

# **PART 12**

## **PRE-BIRTH REFERRAL & ASSESSMENT**

Responding to Concerns about Unborn Children

Practice Guidelines

## **CONTENTS**

Introduction.

Purpose.

Referral.

Assessment and Planning.

Pre-birth conference.

Child Protection Plan.

Pregnant Women who are Missing

Appendices

Appendix 1: Flow chart. Referral and Response to Concerns  
Regarding Unborn Children

Appendix 2: Assessing Unborn Children – Guidance for  
Social Workers

## **Introduction**

1. In some circumstances, agencies or individuals are able to anticipate the likelihood of significant harm to an unborn child. The circumstances, lifestyle and/or personal history of the parents, may indicate sufficient concern that the needs of the baby might not be met.
2. Working Together 2006 (5.14) says “The procedures and timescales set out (for safeguarding children), should also be followed when there are concerns about the welfare of an unborn child.” However the timescale of pregnancy does not readily fit with Inter-agency safeguarding procedures, duty to investigate (Section 47 Children Act 1989), or with the timescales associated with the Framework for the Assessment of Children in Need.
3. This procedure should be read in conjunction with ‘Inter-Agency Procedures for Safeguarding Children and Promoting their Welfare 2007’ (see note below) and particularly with guidance on Concealed Pregnancy.
4. ‘Inter-Agency Procedures for Safeguarding Children and Promoting their Welfare 2007’ replaces ‘Inter-Agency Child Protection Procedures 2001.’ Throughout these practice guidelines, what were formerly known as Child Protection Procedures will be referred to as ‘safeguarding procedures’

## **Purpose**

5. The purpose of this procedure is to provide all contributing agencies with clear expectations as to how concerns will be dealt with.
6. The procedure does not necessarily apply where an unborn baby is deemed ‘a child in need’ rather than a ‘child in need of safeguarding’. However it should be followed when the level of concern might not be fully established, but the information indicates significant pre-disposing risk factors. It allows for concerns to be dealt with at the most appropriate level until the point at which a decision must be made about convening an Initial Child Protection Conference.
7. This procedure is intended to be used where the prospective parents do not have substantive care for any children. It is not intended for use when Children’s Social Care have a current role with existing children within the family and where inter-agency working is well established.
8. When agencies or individuals anticipate that an unborn baby may be at risk of significant harm, a referral must be made to Children’s Social Care as soon as the concerns are recognised.

9. Should practitioners be at all unsure as to whether they should make a referral, they should discuss their concerns with their Team Manager, or with their Designated or Named professional for Child Protection.
10. Where the concerns centre on the parents' behaviour e.g. substance misuse, the referral must make clear how, in their professional opinion, this is likely to impact on the baby.
11. Delay must be avoided when making referrals in order to:
  - Avoid initial approach to parents in the last stages of pregnancy, at what is already an emotionally charged time;
  - Allow sufficient time for a full and informed assessment;
  - Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome to assessments;
  - Enable the early provision of support services so as to facilitate optimum home circumstances prior to birth;
  - Allow sufficient time to make adequate plans to safeguard the baby.

### **Consent to Share Information**

12. It is good practice to share concerns with the prospective parent(s) and seek their agreement to a referral to Children's Social Care, **however, where there are clear safeguarding issues referral can be made without consent, though the reasons for doing so should be made clear.**
13. The prospective parent(s) should be informed of the referral unless this action itself may place the unborn child at increased risk of harm, eg, if there is a concern that the parent(s) may move/disappear to evade contact with agencies.
14. Workers from agencies whose primary responsibility is to the welfare of the prospective parent may feel worried about the impact of making a referral and the parent's continued engagement. This may be of particular concern where engagement with their service will be necessary to reduce risks to child (ie Drugs and Alcohol Service, Mental Health Services), **however, the needs of the unborn child should be paramount over all other considerations.**
15. Workers from such agencies should discuss their concerns with Children's Social Care to consider the most effective way of constructively engaging the parent(s).

16. If professionals feel uncertain about sharing information, they should discuss their concerns with their team manager or Designated or Named professional for Child Protection.

### **Identifying the Risks**

17. Serious Case Reviews and other child death enquiries over many years have identified a range of risk factors which should alert professionals to the possibility that a child may be at risk. Many of these factors can be identified prior to birth and should form the basis for referral. The most significant are:-

- Parents where previous children have been removed from their care. (Including Residence Orders made to other family members).
- Parents who have offended against children or otherwise are demonstrably a 'Risk to Children.'
- Domestic Violence. **(See Part 22)**
- Substance misusers not cooperating with treatment. **(See Part 14)**
- Parents with learning or untreated mental health difficulties with limited parenting capacity, particularly where there is inadequate family support.
- Parents with a history of abuse and/or neglect within childhood presenting concerning behaviour/attitude towards pregnancy and support services. (Including those who have 'looked after' by the Local Authority)
- Unstable/chaotic households, unprepared or unsuitable for a baby.
- Young vulnerable parents.
- Vulnerable parents expecting twins/triplets etc.
- Where concerns that a pregnancy is being or has been concealed. **(See Part 16)**

**18. This list is not exhaustive and should not discourage taking action where concerns not listed are identified.**

19. More than one risk factor should, of course, heighten concerns.

## **Making a Referral**

20. Children's Social Care needs detailed information to assist in understanding and prioritising the concerns referred to them. The person receiving the referral will ask for the following details:

- Prospective parents names and dates of birth
- The expected date of delivery
- Address(es)
- Names of any previous children and dates of birth
- Details of any other family members or significant people connected to the household
- The details of the concerns
- Whether the family is aware that the referral is being made
- Details of any other professionals involved who may have relevant information about the concerns.

**Referrals should be made to the First Response Service.**

**Tel: 0800 1313126**

Telephone referrals should be followed up in writing within 48 hours.

## **Assessment and Planning**

21. On receipt of referral where there are potential safeguarding concerns, Children's Social Care will make a decision within 24 hours as to how the case will proceed.

22. Children's Social Care should acknowledge written referrals, including brief details as to the proposed action within one working day of receiving it. If the referrer has not received an acknowledgement within 3 working days, they should contact Children's Social Care again.

## **Referral Received During the First 20 Weeks of Pregnancy**

23. As a result of the referral Children's Social Care will undertake a pre-birth initial assessment. This should be completed within 7 working days. Parents are asked to consent to the assessment and to agree to the social worker obtaining information from and sharing information with other agencies. It is essential that full and thorough checks are completed. An unwillingness to consent to the assessment or to contact other agencies will lead to the initiation of safeguarding procedures. Where parent(s) give consent, a Criminal Records Bureau (CRB) check should be undertaken.

24. The outcome of the assessment will determine further action. This could be:

- No Further Action, where it is felt that there is no need for Social Care involvement, or that another agency could better meet the identified need;
- Service Plan, where it is felt that the provision of services will meet the need;
- Where there are significant safeguarding concerns, initiation of child protection procedures.

### **Child in Need Service Plan**

25. In some instances, it may be that while concerns exist, they do not cross the 'significant harm' threshold. In other cases, it may be that it appears that there is a good prospect of achieving any necessary changes prior to birth. In such cases, while in the early stages of any intervention, it may be more appropriate to provide a service to the prospective parents that will address the need, or to test the potential to make changes (i.e. to test motivation to engage with substance misuse agencies). A service plan should be drawn up which details the changes that are required, the services which will be provided to assist, the nature of any on-going monitoring and the consequences should the required changes not be achieved. A date for a service plan review should be set. (See below).

Where files exist which are held by other Local Authorities, either because there have been concerns about a previous child, or because one or both of the parents were previously looked after, or otherwise had significant social care involvement, the social worker should plan to view the file as soon as possible. This should be an agreed action for the service plan. **(Lesson from Internal Management review).**

26. The service plan should be reviewed by a meeting of all agencies involved at around 24 week's pregnancy.

27. Where the service plan review identifies safeguarding concerns, either because the required changes have not been made, or because further concerns have come to light, the meeting should agree that a core assessment will be undertaken. The tasks for parents and professionals should be set out, with agreed timescales for completion. The core assessment should be completed within 35 working days. The service plan review meeting may be convened under S47 (Children Act, 1989) child protection procedures as a 'strategy meeting' where it is determined that the core assessment is commenced under section 47 procedures. Appropriate records should be completed (Section 47 Enquiry Record SW 116 and Strategy Discussion record SW47). (See Multi-Agency Strategy Meeting below)

## **Initiation of Safeguarding Procedures**

28. Where the parent(s) do not consent to an initial assessment, or where the concerns clearly indicate a likelihood of significant harm then section 47 (duty to investigate) procedures should be invoked with 'Section 47 Enquiry Record' including full lateral checks (SW116) and 'Strategy Discussion Record' (SW47)) completed. A brief initial assessment should be completed and a core assessment commenced.
29. Where case records exist, including those held by other Local Authorities, either because there have been concerns about a previous child, or because one or both of the parents were previously looked after, or otherwise had significant social care involvement, the social worker should plan to view the file as soon as possible, as an agreed action for the core assessment.
30. The outcome of the strategy discussion is likely to be 'Section 47 and Core Assessment' and a further strategy meeting. This further strategy meeting should be planned for 24 weeks pregnancy and should involve midwifery and any other agencies involved, unless circumstances dictate an earlier strategy discussion is required.
31. Where possible the social worker should aim to complete the core assessment prior to the Multi-Agency Strategy Meeting.

## **Multi-Agency Strategy Meeting**

32. Whichever route by which the referral has progressed, the aim should be to hold a planning meeting with all relevant professionals involved at around 24 weeks into the pregnancy. This should be chaired by a Children's Social Care Team Manager.
33. Within Staffordshire Safeguarding Procedures, parents do not normally attend strategy meetings. However, given that a strategy meeting about an unborn child is unlikely to involve a criminal offence against a child, it may be reasonable for parents who are fully cooperative with professionals to attend part or all of such meetings. Where parents are hostile and/or uncooperative the normal procedure for strategy meetings for professionals only should apply. Professional agreement should be reached regarding potential parental attendance in advance of the meeting.
34. The meeting should ensure that parents and professionals are fully aware of the concerns, outline the changes that are required to reduce the risks to the child and the consequences should the required changes not take place.
35. The meeting should explicitly consider the need for an initial child protection conference. It may be clear at this point that an initial conference will be necessary, in which case a telephone strategy

discussion with relevant agencies should confirm this at 29/30 weeks pregnancy. Each strategy meeting or discussion should be formally recorded on a 'Record of Strategy Discussion/Meeting' (SW47)

36. 'Record of Outcome of Section 47 Enquiries and Investigation' (SW116a) should be completed when the final decision is made to convene an initial child protection conference at 29/30 weeks pregnancy. There is then 15 working days in which to convene an initial child protection conference.
37. Where parents are working well to the service plan and the possibility remains that child protection procedures may be unnecessary, a further service plan review should take place at 29/30 weeks pregnancy. This should be chaired by a Children's Social Care Team Manager. If all agencies involved agree that a child protection conference is not necessary then further service plan reviews should be agreed according to the needs of the family. However, if there is disagreement among professionals about potential risks, an initial child protection conference should be agreed, and the meeting convened as a strategy discussion under section 47 procedures, with all relevant Section 47 records completed from the date of the meeting.

### **Referrals Received in the Second Half of a Pregnancy**

38. Clearly at this later stage of pregnancy there is less time to assess the child's needs, including the parents' potential for change before the baby is born.
39. Where there are concerns which identify a potential risk to the unborn child, section 47 procedures should be initiated, with full and detailed lateral checks and strategy discussion.
40. The decision of the strategy discussion is likely to be 'Section 47 Investigation and Core Assessment' and to convene a further strategy meeting, if time permits before 30 weeks pregnancy. A core assessment will be commenced. The reasons for late referral should be clearly identified as this may be relevant to the assessment.
41. A multi-agency strategy meeting should take place no later than 30 weeks pregnancy. This should be chaired by a Team Manager from Children's Social Care. The meeting should consider whether or not an initial child protection conference is required. If all professionals attending the meeting agree that this is not required, a service plan should be drawn up with a review planned according to the needs of the family. However should there be disagreement among professionals about potential risks, then an initial child protection conference should be agreed. The 'Outcome of Section 47 Enquiries and Investigation Record' (SW116a) should be completed at this point.

42. If the referral is received after 30 weeks pregnancy, there may be insufficient time for a multi-agency strategy meeting. The strategy discussion, which will usually take place over the telephone, will make the decision to proceed to an initial child protection conference. The 'Outcome of Enquiry and Investigation Record' (SW116a) will be completed with this decision.
43. Please refer to **(Part 16, Concealed Pregnancy Guidance)**, for very late referrals.
44. Except in cases of very late referrals, social workers should aim to convene an initial child protection conference 8 weeks before the expected date of delivery.

### **Pre-Birth Conference**

45. Working Together 2006 (5.147) says "Where a core assessment under section 47 of the Children Act gives rise to concerns that an unborn child may be at future risk of significant harm, Local Authority Children's Social Care may decide to convene an initial child protection conference prior to the child's birth. Such a conference should have the same status, and proceed in the same way, as other initial child protection conferences; including decisions about a child protection plan.....The involvement of midwifery services is vital in such cases."
46. Where possible the pre-birth child protection conference will be convened eight weeks before the baby is due. This is to allow sufficient time for planning support to the family and to take account of the possibility of premature birth.
47. The conference should be convened no earlier than this or the possible subsequent review conference may then take place around the date of baby's birth, should baby be delivered after the estimated date of delivery.

### **Attendance**

48. Professionals who normally attend a child protection conference must be invited, and any agency involved with the parents (Drugs/ Alcohol Services, Mental Health, Disability Service, Leaving Care). **Midwifery personnel must be invited.**
49. The social worker should ensure that an invitation is sent to both the community midwife and the maternity service at the hospital where the baby will be delivered.
50. Local Authority legal services should be invited where legal action is being considered or where legal advice may be required.

51. Parents or potential carers should be invited as in any other child protection conference and should be fully involved in plans for the future.

### **Decision Making**

52. The initial child protection conference must decide whether or not the child is in need of a child protection plan.

53. The conference should agree the outline plan and a core group of professionals and parents identified to take the plan forward.

54. The conference should record a recommendation about whether the child can return home with parents and in what circumstances.

55. If the parents have not attended the conference, they should be made aware of the outcome at the earliest opportunity, unless to do so would put the child at further risk of significant harm.

### **Child Protection Plan**

56. The core group must meet within 10 working days of the conference. The core group is responsible for developing the child protection plan.

57. As well as all the usual aspects of a child protection plan around on going contact/residence, assessment and monitoring arrangements the plan should include:

- Antenatal plans, ie expectations of antenatal care.
- Delivery plans, including getting to hospital, who may be present at the birth, immediate plan for baby.\*
- Length of stay in hospital.
- Visiting arrangements, who may visit mother and baby in hospital both in Delivery and Maternity wards\*
- Contact arrangements, can parents have contact with baby on ward unrestricted, or is full and close supervision required?\*
- Discharge plans, to ensure all arrangements are agreed and clear to all professionals and parents.

\* Consider potential risks to hospital staff or patients/visitors.

58. At the point of discharge, the plan should be reviewed by social worker, midwife and health visitor. Ideally this should take the form of a discharge meeting, but may be by telephone if necessary.

### **Pregnant Women who are Missing**

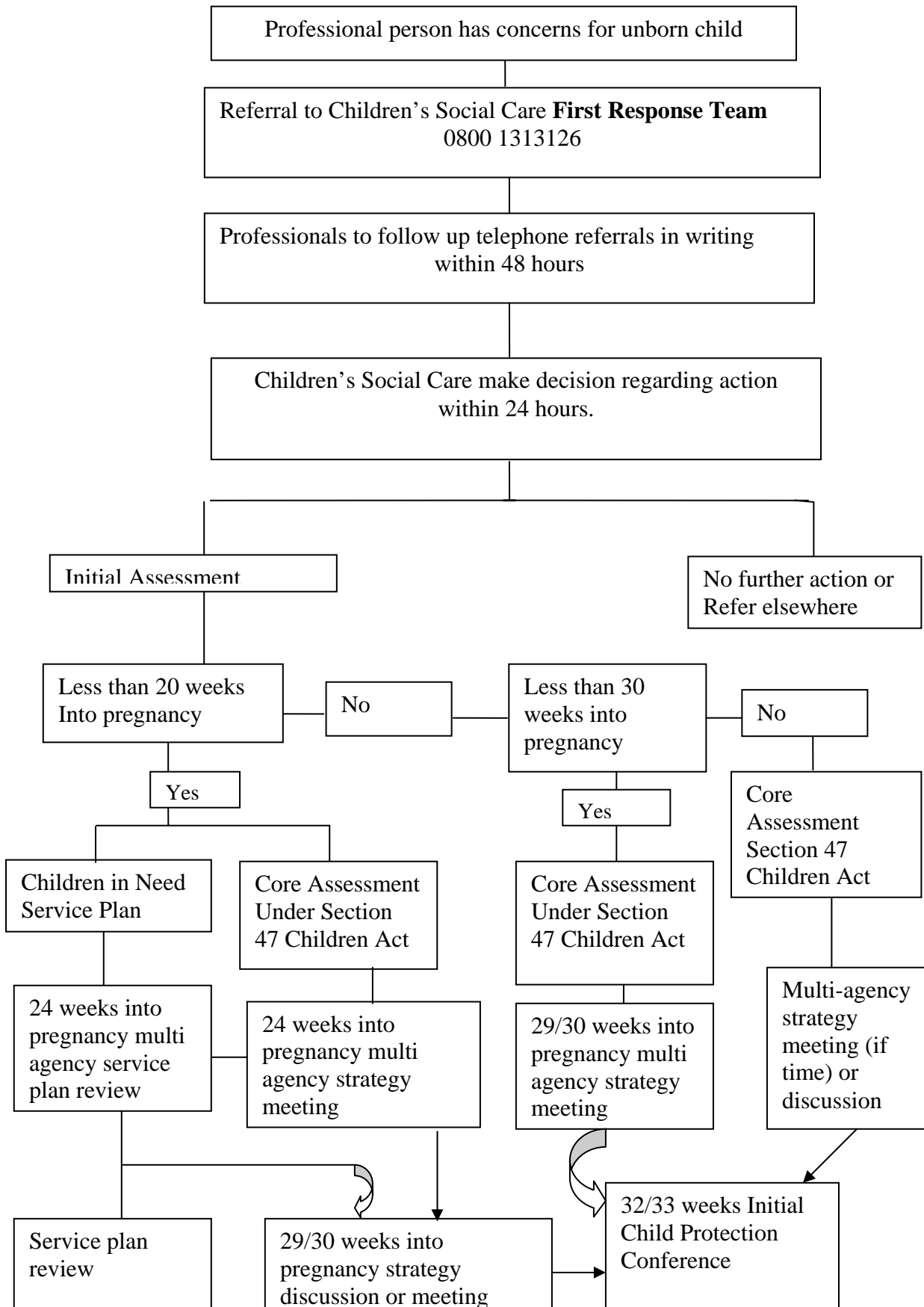
59. The loss of professional contact with a pregnant woman where there are safeguarding concerns for the unborn baby must always be taken seriously. Once loss of contact is established, agencies should be

proactive in making efforts to locate the woman. All actions taken must be recorded. The following procedure should be followed:

- The agency identifying the missing woman should inform their relevant line manager.
- Measures should be taken to trace the woman informally through family, friends, neighbours etc as is considered reasonable and appropriate. Information systems should be checked countywide.
- Enquiries should be made through other local agencies involved with the woman/unborn baby.
- Children's Social Care should initiate a strategy discussion, involving police, midwife and any other relevant agency to develop a plan to locate the woman and put in place measures to safeguard the baby when born.
- In conjunction with the police and family as appropriate, consideration must be given to tracing the woman with the help of the media.
- Children's Social Care should give consideration to circulating the woman's details and the concerns about the unborn baby to other Local Authorities if all other avenues have proved unsuccessful. This should be regarded as a last resort. See below.
- The Custodian of the Register will take responsibility for circulating other Local Authorities. The social worker needs to provide the following details:
  - i. Woman's name
  - ii. Date of birth
  - iii. Description
  - iv. Estimated date of delivery
  - v. Name and date of birth of any person the woman may be with.
  - vi. Reason for concern
  - vii. Other information necessary to raise concern upon encounter, particularly where names are unlikely to identify
  - viii. The least information necessary to enable an Emergency Duty Worker to react appropriately
  - ix. Contact points, including out of hours arrangements
  - x. Scope for circulation, i.e. likely destinations
- Where there may be reason to believe that the woman has left the country, contact may be made with International Social Services (020 7735 8941).
- The progress of plans made at the strategy meeting should be reviewed regularly. The Inter Agency Policy and Procedure in

relation to 'Children who go missing from care or from home and vulnerable missing families' states that plans should be reviewed monthly. This may be appropriate during the earlier stages of pregnancy, however as the estimated date of delivery draws nearer, or if there is believed to be a likelihood that baby will be premature, the members of the strategy meeting may need to plan to reconvene more frequently.

**Referral and Response to Concerns Regarding Unborn Children**



## **Assessing Unborn Children - Guidance for Social Workers**

Undertaking assessments for unborn children is not substantially different to the assessment of any child, and as such, 'The Framework for the Assessment of Children in Need and their families' (DOH 2000) provides excellent guidance and signposts to the necessary theoretical knowledge base required for undertaking assessments.

There are particular issues to bear in mind when commencing an assessment regarding an unborn baby. These are:

1. Fears and anxieties of the parent
2. Threshold criteria for significant harm
3. Information sharing and confidentiality issues
4. The role of the father/partner
5. Parenting capacity assessment
6. Risk and vulnerability factors
7. Delivery Plans
8. Limits to legal intervention.

### **1. Fears and Anxieties of the Parent**

There can be few things more emotive than the thought of a baby being removed from its mother at birth, and this may be the image which comes into the mind of any mother-to be when she is contacted by a children and families social worker. Clearly the fear that a child may be removed will worry any parent, but may be a particular issue for a new parent. This fear may have an impact on how the parent(s) respond to a social worker.

Social workers should take particular care in planning how they make initial contact with the parent(s). A brusque standardised type of letter making an appointment will increase anxiety. Any letters to make appointments should sensitively explain the reason for the appointment and offer reassurance. Where the referral suggests the parent(s) may be particularly fearful or anxious, consideration should be given to making a joint visit with another professional who is already known to them, such as the midwife, community mental health worker or substance misuse worker.

## **2. Threshold Criteria for Significant Harm**

Section 47 safeguarding procedures are often sparked by an incident or an injury. Until the date of birth approaches, the prospect of significant harm is not imminent during a pregnancy, therefore social workers may not readily think about initiating safeguarding procedures. The police may rarely be involved in investigating concerns about an unborn baby, and the main partners will be health professionals, but the same procedures apply.

Section 47 of the Children Act 1989 is clear that that the duty to investigate arises not only when a child has suffered significant harm, but also where there is cause to suspect that a child is likely to suffer significant harm. In thinking about whether the concerns meet the significant harm threshold, it may be helpful to ask 'if this child was born tomorrow would I be confident that he/she would be safe and well in the care of these parents/carers?' If the answer is 'no' the criteria is likely to be met. If the answer is 'I don't know' and parents refuse to cooperate with assessment, including consent to obtain from and share information with other agencies, then the criteria is also likely to be met.

Clarity about the threshold is important because of its significance for information sharing. See point 3 below. It is also important to clearly demonstrate the decision making process via established safeguarding procedures and this equally applies to unborn children.

Procedures allow for strategy meetings or discussions to take place through the course of a pregnancy until a final decision or confirmation for the need for an initial child protection conference (ICPC) at 29/30 weeks pregnancy. Although the need for this may seem clear before this, social workers should bear in mind that, once the decision is formally made, an ICPC should be convened within 15 days, and an ICPC should not take place earlier than 32 weeks into the pregnancy. There is no reason, however, to prevent the social worker discussing possible dates with independent conference chairs at an earlier stage.

## **3. Information Sharing and Confidentiality Issues**

### **(Also see Part 2).**

As with any assessment it is essential to explain to parents that there is a need to speak to professionals from other agencies. In most cases, the parents consent to contact other agencies should be sought, unless the threshold for safeguarding procedures has been crossed. In this case, the parents should simply be told that this will be the case. If parents refuse to consent to the sharing of information, a view will need to be taken as to whether this in itself will push the concerns over the threshold. The fact that the concern is about an unborn child should

make no difference. However seeking information from other agencies regarding adults rather than children can be problematic.

Where the threshold for safeguarding procedures has not been crossed, many agencies will need written consent from the adult before information will be provided. In relation to police information, a Criminal Records Bureau form will need to be completed by each adult. Again, an unwillingness to complete a form or written consent should raise the question about the safeguarding threshold. Can a proper decision about the welfare of the child be made without a full assessment?

Where the criteria for safeguarding procedures are met, all agencies, including those whose prime responsibility is the welfare of the adults, are obligated to share information.

Any difficulties in this area should be discussed with the Children's Social Care team manager.

#### **4. The Role of the Father/Partner**

It will be essential to check out at an early stage the role that the father and/or any current partner will play in the child's life and to include them in the assessment as appropriate. Whether or not the father/partner will have Parental Responsibility should not influence the decision about their involvement in the assessment, and full agency checks should be completed on any adults who will have substantial care of the child.

Social workers should be alert to the possibility of domestic abuse when a partner attends all appointments with professionals with the mother and is reluctant to allow her to be seen alone.

#### **5. Parenting Capacity Assessment**

Where neither parent has had substantive care of a child in the past, it is not possible to fully evidence the parenting capacity dimension of the Assessment Framework and it is likely that this will need to be completed post birth.

However it is possible obtain a view about parenting capacity pre-birth by considering the following aspects:

- i. Antenatal Care. Failure to attend antenatal care is a well known significant risk indicator, and neglect of the welfare of the baby in utero may indicate the possibility of neglect following birth. Similarly, failure to follow professional advice to safeguard the health of the unborn baby may also indicate an increased likelihood of neglect.

- ii. Self Care. Parents who are unable to care adequately for themselves are unlikely to provide an adequate level of care for their baby. Parents who are unable to maintain their home, keep themselves clean and safe may be unlikely to be able to do so for their child. This includes parents who do not address their own health (including mental health) needs.
- iii. Understanding of a child's needs. Direct educative work can be done with parents to teach them basic care needs of babies. Parents' responsiveness and ability to understand such work will also provide a helpful indication about parenting capacity.

(NB When undertaking such work with parents with learning difficulties, it is essential to ensure that the materials used are appropriate. Advice can be sought from the Learning Disability Service.)

## **6. Risk and Vulnerability Factors**

Where there is no child to assess, it will be the parents' backgrounds and behaviours that will form the main basis of the assessment.

Previous behaviour is the best indicator of future behaviour and therefore a history of having previously harmed a child should always trigger safeguarding procedures.

- Other known predisposing risk factors include:
- Adults who experienced abuse or neglect as a child, or who were 'looked after' as a child.
- Adults with an unstable or chaotic lifestyle, including those who move house frequently
- Adults with untreated mental health or learning difficulties where there is inadequate family support.
- Domestic abuse within the parent's relationship. Research shows that pregnancy can be a trigger for domestic violence.
- Substance misuse by either parent which is chaotic.

Social workers should refer to **(Part 14, Working with parents who Misuse Substances)**, as there is helpful assessment guidance included.

'Children's Needs-Parenting Capacity, The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development' (Cleaver et al, DOH 1999) is a valuable resource for pre-birth assessments.

The existence of more than one of these pre-disposing risk factors should be sufficient to initiate safeguarding procedures.

In assessing an unborn baby, social workers need to bear in mind that babies under one year old are **the** most vulnerable group of children, as evidence in numerous Serious Case Reviews.

Parents with additional difficulties will struggle with the stresses of one healthy full term baby, so it is vital to bear in mind the potential for there to be even greater stress created if babies are premature, addicted or born with health problems/ disabilities. This, of course, is multiplied if there are twins or triplets etc.

## **7. Delivery Plans**

As babies rarely arrive at an appointed day or time, it is vital to have in place a clear plan around delivery, including the parent(s) plans to get to hospital.

Maternity staff at the hospital, as well as the community midwife, need to have clear written plans which detail that concerns and the proposed actions.

If the plan is for the child to be removed from the mother at the hospital, hospital staff need to be advised as to whether the parents may have contact with the child prior to his/her placement.

If contact with parents is permitted at the hospital, hospital staff need to know what degree of oversight is expected. They will not be able to provide one-to one supervision of such contact.

Where difficulties with parents behaviour or reactions are anticipated, a meeting should be held with the senior hospital midwife and other relevant staff (possibly to include hospital security or the police) to ensure there is full awareness of all the issues and any health and safety implications considered.

The nature of staffing levels on Maternity wards is such that they will be unable to provide care for the baby if he/she is fit for discharge therefore there is a need to ensure that there is a placement ready immediately after delivery where removal from parents is planned.

## **8. Limits to Legal Intervention**

An unborn child has no legal status and no legal action can be taken to protect the unborn child until they are born. Mother's cannot be compelled to action to protect the unborn child.

The purpose of the pre-birth assessment is to ensure timely and effective decision making to safeguard the baby from the day they are born.