PAN-CHESHIRE
PRE-BIRTH ASSESSMENT PROCEDURE AND PRACTICE GUIDANCE

PLICY/PROCEDURE APPROVAL			
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Contents

1. Introduction

1.1 This guidance is to support and develop consistent best practice in pre-birth assessments across the pan Cheshire region. It seeks to clarify what is meant by pre-birth assessments, their purpose, the circumstances in which one needs to be considered and how they should be undertaken**. This guidance should be read in conjunction with single agency and local safeguarding procedures.**

1.2 This guidance has also been informed by the Born into Care Research, 2022 identifying best practice and principles in pre-birth assessment. The principles of pre-birth assessment are underpinned by family inclusive practice, which is empowering, trauma informed and trauma responsive and built upon a collaborative multi-agency approach.

1.3 Research and experience tell us that very young babies are extremely vulnerable to abuse and neglect. Multi agency working in the ante-natal period to assess risk vulnerabilities and need will inform intervention and support, to reduce risk of harm and improve outcomes for the infant and their family, yet unlike other safeguarding concerns pregnancy provides a window of opportunity to support change and improve outcomes for baby and their family post birth, with the right support, assessment and intervention in place.

1.4 ***Children Act (1989) is clear that there are grounds for intervention if there is a likelihood of significant harm and that the needs of the child (and baby to be born) are paramount***. A pre-birth assessment therefore is a proactive means of analysing potential risk to a baby and what help and support they may need, when there are concerns about the expectant mother, expectant father or her partner and immediate family.

1.5 It is important to acknowledge that pre-birth assessments are a source of anxiety for expectant parents who may fear that a decision will be made to separate their child at birth, therefore prioritising timely and quality pre-birth assessments by 30 weeks' gestation is paramount. Ensuring transparency and approaching pre-birth assessments in a trauma informed and trauma responsive way will support engagement; be trauma reducing and inform the effectiveness of planning and intervention to keep baby in the care of parents where it is safe to do so. (Born into Care, 2022)

1.6 This guidance acknowledges the increased anxiety that professionals may experience in relation to risks for a newborn baby which can be anxiety provoking for professionals and can induce increased stress and secondary trauma especially if clear and timely decision making is not in place prior if to birth.

1.7 This guidance provides clear timescales for decision-making across pan Cheshire to ensure family inclusive practice and provide key milestones for professional assessment and decision-making in the antenatal period, with a focus on making quality, safe and timely decisions for infants. *See appendix i.*

2. Purpose of pre-birth assessment

2.1 A pre-birth assessment is a multi-agency collaborative assessment led by Children's Social Care with the expectant parent(s), midwife and multi-agency professionals. Born into Care research identifies that, pregnancy provides a critical window for the opportunity for change, (Powell et al 2020 & Barlow et al, 2016, cited in Research in Practice, 2025,).

2.2 The purpose of a pre-birth assessment is to identify potential risks, vulnerabilities and need to help, support and inform timely planning and decision making for the unborn baby and expectant mother. Alongside this assess whether the parent(s) can meet their baby's needs or have the capacity to change circumstances in a time frame that would meet their infants long term needs.

3. Key considerations and approaches to pre-birth assessment

3.1 A pre-birth assessment requires the gathering and analysis of information available from all relevant agencies, the expectant parent(s) and their family if appropriate. Work with the family should be undertaken in a trauma responsive way and care taken when using genograms and trauma histories to reduce re-traumatisation.

3.2 Drawing on the Born into Care research the assessment should be dynamic, (Dr Sheena Webb, 2023), and consider parental trauma and view mother as a survivor of trauma herself, if trauma has been part of her lived experiences. It should consider how this impacts the daily life of the mother and father, how this informs risk and the management of risk as well as identifying the strengths and protective factors to be built through the assessment. Due to parents lived experiences it may create barriers to engagement which professionals need to work with and overcome. The assessment should identify risks and vulnerabilities to be reduced, and recommend, help and support.

3.3 Maximising continuity throughout the assessment and beyond should be a paramount principle where possible in the allocation of Social Worker, midwife and other professionals. The use of an identified key worker provides continuity of care for parents through the assessment period and post birth support. This can make a difference and improve outcomes for parents and baby. Relationships formed, understanding mother and fathers' needs and history can positively impact on outcomes for the baby and parents and prevent the need for parents to re-tell their story. (Born into Care, 2022)

4. When to refer to Children's Services?

4.1 All professionals need to be aware of indicators that a baby could be at risk of harm either before or following birth, or that the family will require additional or intensive support to care for their baby safely. For further information please refer to: Pan Cheshire Safeguarding Children Procedures

5. Pathways of referrals

5.1 Women who are pregnant may present via multiple pathways: including GP, hospital antenatal services, community midwifery, or social worker. Other agencies may become aware of a

pregnancy prior to formal referral to midwifery services, for example drug and alcohol services, probation or health visitor.

5.2 Local learning has informed that as soon as an agency is aware of a pregnancy, and there are concerns for safeguarding, or additional support needed, a referral to the Local Authorities front door **must be made** and not delayed in expectation of another service making the referral or waiting for a viable scan. This could cause delay which could negatively impact on the quality and timeliness of the pre-birth assessment (if threshold is meet), and the outcomes for baby at birth.

6. Timescales to refer

6.1 Across Pan-Cheshire, Children's referral and front door teams are structured differently. Some have integrated front doors, including both Early Help and Children's Social Care, others have separate Early Help and Social Care teams. It is important that professionals are aware of local routes and pathways when there are concerns for an expectant mother and an unborn baby. The expectant parent(s) should be informed and supported to understand the reasons a referral is being made and informed of the outcome of the referral.

Where safeguarding concerns are identified it is not necessary to wait until pregnancy is considered viable or wait for a dating scan to be completed to submit a referral to Children's Social Care and Early Help.

6.2 This will enable an assessment of threshold by the Local Authority's (LA) front door and ensure a timely, quality pre-birth assessment or pregnancy support through a Team Around the Family (TAF) plan. This will ensure that parents and professionals are clear on the plans for baby at birth, and post birth especially if the plan is of separation. The timeliness of the initial referral and assessment and intervention is therefore paramount. For midwifery supporting the family through the Social Complexities Pathway will ensure that timely and appropriate services are in place and will inform the pre-birth assessment. *(see appendix ii)*

6.3 Where there are local arrangements such as a pregnancy panel or midwifery liaison meetings, these should not incur additional delay for the referral to be made by 8 weeks if known to the Local Authority and no later than 12 weeks if not previously known. Please refer to single agency procedure for late bookings and pregnancies where expectant mothers do not feel emotionally and psychologically safe to disclose (concealed pregnancy).

7. Links to Pan Cheshire Local Authorities Front Door teams:

Cheshire West and Chester
Halton Borough Council
Cheshire East
Warrington Borough Council

7.1 Additional multi agency referrals to support parent(s) and form part of the pre- birth assessment should also be made in parallel to the front door for *example, Family Nurse Partnership, Perinatal Mental Health support and Alcohol and Substance Misuse Services.*

8. Children in Care or Care Leavers who are expecting a child

8.1 A referral for an unborn baby of a mother or father who is a child in care and under 18 years of age should be made to the Local Authority who is the Corporate Parent, for assessment and support.

8.2 Where the expectant mother or father is over 18 years but is a care leaver, up to the age of 25, a referral should be made to the front door for threshold decision making. This should be to the Local Authority in which the mother resides, however the Leaving Care Services of mother's responsible Local Authority should be informed and involved in the pre-birth assessment and support. Where father is a care leaver, leaving care services should also be involved.

9. Referral to Early Help Services for pregnancy support

9.1 Referrals to the Local Authorities front door for Early Help are to be made:

- **no later than 12 weeks** for Team Around the Family (TAF) assessment and support during pregnancy.

9.2 An Early Help TAF assessment can be considered within the first trimester where there are no safeguarding concerns, or the parent(s) have not experienced a separation(s) from their previous child/ren.

9.3 Pregnancy Support TAF Assessments need to be completed in 6 weeks, and reviewed by 16 weeks' gestation, to consider if a pre-birth assessment needs to be undertaken by Children's Social Care. This ensures a timely, quality assessment that enables a clear plan for birth and post birth by 36 weeks (if on a pre-birth proceeding pathway).

9.4 A pregnancy support TAF may take the form of either a partner led or local authority 'Early Help' or 'Family Help' plan. Professionals should ensure they understand local pathways for TAF assessment and recording.

10. Stepping Down across the Continuum of need

10.1 When a pre-birth assessment has been undertaken by Children's Social Care at Child in Need (CIN) or Child Protection (CP) and there are no further safeguarding concerns, a step down from CP to CIN or a pregnancy supported TAF can be made, as per the Local Authorities step down procedure. **Multi-agency planning and support should remain in place for at least 8 weeks following arrival of baby.**

11. Thresholds for referrals for Early Help and Children's Social Care:

Examples where consideration would be given to supporting through Early Help (TAF) could include: *(Note: 'Early Help' could be Local Authority led OR partner led Early Help depending on*	**Referrals to Children's Social Care (front door screening) must always be made in the following circumstances:**

local arrangements/level of need – a referral to children's front door may be required for LA based service)	
• Parent/s are asking for help and support • Food, warmth and other basics may not always be available. • Parent/s may struggle without the provision of support/ resources. • Young, inexperienced parents with inadequate support from family/ friends • Parent/s are challenged because of the needs of their children, e.g. children with additional needs. • Family dynamics result in levels of instability. • Parent/s struggling to maintain standards of hygiene/ repair with the family home. • Parent/s accruing rent arrears which may jeopardise tenancy if action not taken • Failure to attend for ante-natal care and additional services are required to support engagement / attendance. • Homelessness but support services in place. • Where there are low level concerns about parental self-care and neglect where engagement with services is good, and parents recognise the challenges of caring for a new baby. • Family stability will be impacted on the arrival of a of new baby which may exacerbate existing stressors. • Parental mental health needs where engagement with services is good, parents recognise the challenges of caring for a new baby. • Drug and alcohol use by the expectant partner. Engagement with services is good, parents recognise the challenges of caring for a new baby. • Parent/s with learning needs (not disabilities) or neurodiverse presentations. Engagement with	• The expectant mother is a child under the age of 13 years • Where there are concerns that the expectant mother is a victim of sexual abuse or exploitation. • There has been a previous suspicious or unexplained death of a child. • A parent or other adult in the household is a person identified as presenting a risk, or potential risk, to children. • Children in the household (including expectant parents) currently subject to a child in need or child protection plan, OR previous child protection (including contextualised safeguarding) concerns, including children previously separated from parents' care. • There are concerns for parental risk factors including substance misuse, mental health needs, domestic abuse; there are concerns about non-engagement with services and/or level of impact or risk to baby. • There are concerns about parental self-care and neglect and early support is ineffective. • Expectant parents have an assessed or suspected learning disability, may be Care Act eligible and may be in receipt of adult services support. • Expectant parents have neurodiversity needs and early help support with challenges with caring will not be sufficient or has not been effective. • Expectant parents have a physical disability / medical care needs which means they will be reliant on services or others to care for the baby. • There are maternal risk factors, e.g. denial of pregnancy, avoidance of antenatal care, non-cooperation with services and/or treatment /support with potential detrimental impact for the

services is good, parents recognise the challenges of caring for a new baby. • Where there are concerns about domestic abuse, but the expectant mother is reporting to no longer be in a relationship and deemed to be able to appreciate the risks to herself and baby. • Where one or both parents are previously cared for and there are no current safeguarding concerns but may require support above universal services. • Where there is a reasonable explanation for late booking and where parents are willing to engage with services and help to meet support needs.	baby, including frequent area or hospital moves. • Concerns that expectant parents are at risk from honour-based violence, or other cultural/ religious harmful practices, e.g. FGM, Forced Marriage. • Any other concern exists that indicate that the baby may be at risk of significant harm • Concealed pregnancy. • Late presentation and parents are unwilling to engage with services to help meet identified support needs or concerns about care of the baby. • One or both parents are in care of the Local Authority. Or previously cared for and there are current safeguarding concerns and/or support needs which may require robust planning. • Where there has been a history or indicators of Fabricated and Induced Illness for previous children or emergent concern in pregnancy.

11.1 Screening at the Children's Front Door should consider the criteria matrix and expectant parent(s) should be consulted within this, alongside the gathering of further information to support initial threshold application, including current and historic family history and genograms.

11.2 Threshold application decision should be made within 24 hours; if progression to a referral to Children's Social Care, expectant parent(s) should be made aware of the outcome of screening. Dependent on local arrangements the referring agency should inform parents of the outcome to ensure continuity and be trauma reducing.

12. Assessing during Pre-Birth

12.1 Early Help Support during pregnancy

12.1.2 The development of an Early Help pregnancy support assessment and plan should follow the same principles of multi-agency collaboration, planning, and review as directed in this guidance. Contributing professionals should be mindful that the plan may form the evidential basis for future intervention to safeguard the child either

before or after birth if concerns escalate.

12.1.3 **If there are increased risk and vulnerabilities or is no agreement from parent(s) to work within a TAF**, **the referral should be escalated to Children's Social Care** within local area arrangements. For threshold to be reviewed. Under the principles of this guidance, of family inclusive practice and trauma informed, parents are to be informed of this multi-agency decision outlining the concerns, risks and why further assessment is needed.

12.2 The Pre -Birth Assessment

12.2.1 Where threshold has been established by the children's front door, a single assessment should be completed. Due to the time sensitivity of a pre-birth assessment this initial assessment should be made within **10 working days, inform decision about a pre-birth assessment being required and any initial plan required**.

Examples of implementing a plan under Section 17 (CIN) *(Note: CIN planning should commence alongside PBA assessment)*	**Examples of a child protection enquiry & consideration of a pre-birth child protection conference**
• Referral previously managed via early help but no or limited progress impacting care of baby. • Where one or both expectant parent/s is in care but **does** engage with social worker and services. • Where the expectant parent/s are previously cared for will engage with services to support them to care for their baby around identified needs. • Financial or other struggles have led to loss of utilities, accommodation and basic amenities but parents are engaging. • Where there are concerns for self-care, self-neglect by expectant parents and/or poor home conditions or environment with concerns for the care of baby but parents are engaging with services to address needs and progress seen. • Where the expectant mother is not engaging in ante-natal care and there are concerns related to the care or health of mother and/or baby, but mother is engaging with services.	• Concealed or denied pregnancy where there are other current safeguarding concerns and/or previous social care or health history for either parent, for example previous concealed or denied pregnancy. (*see appendix iii, pan cheshire concealed pregnancy procedure*) • Pregnancy in a child under 13 yrs and there are concerns for safeguarding of both mother and baby. • The expectant mother is not engaging with antenatal care and there are concerns for health of mother and/or baby, and mother is not engaging with pre-birth assessment and/or child in need planning. • Disclosure or evidence of domestic abuse in pregnancy, mother is unable/ unwilling to leave relationship with person who harms, lack of engagement with intervention/ support and risk to baby is indicated. • Serious concerns about parental substance misuse or mental health and/or parental struggling to engage and access services to reduce impact on baby. • Significant concerns about an adult who may have contact with baby and who "poses a risk to children"

• Domestic abuse (dependant on level of concern/number and severity of recorded incidents) • Parental substance misuse with sporadic compliance with support agencies. • There is a history of mental health issues, inconsistent engagement with services or where mental health issues may impact on the care of the baby.	• Significant concerns about extra-familial or contextualised harm. • Significant concerns about expectant parents' self-care and neglect, and/or home conditions/ environment and concerns exist in relation to motivation and capacity to change. • Expectant parents who have Learning Disabilities and/or serious impact from Neuro-Diverse needs. • Current child protection plan for siblings. • Previous history of Non-Accidental Injury to children and risks remains in relation to this baby. • Parents have had previous children permanently separated from their care. • History of chaotic lifestyle with concerns for motivation and capacity to change. • Safeguarding concerns from possible compromised parenting due to expectant parents' history indicating possible significant harm to this baby. • Homelessness with concerns for motivation and capacity to change. • Safeguarding concerns that the expectant parents are at risk from honour-based violence, or other cultural/ religious harmful practices, e.g. FGM, Forced Marriage. • Mental /perinatal Health needs, that may present a risk to unborn baby or concerns that their needs may not be meet and protected once born. • Decision taken to convene a legal planning meeting.

12.3 Complex parental presentations in pre-birth assessments:

Domestic Abuse

12.3.1 Pregnancy can be a trigger for domestic abuse, and existing abuse may increase during pregnancy or post birth. Domestic abuse can be physical, sexual, emotional, psychological or financial or a combination of these. '*Research shows that 30% of domestic abuse begins during pregnancy, rising to 40% within a baby's first 1001 days of life, a critical developmental period*'. (L. Seager-Smith, Research in Practice, 2024)

12.3.2 The Domestic Abuse Act 2021 **identifies children as victims of domestic abuse**. Section 3 determines that a child who is a person under the age of 18 years (s.3.4) **who sees or hears, or experiences the effects of, the abuse** (s.3.2.a). This legislation should be considered in the context of unborn baby, as the impact of domestic abuse in pregnancy can be direct (*physical assaults on mother*) and indirect *(impacting maternal mental health and attachment to unborn baby)*. This can lead to a significant association between domestic abuse in pregnancy, perinatal mental health needs and Post Traumatic Stress Disorder (PTSD), (For Baby's Sake, July 2024)

12.3.3 The presence of domestic abuse in pregnancy also increases the risk to both mother and baby; of miscarriage, infection, premature birth, and injury or death to the baby. (NHS, 2024) Therefore, '*Domestic abuse during this time not only threatens the well-being of mothers but also endangers the health and development of unborn babies and infants'* (L. Seager-Smith, Research in Practice, 2024). It can further impact on the crucial early years of infant, bonding attachment and development. (Huth-Bocks, et al 2004).

12.3.4 The Child Safeguarding Practice Review Panel: Multi Agency and Safeguarding Domestic Abuse, 2022, found that nearly all families impacted by domestic abuse, involved death or serious injury to the infant through deliberate harm/physical abuse or accidental harm. The review identified an over-emphasis on physical violence as being the primary indicator of domestic abuse, and a lack of appreciation of the risks of controlling and coercive behaviours. '*There was also evidence in some cases that the risk of domestic abuse was not being explored throughout pregnancy and postnatal care'.* (The Child Safeguarding Practice Review Panel, Annual Report, 2022-23)

12.3.5 The findings advocated for a domestic-abuse informed approach; that names the source of harm, focuses on continuous patterns of behaviours, (*opposed to incident led*), works with the person causing harm, takes a whole family approach, is aware of intersectionality and recognises wider networks, to inform effective safeguarding practice.

Fabricated and Induced Illness (FII) & Perplexing Presentations (PP)

12.3.6 Fabricated or induced illness in pregnancy, involves a caregiver falsely reporting or inducing medical problems in a pregnant person. The reasons for FII / PIP are complex and can include a range of factors, such as mental health and past or current trauma manifesting through presenting behaviour. For further guidance practitioners must refer to the **Pan Cheshire and Merseyside Guidance for Management of Perplexing Presentations and Fabricated or Induced Illness:** Pancheshire policies & procedures

- **Identifying FII,** key consideration; inconsistencies in reports, unusual or unexplained symptoms, over-reporting or pushing for invasive procedures & history of seeking multiple opinions.
- **Risks of FII in pregnancy,** could lead to; induce premature delivery, foetal loss, unnecessary procedures, delayed diagnosis and treatment.

If there is a history of FII perpetrated by a pregnant woman in another child/sibling, before or during pregnancy, referral to CSC is needed, to consider the safety of the unborn child.

Learning Needs

12.3.7 **Global Learning disability**: parents experience significant cognitive impairment and an IQ below 70 has a significant impairment on daily living skills and a lasting effect on development and into adulthood. Parents who present with global learning disabilities are likely to need a high level of professional support**. Referral for a prebirth assessment should be made at the earliest opportunity to allow maximum time for appropriate interventions prior to the baby's birth.**

12.3.8 **Parents with learning difficulties** where there could be an impact on parenting capacity, they should receive support to enable them to become the best parents they can be, from multi-agency professionals, including midwifery, family intervention and family nurse partnership (if eligible). This could be at an early help (TAF) level in the first instance.

Parental Mental Health.

12.3.9 **Mental health concerns** are relatively common, and their presence does not mean a pre-birth assessment is required unless there are concerns regarding impact on unborn baby and parental capacity. Parents can be engaging with mental health service, taking medication and accesses other interventions where Early Help support would be appropriate.

12.3.10 **Parents with significant mental health** diagnoses such as schizophrenia, bipolar disorder or psychosis and are unwell during the pregnancy should be considered for a pre-birth assessment where there is an identified need or risk and poor social/family support.

12.3.11 **Parental mental health is unstable, or in crisis** where there is increased risk of significant impact on parenting capacity a referral to CSC should be considered for a pre-birth assessment.

12.3.12 **Neurodiversity:** Where neurodivergent needs appear significant and could impact parenting capacity, (for example, if there is a historic Education and Health Care Plan (EHCP) or comorbidity), consideration is to be given to an early help, pregnancy support assessment, or where threshold is meet for CSC pre- birth assessment.

Alcohol and substance misuse considerations

12.3.13 It is essential to identify assess and monitor any current or historical use of alcohol or drugs by the expectant parents as substance misuse can significantly impact on both antenatal development, engagement and parenting capacity. Exposure to alcohol or drugs in utero increases the risk of premature birth, low birth weight, developmental delays, and long-term health complications for the unborn child.

12.3.14 Where substance misuse is identified, a coordinated multiagency response involving health services, social care, and specialist addiction support is vital to ensure the safety and well-being of the baby. Early intervention and engagement with appropriate treatment services can support the parents in achieving stability, promoting safer outcomes for the child.

12.8.15 A referral **should be made** to the front door for an early help, pregnancy support TAF, or if threshold is meet for CSC pre-birth assessment will support the coordination of a multi-agency approach.

Female Genital Mutilation (FGM) Considerations

12.3.16 Where a woman has experienced FGM, it is vital that this is sensitively explored as part of the pre-birth assessment, with appropriate support offered. FGM can have significant long-term physical and psychological impacts, particularly during pregnancy, childbirth, and postnatal care.

12.3.17 Midwives and healthcare professionals should be informed to ensure that maternity services are tailored to meet her specific health needs. The assessment should also consider any potential safeguarding concerns, particularly if there are female children in the family or extended network who may be at risk. A multiagency approach is essential to ensure culturally sensitive, trauma-informed care, while also fulfilling statutory safeguarding responsibilities.

13. The approach to pre- birth assessment:

13.1 The pre-birth assessment and intervention needs to be **well planned and coordinated by the multiagency partnership** and completed no later than **30 weeks**, inclusive of concerns reaching threshold for Public Law *outline (pre-proceedings or decisions made to issue Care Proceedings following birth)* and parents informed of Local Authority decision about assessment outcomes by 34 weeks.

13.2 This enables parents and professionals to have a clear understanding of the assessment and intervention outcome, recommendations, and any further birth planning required especially if there is an increased risk of early labour prior to 38 weeks' gestation.

13.3 The Pre-Birth Assessment should be a standing item for all multi agency partners supervision. In line with the Born into Care Guidance (2022), where possible, multi-agency joint supervision should take place to support professional reflection and keep baby yet to be born in focus. Supervision should be delivered through a trauma informed lens, to support and reduce the impact of secondary and vicarious trauma.

13.4 The pre-birth assessment will be supported by multi-agency meetings at a frequency determined by Child in Need or Child Protection pathways (See local guidance). These should include parents, family members, midwife and any other professionals, chaired by Children's Social Care. The importance of co-produced birth plans (*see appendix iii,* birth arrangements plan) building on the assessment outcomes are essential to supporting and improving outcomes for baby and parents during this time and need to form part of the multi-agency planning, enabling family inclusive practice, choice and collaboration for parents where possible, whilst ensuring baby is safe and protected.

13.5 If there are emergent safeguarding considerations, **a strategy meeting** is to be held as per local procedure. The need for a **Family Network or Family Group Meeting** should be considered to enable the timely involvement of wider support networks.

14. Interventions and support during the pre-birth assessment

14.1 Interventions and support through a trauma informed and responsive lens have been identified through research (Born into Care, 2022) to address risks, vulnerabilities and need, including parenting skills are essential informing the plan. Key learning from Born into Care, has shown that a timely assessment undertaken alongside a targeted pre -birth intervention, can dove tail to inform need, risk, and capacity to change. With this concurrent approach it can lead to improved outcomes for mother and child.

14.2 Interventions may include support such as peri-natal mental health, drug and alcohol use, domestic abuse. Specialist pre-birth interventions to support parenting from Family Nurse Partnership, and other services include for example, Welcome to the World (pre-birth), and Solihull (pre-birth).

14.3 Mentalisation (also known as reflective functioning) has been identified by Born into Care, 2022 and other studies as useful concepts in assessing and promoting parental attachment to the unborn baby and thus empowering internal motivation to change. Translated to pre-birth, the concept recognises the impact of expectant parent/s being able to visualise and appreciate their baby as having a developing identity and needs separate to those of the expectant mother. Activities can be undertaken with expectant parent/s during pregnancy to enable parent/s to understand the impact of external stimuli in utero, such as noise and conflict, or internal stimuli from substance use or anxiety (as example). Similarly, activities such as singing or massaging of the tummy will promote positive responses and attachment. Expectant parent/s willingness and ability to understand and engage in such activities can be used to inform the assessment.

15. Planning where there are concerns for safeguarding

15.1 During the course of a Pre-Birth assessment, if there are concerns for significant harm, then local and Pan Cheshire Safeguarding procedures are to be followed. The child protection plan will identify what needs to happen to ensure that risks are reduced, and baby is safe when born. The plan should include all relevant professionals and should build on assessment, recommendations.

15.2 Where there are increased concerns for; safety of the baby, previous proceedings in respect of previous children for either or both parents, then a Legal Planning/ Gateway Meeting, should be convened and be consider under the Public Law Outline (PLO). Where there is an indication that care proceedings maybe initiated at birth, the Local Authority should commence pre proceedings as early as possible and at the latest 30 weeks' gestation.

15.3 The Cheshire and Merseyside Newborn Protocol (see Appendix v) should be followed where decisions are being made to issue care proceedings following birth. This requires the pre-birth assessment and intervention to be completed by 30 weeks, with a final assessment of all work completed, analysis of risk and need leading to **the recommended plan for unborn by 36 weeks' gestation.** Expectant parent(s) should be informed of the plan for birth and post birth no later than 36 weeks.

15.4 Social Workers should share the outcome of the amendment to the pre-birth assessment and plan at 35 weeks' gestation allowing 7 days before the final pre proceedings meeting, with parents, parental advocates and legal services. Arrangements for family time, including frequency and location should be agreed to ensure that parent/s are aware of what to expect and prepare. At this meeting there is the final opportunity to explore if there are any other kinship supports to be considered. Parents should be advised to discuss this meeting with their solicitors and provide instructions on their behalf if this is too difficult and traumatic for them to attend.

15.5 Safe planning discussions need to be reviewed weekly from 36 weeks and once birth is imminent. A court date is to be in place, out of hours notified and Newborn notification made to CAFCAS.

16. Planning for the BIRTH with parent(s)and multi-agency parents

16.1 A Birth Arrangement Plan (see appendix iv) should be discussed as part of a CIN or Core Group Meeting during the end of the second trimester and start of the third and should include **a birth planning meeting as early as possible especially where there are concerns that birth could be premature or earlier than the due date.**

16.2 Care and support during and after birth should consider mothers preferences around either a bed on the open ward or a side room, whilst also considering risks and possible supervision arrangements that might be required.

16.3 When there is a proposed plan to separate a baby from parents following birth, it is crucial to involve expectant parent(s) in this plan and enable them choice and control where possible, to support reduced anxiety and promote parental identity at a time of heighten, stress, grief and loss.

16.4 The plan will include arrangements for both practical and emotional support, HOPE Boxes where they are available with Local Authorities and Health Trusts, should be offered and discussed with parents, as a choice to support them and their baby. This will enable therapeutic support to parents and consider key details at the point of separation.

This support includes:

- Enabling choice and collaboration in meeting the foster carers before birth or separation where possible, foster carers being part of the hospital support plan for baby and mother.
- Seeking parents' views and provide choice over, type of nappy or milk which may matter to them and provide consistency for the baby;
- Choosing who they will hand their baby to or place in the car seat
- What they would like their baby to wear
- How they would like to say goodbye

16.5 Consideration is to be given to how a Hope Box can be used to support parents(s) at this critical time as well as ensuring that a Hope Box journeys with baby from hospital. (Born into Care Report Summary, 2022)

16.6 Consideration is to be given to how parent(s) are able to travel to the hospital and home again, who will be with them on their journey home or in the home when they arrive, recognising

and understanding the impact of grief and loss for parents at this critical time, and ensuring that practice is trauma reducing and family inclusive to enable the parents to grieve and feel supported. Consideration is to be given to how the family's network can support them during pregnancy, birth preparation and post birth is critical in the postnatal period of trauma, grief and loss.

17. Multi Agency Discharge Planning Meeting (DPM)

17.1 The Discharge planning meeting should be held across all pathways, to inform next steps of the plan, considering any increase in risk or vulnerabilities for parent(s) and baby. Baby's allocated Social Worker should visit mother and baby on the ward post birth, ahead of the DPM. The DPM should be held face to face to support the family at this critical and vulnerable time – the birth arrangements plan can aid further planning at this time.

17.2 Attendance at the DPM should include Foster Carers/Kinship Carers and supervising social workers as well as baby's social worker and midwifery/health professionals.

17.3 The DPM should consider postnatal care, up to 28 days, and where there has been a separation, to consider who will support parents, in leaving the hospital and arriving home, and provide support for grief, loss, and mental health. If a Hope Box has been accepted by mother (in an NHS Trust and LA) where this is offered the family intervention worker should also attend the meeting.

18. Preparing for the first court hearing and separation

18.1 Whilst on the ward, mother (and father/mothers' partner where appropriate), should be given maximum opportunity to parent and care for baby where is it safe and within the baby's best interests to do so. Family and friends support network should be utilised as much as possible to support parents and provide supervision of care if this is required.

18.2 The level of care provided by parent(s) should be proportionate to the risks, and there should be a shared understanding of professional roles and responsibilities.

18.3 Continuity of independent legal advice/ representation should be ensured to enable parent(s) to participate in a court hearing. Mothers should receive support to attend court from the ward, including transport, and offered an alternative of a private remote hearing if they prefer. Consideration should be given to duration of the hearing post labour and subsequent post-partum needs as well as ensuring continuity of care post-natal from all multi agency partners.

18.4 Parent(s) must be offered adequate time to prepare for separation once the court decision is made, with attention paid to their wishes regarding the detail of separation, ensuring they are offered choice wherever safe and possible.

18.5 Opportunities should be enabled for parent(s) to create memories of their first hours and days with the baby to support ongoing connections and reduce trauma, support parental identity, grief and loss. Services such as those provided from Hope Boxes should be considered, where Trust and Local Authorities have this offer, and offered to parents. It is their choice to accept this offer, if this is accepted a box and accompanying letter is provided to mother and a matching Hope

Box to baby alternatively ideas such as sharing blankets or clothes worn, and baby's ID bracelet are important for both parent/s and baby.

19. Other Considerations

19.1 Where expectant parent(s) move outside of the local authority area, there should be consultation of the NWADCS, North-West regional transfer protocols (*See appendix vi*).

19.2 Where transfer is outside of the North-West region, Children's Social Care will utilise similar steps and principles with the relevant Local Authority. In line with these protocols, and dependant on the point within pregnancy and planning which the move takes place, midwifery care may move to another Hospital Trust whilst the Local Authority remain responsible for planning until such a time transfer is agreed. Where there is transfer of midwife care, there must be holistic and timely handover of all information, assessments and plans.

Appendices

Appendix i

Pan-Cheshire-Pre-Birth-Timeline.docx

Appendix ii

Maternity-Social-pathway-APRIL-2025.docx

Appendix iii
Concealed Pregnancy

Appendix iv:

Birth-Arrangements-Plan-Pan-Cheshire.docx

Appendix v

The-Cheshire-and-Merseyside-Newborn-Protocol.docx

Appendix vi

NW Children in Need Moving across Local Authority Boundaries Procedure 2021.pdf

NW Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure 2021.pdf

References

Born Into Care summary report.pdf

Born into Care: Developing best practice guidelines for when the state intervenes at birth - Nuffield Family Justice Observatory

Cheshire East

Cheshire West and Chester
Children Act 1989

Domestic Abuse Act 2021

Domestic abuse in pregnancy - NHS

For Baby's Sake: Understanding the impact of domestic abuse on infants | Research in Practice

Halton Borough Council

The impact of maternal characteristics and contextual variables on infant-mother attachment - PubMed, Alissa C. Huth-Bocks, Alytia A. Levendosky, G.Anne Bogat, Alexander Von Eye , 23rd March 2004.

Multi-agency safeguarding and domestic abuse

Pregnancy as an opportunity for change |Pre Birth Change Project, Research in Practice,

The Child Safeguarding Practice Review Panel Annual Report 2022-23

Warrington Borough Council
Welcome to the Pan Cheshire Safeguarding Children Procedures

Why Is Domestic Abuse So Prevalent During Pregnancy? - For Baby's Sake

Working together to safeguard children: statutory framework