |  | | |  | | | |
| **Health visitor to be informed by Ward Staff** | | **Yes** | | | **No** | | | | |  | **Health visitor ……………………………….** | | | |
| **On admission** | |  | | |  | | | | |  |  | | | |
| **At Delivery** | |  | | |  | | | | |  | **Contact number …………………………….** | | | |
| **Prior to discharge** | |  | | |  | | | | |  |  | | | |
| **Maternal contact** | | Yes | No | | |  | | **Paternal contact** | | | | | Yes | No | |
| Family time (Contact) | |  |  | | |  | | No Contact | | | | |  |  | |
| Supervised Family time (Contact) \* Hospital staff can monitor and observe but are unable to supervise | |  |  | | |  | | Supervised Family Time (Contact) \* Hospital staff can monitor and observe but are unable to supervise | | | | |  |  | |
| Free Access | |  |  | | |  | | Normal visiting | | | | |  |  | |
| **Family members** | | Yes | | No | | | **Names and relationship** | | | | | | | | |
| No Family Time (Contact) | |  | |  | | |  | | | | | | | | |
| Supervised Family time (Contact) \* Hospital staff can monitor and observe but are unable to supervise | |  | |  | | |  | | | | | | | | |
| Normal visiting | |  | |  | | |  | | | | | | | | |

Contact supervised by **…………………………………………………………………………………………………………………………………………**

**Length of stay in hospital – Maximum of 4 days**

**In the absence of any obstetric or paediatric reason to remain in hospital, Children’s services to arrange place of safety .**

|  |  |  |  |
| --- | --- | --- | --- |
| **On discharge child will be going to** | **Tick** |  | **Other…..** |
| Home |  |  |
| Foster care\* |  |  |
| Mother and Baby unit |  |  |
| Other |  |  |

**Core Group signatories ……………………………………………………………………. Date ………………………….**

**\*If Foster Care is outside of Wolverhampton the Health visitor to inform receiving in Health Visitor Service.**

**Copies of record to be made available in mother’s and Child’s medical Records. \*\*Uploaded to the Maternity Information System electronic record.**