

NETWORK GUIDELINE

Guideline:	Where a Baby is Admitted to a Neonatal Unit with Safeguarding Concerns
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Risk Managed:	Inappropriate management of babies who require safeguarding input

This document is a guideline. Its interpretation and application remains the responsibility of the individual clinician, particularly in view of its applicability across the different Trusts in the East Midlands Neonatal Operational Delivery Network. Please also consult any local policy/guideline document where appropriate and if in doubt contact a senior colleague.

Caution is advised when using guidelines after a review date.

REVIEW AND AMENDMENT LOG

Version	Type of Change	Date	Description of Change
1	N/A	July 23	New guideline

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1. Introduction

In some circumstances, agencies or individuals are able to anticipate the likelihood of Significant Harm with regard to an expected baby (e.g., as a result of Domestic Violence and Abuse, parental substance misuse, removal of previous children in the family or mental ill health).

Any such concerns should be addressed as early as possible before the birth so that a full assessment can be undertaken, and support offered to enable the parent/s (wherever possible) to provide safe care. Where concerns or needs have been identified, that meet the threshold for intervention by Children's Social Care (CSC), they will lead on this assessment and planning.

The majority of assessments undertaken for pregnant women will result in the provision of support and services for the family with a plan that the baby will be discharged to parents care from hospital after birth. There are occasions where the risks are considered too great for them to be discharged home in which case legal planning should take place prior to birth with regards to removal and accommodation of the baby following birth.

2. Usual pre-birth assessment pathway

A Strategy meeting should take place ideally between 12-16 weeks gestation including a midwife and if section 17 or 47 is agreed then an initial assessment should be undertaken by the social worker. This should be completed within 15 days of the strategy meeting (usually it will be delayed until after 20 weeks gestation). An Initial Child Protection Conference (ICPC) should then take place shortly after this which should include a midwife and neonatal team if appropriate. If there is agreement that a child protection plan is required a Core Group should be convened with 10 days of the ICPC to add detail to the Child Protection Plan (CPP) recommendations. This will usually include development of a practical action plan around safety of the baby for delivery and immediately after birth but occasionally there is a separate Birth Protection Planning Meeting to agree this.

If there is a plan to consider accommodation or removal at birth then CSC will arrange a legal planning meeting which health colleagues will not be invited to.

3. Impact of Preterm Birth

The aim is that the above assessment will be completed by 36 weeks gestation. If preterm birth is deemed likely, the aim is to complete prior to 34 weeks. In the case of concealed pregnancy or preterm birth prior to 34 weeks it is likely that the assessment will be.

incomplete with the most vulnerable babies born earliest likely to be most affected by lack of time for a pre-birth assessment and plan.

Every pre term baby admitted to the neonatal unit should have consideration to review the impact of their preterm birth on their safety and welfare and this should include all areas of the assessment framework; developmental needs, parenting capacity, family and environmental factors. This is particularly important if there was a concern identified regarding unborn child in the early stages of pregnancy. It is particularly important that if previously the concerns did not meet the threshold for CSC, or for section 17 or 47 enquiry that this is reviewed in light of the likely impact of the preterm delivery on the needs of the baby and the capacity of the parents to meet these needs. This may mean that a new referral to CSC detailing these concerns is required.

4. What actions should midwifery and neonatal teams take where there have been concerns about the unborn baby

All babies admitted to the neonatal unit should have a SBAR handover from midwifery to neonatal teams regarding any safeguarding concerns.

Many birth protection plans will require the social worker or Emergency Duty Team (EDT) to be informed when the woman presents in labour. If the birth occurs before the Birth Protection Planning Meeting has taken place, there should be a discussion between social care (including the EDT out of hours), the Named Midwife (safeguarding) for the appropriate hospital, the community midwife and the police where appropriate and the outcome of this discussion must be recorded. This should take place as early as possible once it is clear that premature delivery is likely or following delivery if this is not possible. The neonatal team should be part of this meeting, or receive a clear handover from the safeguarding midwife.

This discussion should decide if the delivery impacts on the immediate safety planning for the baby and any children in the family and should clarify what should happen next to ensure any unfinished assessments are completed and that the impact of the preterm birth is considered. It is important that this meeting considers any safety issues around visiting, current social care preferred plan for baby at discharge and parental understanding of this.

It is important that following admission to the neonatal unit there is communication at the earliest possible opportunity between the neonatal team and the social worker. It will depend on where the pre birth planning process has got to as to, and how serious the concerns are as to what type of meeting should take place. If there are new immediate concerns there may need to be a strategy meeting, but it may be appropriate to hold an ICPC or Core group meeting. Whatever type of meeting it is imperative that the neonatal team are invited and represented at this meeting as well as anyone else who may have information or be involved in future discharge planning such as midwifery, health visitor, education for siblings.

In addition to the usual information sharing and safety planning this would also be an opportunity for professionals who have previously worked with the family to advise on potential support network for the parent/s and whether the parent/s require reasonable adjustments for example if there is a learning disability. As with previously discussed it will be important for the multi agency team to consider immediate safety planning for the baby and any children in the family and should clarify what should happen next to ensure any unfinished assessments are completed and what the impact of the preterm birth might be. Parents of infants admitted to the neonatal unit are known to experience heightened distress, including increased anxiety, depression, and trauma symptoms, compared with parents of healthy infants. It also places a financial burden and causes difficulties balancing other caring responsibilities all of which place additional stress on any family. It should be explored what this additional stress might look like for families and a 'Think Family' approach to consider the needs of all family members including potential impact on any previous concerns and consideration of immediate support and help available either in the form of family members, other services.

There should also be consideration regarding feeding options to ensure that the best interests of the baby and the wishes of the mother are considered when offering feeding options. Whilst the pre term infant may be too small or sick to start feeds immediately, the research evidence clearly supports starting feeds as soon as possible and that breast milk is the best option if available. Most babies will be ready to have at least small amounts of feed within the first few days of birth. It is important that discussions with mother's are sensitive and particularly where removal is likely to be the preferred option there should be multi agency discussion regarding what conversations should be had with mum regarding feeding including expressing breast milk,

and subsequent breast feeding. There is a risk that Mum's will feel pressurised to enter into expressing breast milk or trying to establish breast feeding in an effort to 'keep their baby' and this can be not only emotionally distressing for the mother but also result in suboptimal nutrition of the baby if the mum is subsequently not really invested in the time and commitment expressing breast milk and establishing breast feeding entails. If expressed breast milk is not an option then donor breast milk might be an option and consent would need to be obtained for this.

If the baby requires transfer to another NNU for uplift of care then the transferring unit should ensure that this information is shared with the social worker. If a transfer is to be considered for capacity reasons this should be carefully considered (see [Appendix A](#)) ideally in consultation with the social worker to consider impacts on the family including other children in the family.

The minutes of any pre-birth multi agency minutes, including strategy meeting, ICPC, Core group and Birth Protection Plan, if completed, should be provided for filing in the baby's neonatal notes.

5. Subsequent social care assessment whilst on the neonatal unit

The timescales for completion of social care assessments and meetings should not be delayed based on the assumption that the baby is 'in a place of safety'. The timescales for assessments, meetings including ICPC and Core Group should adhere to as agreed local safeguarding partnership procedures.

In most circumstances it is important that this assessment is not unnecessarily delayed as having a preterm baby is a stressful and difficult time for any parent and uncertainty about the plan regarding potential removal or accommodation at discharge is likely to compound this. It is also likely to impact on the parent(s) ability to bond / attach with the baby which would be a further vulnerability factor should they remain in their care. It is important that there is clear communication between social worker, parent(s) and neonatal staff to ensure that professionals can respond/support parent(s) in a safe and sensitive manner. It will be particularly important for professionals to be mindful that if the baby is extremely unwell, or not able to stay in a regional neonatal unit, the potential impact on the parents emotional and/or physically available to contribute to the social care assessment in these circumstances. Social care should be guided by the neonatal unit on this.

If a social worker assessment has not been completed as yet then there should be a clear plan made between CSC and the neonatal unit regarding what expectations are for completing this assessment. The social worker assessment must be conducted on an individual basis and in a child centred manner and should include the circumstances and needs of other children in the family led by the assessment framework.

If the baby is likely to be medically ready for discharge in under two weeks CSC should be asked to take more urgent action including scheduling emergency legal planning meeting if required.

6. Actions for Neonatal Staff

If it is agreed that neonatal staff are required to keep enhanced records of visiting and observations of parenting interaction with baby for the purposes of safeguarding this should be discussed with parents and social care. These records should then be documented in the safeguarding section of the baby's notes. Whilst relevant observations of parent(s) by the neonatal staff should be included in the social work assessment, it should be recognised that these are observations of the parenting capacity in a very artificial situation which is highly supported and supervised and likely highly stressful for parent(s).

It is important that the admission is considered as an opportunity to support parent(s) and as a possible “teachable moment” (def. a naturally occurring life transitions or health events thought to motivate individuals to spontaneously adopt risk-reducing health behaviours; the concept of “teachable moments” has a strong foundation in widely accepted conceptual models of behaviour). This may mean that over the period of the admission the neonatal staff may be able to support parent(s) to enact change which increases their capacity to support and keep their baby safe. It is important that both health and social care staff are careful to recognise that the neonatal unit environment is very artificial and highly supported and is not an appropriate environment to make assessments about parenting capacity once home. It is also important that professionals guard against applying a “rule of optimism” i.e. professionals working closely with families are more likely to be optimistic in their observations and think the best of families. Where it was likely had the baby been born at term CSC would have recommended removal or accommodation, a change in this decision because the parents have engaged with positive parenting within the protective environment of the neonatal unit should be taken with extreme caution. The addition of prematurity will only add to the vulnerability of the child, and therefore the requirements of the parents to safely care for them.

7. Where teams are working towards home as the most likely outcome

If the baby is likely to be discharged to the care of the parent(s) there should be a discharge planning meeting as soon as the baby is no longer requiring intensive or high dependency care, if this hasn't already happened, to allow time for appropriate planning, referral to other services or housing issues to be addressed as necessary. This meeting should include the members of the core group along with the neonatal home care team and a neonatal consultant. It should include a plan for the health visitor, and neonatal home team to meet with the parent/s in the planned discharge location to consider if the home environment is optimal for discharge. It should also agree estimates of the expectation regarding time to be spent with the baby each day and any episodes of residential parent led care required to support the parents to be able to provide safe care for their baby on discharge. This should form part of the plan to be signed by parent(s). If parents are not able to meet the requirements of the plan in the run up to discharge the social worker should be informed of this.

8. Where removal from parent/s is the most likely outcome

If the baby is unlikely to be discharged home to parent/s it is important that the social worker is clear with the family and team regarding this at the earliest opportunity. Research evidence confirms that removal of a baby from a parent causes high levels of emotional distress and grief reactions. Social workers and neonatal staff need to be in a position to recognise and acknowledge this and provide support to them if they are continuing to visit their baby on the neonatal unit. This is a challenge even if there is open and honest communication but if there is uncertainty around the plan this is highly likely to heighten the distress for the family. This also makes it more likely that there will be an escalation of distressed, abusive or aggressive behaviour from parent/s whilst on the unit which may put babies, other parents or staff at risk of harm.

For these reasons the legal planning arrangements should not be delayed. It should also take into account the time it will take for the carers who will be looking after the baby at discharge to be supported and trained to provide additional support such as nasogastric feeding, or management of home oxygen. Even very experienced foster carers who have looked after pre term babies should be expected to undertake the assessments required of the neonatal unit prior to discharge to ensure they are fully aware, and trained, to provide for the individual babies needs.

Appendix A

PATHWAY FOR SHARING OF SAFEGUARDING INFORMATION FOR MATERNITY & NEONATAL SERVICES

This outlines the process for maternity and neonatal services to follow when there are safeguarding concerns and the client and/or baby requires transfer to another maternity and/or neonatal service.

Maternity Units and Neonatal services planning to transfer a client and/or baby will ensure that:

- The decision to transfer clearly documents consideration of safeguarding concerns balanced with clinical need, particularly if the transfer is as a result of capacity challenges. These conversations are held by senior decision makers in both referring and receiving units. This should include consideration of whether the transfer is likely to place other children in the family at increased risk of harm, and what support may be needed to allow the family to maintain contact with their baby



- The EMNODN Safeguarding Notification Form ([Appendix B](#)) is completed
- Hard copy to go with the client and/or baby to the receiving unit (DO NOT include any sensitive information if going with the client). It may put someone at risk to send information e.g. domestic violence, then forward the form via secure email
- Hard copy is filed in the safeguarding section of the clients and/or baby referring unit notes
- Additionally electronic version to be sent to the referring and receiving Trusts secure safeguarding email addresses



- If unborn or born child is known to Children's Social Care referring unit to telephone social worker to advise regarding transfer. Out of hours the Emergency Duty Team of the Local Authority the child is under should be informed

Referring Trust's Nominated Safeguarding Team will ensure that:

NB: it is likely that this will take place on the next working day, so it is important that the clinical teams have direct contact out of hours.

- The file is reviewed and if the file is large, the situation is complex or there has been social care involvement a summary and/or a chronology is completed and forwarded to those caring for the client/baby



- If the case is currently open to social care ensure that the social worker, team manager and team contact details on the EMNODN Safeguarding Notification document are correct and that they have been informed about the transfer



- The records are transferred electronically, securely to the receiving Trusts secure safeguarding email with a read receipt

Receiving Trust Maternity Units and Neonatal services will ensure that:

- They review the EMNODN Safeguarding Notification Form and take any immediate action required
- They will contact the referring Trust on the number provided to receive a full safeguarding handover
- This information should be documented in the safeguarding section of the client and/or baby's notes along with the EMNODN Safeguarding Notification Form



- If unborn or born child is known to Children's Social Care the receiving unit should make contact with the social worker to discuss ongoing planning

Receiving Trust Nominated Safeguarding Team will ensure that:

- They review the EMNODN Safeguarding Notification Form and liaise with the clinical team to ensure that any immediate action required to safeguard has been taken, including informing CSC if appropriate



- Liaise with the receiving maternity and neonatal unit to ensure all information is shared



SAFEGUARDING NOTIFICATION FORM

Do not include details of the concerns if this is transferred with the client or baby

Is the safeguarding information all included on the Transfer Letter? Yes / No

Details of client and/or baby

Client Name DOB NHS Number

Baby Name DOB NHS Number

Does the Trust hold safeguarding information regarding this client/baby? Yes / No

If yes, please provide contact details of where to contact for full safeguarding handover

Are the family fully aware of these concerns? Yes / No

Are there immediate risks to the safety of client/baby/staff/other patients? For example, around visiting Yes / No

If yes, please provide details

Are there any immediate actions needed by the receiving team? Yes / No

If yes, please provide details

Is the case open to CSC?

Yes / No

If yes, please provide the details of social worker

Name

Local Authority Area

Telephone Number

Secure Email

Has the social worker been informed about the transfer?

Yes / No

Trust Secure Safeguarding Team
Email

Referring Unit

Receiving Unit

Safeguarding handover to be completed once client/baby received if not already done