WSCB Interagency Protocol for Unborn children and young babies

1.0 Introduction

1.0 In November 2013 Wolverhampton Safeguarding Children Board published a Serious Case Review in respect of Daniel Jones. As a result of learning from Daniel's death, the review made a series of recommendations one of which was that ‘WSCB should develop an interagency pathway and protocol for assessing the needs of unborn babies in all circumstances where there is the likelihood of compromised parenting’. In response, this Pathway has been developed and seeks to offer advice to professionals at to the action they should take to support parents and safeguard unborn children and young babies.

Young babies are particularly vulnerable to abuse and work carried out in the antenatal period can help minimise harm if there is early assessment, intervention and support. This multi-agency protocol sets out how to respond to concerns for unborn children, emphasizing clear and regular communication.

1.2 Professionals should be concerned where there are:

- Worries about either parent’s current behaviour, e.g. known mental health concern or substance misuse
- Concerns 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 and discussion with your line-manager.

1.3 Starting assessments and 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 intervention minimises the need for child protection intervention

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

2.0 Early Intervention
2.1 Assessment is an on-going process before and after birth. The Assessment should always consider:

- Details of the mother’s partner(s)
- Wider social and family history (inc. previous agency involvement, obstetric history etc)

2.2 Be particularly aware and explore the potential of:

- Domestic abuse
- Adult mental health issues
- Substance misuse

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

Public Health England estimates in December 2012 show that:

There are 2,135 opiate/crack users and 5264 dependent drinkers in Wolverhampton.

There are a total of 165 adults in drug treatment and 759 in alcohol treatment in Wolverhampton.

The Wolverhampton Domestic Violence Forum, in the same period, identified there were 3518 Domestic Violence incidents recorded by the Police and that 45% of the children subject of a Child Protection Plan had domestic violence as a contributing risk factor.

2.4 GOOD PRACTICE

- Where possible see the mother alone, without partner or extended family members.
- Do not exclude fathers from the assessment
- Provide an interpreter for any families where English is not their first language,
- Ask about domestic abuse, alcohol/substance use and mental wellbeing
- Use the information gathered to inform next steps

3.0 NEXT STEPS (See Appendix 1)

3.1 Once the professional pre-birth assessment is completed there are three possible outcomes/types of intervention that may be offered:

Outcome 1
Single-agency to support and monitoring. (*NB Remain vigilant at every contact, circumstances can change)

**Action:**

The agency continues to offer universal services

---

**Outcome 2**

Multi-agency intervention is required to ensure mother and unborn child/young child are supported in achieving optimum outcomes.

**Action:**

1. Talk to the family about your concerns, and explain you need to talk to other professionals to get them the right support for their baby.

2. Obtain consent (if declined, discuss with line-manager or a senior REMEMBER Consent can be overridden if there is a safeguarding issue)

3. Two possible pathways:
   
   i/ Discuss at Early Intervention meeting to determine what support is available or offered
   
   ii/ Refer to local Children Centre for targeted family support and initiate an Early Help Assessment (lead by the most appropriate professional)

---

**Outcome 3**

Multi-agency intervention is required to ensure the safety of the unborn baby/young child.

**Action:**

1. Follow this procedure where when there are concerns an unborn baby may be ‘in need’ (section 17) or ‘in need of protection’ (section 47) which means that their basic physical and/or psychological needs will not be met and is likely to impair the child’s health or development.

2. Discuss with line-manager/safeguarding lead within your agency.

3. Contact MASH and discuss referral

4. Complete MARF Referral Form within 24 hours (secure email)

**NB** if the family already have an identified Social Worker then the referral needs to be made to them.
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. It is essential, for good communication and practice to have a Birth Plan (name to change in future) and where the unborn baby is subject of a Child Protection plan a ‘CP Checklist’ (*see Appendix 2*) is completed by the core group.

If necessary, a child protection conference will be held, or a children 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 when plans must be agreed as soon as possible following identification of concerns.*

Father and extended family must be involved in the Child Protection conference or Child in Need meeting unless there are strong reasons to prevent this.

3.3 **Escalation/resolution policy**

If after following these protocols professionals or agencies still have concerns contact your named professional for child protection and if required implement the WSCB escalation policy (*add link*).

3.4 **Concealed pregnancy**

Where there is a suspicion that a pregnancy is being concealed follow the Guidance outlined in Outcome 3.

**Definition**

**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.

Women of all ages conceal pregnancy but younger women, aged 16 to 24, predominate in studies. Most women are single but some are married or separated. Concealment of pregnancy has been observed among women of all social classes, levels of education and employment and professional status. 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 concealed pregnancy will be unbooked.

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

However a woman may conceal a pregnancy for reasons that are completely 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 PN 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. Assessment should focus around the needs of the woman and unborn baby on an individual basis.

**3.6 Late booking**

After 22 weeks of pregnancy if a woman presents for ‘booking’ it is treated as a high risk pregnancy

Requires consultant obstetrician care

Consider

- Safeguarding referral
- Mental health referral
- Specialist midwifery services
- Family support/Children Centre
- Involve Health Visitor as early as possible
• Discharge plan
• Future pregnancies.

Research:

Reder et al (1993) summarised thirty-five major child death inquiries and highlighted evidence of considerable ambivalence to or rejection of some of those pregnancies and a significant number with little or no antenatal care. They also draw attention to ‘the meaning of the child’. Reder & Duncan (1999) reinforce their previous evidence in a follow-up study but also identified a small sub-group of fatality cases where mothers did not acknowledge that they were pregnant and failed to present for any antenatal care and the babies were born in secret. A Review of forty Serious Case Reviews (DH 2002) identified one death was significant to concealment of pregnancy. Earl (2000, Friedman et al (2005), Vallone & Hoffman, highlight that there is a well-established link between neonatacide; infanticide in the 24 hours following birth; and concealed pregnancy.

As far as is known, the majority of babies born of concealed pregnancy are healthy and go home with their mothers. However, little is known about the long-term outcomes for children and families of concealed or late booking 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 child protection concerns must be referred to Children’s Social Care in accordance with the Wolverhampton safeguarding Children Board Child Protection Procedures.

Actions

1. Where there is a suspicion that a pregnancy is being concealed follow Outcome 2 /Outcome 3 pathway. If you cannot obtain consent to share information a strategy meeting should be convened, overriding this decision.
2. Every effort should be made by the person alerted to suspicion of concealed pregnancy to encourage the woman to obtain medical advice.
3. If the mother is under 16 make a referral to children’s social care in her own right.

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, often known as an independent midwife).

‘Free birthing’ is legal as long as the birth is not attended or the responsibility for care is not assumed or undertaken by an ‘unqualified individual’. An ‘unqualified individual’ is a person who is not a registered doctor or midwife but acts in that capacity during birth. The woman assumes full responsibility for her child’s birth, but she may and can have her partner, a relative or a friend present in a supportive role.
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.

Whilst acknowledging and supporting the right of any woman to decide to have a ‘free birth’, it is recommended that before embarking on this course of action, a woman discusses the pros and cons of ‘free birthing’ with a suitably qualified person and gives serious consideration to any identified risks that may be associated with ‘free birthing’ and their personal, individual circumstances.

3.8 Attendance by unqualified persons at childbirth

The Nursing and Midwifery Order 2001, 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.

They 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 you suspect an ‘unqualified person’ has acted illegally you should inform the local maternity unit, specifically the Head of Midwifery and Safeguarding Lead.

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 health authority.

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 present at the birth, including the midwife.

3.11 Midwife’s role

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
If a midwife is called 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. Should you have any concerns in relation to the mother’s physical or psychological wellbeing, mental capacity or safety you should refer to the appropriate professional and inform your line manager and a Supervisor of Midwives.

If a midwife is summoned during labour or birth, all remaining care should be performed, findings documented and emergency help requested if needed. If child protection or safeguarding concerns are an issue you must inform your employer, child protection lead and supervisor of midwives as per national and local policy.

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 Person 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 Child Protection 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 Children Social Care.
As with any referral to the relevant Children’s Social Care Department, 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

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.

Good communication between health professionals is key to ensure positive outcomes for the women and children of Wolverhampton.

4.2.1 Midwives

If an appointment is made very late for antenatal care (after 22 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. 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 a booking has not been made, a referral should always be made to the relevant Children’s Social Care Department by the named 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.

Discharge summary from Maternity Service to Primary Care must report if a pregnancy was concealed or booked late (after 22 weeks).

(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 Department 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 contact 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 endeavour to make plans to safeguard the baby’s welfare at birth.

A multi-agency meeting should be convened, to 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 WSCB 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.

4.4 Police

The police will be notified of any Child Protection inquiries made the relevant Children’s Social Care Department following a concealed pregnancy.

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 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 MASH via telephone and supported by a MARF.

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.
Concerns are:
- Mental health of parent
- Substance issue
- Learning difficulty
- Previous Evidence of poor parenting/neglect
- Previous children subject to CP or removed from parents
- Domestic Abuse
- Allegations of conviction of offences against children
- Parental conflict or poor relationship
- Concerns around mother unwilling or unable to name father.
- Concealed or late Booking

**GOOD PRACTICE**
- SEE MOTHER ALONE
- DO NOT EXCLUDE FATHERS FROM ASSESSMENT
- USE INTERPRETERS
- ASK ABOUT DV/ALCOHOL/

**DO YOU HAVE CONCERNS ABOUT AN UNBORN CHILD?**

**PRE-BIRTH ASSESSMENT OF NEEDS (EHA)**

**OUTCOME 1**
Single agency support

- Complete Pre-Birth Early Intervention Assessment and Birth Plan
- Multi-agency Team around the Child
- Lead Professionals
- Support in place

**CONCEALED PREGNANCY SHOULD REFER TO MASH**

**OUTCOME 2**
Early Intervention and Help

**OUTCOME 3**
Risk of Significant harm: Complete MARF referral to MASH within 24 hours

- Are there significant concerns?
- Complete Pre-Birth Assessment and Birth Plan

**CSC**
Arrange CIN meeting

CIN support put in place

**Risk of significant harm: Strategy meeting/ S47**

**ARRANGE PRE-BIRTH CP CONFERENCE**
No later than by week 24 of Pregnancy

Support a CP Plan – complete Unborn Baby Checklist Procedure

If concerns are such that child needs to be removed at birth, attend Admission to Care Panel

**Is the family already open to a Social Worker?**

Refer direct to Social Worker

**APPENDIX 1**

May 2016
## CHILD PROTECTION CHECKLIST AT PRE-BIRTH CASE CONFERENCE/STRATEGY MEETING

<table>
<thead>
<tr>
<th>Mother’s Name</th>
<th>GP</th>
<th>Address</th>
<th>CMW</th>
<th>Social Worker number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DOB</th>
<th>EDD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Social worker to be informed

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day of Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to Transfer home</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health visitor to be informed by Ward Staff

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>On admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior to discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health visitor ............................................

Contact number ..........................................

### Maternal contact

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free Access</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Paternal contact

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal visiting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Family members

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervised Contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal visiting</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Names and relationship

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>

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 .

<table>
<thead>
<tr>
<th>On discharge child will be going to</th>
<th>Tick</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td></td>
</tr>
<tr>
<td>Foster care*</td>
<td></td>
</tr>
<tr>
<td>Mother and Baby unit</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### 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.